EDITOR'S CHOICE

Renaissance or requiem?

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Fifteen years ago Martin Marshall and Martin Roland asked whether the Quality and Outcomes Framework (QOF) would bring a renaissance or requiem for general practice in England.¹ The mood is sombre, if not quite a requiem, but it's hard to pin the blame entirely on QOF. The pay for performance scheme contributed by burdening general practitioners with administrative demands, diverting attention from interpersonal elements of care to financial incentives, and favouring poorly evidence based or managerial (over clinical) agendas. However, QOF delivered some "modest improvements in some aspects of clinical care," Marshall and Roland now say in *The BMJ* (doi:10.1136/bmj.j4681). That isn't a ringing endorsement. Indeed, QOF has produced no clear effect on overall mortality. But while there is little sign of benefit, there isn't much to suggest a negative effect on care or patients' experience either. QOF was one of the most ambitious experiments in general practice, and though it hasn't entirely failed it's time for a rethink. The question now is how to replace it. Some of QOF's indicators might be retained, Marshall and Roland propose, but only those with a clear relation to beneficial health outcomes. Any replacement must harness the goodwill and professionalism of general practitioners. Also, a process of continuous improvement in care is preferable to standard setting. These components would value better the complexities of general practice, which require attention to managing uncertainty, social determinants of health, and shared decision making.

Twelve clinical commissioning groups in the north east of England decided to make shared decision making a central feature of one of their policies. In a disruptive innovation,

described by Deborah Cohen's investigation this week (doi:10.1136/bmj.j5016), the commissioning groups are offering bevacizumab (Avastin) to patients with wet age-related macular degeneration. Bevacizumab is not licensed for this indication, but it is cheaper and just as safe and effective as the alternatives. This move is against General Medical Council and National Institute for Health and Care Excellence guidance—both of which *The BMJ* questions—and faces legal threats from drug companies. In a Commentary David Hambleton, chief officer of South Tyneside Clinical Commissioning Group, estimates that the switch will save the region's NHS £13.5m (€15m; \$18m) a year. "In a financially stretched NHS," he argues, "the alternative for CCGs is that we may have to make less evidence based savings" (doi:10.1136/bmj.j5013).

Just as with QOF and macular degeneration, in cancer care too what matters to patients doesn't seem to be a sufficiently high priority. Tessa Richards, *The BMJ*'s pioneering editor for patient partnerships, describes her personal experience as a cancer patient on the receiving end of care that offered bewildering options and limited her involvement in discussions about treatments (doi:10.1136/bmj.j4956). What patients seek, she maintains, is "a doctor we know and trust and who knows and understands us, and who helps us to weather the storms, including the final one."

1 Marshall M, Roland M. The new contract: renaissance or requiem for general practice? *Br J Gen Pract* 2002;52:531-2.12120720

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