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]

Tim Stokes,
Consultant Clinical Adviser, National Institute for Health and Clinical Excellence (NICE), Manchester, M1 4BD.
E-mail: tim.stokes@nice.org.uk

Nicola Bent,
Associate Director, Centre for Clinical Practice, NICE.

Dan Sutcliffe,
Programme Manager, Centre for Clinical Practice, NICE.

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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

Confederation Negotiating Team (now CEO NHS north west [SHA]) said:

> *PRICCE practices have shown that where effort is targeted they have met with considerable and sometimes unexpected success. This has demonstrated that it is unwise to underestimate what is possible. I commend this project to you as a good working example of how to implement the Quality and Outcome Framework of the GMS2 contract.*

I suggest it is time recognition was given where it is due.

John Ashton,
Retired GP and Late Medical Secretary to the East Kent Local Medical Committee, Orchard House, Somerset, TA14 6SN.
E-mail: Ashton.john@btinternet.com

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NHS

Your comments regarding the latest re-structuring and the need instead for a serious consideration of a new approach to funding struck a note of clarity, at long last, in the debate about how best to make the NHS more efficient and effective.[1] I have spent most of my working life under the aegis of the NHS in Northern Ireland, but have many family members in the Republic of Ireland, and while its system of health care has its own problems, the insurance-based funding ensures that both consumers (patients) and providers (health professionals) are made very aware of the actual costs of treatment. The patients may (and often do) obtain reimbursement but the message is clear. I acknowledge that there are significant transactional costs in such schemes but until we can depart from the Holy Grail of a comprehensive 'cradle to grave' service, also 'free at the point of use', no amount of restructuring will address the need for all parties in the NHS to use the service in the most effective way. I hope sincerely that your excellent article is read by those in the medico–political arena, the NHS as it stands is indeed both uncontrollable and now unaffordable.

Denis Boyd,
Retired GP, 31 Lislunnan Road, Kells, Ballymena, County Antrim, BT42 3NR.
E-mail: denis.boyd2@btinternet.com

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Colour vision problems

I read with interest the correspondence from Jayakrishnan and Al-Rawas on the use of universal dots to colour code and identify asthma inhalers.[1]

I appreciate the authors' desire to ensure a universal and consistent system but, unfortunately, the interpretation of colours is fraught with complication. The problem of colour vision deficiency has been known since John Dalton first described the condition in 1798.[2] Some 8% of men and 0.5% of women have some degree of a problem, that is an estimated 2.4 million men in the UK alone. Red–green colour vision deficiency is the most common and brown is a colour where particular difficulty is encountered.

The problems with colour vision deficiency have been documented but continue to be generally under-appreciated in the medical environment, for example, there is good evidence that doctors and patients can struggle to spot red rashes.[3] Those with colour vision deficiency can also fail to recognise blood in bodily fluids[4] and this has translated into evidence that those with colour vision deficiencies are more likely to present with late stage bladder cancer.[5]

I would plead the case on behalf of those of us who are colour blind and I would resist the use of colour in the identification of medicines. In the diagram[1] I was unable to differentiate between the brown, green, or red universal dots. It is particularly challenging to identify small dots or bands of colour, and great care needs to be taken in assigning surface colour codes as those with colour vision deficiencies are prone to error, particularly under lower levels of illumination.[6]

Euan Lawson,
E-mail: euanlawson@googlemail.com

Competing interest

I have been confirmed as having protanopia and it is clearly not in my personal interest to see the increasing use of colour coding.

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Authors' response

We understand clearly the concern raised by Lawson. Our aim is not to substitute the labelling of the drugs with colour coding, but to suggest uniformity for the existing colour selection of the inhaler's casing.[1] Often the patients are instructed to take the 'blue inhaler' in case of need and to use the 'purple or red inhalers' regularly, rather than identifying them by the drug names. Instead, they could now be asked to take the 'blue dot inhaler' in case of need and to use the