Letters

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QOF

We welcome the editorial by Ashworth and Kordowicz on the Quality and Outcomes Framework (QOF).[1] The Department of Health appointed the National Institute for Health and Clinical Excellence (NICE) to manage a new process for developing QOF indicators from April 2009. The new NICE process has a number of significant changes that should lead to the QOF acting as a vehicle for quality improvement and deliver more rigorously developed QOF indicators.

First, NICE is an independent body that works in a transparent manner so it should be clear to all stakeholders why certain clinical areas have been prioritised for development as QOF indicators. Crucial to this has been the setting up of an independent NICE QOF advisory committee. Second, cost-effectiveness as well as clinical effectiveness will be taken into consideration when developing QOF indicators. Third, QOF indicators developed through the existing consensus process will now be piloted in a sample of UK general practices and be subject to public consultation. Fourth, there is an expectation that the QOF will continue to develop, and existing indicators will be retired with new indicators introduced when certain criteria are met. It still remains, however, for the negotiators to decide if indicators on NICE's menu should form part of QOF.

We would, however, like to correct the authors' on their assertion that 'many evidence-based indicators are not included in QOF simply because QOF is only designed to reward services that are available nationally. Thus, indicators covering interventions of proven effectiveness, such as pulmonary rehabilitation, cardiac rehabilitation, and diabetic educational initiatives, are not incorporated into QOF'. This is not the case under the new NICE managed process. NICE's Primary Care QOF Indicator Advisory Committee has agreed a position statement that 'service provision should not be a deciding factor on which topics or guideline recommendations are put forward for further development, or on whether indicators should be approved by the Advisory Committee for publication in the NICE menu of indicators'.[2] This decision, therefore, paves the way for the development and piloting of indicators that incentivise referral to secondary care and community services. In this respect it should be noted that the June 2010 NICE QOF Advisory Committee recommended the development of potential QOF indicators for 2012–2013 QOF in areas that will require service provision, notably structured patient education for diabetes.[3]

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No, the story of the precursors to QOF has not been well told despite the assertion by Ashworth and Kordowicz.[1]

QOF did not appear out of thin air but was the end result of initiatives in Scotland and especially east Kent. Rowland[2] does not give enough recognition to this work despite having published a paper with Spooner and Chapple describing the work done in east Kent from 1998 in the PRImary Care Clinical Effectiveness Programme (PRICCE).[3]

PRICCE was the initiative of Dr A Snell of East Kent Health Authority, supported by Dr A Coulson, chairman of East Kent Local Medical Committee, and Dr R Pinnock, chairman of East Kent Medical Audit Advisory Group. The chief executive of the East Kent Health Authority, Mr M Outhwaite, made available £1 000 000 for funding. The initiative focused on the management of chronic disease.

In PRICCE 1, 14 disease areas were identified including asthma, hypertension, atrial fibrillation, hypercholesterolaemia, and among others, diabetes. In PRICCE 2, a further nine areas were introduced including palliative care management, colorectal cancer, anxiolitics in older people, and COPD.

Spooner, Chapple, and Rowland[3] concluded 'when managerial vision is aligned to professional values, and combined with a range of interventions known to have influenced professional behaviour including financial incentives, substantial changes in clinical practice can result. Lessons are drawn for future quality improvement in the NHS'.

Mr M Farrar, chairman of the NHS