

## The increase in spend

Clare Gerada offers no response to the problem of increasing spend on health at a time of diminishing funding whether due to political or economic circumstances. We have to face up to this before more and more of our gross domestic product feeds an increasingly medicalised, secondary care-based system.

I am deeply involved in the clinical commissioning group (CCG) in Sheffield but that does not mean I agree with the reforms; we have no choice but to make the best of this and resist the pressure to marketise for the sake of it. We are developing deeper levels of joint working and understanding with our teaching hospital trusts than we have for years, with a radical reform of urgent and non-urgent care in development.

Of course there is pressure on the soft target of elective referrals while we learn how to free up resources from cost-effective alternatives to non-elective hospital admissions. Audits have shown a generic waste of resources through poor quality referrals; we have to address this directly, as reliance on professional behaviour is not going to work. We have been building an awareness of cost as a consequence of GP behaviour through practice-based commissioning. However, we can learn to look at cost as organisations, whether practices, federations, or CCGs; it is patronising to GPs if cost is only ever translated as something that enters the consultation.

We are reaching a point where GPs are starting to take part in the potential positive outcomes of joint work. I don't recognise much about the scenarios Clare uses as outcomes of this bill, and am concerned that this message will neither encourage engagement that gets the best out of bad legislation nor result in a mass protest; instead we will all have ourselves to blame for keeping our heads in the sand.

If on the other hand Lansley has played a magnificent sleight of hand, I have a substantial hat to eat.

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## Ubi Scientia in the midst of the cosy cardigans of Caritas

Checkland's letter raises important concerns about barriers to engagement between academic and 'applied' primary care settings.<sup>1</sup> Academic primary care is a distinct scientific discipline working within, and alongside, primary care to support and challenge practice through scholarly activity. Issues related to scientific rigour and trustworthiness of scholarly activity, along with the evaluative validity/utility and coherence of ideas are of importance in both the academic and applied settings. Identifying how best to integrate these two perspectives highlights a key challenge to engagement; in thinking about how we communicate ideas about, and the results of, academic practice and scholarly activity. These are issues that the Society for Academic Primary Care (SAPC) is actively debating and addressing and are reflected in our revised position statement.<sup>2</sup>

The 2012 SAPC conference will be held jointly with the Royal College of General Practitioners, bringing academic and applied practice together in one meeting. We are revising the abstract submission process to require an explicit description of the utility and significance of the submitted work for primary care practice and policy. We are programming workshops that address the utility of sociological scholarly activity in the consultation room and the latest evidence-base on commissioning. And we will be introducing a new festival of dangerous ideas,<sup>3</sup> the use of scholarly activity to challenge, spark news ideas, and identify and promote change.

We will be posting plans for 2012 on our website as they emerge. We welcome comments on these ideas. And invite everyone, including Dr Checkland, to join us at the 2012 meeting.<sup>4</sup>

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## REFERENCES

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## The QOF, NICE, and depression

In his defence of the depression parts of the QOF, Alan Cohen also unwittingly illustrates some of the problems of the whole process.<sup>1</sup> For instance, when he states that patients like the use of questionnaires, it is because 'they feel as though their symptoms are being taken seriously', not because he can quote more substantive evidence that it makes a difference to harder outcomes. Too much concentration on process and not outcomes. Note that Dr Cohen is not claiming GPs are taking the symptoms more seriously; the implication is that the designers of the QOF would favour the quick, somewhat superficial, and very impersonal patient health questionnaire (PHQ) over serious engagement between GPs and their patients' personal concerns. Not only de-professionalising, as Toop pointed out in his editorial,<sup>2</sup> but very destructively reducing all patients from individuals with their own contexts and concerns to units in a production line.

Then there is the encouragement to over-reliance on the PHQ. This has been consistently shown to overestimate severe depression when compared with other measures. The widespread and uncritical use of the PHQ may be leading to over-diagnosis of depression with excessive antidepressant prescribing. Those responsible for the workings of the QOF need to be reminded constantly that all medical interventions capable of doing good