LETTERS

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FRIENDS AND FAMILY TEST

Reconsider how this test is conveyed to the public

LIFE IN VIEW/SPL

In July 2013 the first data from the friends and family test (FFT) became publicly available on NHS Choices.[1] Hospitals are given an FFT score and ranked "best," "OK," or "worst."

There are several problems about how these data are currently conveyed to the public.

Firstly, no details are provided on how the FFT score is calculated, in particular that answering that you would be "likely" to recommend a hospital is treated as a "neutral" response. This could cause considerable confusion for people who then try to work out how the FFT score was generated by looking at the breakdown of responses by category.[2]

Secondly, information is not given on the range that the test score should fall within (–100 to 100). Without knowing the range, what does a score of 68 really mean to people?

Thirdly, using current data from NHS Choices, I compared findings from six London hospitals against how they have been ranked using the FFT scoring method.[3] I found little difference in terms of favourable attitudes between the better and the poorer performing hospitals. Between 96% and 98% of patients would recommend ("extremely likely" or "likely") the hospitals ranked OK compared with between 90% and 93% of patients who would recommend the hospitals ranked worst.

How these data are presented is not only misleading but potentially anxiety provoking. Would people prefer to know that their hospital is ranked worst or that 92% (out of a given number of responses) of people would recommend it? I would argue for 92% with a known denominator. Presenting these findings as percentages is easy to understand and much less open to interpretation.[4] The Department of Health should reconsider the way in which this information on care is conveyed to the public.

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1 Iacobucci G. Caution urged amid wide variation in response rates to friends and family test. *BMJ* 2013;347:f4839. (31 July.)
2 Davis R. Rapid response to Are "friends and family tests" useful: agree, disagree, neither, don't know?. *BMJ* 2013. www.bmj.com/content/346/bmj.f2960/rr/656520.
3 Davis R. Public anxiety could be increased by the release of data from the Friends and Family Test. Rapid response to Caution urged amid wide variation in response rates to friends and family test. *BMJ* 2013. www.bmj.com/content/347/bmj.f4839/rr/656675.
4 Ipsos MORI. Scoring and presenting the Friends and Family Test: A review of options. 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214942/FFT-Ipsos-Mori-research-report.pdf.

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MINIMUM ALCOHOL PRICING

What is convincing evidence on alcohol pricing?

In a week described as a disaster for public health, the UK government shelved two proposed alcohol pricing policies.[1] Insufficient "concrete evidence" was the justification for dropping minimum unit pricing, while there was a "lack of convincing evidence" for banning multi-buy discounts. What criteria the government used to assess the evidence, however, is not clear.

The University of Sheffield's econometric model shows convincingly that minimum unit pricing would make cheap strong alcohol less available, thereby reducing alcohol consumption and harms.[2]

Importantly, the evidence base has moved beyond modelling studies. In British Columbia, a 10% increase in minimum prices was significantly associated with a 3.4% fall in consumption and a 32% decline in alcohol related deaths.[3]

So what about banning multi-buy promotions? In Scotland, such legislation was implemented in October 2011 and our research found that it was associated with a 2.6% fall in off-trade sales, largely because of a 4.0% fall in wine sales.[4] In England and Wales, where the ban does not apply, no changes occurred over the same period and the findings could not be explained by confounders.

The government's assertion of lack of convincing evidence does not stand up to scrutiny. More worryingly, the replacement intervention, a ban on below cost selling, has no supporting evidence: the Sheffield team recently estimated that in 2014 a ban on below cost selling would reduce consumption by only 0.04%.[2]

As public heath bodies quit the industry favoured responsibility deal in protest,[5] the government should be transparent about the criteria used to assess the evidence. The Scottish government has reiterated its intention to press ahead with minimum unit pricing, offering some hope that evidence informed policies will prevail.

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Full list of references at: www.bmj.com/content/347/bmj.f4622/rr/654853.

1 O'Dowd A. Government drops plans for minimum alcohol pricing in England and Wales. *BMJ* 2013;347:f4622. (18 July.)
2 Sheffield Alcohol Research Group. Alcohol policy modelling reports. www.shef.ac.uk/scharr/sections/ph/research/alpol/publications.
3 Stockwell T, Thomas G. Is alcohol too cheap in the UK? The case for setting a minimum unit price for alcohol. Institute of Alcohol Studies, 2013. www.ias.org.uk/What-we-do/IAS-reports.aspx.
4 Robinson M, Geue C, Lewsey J, Mackay D, McCartney G, Curnock E, et al. The impact of the Alcohol Act on off-trade alcohol sales in Scotland. NHS Health Scotland, 2013. www.healthscotland.com/documents/21101.aspx.
5 Limb M. Public health body quits responsibility deal over government's failure to act on tobacco and alcohol. *BMJ* 2013;347:f4590. (16 July.)

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OPEN DATA

EFPIA-PhRMA's principles have been misunderstood

The recent joint statement of the European Federation of Pharmaceutical Industries and Associations (EFPIA) and the Pharmaceutical Research and Manufacturers of America (PhRMA) of their principles for responsible sharing of clinical trial data[1] has been misunderstood in two important ways, exaggerating the perceived progressiveness of the principles.

Firstly, despite reports that all member drug companies have agreed to set up independent or external review panels to judge third party requests for clinical trial data,[1 2] the principles document calls only for review

boards containing non-employee members. The principles do not prescribe how many non-employee members there should be or require that the non-employee members have no financial relationship with the company.

Secondly, despite the impression that industry is on the verge of opening up vast stores of data, the principles document is almost entirely focused on clinical trials of the future, declaring standards for sharing the results of trials of new drugs and new indications of old drugs. The document therefore provides no principles for sharing data from the tens of thousands of already completed industry trials that investigated the indications of drugs currently approved for use.

Even companies such as GlaxoSmithKline and Roche, both praised for having progressive new data sharing policies (which do extend to past trials), are committed only to providing controlled access to trials of products tested in approved indications and of terminated products.[3 4] Therefore access to patient level data from trials of so called off label uses of drugs is off the table. As Deborah Zarin, director of ClinicalTrials.gov, has recently pointed out, these practices may ultimately "perpetuate a dissemination bias by increasing the amount of information available for some trials while keeping other trial results inaccessible."[5]

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Competing interests: PD has a UK National Institute for Health Research grant to carry out a Cochrane review of neuraminidase inhibitors (www.hta.ac.uk/2352) which used (and is using) clinical study reports obtained from the European Medicines Agency, GlaxoSmithKline, and Roche. PD received €1500 from the European Respiratory Society in support of his travel to the society's September 2012 annual congress, where he gave an invited talk on oseltamivir.

1 O'Dowd A. Drug industry pledge on access to trial data is met with scepticism. *BMJ* 2013;347:f4829. (30 July.)
2 Thomas K. Drug companies promise more data transparency. *New York Times* 2013 Jul 24. www.nytimes.com/2013/07/25/business/drug-companies-promise-more-data-transparency.html.
3 Roche. Roche global policy on sharing of clinical trials data.http://roche-trials.com/dataSharingPolicy.action.
4 Nisen P, Rockhold F. Access to patient-level data from GlaxoSmithKline clinical trials. *N Engl J Med* 2013;369:475-8.
5 Zarin DA. Participant-level data and the new frontier in trial transparency. *N Engl J Med* 2013;369:468-9.

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SPINAL INJURY

Concerted effort is needed to tackle sciatica and back pain

Martin Davies's account of his experience of spinal injury is all too familiar to spine surgeons, reflecting the inadequacy of current NHS spinal services.[1] I am sure Mr Davies would be happier if his intervention could have been discussed much sooner than it was, however poor the outcome.

Back pain has ranked top in two cycles of the Global Burden of Disease Study,[2] but it is well down the list when both clinical and research resources are distributed. The National Institute for Health and Care Excellence recently rejected requests for an early review of the evidence for the optimum management of sciatica. The National Institute for Health Research's health technology assessment programme is currently processing responses to a call looking at some non-surgical interventions.

The sad truth is that understanding about this most common condition is very poor, with an extraordinary diversity of views from different practitioners, both conventional and alternative, on cause and treatment. It cannot be right to make a working man with radicular pain wait so long for access to a consultant. Most commissioning has developed systems that encourage these delays. The commentary makes clear the problems of communication and expectation. The NHS Spinal Task Force (www.nationalspinaltaskforce.co.uk) has looked at current delivery systems and made recommendations to commissioners. It has repeatedly been told of the plight of patients such as Mr Davies.

A concerted effort is needed to develop thinking on sciatica and other aspects of back pain, with testable hypotheses being examined in large clinical and basic science studies. Many much rarer but fashionable conditions have had substantial resources thrown at them compared with the pittance spent on back pain.

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1 Davies M, Carter P, Drake L. Spinal injury. *BMJ* 2013;346:f3374. (7 June.)
2 Vos T, Flaxman A, Naghavi M, Lozano R, Michaud C, Ezzati M, et al. Years lived with disability (YLDS) for 1160 sequelae of 289 diseases and injuries 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012;380:2163-96.

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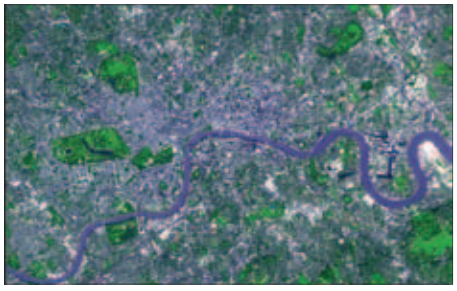
LEADING HEALTHCARE IN LONDON

Hold on tight and be prepared to change in a few years

The King's Fund report *Leading Health Care in London*[1] and the linked *BMJ* editorial[2] describe the latest episode in the problem of London's hospitals over the past two centuries.[3]

The development and implementation of the 2012 act is as messy as the multiple schemes leading to the 1974 reorganisation, which it beats hands down in terms of its unworkable complexity. The Grey Book could at least be understood.[4]

The more complex a system is the more it is likely that something will go wrong. The new set



up is unstable and under stress and the cracks will show first in London. In the many overlapping bodies now setting up shop is an echo of the failed experiment in consensus management in 1974, when nothing happened unless everyone agreed.

We have lost NHS London, the only central board in 200 years, and will end up with coordinating bodies to coordinate each other. The description of the present confusion as "a self-regulating eco-system"[1] is courteous but "savours of the calm of the academic cloister," to quote Sir Frederick Menzies, London County Council's great medical officer for health.[3] For us to look to health promotion for our financial salvation (we all die sometime), or to the unsubstantiated hope that a lot of money can be saved by transferring care into the community or by mega mergers, is whistling in the dark. Totally integrated schemes such as Kaiser Permanente and the Veterans' Health Administration (VA) probably are worth piloting,[2] but, as a patient, I would like the choice of several integrated schemes. Academic health science centres are great, but they were not designed to run the NHS.

So what should we do? Hold on tight and let things run, but be prepared to change in three years' time as sadly we will have no option. By then the way forward will be clearer.

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1 Ham C, Edwards N, Brooke B. Leading health care in London: time for a radical response. King's Fund, 2013.
2 Fulop N, Raine R. Leading healthcare in London: time for a radical response? *BMJ* 2013;347:f4711. (29 July.)
3 Rivett GC.The development of the London hospital system, 1823-2013. www.londonhospitalsystem.co.uk.
4 Department of Health and Social Security. Management arrangements for the reorganised NHS. London: HMSO, 1972.

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EDITORIAL, p 5; ANALYSIS, p 13

CORRECTION

Formation of the "Multinational Health Service" is to blame for financial crisis in the NHS

This Letter (*BMJ* 2013;347:f4864) incorrectly states that "Serco is being investigated by the Serious Fraud Office for allegedly cheating the government over tagging schemes for offenders." We apologise for this mistake.