of evidence quoted in support of my comments about the effectiveness of the Quality and Outcomes Framework (QOF) in improving standards and contributing to a reduction in health inequalities.[1] In particular to the three articles I quoted after the statement 'research has illustrated that practices in deprived localities improved performance to the level of their peers in the least deprived areas over a period of only 3 years'.

The article quoted by Campbell and others[2] describes the positive changes in quality of care associated with the introduction of the QOF in targeted conditions. In the discussion they quote 'an unanticipated benefit of the scheme has been a reduction in sociodemographic inequalities in health care' citing other work by the same group of researchers.[3] I agree with Treasure that reference to this article would have provided a more direct link to the evidence on the timescale of improvement that he sought.

I make no excuses for quoting the editorial by Asworth[4] as illustration of this point. The piece provides an excellent narrative summary of the QOF story, quoting the evidence again for 'the convergence between achievement in prosperous and deprived communities' and also discussing the improvements in performance for small practices.[5]

The final paper in question is an interesting attempt to link high cardiovascular QOF scores to improved cardiovascular disease (CVD) outcomes (admissions and mortality). The cross-sectional study shows a stronger association in more deprived areas suggesting that improving the quality of primary care through the QOF pay-for-performance scheme reduces the inequalities in CVD outcomes.[6]

There is now a large body of evidence supporting the view that QOF has both improved performance in the targeted clinical domains, and that performance in deprived localities has improved disproportionately. Both these factors will contribute to a reduction in health inequalities.

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Confident and competent

As a newly-qualified GP, who has benefited from an extension in training from the standard 3 to 4 years I felt I should reply to the 'Competent but not confident?' article.[1]

Valid arguments were presented, including the need to review the quality of the current 3-year training programmes, and tailoring them to the individual trainee needs. However, the assertion that newly-qualified GPs are 'not as well prepared as they used to be' and an extension of training will 'slow down the conveyor belt' and 'not make for better bangers' is unfounded. Rather than being less prepared than trainees in previous years, it seems more obvious that the level of preparation required to fulfil the increasingly complex clinical and managerial role of a GP has increased, thus leading to calls for an extension in training.[2,3,4]

From my own personal experience the ST3 (registrar) year was very much focused on passing the components of the MRCGP such as the examinations and workplace-based assessments (WBPA). While these do offer an educational benchmark, I felt that they did not fully equip me for the diverse potential role of a GP including areas of research, service development, and commissioning. I, therefore, participated in a voluntary extension of training as an 'Academic ST4', splitting my time between primary care and a university primary care department.[5] The ability to move beyond strategic learning targeted at exams, and developing new skills in research and practice development in a supported environment has been an excellent experience and was certainly not 'always having one's hand held'.

The option to extend training by another 1 to 2 years offering varied programmes developing skills in clinical, teaching, academic, and management settings can only be encouraged. I feel this would lead to more confident GPs with an enhanced portfolio of skills to meet the challenges of the 21st century healthcare environment.

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Chronic daily headache: Authors' response

We thank Hamilton and Roobottom for their recent correspondence regarding our research.[1] Our conclusion that direct access CT is now the preferred choice for patients with chronic daily headache in primary care was not based upon our identification of abnormal findings or economic analysis, as suggested by Hamilton and Roobottom, but simply a reflection of the questionnaire information that was returned to us by GPs using this service.

Hamilton and Roobottom identify that we found a higher rate of imaging abnormalities in an asymptomatic