LETTERS

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WEIGHTED CAPITATION FORMULA

Deprived areas will lose out with new capitation formula

NHS funding is allocated to areas on the principle of providing "equal opportunity of access for equal need."[1] To help achieve this, the current NHS allocation formula incorporates a deprivation related measure: the "health inequality weighting."[1] The relative roles of deprivation and age as determinants of health have been subject to political debate over the past years,[2-4] and NHS England is consulting on a new "weighted capitation formula."[1 5] This removes any health inequalities style weighting in favour of a person based allocation model of previous health utilisation.[1]

Using the data provided by NHS England,[1] we mapped the difference in funding per person between the current formula and the new formula for clinical commissioning groups (CCGs) and NHS area teams (figure). This showed that the more affluent, healthier south east will benefit most and the poorer, less healthy north will lose out substantially. For example, in CCGs like South Eastern Hampshire, where healthy life expectancy is 68 years for women, NHS funding will increase by £164 (€193; $261) per person (+14%). This is at the expense of CCGs such as Sunderland, where healthy life expectancy is 58 years for women, and where NHS funding will decrease by £146 per person (−11%). More deprived parts of London will also lose out, with Camden receiving £273 less per head (−27%).

Although these changes are not on the scale that a purely "age only" allocation formula would produce,[3] they are still sufficient to undermine the principle of "equal opportunity of access for equal need." They are also potentially a first step towards an age only allocation, and they could widen the north-south health divide by reducing NHS services in the north. The new capitation formula is out for consultation and worried *BMJ* readers should respond.[5]

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Competing interests: None declared.

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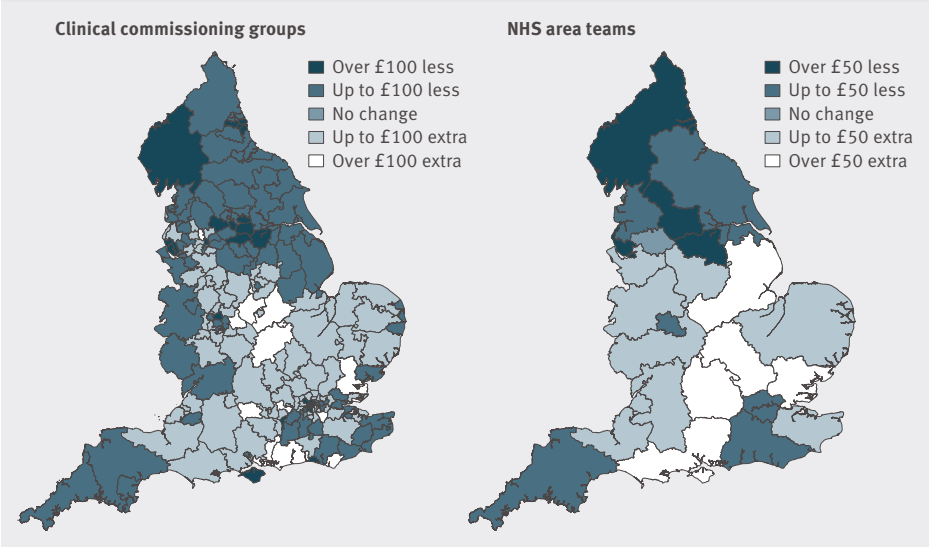

Change in spending (£/head) between new and old resource allocation funding formulas by clinical commissioning group (left) and NHS area teams (right)

CHRONIC FATIGUE TREATMENT TRIAL

PACE trial authors' reply to letter by Kindlon

Kindlon states that access to the committee minutes of the PACE (Pacing, Graded Activity, and Cognitive Behaviour Therapy—a Randomised Evaluation) trial is needed "to find out why outcome measures were changed."[1] We disagree.

Firstly, the primary outcome measures were the same as those described in the protocol—fatigue and physical disability.[2]

Secondly, details and explanations of independently approved changes to the scoring system and analysis of the outcomes are already in the public domain—in the published papers and on the PACE trial website (www.pacetrial.org/faq/).[3 4]

Thirdly, his suggestion that there were problems in the reporting of harms is also incorrect.[1] Unusually for a non-drug trial, we adopted the same stringent procedures as recommended by the European Union Clinical Trials Directive for Pharmacological Interventions. We measured safety by serious adverse reactions and events, non-serious adverse events, withdrawals from treatment because of worsening, self rated global worsening, and a composite measure of serious deterioration.[2 3] All adverse events were reviewed by an independent panel.

Finally, readers should know that the information tribunal's unanimous judgment on the appeal was that: "The tribunal has no doubt that properly viewed in its context, this request should have been seen as vexatious—it was not a true request for information—rather its function was largely polemical."[5]

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Competing interests: PDW has done voluntary and paid consultancy work for the UK government and a reinsurance company. TC has received royalties from Sheldon Press and Constable and Robinson. MS has done voluntary and paid consultancy work for the UK government, has done consultancy work for an insurance company, and has received royalties from Oxford University Press. KG and TJ declare that they have no conflicts of interests.

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NON-PHARMACOLOGICAL INTERVENTIONS

Providing fit for purpose descriptions in surgical trials

Cook and colleagues highlight that descriptions of non-pharmacological interventions in randomised controlled trials are inadequate.[1] Although reporting standards need to be improved, the level of information they suggest may not always be necessary.

Surgical interventions are complex, comprising many components that are delivered with multiple concomitant interventions (such as anaesthesia and postoperative care), so it may be impractical to control them all. Individual surgeons have clear ideas about how interventions should be performed and mandating each individual step of an intervention may cause problems. Surgeons may disbelieve trial results because interventions were not delivered "my way," or they may choose not to undertake interventions because they disagree with the details of how they should be performed. Thus, even when adequate descriptions are provided, implementation into routine practice may not occur, wasting research money.

In explanatory trials, which determine the efficacy of interventions, this level of detail may be necessary, but this approach does not reflect routine practice. Pragmatic designs, which determine whether interventions are effective in the real world, are multicentred, with large numbers of surgeons, so practice varies widely. To specify each operative step (and those of all concomitant interventions) creates difficulties, and ensuring each step was delivered as planned is unrealistic. A balance between "adequate" descriptions and practicality is necessary.

This balance can be achieved by determining an intervention's active ingredients—those that influence outcomes. Pragmatic studies may have fewer mandatory steps than explanatory trials and consequently less need for monitoring. This approach requires agreement on the key details about how an intervention should be performed and within what boundaries. Other elements can be undertaken according to personal preference, removing the need to conform to a detailed operative script. We are developing a typology of surgical interventions to guide surgeons and trialists in selecting key intervention components to design surgical trials that will be believable and change practice.

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HOSPITAL MORTALITY COMPARISONS

HSMRs should not be used to make interhospital comparisons

As Spiegelhalter notes, not knowing which countries are included in Brian Jarman's analysis makes it difficult to assess their validity.[1] However, it is instructive to look at what researchers studying hospital standardised mortality rates (HSMRs) in other countries have concluded.

A Danish study that analysed 2007-11 data could not reconcile the substantial and often sudden changes in HSMRs with changes in quality of care, but the authors thought they were due to inherent noise in calculating HSMRs, such as variable quality of diagnostic coding.[2]

A Canadian paper found a lack of empirical evidence supporting the use of HSMRs in measuring reductions in preventable deaths. It also found that limitations in standardisation and differences in palliative care coding and place of death made inter-facility comparisons

of HSMRs invalid, and concluded that these measures should not be viewed as an important indicator of patient safety or quality of care.[3]

In Australia,[4] researchers decided that "Despite its apparent low cost and ease of measurement, the HSMR is currently not 'fit for purpose' as a screening tool for detecting low quality hospitals and should not be used in making interhospital comparisons."

One Dutch paper,[5] noting improvements in hospital mortality, concluded: "There can be many reasons . . . including improved quality of care; however, it may also be due to, for instance, changes in hospital admission and discharge policies," while another,[6] examining the effect of inflation of denominators by increased readmissions, found that models that did or did not adjust for this "produced substantially different HSMR outcomes."

These conclusions suggest that rather more thought might have been appropriate before publicising these findings on national television.

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Competing interests: None declared.

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Claims without robust data undermine trust in the NHS

The authors of a 2012 *JAMA* paper analysed coding data from the 2003-09 period and damningly suggested that the fall in hospital

mortality in US patients with pneumonia was a result of trends in diagnostic coding.[1]

This is not surprising, given that the US has an army of professional coders who exist to maximise hospital revenue. Miscoding and upcoding are widespread in the US, and billions of dollars are thought to be lost to healthcare fraud.[2 3]

By contrast, coders in the UK were mostly invisible until payment by results and damnation by hospital standardised mortality rates recently brought them into view.

A cursory glance at patient discharge summaries from UK and US hospitals shows the huge gulf in coding practices between the two healthcare systems.

Hence, Brian Jarman's exploratory data on mortality from pneumonia, although deserving of careful scrutiny by policy makers, should not be accepted at face value.[4]

The editorial accompanying the *JAMA* paper prophetically warned about "naive analysis of administrative data" and "lack of appreciation of the nuances in diagnostic coding."[5]

Jarman is clearly passionate about improving patient outcomes, and the NHS is far from perfect. But bold claims about NHS deficiencies without robust data needlessly undermine patients' trust in the NHS and denigrate NHS staff.[4]

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MILITARY AVIATION AND HEALTHCARE

Medical incident reporting needs a global online system

As an ex-Royal Marine helicopter pilot and anaesthetics trainee I think that incident reporting is the one area where we can, and must, learn from an effective military system.[1] The reporting of medical and surgical incidents is currently a mysterious and tribal procedure, with specialties and subspecialties reporting through their own journals and online systems. But does the information ever reach the correct people? By contrast, military pilots are required to enter the details of an incident within a specific time frame and the data are forwarded to all relevant pilots almost instantly.

London Deanery anaesthetics trainees were recently surveyed and asked if they knew where to report an incident or near-miss, and how and where they would report it. Although 88% stated that they knew where to report an incident, answers to where it should be reported lacked any common theme. The leading two responses were hospital intranet (37%) and DATIX systems (35%). However, the other 28% of suggestions included patient's notes, departmental meetings, the Association of Anaesthetists of Great Britain and Ireland, Royal College of Anaesthetists, and other clinical governance bodies.

This result suggests that the procedure is far from clear. Medical incident reporting needs a global online system free from interspecialty territorialism. It should be managed by a major medical organisation, most likely the General Medical Council, and the reading, or at least viewing, of the material it contains must become mandatory. The material must be filtered, prioritised, and channelled to the correct people to prevent thousands of irrelevant incidents being fired to uninterested parties. The days of A4 messages on fridge doors announcing the most recent safety announcements must, for the sake of everybody's health, come to an end.

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Competing interests: None declared.
Full response at: www.bmj.com/content/347/bmj.f5570/rr/665090.

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TOO MUCH MEDICINE

CANTABmobile and its misleading promotion

Glasziou and colleagues' editorial on too much medicine suggests we ask: "Does this new test detect more or earlier 'disease'? Do we understand the course of disease in these extra cases?"[1] I have had concerns for some time about "a new touch screen test for dementia" (www.cantabmobile.com/).

CANTABmobile is a computer based tool that has been widely promoted by Cambridge Cognition to primary care services across the UK as a five to seven minute "test for dementia." Given this test was being "piloted" in a practice in my catchment area, I wrote to Cambridge Cognition outlining my concerns about the promotional claim. I asked for evidence that it was a "test for dementia" and whether the company envisaged any potential harms associated with this claim.[2]

CANTABmobile is a test of paired associates learning. This is useful for assessing patients with memory problems. In isolation it cannot diagnose dementia. After reading the literature provided, it is easy to conclude that used alone CANTABmobile is sensitive for "mild Alzheimer's disease." It is not made clear that only 5-10% of those who get an amber or a red light on this test will progress, over the next year, to dementia. Evidence shows that even after five years, at the very most, only 50% of this group will ever develop dementia.[3] The harm caused by overdiagnosis is ignored—this is particularly unbalanced when CANTABmobile has been promoted as useful for reassuring the worried well.

The reply from Cambridge Cognition stated: "We have also changed the wording on the website to clarify that CANTABmobile is a test of memory impairment, not dementia per se." This was not before I saw patients referred to me based on the original claim.

I am concerned about the promotion of and government support for an isolated test that has been presented misleadingly and avoids discussion of uncertainty and harm.[4 5]

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Competing interests: None declared.

Editorial note: We asked Cambridge Cognition for a reply to this letter but they declined to comment.

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SCREENING FOR PRE-DEMENTIA

Everyone with dementia needs assessment and support

Le Couteur and colleagues warn that effort and money may be wasted if we lose our focus.[1] Activity that might be appropriate for research is sometimes wrongly translated into routine clinical work, where it adds nothing useful, but can cause harm. Memory clinics are said to be of unproved worth, to generate stress as well as expectations, to risk excess use of investigations and drugs, and to contribute little, if anything, to people with advanced disease.

We agree, but we believe that the move to create memory clinics and services throughout the country is right.

Our experience at Gnosall goes further than that reported by Meeuwsen.[2] In our primary care memory clinic, we provide assessment and ongoing support for people with memory problems alongside other disorders.[3] Cost per diagnostic assessment is a fraction of that quoted from the United BioSource Corporation simulation of a screening programme for early detection of Alzheimer's disease,[4] and it has been accompanied by huge savings from reduced use of other healthcare resources.[5] The key is to provide competent clinical assessment and care planning from the point of first contact in partnership with the patient and family.

It is true that "the clinical features of people with established dementia are unmistakable,"[1] but an accurate and comprehensive appraisal of every individual requires time, experience, and knowledge—it is not a paper exercise based on checklists of symptoms. At best, it is a living interactive process, which leads to support for the rest of that person's life.

Good assessment, diagnosis, and treatment should be available everywhere to everyone with dementia. We must be careful not to throw the baby out with the bathwater.

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Competing interests: All authors are members of the Gnosall primary care memory clinic team.

Full response at: www.bmj.com/content/347/bmj.f5125/rr/663294.

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RESPONSE

Alistair Burns and 51 colleagues reply to David Le Couteur and colleagues

In their article "Political drive to screen for pre-dementia: not evidence based and ignores the harms of diagnosis,"[1] Le Couteur and colleagues contribute to the *BMJ*'s "Too Much Medicine" campaign and attempt to repudiate three decades of dementia research and clinical practice. It completely misses the main aims of the current political approach and is in danger of affronting the millions of people with dementia and their families affected by this devastating illness, and of undoing much of the good done over recent years.

The impact of dementia is unique. It affects an estimated 36 million people worldwide, costs $600bn (£376bn; €444bn),[2] and attracts profound stigma, which demotivates people to come forward for assessment and contributes to less than half of people with dementia being formally diagnosed.[3 4] There are three points we would like to make.

Firstly, most of us in clinical practice recognise the scenario of, usually, an older person with cognitive problems coming forward for advice and reassurance. A sensible and sensitive clinical assessment can identify remediable causes for this. Where such causes are found but the person is not regarded clinically as having dementia, it is important to respond to that.

Secondly, initiatives such as memory clinics help provide support to colleagues in primary care. Novel services (which should be evaluated) are being developed that result in better outcomes for patients and their carers and that can potentially save money.[5] They also have the effect of emphasising that dementia does not need to be a "specialist" condition but one that, if proper support is provided to primary care (whose services are already stretched), can be detected and diagnosed in the community. The drugs we have to treat many of the underlying causes of dementia would not be available without research and development from industry (an error appeared in the article—the authors state that the cholinesterase inhibitors cost £800-1000 per patient each year in the UK, when this cost is £23 for donepezil[6]).

Thirdly, the developments in policy and practice are directed towards the estimated 400 000 people in the UK who have dementia but who do not yet have a formal diagnosis and therefore are being denied access to the financial, psychological, and practical support that the diagnosis can bring. To speak of the "curse of diagnosis" is misleading and bordering on an insult to the many people who seek one. Surveys of patients, carers, and the general population consistently find that diagnosis is generally what people want.[2] There is no suggestion that population screening for dementia will or should be introduced in practice, and the initiatives aim to identify people who have dementia, as yet undiagnosed, by case finding.

Mature and open dialogue with patients, carers, and colleagues from all disciplines will help us enable people to live well with dementia by normalising and destigmatising dementia, as well as ensuring that patients and their carers have the opportunity to optimise their involvement in planning their care. We need high quality education for everyone involved in dementia care and evidence based services that respond to the needs of people with dementia and balance the supply/demand sides, so that we can avoid the inverse care law of giving the most care to the least in need. At the same time, we need to know more about the natural course of dementia and the nature of its main causes. We hope others share a similar view.

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Full response at: www.bmj.com/content/347/bmj.f5125/rr/664725.

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