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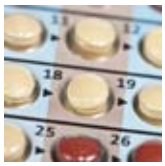

bmj.com
US gynaecologists endorse sale of birth control pill in drugstores

Deaths from elective surgery to repair AAA fall to new low in England

Zosia Kmietowicz BMJ

The death rate in England from elective surgery to repair abdominal aortic aneurysms fell to 1.6% (three deaths from 190 operations) in 2011-12, the first year during which most men who turned 65 were offered screening.[1] Before the screening programme was introduced in 2009 the death rate from elective repairs in the United Kingdom was 7.5%, the highest in Europe.

An audit published in February by the Vascular Society of Great Britain and Ireland found that in 2009-10 the death rate after elective surgery for abdominal aortic aneurysms was 2.4% (197 deaths among 8380 patients treated).[2]

The latest figures have come from the national abdominal aortic aneurysm screening programme, which now covers 80% of England. These show that 107 000 men were screened for the first time in 2011-12, 75% of those invited. Altogether, 1619 men were found to have aneurysms that were more than 3 cm in diameter, meaning that these needed to be monitored. Of those men with large aneurysms, 190 elected to have surgery, and three men died during or after the procedure. Most men are offered surgical repair when their aneurysm is more than 5.5 cm in diameter.

Eight men had a spontaneous rupture after screening and, of these, three died.

Research has shown that screening should reduce such deaths by up to 50% by detecting aneurysms early so that they can be repaired before they rupture. England was the first UK country to introduce screening, and programmes are under way in Scotland and Northern Ireland, while Wales is set to follow in 2013.

Ross Naylor, president of the Vascular Society of Great Britain and Ireland, said, "The UK can be justifiably proud of being one of only a few countries to have implemented a national aneurysm screening programme which has met every quality target regarding deliverability and low procedural risks. Only a few years ago Britain was named as having the highest mortality rates following elective aneurysm surgery. The 1.6% mortality rate highlighted in this report more than justifies the validity of adopting this approach."

Cite this as: *BMJ* 2012;345:e8066

Lord Howe (above) "could have been delivering a précis of our briefing notes," the document said

"Pause" in passage of bill saw heavy lobbying by private sector

Gareth Iacobucci BMJ

The close relations between private healthcare lobbyists and the prime minister's office during the "pause" in the passage of the Health and Social Care Bill last year is revealed by a document published this week.

David Worskett, director of the NHS Partners Network, which represents firms such as Care UK, Circle, and UnitedHealth, described the network's access to the prime minister's office in a briefing paper published by the Social Investigations blog (http://socialinvestigations.blogspot.co.uk). Health ministers had told him that they shared the network's views on the key issues, he said.

The two month "listening exercise," announced by Prime Minister David Cameron in April 2011, was launched in response to fierce criticism from the medical profession and opposition politicians of the plans to expand competition in the NHS in England.[1]

The briefing from Worskett, written in May 2011 during the pause, said, "Several members [of the NHS partners network] have used their own 'routes' to gain access to key players within No 10 and have been able to report back that the stance there is supportive, though there is low awareness of exactly what the independent sector does or could do."

Worskett added, "I did brief the new No 10 health policy adviser very fully, and indeed 'cleared' our materials with him. I have had several other 'stock-take' phone conversations with him. We are certainly on No 10's radar."

He said that Department of Health ministers and senior civil servants had given him "every signal possible that they understood and sympathised with our concerns and shared our view of the key issues and priorities."

Worskett said that the health minister Lord Howe had suggested that the government's position was that choice was "non-negotiable," adding: "He [Lord Howe] could have been delivering a précis of our briefing notes (which of course he had already seen)."

The document also shows how the group targeted individual members of the NHS Future Forum, the body set up to conduct the listening exercise, in response to the group's concern that the private sector could be blocked from expanding its reach if the forum's report to the prime minister had watered down the legislation.

A joint spokesman for Number 10 and the health department said, "It is nonsense to suggest that the NHS listening exercise was not genuine and robust. This government is committed to protecting an NHS that is universal and free at the point of use.

"Government ministers, officials, and the NHS Future Forum met with a large number of representatives from all areas of health and social care during the listening exercise."

Cite this as: *BMJ* 2012;345:e8111



The views of Charles Alessi (left) and Michael Dixon (centre) were rejected by Ian Dalton (right)

GPs' pleas for conflict of interests to be treated leniently are rejected by NHS board

Gareth Iacobucci BMJ

Potential conflicts of interest among GPs who are both providers and commissioners of healthcare services must be dealt with robustly for the new clinical commissioning groups (CCGs) to start off "on a good footing," the deputy chief executive of the NHS Commissioning Board has said.

Ian Dalton, who is also responsible for the board's Operations Directorate, said that although there was nothing improper about GPs holding dual roles, conflicts needed to be fully scrutinised and tackled to give "credibility" to clinical commissioners.

His comments, made during a panel debate at the NHS Alliance's conference in Bournemouth this week, came after leading GP advocates of clinical commissioning had called for a lighter touch approach to managing GPs' conflicts of interest, to ensure a proper flow of services out of hospitals into the community.

Michael Dixon, chairman of the NHS Alliance, who is also interim president of NHS Clinical Commissioners, the independent representative body for CCGs, and a GP in Devon, argued that most conflicts could be dealt with by GPs adopting the right "values" and "culture."

He said, "I think, historically, we've probably been overcautious in managing those conflicts, which is why there hasn't been an incentive that's been effective to move enough services from hospitals into general practice when they should have.

"I think it is going to demand a bit more leniency . . . on behalf of general practice and everyone else. We don't want to have masses of laws that people try and get around. You need a culture that recognises those conflicts, where they are totally transparent, and where they can accept they exist."

Dixon's view was shared by Charles Alessi, interim chairman of NHS Clinical Commissioners and a GP in southwest London, who urged the NHS Commissioning Board to look at the issue again. "We have overshot the mark in terms of assurance. It's very easy to say we must make sure the process is so completely and utterly pure that there is no chance at all of something adverse happening. But I think the balance . . . needs to be looked at again."

But Dalton said that it was the board's belief that a "rigorous" scrutiny was needed, given the responsibilities being afforded to the new commissioning bodies.

He said, "We shouldn't underestimate the importance of getting off on a good footing on this. This is about the credibility of the new system spending billions of pounds of public money. Now, by starting to ask CCGs how they would deal with the issue, we can be on the front foot."

He added, "It's absolutely a strength of English general practice that the providers are influencing the commissioning decisions. But we do need some systems around that.

Cite this as: *BMJ* 2012;345:e7967

Controversial mental health programme closes down after criticism

Jeanne Lenzer NEW YORK

A "model" programme that was part of a controversial plan to screen all US citizens for mental illness has announced that it is closing down.

On 15 November, TeenScreen, a programme to detect depression in young people, announced on its website: "The National Center will be winding down its program at the end of this year." TeenScreen was endorsed by the New Freedom Commission on Mental Health, which was established by the former US president George W Bush in 2002.[1]

The commission recommended that "consumers of all ages," including preschool children, should have comprehensive mental health screening. The commission said: "Each year, young children are expelled from preschools and childcare facilities for severely disruptive behaviors and emotional disorders."

Schools, wrote the commission, are in a "key position" to screen the 52 million students and six million adults who work at the schools.

The centre did not give a reason for the closure of its multimillion dollar project, nor did anyone from TeenScreen respond to inquiries by the *BMJ*.

Critics of the programme said that the test had not been proved to reduce suicides and that an analysis by its inventor, David Shaffer, showed that the computer based screening test had a positive predictive value of only 16%.[2] Shaffer is chief of the division of Child and Adolescent Psychiatry at Columbia University Medical Center.

They also cited a finding from the US Food and Drug Administration that depressed adolescents treated with antidepressants were twice as likely to be suicidal as depressed adolescents treated with placebo.[3]

Cite this as: *BMJ* 2012;345:e8100

Regulator tells trust to appoint expert to tackle deficiencies

Gareth Iacobucci BMJ

One of the country's leading teaching hospitals has been found to be in "significant breach" of its terms of authorisation by the regulator of NHS foundation trusts, Monitor.

Cambridge University Hospitals NHS Foundation Trust, which incorporates Addenbrooke's Hospital, has been served with regulatory action because of its "successive failure" to meet NHS targets, including those on waiting times for cancer treatment and emergency department performance.

Monitor said that the concerns were compounded by numerous instances of "preventable patient safety incidents" and "poor financial performance."

Four so called "never events" were reported between 7 September and 7 October 2011, one relating to surgery done on the wrong person, one relating to surgery on the wrong part of the body, and two relating to instruments left inside patients.

For the third consecutive quarter (the first of 2012-13) the trust missed its target for 85% of patients urgently referred by a GP for suspected cancer

JULIAN EALES/ALAMY

Cambridge University Hospitals Trust was served with action for its "successive failure" to meet targets

Countries that use large amounts of high fructose corn syrup have higher rates of type 2 diabetes

Zosia Kmietowicz LONDON

Countries that use high fructose corn syrup (HFCS) in their food supply have a significantly higher prevalence of type 2 diabetes than countries that do not use the sweetener, an analysis has found.

The research, published in *Global Public Health*, looked at average body mass index, diabetes prevalence, sugar intake, and HFCS intake in 42 countries around the world.[1] The information came from a variety of sources, including the International Diabetes Federation and the UN Food and Agricultural Organization.

It found that of the 42 countries studied the United States had the highest per capita consumption of HFCS at a rate of 25 kg (55 lb) a year. Second was Hungary, with an annual consumption of 16 kg per person. Canada, Slovakia, Bulgaria, and Belgium, were also relatively high consumers of HFCS.

Countries with per capita consumption of less than 0.5 kg a year included Australia, China, Denmark, France, India, Ireland, Italy, Sweden, the United Kingdom, and Uruguay. Altogether 14 countries, including India, Ireland, Sweden, Denmark, and Austria, consumed no HFCS.

The analysis found that countries with high use of HFCS had an average prevalence of type 2 diabetes of 8%, whereas in countries that didn't use HFCS prevalence was 6.7% (P=0.03). High consumption countries also had a higher average fasting plasma glucose concentration (5.34 versus 5.22 mmol/L (P=0.03)). The results were independent of total sugar intake and prevalence of obesity.

The lead author, Michael Goran, professor of preventive medicine and co-director of the Diabetes and Obesity Research Institute at the University of Southern California, said, "The study adds to a growing body of scientific literature that indicates HFCS consumption may result in negative health consequences distinct from and more deleterious than natural sugar."

Commenting on the research, Tim Lobstein, director of policy for the International Association for the Study of Obesity, said, "If HFCS is a risk factor for diabetes—one of the world's most serious chronic diseases—then we need to rewrite national dietary guidelines and review agriculture trade policies. HFCS will join trans fats and salt as ingredients to avoid, and foods should carry warning labels."

The article suggests that the link with diabetes is driven by higher amounts of fructose in foods and beverages made with HFCS. Fructose and glucose are both found in ordinary sugar (sucrose) in equal amounts, but previous work by the researchers found that drinks made with HFCS have 30% more fructose than if they were made with sucrose.

Evidence is growing that the body metabolises fructose differently from glucose: independently of insulin and primarily in the liver, where it is converted to fat. This may be contributing to the rise in the prevalence of non-alcoholic fatty liver disease, a condition that is increasing among Hispanic people in the US and Mexico.

In terms of the effect on risk of diabetes, Goran told the *BMJ*, "Liver fat contributes to greater insulin resistance. And this pathway [of metabolism] produces uric acid and other by-products which affect metabolism in negative ways, [such as] cellular ATP depletion, which can cause oxidative stress and cellular damage."

Currently the European Union sets quotas on HFCS. Although some countries, such as Sweden and the UK, do not take their allotted amounts, others, such as Hungary and Slovakia, purchase extra quotas from countries that do not accept them.

The authors concluded, "Trade and agricultural policies aimed at sugar and especially HFCS supply should be considered as a means to tackle the increasing global prevalence of diabetes."

Cite this as: *BMJ* 2012;345:e7994

Of 42 countries, the US had the highest consumption of HFCS, at a rate of 25 kg per person per year

to be seen within 62 days, achieving only 78.1%. This meant that it had breached this target in seven of the eight quarters to that point.

In the same quarter it missed the target for 90% of patients to be treated within 18 weeks of their initial referral for the second time in a row, achieving 85.9%.

The trust also missed its target to see 95% of emergency department patients within a four hour time limit for two quarters in a row, achieving 92.5% in the first quarter of 2012-13.

As a result, Monitor has instructed the trust to commission a board governance and effectiveness review and to appoint an "experienced turnaround expert" at board level to deal with the deficiencies.

The regulator, which will set the scope and timescale of the review, pledged to keep the trust under close scrutiny, and the board is required to provide a monthly update report on its performance.

Monitor said that it may decide to use its regulatory powers and take further action if improvements have not been seen in the agreed timescales.

Stephen Hay, managing director of provider regulation at Monitor, said, "This is not the first time we have called the trust in to explain itself. We are disappointed that the board has not resolved these issues.

"We note the trust has a new chair and will shortly appoint a new chief executive. We expect them to demonstrate they are getting the trust back on track as quickly as possible."

Jane Ramsey, the chairwoman of Cambridge University Hospitals, said, "We take Monitor's concerns very seriously, and we are determined to reverse the situation as soon as possible. My top priority, as the new chairman, will be to get to grips with these performance issues with my team."

Cite this as: *BMJ* 2012;345:e8048

IN BRIEF

MMR coverage in England is at highest in 14 years: More than nine in 10 children (91.2%) in England in 2011-12 had received their first dose of vaccine against measles, mumps, and rubella by their second birthday, the highest recorded coverage since 1997-8, when the figure was 90.8%. The lowest was in 2003-4, when it was 79.9%, says the report from the Health and Social Care Information Centre.[1] The World Health Organization target is that at least 95% of children be vaccinated.

Novel coronavirus claims second death: A second person has died from a novel coronavirus, WHO has said. Altogether six cases of infection have been reported, four (including the two deaths) from Saudi Arabia and two from Qatar. Coronaviruses include the common cold and the severe acute respiratory syndrome virus. Doctors do not think that the virus spreads readily from person to person.

Second inquiry announced into death related to miscarriage in Ireland: The Irish public health watchdog has announced that it will investigate the death of Savita Halappanavar, who had a miscarriage and died on 28 October from septicaemia after being refused an abortion.[2] The Irish Republic's health service is already conducting an inquiry, which is now described as a clinical review. The Health Information Quality Authority, an independent health safety body, will conduct a parallel inquiry.

Spain plans to double number of bone marrow donors: The Spanish national plan for bone marrow donation, released on 21 November, aims to double the number of registered donors from 100 000 to 200 000 people over the next four years. The plan aims to reduce the need to import marrow when a compatible donor is not found in the country, which costs €14 000 (£11 300) each time.

Grapefruit-drug interactions are markedly increasing: More than 85 drugs have the potential to interact with grapefruit and cause harm, a study has found.[3] Of these drugs, 43 have interactions that can result in serious adverse effects, up from 17 in 2008. The increase in adverse effects, which include torsade de pointes, rhabdomyolysis, myelotoxicity, respiratory depression, gastrointestinal bleeding, nephrotoxicity, and death, is a result of new chemical entities and formulations.

Cite this as: *BMJ* 2012;345:e8083

Cochrane group rejects Roche's offer to discuss analysis of oseltamivir data

Zosia Kmietowicz BMJ

Cochrane Collaboration researchers have repeated their plea to the drug giant Roche for the company to honour its promise made in 2009 to make public its full clinical study reports on oseltamivir (Tamiflu).

They were responding to an offer by Roche to set up a multiparty advisory board to review what type of analysis of data on oseltamivir would be useful to researchers who are trying to establish the drug's effectiveness.

Although they read the offer "with great interest," the researchers added, "On 8 December 2009, you promised in the *BMJ* to make 'full study reports' available 'within the coming days to physicians and scientists undertaking legitimate analyses.' . . . We have requested these data numerous times and have yet to receive a single full study report from Roche. We are still waiting for Roche to honor its promise."

Christopher Del Mar (left) and Tom Jefferson: debate is not an option while Roche holds onto data

The Cochrane group said that the data were essential for them to assess properly the effectiveness and safety of oseltamivir.

The researchers objected to Roche's suggestion that there was a debate concerning the data on the drug. "There is no debate nor can there be any debate about the data whilst you do not honor your promise," they wrote. "The only reason we keep asking Roche to keep its promise, rather than simply getting the data from the European Medicines Agency directly, is because Roche has not supplied all of the data to the European regulator."

The *BMJ* has also been pressing Roche to release all clinical trials involving oseltamivir as part of its open data campaign (bmj.com/tamiflu).

In a letter to Christopher Del Mar in his capacity as coordinating editor of the Cochrane Acute Respiratory Infections Group, Don MacLean, lifecycle leader on oseltamivir at Roche, said that the advisory board would be made

Europe's drug agency will publish all clinical trial data from 2014

Ingrid Torjesen LONDON

The European Medicines Agency has committed itself to publishing full clinical trial data submitted by companies for a clinical product once it has recommended granting marketing authorisation for that product.

The commitment will apply only to products that complete the marketing authorisation process from a set date, expected to be 1 January 2014. It will not apply to products granted marketing authorisation before this date.

This means that the agency will not have to make data available on cases of sudden death after a first dose of the multiple sclerosis drug fingolimod or safety data on two weight loss products, for which it has declined requests from researchers for access.[1 2]

A spokeswoman for the agency said, "The policy will be forward looking. It will apply to clinical data submitted for new medicines. For other clinical data, the current agency approach relating to reactive disclosure as part of the access to document policy remains unchanged."

The agency has been releasing clinical trial reports on request since October 2010; and so far, it claimed, more than 1.5 million pages have been released in this way in response to safety requests. However, requests for some key data have been turned down.

The announcement on proactive disclosure was made by Guido Rasi, its executive director, at a workshop in London on 22 November.

He said, "The European Medicines Agency is committed to proactive publication of clinical trial data, once the marketing authorisation process has ended. We are not here to decide if we publish clinical trial data but how."

The agency said it would establish five advisory groups involving stakeholders early next year to look in detail at protecting patients' confidentiality; clinical trial data formats; rules of engagement; good analysis practice; and legal aspects. The groups would report in April 2013 with policy recommendations on how best to implement proactive publication.

Cite this as: *BMJ* 2012;345:e8061

BMJ podcast: http://bit.ly/TiSvyl

up of "experts from academia and private institutions, including the Cochrane Collaboration, to review the totality of Tamiflu data with the objective to agree on a statistical analysis plan outlining the types of analyses that would be useful in a public health discussion on Tamiflu. Once an analysis plan has been agreed the board would decide how best to execute the work."

He added, "We believe this proposal is a sensible, fair and transparent way of addressing this public debate and look forward to your consideration of this proposal."

However, the Cochrane group said that the analytical methods it used in its reviews had been published and that it was "unaware of any objection, let alone comments, by Roche regarding our study methods."

It added, "Your letter mentions 'disagreements on the type of analyses you wish to do.' Our methods and analyses follow Cochrane procedure but extra effort was needed to identify and locate your unpublished trials. Given the same methods and analyses have now been applied to over 5000 reviews in the Cochrane Library, what are your disagreements? As you know, all Cochrane protocols and reviews undergo pre and post publication peer review. We would like to be apprised of any specific concerns that Roche may have."

Cite this as: *BMJ* 2012;345:e8072

UK must improve its recruitment rate in clinical trials, report says

Nigel Hawkes LONDON

Clinical trials in the United Kingdom cost significantly more than in other European countries, largely because of the need for lengthy negotiations with NHS organisations and poor rates of recruitment, concludes a report produced for the drug company Novartis.[1]

The number of trial applications in the UK has been falling and could fall further, it warns, unless the system is made more efficient and a "cultural shift" takes place in the NHS.

The report, by Europe Economics, a consultancy that specialises in the application of economics to public policy, says that the average cost of a trial per patient in the UK is now €9758 (£7890; $12 650), higher than in Spain (€7310), Germany (€7232), Italy (€5810), and Poland (€5679). Because of its decentralised system for recruiting patients, the UK does particularly poorly in recruitment, with just 55% of trials reaching a target rate of 90%. Spain and Poland perform much better, with 100% of Spanish trials reaching the target.

Cite this as: *BMJ* 2012;345:e8104

CC STUDIO/SPL

Earlier detection and better management of kidney injury could save 12 000 lives a year

Hospitals told to produce fluid therapy guidelines to reduce acute kidney injury

Bryan Christie EDINBURGH

Every hospital in the United Kingdom is being urged to produce fluid therapy guidelines in an attempt to improve the care of acute kidney injury and potentially save thousands of lives a year.

A consensus conference organised by the Royal College of Physicians of Edinburgh also supports the use of electronic alerts to warn clinicians of a patient's deteriorating condition and calls for better training and education for clinical teams.

Acute kidney injury is a common condition that affects around a fifth of hospital patients in the UK and is associated with poor outcomes. Death rates from the condition have not fallen in the past 40 years, and a National Confidential Enquiry into Patient Outcomes and Deaths report in 2009 found that the standard of care was inadequate in 50% of cases of patients with the injury who died.[1]

Healthcare professionals who aren't kidney specialists are often involved in administering fluids and adjusting treatments in the early stages of acute kidney injury, care that can be critical in reducing the severity of the condition.

The consensus statement says that the financial costs of treating acute kidney injury are greater than those of treating prostate, lung, and bowel cancer combined and that up to 30% of cases can be avoided through earlier detection and better management.[2] This could save up to 12 000 lives a year.

It makes a series of recommendations:

- Doing the basics well, such as improving training and education, agreeing referral criteria for specialist input, and developing and implementing scoring systems that better define patients at risk of acute kidney injury
- Developing a system of e-alerts, which, it says, have a valuable role in primary and secondary care, and establishing a national group to develop agreed standards on e-alerts while recognising the need for some local flexibility, and
- Ensuring that hospitals have adequate systems and staffing to ensure good continuity of high quality care, including appropriate referral to senior medical staff for assessment of complex cases.

The conference considered the work being done on developing novel markers of early kidney disease but concluded that it was premature to recommend their use in current clinical practice.

The two day conference was organised with the support of NHS Kidney Care and was attended by more than 100 healthcare professionals, including kidney specialists from around the UK.

Mike Jones, vice president of the Royal College of Physicians of Edinburgh and the event's lead organiser, said that it was essential for the NHS to recognise that urgent action was needed to reduce the burden of death and disability from acute kidney injury. "Central to this is the need for early identification and treatment, which could improve patient outcomes immeasurably," he said.

"In addition to improving the care for patients, there is tremendous potential to benefit the NHS, as it has been estimated that the savings derived through early identification and treatment of AKI could pay for another 2-3 nurses in every hospital throughout the country."

Competing interests: BC was a member of the consensus panel that drew up the statement.

Cite this as: *BMJ* 2012;345:e7946

Members of the citizens' jury preferred the term "overtreatment" to that of "overdiagnosis," as it was easier to understand

"Citizens' jury" disagrees over whether screening leaflet should put reassurance before accuracy

Nigel Hawkes LONDON

A "citizens' jury" of 25 women, assembled this week to provide advice for the drafting of a new leaflet on breast cancer screening, has reached consensus on some of the tricky issues.

The leaflet is being rewritten after criticism that it conveyed a falsely optimistic message and in the light of the Marmot review of breast cancer screening, which found that women invited to mammographic screening were three times as likely to be "overdiagnosed" as they were to have their lives saved.[1]

The jury did not draft a new leaflet or the covering invitation letter that will accompany it but did consider some of the central issues to be considered by those who will draft them. For example, the jury preferred the term "overtreatment" to "overdiagnosis" by a majority of 21 to four, on the grounds that it was easier to understand, and also preferred expressing benefits in terms of lives saved rather than deaths avoided, though by a smaller majority.

One juror said that lives saved set a more upbeat message than deaths avoided. Put to the vote, 13 women favoured lives saved and three preferred deaths avoided, while eight believed that both terms should be used—and one neither.

The women, who had listened to two days of presentations about breast cancer and the screening programme, were broadly content with the terms benefits and risks, preferring them to alternatives such as pros and cons, but a substantial minority (seven) preferred "disadvantages" to "risks."

Benefits and risks should both be measured by reference to the number of women actually screened, not the number invited to screening, the women said, and a clear majority favoured using the same denominator throughout the leaflet to express these benefits and risks. What that denominator should be was not so important to them as ensuring that it was used consistently, but the jury seemed to lean to 250 as the favoured number. Percentages were not favoured.

Defining what was meant by overdiagnosis, even if the term itself was not to be used, produced a consensus on the sentence, "Screening detects many cancers that may never have become a problem in the patient's lifetime."

There was agreement, though the question was not put to a vote, that the leaflet should begin by citing the numbers of lives saved by breast cancer screening, 1300 a year according to the Marmot review, followed by the caveat that a small number of women would suffer overtreatment after their diagnosis.

But which matters most, to reassure or to be accurate? The majority (15) wanted the leaflet to do both, while three opted for reassurance as the first priority and seven for accuracy. The drafters, led by Amanda Ramirez of King's Health Partners, may not have found this advice quite so helpful. Joanne Rule, the former chief executive of the charity Cancerbackup, who chaired the discussions, acknowledged that on this point the jury did not reach consensus.

There was a similar division over how to list the benefits and harms. Should they be expressed together in the same sentence or separately? Four jurors voted for the first option, eight for the second, but 12 voted for firstly expressing the benefits and harms separately and then together. (One juror did not vote on this occasion.) The jury was, however, almost unanimous in its view that it was necessary to make it clear that there was uncertainty about both benefits and risks.

The women who made up the jury, volunteers recruited on the street or outside community centres by the Office for Public Management, spent two days listening to a series of witnesses.[2]

Cite this as: *BMJ* 2012;345:e8047

NHS is doing well, but financial squeeze poses serious risks, King's Fund says

Nigel Hawkes LONDON

Halfway through the term of the coalition government the NHS continues to perform well, a report from the healthcare think tank the King's Fund has found.[1] Substantial productivity gains have been made (£4.3bn in 2010-11 and £5.8bn in 2011-12), without waiting lists growing longer or patients' experience of care getting worse.

The incidence of healthcare acquired infections has continued to fall, with that of meticillin resistant *Staphylococcus aureus* falling by 42% and *Clostridium difficile* by 55% between May 2010, when the government took office, and September 2012.

Good progress has been made on the commitment to eliminate mixed sex wards, with the number of breaches falling by 96% in 16 months. And by the end of February 2012 around 12 500 patients had been given anticancer drugs that they would not otherwise have had, through the cancer drugs fund set up in 2011.[2]

In the week in which the prime minister was due to announce a consultation on minimum prices for alcohol, the King's Fund reminded us that alcohol consumption has stabilised and started to fall. The proportion of men exceeding the recommended number of units fell from 31% in 2006 to 26% in 2010.

Despite these encouraging findings, the fund strikes a downbeat note, pointing out that waiting times in emergency departments have risen since the end of 2009, that 15 foundation trusts finished 2011-12 in deficit, and that there have been rises in the number of emergency admissions of people with long term conditions.

Anna Dixon, director of policy at the King's Fund, said, "The NHS is continuing to perform well, but there are treacherous waters ahead. There are huge risks, especially in ensuring that quality of care does not suffer with the further financial squeeze."

Cite this as: *BMJ* 2012;345:e8106