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Government's initial response to Mid Staffordshire report

Something old, something new, something borrowed, some things worryingly missing

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The message that Robert Francis took from his two inquiries into the events at Mid Staffordshire was that patients should become “the first and foremost consideration of the system and everyone who works in it.”^{1 2} In its initial response, the government has accepted most of his 290 recommendations, “either in principle or in their entirety.”^{3 4} More detail is promised for later, but *Patients First and Foremost* sets out the government's key early priorities.

Some of the government's responses—such as a wholesale rethink of nursing recruitment and training—map closely on to Francis's recommendations. But others are completely new, surprisingly, given that there are so many well thought out recommendations to choose from. Several are lifted directly from the inspection regime of English schools—the most headline grabbing one being a chief inspector responsible for issuing ratings. The Care Quality Commission will appoint the chief inspector, who “will become the nation's whistleblower—naming poor care without fear or favour from politicians, institutional vested interests, or through loyalty to the system rather than the patients that it serves.”

Because the evaluations will depend heavily on inspections by the commission, which has its own chief executive, it's hard to discern the justification for this new role. Any potential applicants relishing the prospect of telling truth to power could usefully study the histories of two chief inspectors of prisons, Stephen Tumim and David Ramsbotham, who did just that.

The second direct lift from the educational sector will be “a single, clear rating” for hospitals, which could be “outstanding,” “good,” “requiring improvement,” or “poor.” The aspiration is to provide “a single version of the truth.” This is despite the NHS's previous experiences with rating hospitals.⁵

The collection and dissemination of useful data is one of the main themes of the government's response, as it was of Francis's public inquiry. It's not yet entirely clear who will be collecting what, but the commitment to make public as much of

it as possible is commendable. A one third reduction of “paperwork, box ticking, and duplicatory regulation and information burdens,” is promised, with the Health and Social Care Information Centre becoming the single national hub for collecting information.

But just as the bonfire of “redundant” data returns is lit, new requirements for data collection are springing up in their place. Because the publication of individual outcomes has been “hugely successful” in driving up standards in heart surgery, the NHS Commissioning Board will now extend this openness on outcomes to other surgical specialties. In addition, responses will be collected routinely on whether patients and staff would recommend their hospital, and these data will form an important component of the chief inspector's composite rating.

Taking the NHS shilling

Several of Francis's recommendations imply that all providers of services to NHS patients (not only NHS providers) should be held to identical standards, including the requirements for data collection and sharing. This seems wise, given the recent unhappy history of the regulatory leeway given to independent sector treatment centres, foundation trusts, and private suppliers of services to NHS patients. Taking the NHS shilling should entail the same contractual obligations and regulatory burdens for all, so it's disconcerting to discover that “outstanding hospitals will be given freedom from regulatory bureaucracy.”

Francis was struck by how few healthcare workers spoke out about the abuses that were so clearly on display. The government makes the right noises about duties of candour and protection for those who raise concerns about patient care, but the topic warrants the “full and collective consideration” that the government has promised for Francis's knottier problems. In a recent editorial, Brian Jarman provided some of the context for doctors' reticence in coming forward with concerns, relating it to the ascendancy of management over the past 30 years.⁶ Yet the “official” advice is unequivocal. The General Medical Council directs doctors to act on concerns about patient safety and to refuse to sign contracts that attempt to

prevent them from doing so. The NHS Constitution Handbook contains detailed advice on whistleblowing, including how to escalate a concern.

Underlining this, the secretary of state for health has recently written to trusts reminding them that their whistleblowing policies must comply with the Public Information Disclosure Act. Guidance will be updated to make clear that any compromise agreements must include an explicit statement that “nothing within the agreement prevents the parties from making a protected disclosure in the public interest.” However, all these fine words are scattered around in different places. The government, along with healthcare workers' regulatory bodies, unions, and employers, needs to agree a description of rights and obligations that appears in the one place that really matters: the contract of every healthcare worker.

The proximate cause of the problems at Mid Staffs was the reduction of an already depleted nursing establishment to build up a financial war chest in preparation for its application for foundation trust status. In its response, the government accepts that the pursuit of foundation status became a distraction from the quality of care. And a solemn statement of common purpose intones that “Blind adherence to targets or finance must never again be allowed to come before the quality of care.” So it's odd that the government has ducked Francis's suggestion for the single measure that might have nipped these problems in the bud: mandatory minimum staffing levels and skill mix. The government has lamely responded that these could reduce flexibility or lead to organisations aiming for the minimum. But in an accompanying editorial, Allyson Pollock and David Price argue that there is more to this than meets the eye.⁷

Will Francis's report suffer the usual fate of the English public inquiry, with the government doing what it was intending to do anyway, while politely ignoring the recommendations that don't fit? Because this is only the government's initial response it's too early to say.

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● FEATURE, p 18



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Articles on cardiovascular health are at bmj.com/specialties/cardiovascular-medicine

Reducing sodium and increasing potassium intake

More evidence of the benefits of these interventions should prompt robust public health efforts

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Hypertension and its associated cardiovascular and renal complications is a global health problem that imposes a heavy burden in terms of individual disability and financial costs to individuals and communities. Prevention and treatment of hypertension therefore is a major challenge to health institutions. The recommendation to reduce dietary sodium intake has been incorporated into guidelines for preventing and treating hypertension for decades, yet it is widely ignored even by patients with hypertension. In addition, despite the robust evidence that underlies a reduction in sodium intake, its implementation at the population level remains the object of recurrent criticism, with counterarguments often based on confounded study results or analyses that lack statistical power.¹

Two linked research papers that focus on the effects of reduced sodium intake on blood pressure and related health problems are timely and may help dissipate the public's doubts about the value of reducing sodium intake.²⁻³ Another linked paper examines the health effects of higher potassium intake in adults and children and adds to earlier findings of an inverse association between potassium intake, as well as fruit and vegetable consumption, and blood pressure.⁴⁻⁵ Of note, the Department of Nutrition for Health and Development of the World Health Organization was directly involved in two of the three articles, and the results were used in the compilation of the recently updated WHO guidelines on sodium and potassium intake at population level.⁶⁻⁷

All three linked papers are systematic reviews and were conducted according to Cochrane Collaboration recommended methods. All report the results of updated meta-analyses of the findings of relevant studies conducted in healthy people (studies that recruited patients with major illnesses or diabetes were excluded). The authors mainly considered the results of randomised controlled trials of dietary interventions, but cohort studies were also included when information from such trials was unavailable or inconclusive.

The analysis by Aburto and colleagues and that by He and colleagues provide high quality

evidence that moderately reduced sodium intake significantly reduces blood pressure in both hypertensive and normotensive adults, independent of sex. Meta-regression and subgroup analyses in both studies suggest a dose-effect relation between reduced sodium intake and blood pressure—the larger the reduction in salt intake the greater the effect on blood pressure down to salt intake of less than 3 g per day. The estimated falls of 10.8 mm Hg and 4.3 mm Hg in systolic blood pressure associated with a 6 g per day reduction in salt intake in hypertensive and normotensive adults, respectively, are impressive. Accordingly, such a dietary modification would be expected to greatly reduce the incidence of stroke and other cardiovascular events if extended to the whole population. A significant, albeit small, decrease in systolic blood pressure was also seen in an analysis of the findings of trials of reduced salt intake in children.

Reductions in salt intake of the size reported in the current studies were not associated with clinically important changes in blood lipids or a decline in renal function or sympathetic activation, and they led to only minor stimulation of the renin-angiotensin-aldosterone system. These results highlight that the significant changes in neuroendocrine and metabolic factors reported in previous studies occur only with brisk, short term, and extreme reductions in salt intake that are well beyond the range of guideline recommendations.⁸

Aburto and colleagues' analysis of the relation between sodium intake and major cardiovascular outcomes confirms the strong direct association between habitual sodium intake and the incidence of stroke reported by a previous meta-analysis,⁹ after incorporating a few recently published studies. Moreover, it provides new evidence of a significant direct association between higher sodium intake and the incidence of fatal stroke and fatal coronary events. This evidence comes from cohort studies because of the lack of trials. Nevertheless, it is strongly supported by the robust evidence of the effect of reducing sodium intake on blood pressure—in almost all trials conducted so far, even modest differences in blood pressure were associated with substantial differences in the rate of stroke.

Aburto and colleagues' second study provides high quality evidence of the beneficial effect of increasing potassium intake on blood pressure in people with hypertension, again with no evidence of untoward metabolic, neuroendocrine, or renal effects in adults free of major illnesses. It also confirms the recently reported inverse association of potassium intake with the risk of stroke,¹⁰ a conclusion based on cohort studies.

In most countries, most people—even those with hypertension—consume much more sodium and less potassium than is recommended. The current results should prompt doctors and public health professionals to

maximise efforts to increase patients' awareness and motivation regarding the benefits of reducing salt intake (ideally to less than 3 g per day) and of increasing the consumption of potassium-rich foods. To increase the chances that these

Negotiations with the food industry for the reformulation of most processed foods should be undertaken as a matter of urgency

efforts are successful, national strategies to support reduced salt intake at the population level are crucial and negotiations with the food industry for the reformulation of most processed foods should be undertaken as a matter of urgency.¹¹

In addition, the well known excess salt intake in children deserves greater attention and more intensive intervention.¹² Because the effects of reduced sodium intake on blood pressure become progressively greater with advancing age, as shown in Aburto and colleagues' and He and colleagues' meta-analyses, policy makers may overlook the progressive, yet difficult to detect, vascular damage prematurely caused by excess salt intake in young people. Thus, research should be aimed at identifying more sensitive indicators of the harmful effects of high sodium intake in children and adolescents.

Competing interests: PS is an unpaid member of World Action on Salt and Health (WASH), coordinator of the Interdisciplinary Working Group for Reduction of Salt Intake in Italy (GIRCSI), a member of the SINU/INRAN committee for the preparation of the Italian dietary reference intakes, and a former member and treasurer of the executive committee of the Italian Society of Hypertension.

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Should the QOF be a mechanism for incentivising the practice of evidence based medicine in a few key areas, or should it also be a mechanism for steering general practice to help deliver the wider goals of health policy?

Future proofing the Quality and Outcomes Framework

Depends on making it fit for purpose in the era of multimorbidity and cost savings

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As the Quality and Outcomes Framework (QOF) approaches its 10th birthday, radical changes in its content and construction see a parting of the ways between the countries within the United Kingdom. The National Institute for Health and Clinical Excellence and the Department of Health have proposed such changes as dropping the organisational domain; creating a public health domain; raising payment thresholds; introducing directed enhanced services for dementia case finding; ensuring access to online general practice services and telehealth; and case managing patients at risk of hospital admission.¹

Concerns about these proposals mean they have not been universally accepted across the UK's four countries.^{2,3} Practices in England face tougher achievement thresholds and risk losing a sizable proportion of QOF funding if they opt out of directed enhanced services.

In a linked Analysis article, Gillam and Steel wonder about where we are going to next with QOF?⁴ Whether the framework has had a positive impact is unclear. It has modestly improved the quality of care for chronic conditions, improved systems for providing care, and reduced inequalities.⁵ However, the framework contributes to polypharmacy and has arguably made care more technocratic and less patient centred. Furthermore, non-incentivised aspects of care have not improved much, and evidence on health gain and cost effectiveness is mixed. It does not provide a ringing endorsement of the framework, and—given the £1bn (€1.17bn; \$1.5bn) opportunity costs of the scheme—unsurprisingly the government wants to extract more “bangs” for its “buck.” But are the current proposals for the evolution of the framework appropriate?

The wider context is relevant to this debate. Growing demand for healthcare and unprecedented financial pressures make it imperative that the NHS adapts its ways of working to contain demand and deliver more for less without compromising quality. It seems clear that the Department of Health's view is that primary care has to share the pain and deliver more.

Government priorities for the reorganised

English NHS, outlined in the Outcomes Frameworks for the NHS, public health, and social care, include reducing avoidable hospital admissions and premature mortality; for this second outcome, the UK has again recently been shown to compare unfavourably with other countries.⁶ Clinical commissioning groups have a statutory duty to improve the quality of primary care and reduce inequalities, and they are accountable to the NHS Commissioning Board for improving these outcomes, which depend in part on the contribution of primary care. Under a government mandate, the NHS is charged with achieving demonstrable improvements in health. Irrespective of any changes to QOF, general practice will be under pressure to tackle prevention, early intervention, and management of chronic disease and disability.

The direction of travel for prevention in general practice is clear from the decision to transfer 15% of QOF points to the public health domain and engage Public Health England in deciding future QOF priorities. GPs may be required to “make every contact count” under proposed changes to the NHS constitution. This chimes with the Royal College of Physicians' recommendation that GPs be incentivised to manage obesity more effectively.

Almost a quarter of people registered with a GP practice have two or more concurrent chronic diseases, and the absolute number of people with multimorbidities is higher in those under, rather than over, 65 years.⁷ Because QOF is primarily single disease specific, it does not deal with the needs of patients with multimorbidity and can lead to inappropriate and inefficient treatment.⁸ Yet general practice will increasingly be expected to work with clinical commissioning groups and local agencies to improve chronic disease management, reduce use of secondary care, and coordinate care across interfaces.

What should the future role of QOF be? Should it be a mechanism for incentivising the practice of evidence based medicine in a few key areas, or should it also be a mechanism for steering general practice to help deliver the wider goals of health policy? Inevitably there will be some overlap between these goals. General practice must evolve and play its part in tackling the epidemiological and financial challenges of modern times.⁹ Unsurprisingly, QOF is seen as a lever given its cost, but it may not be the ideal mechanism for delivering

some of the systemic changes that are needed, including those that require working beyond practice boundaries.

There are undoubtedly risks in making the framework an all purpose hybrid that dilutes evidence based practice to accommodate wider managerial goals. In this case, we need to consider redirecting QOF funds to other ways of supporting developments in general practice.⁴ The Department of Health also needs to ensure that the different performance assessment (including revalidation), management, quality improvement, payment, and incentive frameworks for general practice are aligned and complement each other. QOF is but one element—albeit a crucial one—in a wider landscape.

Over the past decade, QOF has helped drive UK general practice in an evidence based direction. Other countries are also reorienting their primary healthcare systems to deal with the challenges of multimorbidity and cost containment, including through new delivery models, although approaches vary.^{10 11}

Financial incentives for quality improvement in primary care are used in Australia (including the Indigenous Health Incentive for Aboriginal patients) and some European countries, although none matches the scale of QOF.^{12 13} Some systems also offer incentives for coordinating care. Other payment models are also emerging, such as the “patient centred medical home” in the United States, which rewards practices that meet criteria associated with access, outcomes, and care coordination. In contrast, Israel's strong primary care sector is supported by a robust QOF-like quality monitoring and feedback system that is not incentivised, but which has enabled the four national health plans to improve quality and health outcomes, and to reduce use of secondary care services.¹⁴

As the NHS reorganisation takes effect, giving GPs centre stage as commissioners, it is timely to consider how QOF, along with other levers, can be redesigned to support general practice in improving population health, health outcomes, and care and coordination for people with multimorbidities.

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The current findings add powerful evidence that a reduction in overweight and obesity would have major population-wide benefits. To achieve this is perhaps the major public health and societal challenge of the century

Weight changes and health in Cuba

Learning from hardship

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Changes in food supplies and reductions in physical activity are fueling increases in overweight and obesity, diabetes, and cardiovascular disease worldwide.¹ We have had few opportunities to see a reversal of this process, which is continuing inexorably almost everywhere. One such opportunity was provided by the well developed public health surveillance systems in Cuba, which were maintained during a period of serious economic hardship in the early 1990s. In a linked study, Franco and colleagues used these systems to look at the effects of reduced energy intake and increased physical activity on body weight and the occurrence of diabetes, cardiovascular disease, cancer, and death.²

In Cuba, decreased food availability and increased physical activity, supported by the distribution of more than a million bicycles during 1991 to 1995, led to an average 5.5 kg reduction in weight over five years, shifting the whole population distribution of weight downwards. Predictably, a profound and almost immediate reduction in the incidence of diabetes occurred, and a striking decline in cardiovascular mortality began, with a lag of about five years. These findings are consistent with those of the many epidemiologic and clinical studies that have examined the incidence of diabetes, cardiovascular disease, and cancer.³⁻⁶

The economic crisis was followed by a slow recovery, increased food intake, reduction in activity, and an increase in the prevalence of obesity to three times higher than before the crisis. With weight regain, the trend in incidence of diabetes rapidly reversed, and a decade after the period of weight loss, the decline in cardiovascular disease had greatly slowed. Most troublesome, the continued rapid increase in obesity and diabetes predicts that the decline in cardiovascular disease, and thus total mortality, will be reversed because the full impact of diabetes on incidence of cardiovascular disease is not seen until several decades after diagnosis.⁵ The apparent lack of effect of weight loss on death from cancer seen in the current study is not surprising. Only some cancers are associated with obesity and disease latency can be decades.⁷ More detailed analyses by specific types of cancer would be useful.



TRYGVE BOLSTAD/PANOS

On your bike

Franco and colleagues' findings are consistent with many analyses of body mass index and mortality, including two recent ones that pooled data on about 2.5 million participants from cohort studies, which showed optimal body mass index to be less than 25.⁸⁻⁹ These results are at odds with another recent analysis,¹⁰ which suggested a U-shaped relation between body mass index and mortality, with overweight (body mass index 25-30) being optimal. However, that study included participants with serious underlying illnesses, heavy smokers, Asian populations burdened with undernutrition and chronic infections, and frail older people who had lost weight. Leanness may therefore have been due to illness so that, by comparison, mortality was lower in overweight people.

Franco and colleagues are appropriately cautious in their conclusions and avoid attributing all the changes in disease rates to changes in weight. Consumption of cigarettes declined during the same period and changes in dietary quality, including consumption of red meat, fruits, and vegetables, might also have had some effect. However, these variables could not account for all the trends in disease rates, and there is no question that the current increases in obesity are associated with major adverse effects.

The current findings add powerful evidence that a reduction in overweight and obesity would have major population-wide benefits. To achieve this is perhaps the major public health and societal challenge of the century. Medical treatment of people at high risk for disease will have limited impact on mortality rates if the primary causes of disease are not dealt with, and reviews agree that solutions

will require multisectoral approaches. Potential strategies include educational efforts, redesign of built environments to promote physical activity, changes in food systems, restrictions on aggressive promotion of unhealthy drinks and foods to children, and economic strategies such as taxation.¹¹⁻¹² Although these solutions must extend far beyond our healthcare systems, physicians can help by monitoring weight and counseling patients who gain weight before they become overweight. Recent evidence indicates that clinic based weight loss programs can be effective.¹³

Physicians can help promote healthy social norms by visibly engaging in healthy behaviors. On a recent trip to Cuba, I had hoped to see Havana by borrowing one of the million bicycles that had been distributed. However, there were virtually no bikes, bike riders, or bicycle lanes to be seen; and several people told me that bicycles reminded them of earlier economic hardships. In many countries, walking and bicycle riding are regarded as lower class behaviors. Boston celebrates the example set by Paul Dudley White, probably the most famous cardiologist in America and personal physician to President Eisenhower, who rode his bicycle daily to Massachusetts General Hospital into his 80s. The city named a bike path in his honor, and it is currently expanding its bicycle parking facilities. Dr White may have saved more lives by his bike riding than by putting stethoscope to flesh.

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