hscic Health & Social Care Information Centre

Data Quality Statement

Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses

Provisional 2013/14 data

Introduction:

The Health and Social Care Information Centre (HSCIC) publishes an annual report on the Quality and Outcomes Framework (QOF) Achievement, prevalence and exceptions data.

This standalone report provides provisional numbers of patient with a recorded diagnosis of dementia for 2013/14. These provisional data will be updated in the annual report.

The QOF is a voluntary, indicator-based incentive scheme for GPs. The QOF consists of clinical and non-clinical indicators. Clinical information is available about GPs' patients who are recorded as having specific chronic conditions.

Data source & coverage

The QOF is a component of GP practice contracts. Although voluntary, most practices in England participate in the QOF, therefore coverage is virtually 100 per cent. QOF information is collected in order to calculate QOF payments to GP practices as part of contracts.

Information in this bulletin was derived from the Calculating Quality Reporting Service (CQRS) a national system developed by the HSCIC. CQRS uses data extracted from general practices via the General Practice Extraction Service (GPES), to calculate their QOF achievement.

There are practices for which QOF data are collected, but which do not participate in the QOF (QOF is a voluntary scheme, but the vast majority of practices participate). During the publication process for the full annual publication, the HSCIC removes these practices from the data (in consultation with ATs). We have not undertaken any such cleaning on these data, other than aligning them to the practices included in the 2012/13 QOF publication.

Accuracy:

The accuracy of QOF information depends on:

- Clinical case finding by GPs –information from QOF dementia register depends on people with dementia being diagnosed.
- Clinical coding – for example, when patients are diagnosed with dementia the quality of QOF data about people with dementia depends on the GP practice maintaining accurate, and coded, clinical records.

As QOF information is used to calculate payments to GP practices means that practices' clinical information system suppliers deliver systems to maximise QOF data recording and quality of coding. GP practices are similarly incentivised to ensure that patient records are accurate and up to date so that appropriate QOF information is collected by GPES to calculate practice payments.

The 2012/13 data presented are those collected for the QOF for 2012/13 and published in October 2013. Data presented here have different coverage than presented in the original report, and therefore aggregate counts and rates are different to those originally published. In the original 2012/13 report, data for 8,020 practices was included. To make the most accurate comparison to the provisional 2013/14 data, only practices included in both datasets have been included in summary tables. There is one exception in that all 8,020 practices are included in the time series (table 1.0), for consistency with all previous years, which also use the originally published data.

Applying this constraint, 7,928 practices are included in the tables where 2012/13 and 2013/14 are directly compared (table 1.1 onwards). This constraint was necessary because the annual QOF data routinely

published by the HSCIC is validated by Area Teams to ensure that only data for appropriate practices are included. Some practices do not participate in the QOF, for example those which provide services to the homeless; other practice codes are set up for other administrative purposes and do not represent a 'real' practice. In consultation with Area Teams, the HSCIC identifies these practices and if necessary removes them from the publication dataset. For data presented in this report, and any subsequent monthly data, it is not feasible to undertake this validation exercise. Therefore, the most straightforward way to ensure that only appropriate practices are included is to match the practices against the practice list from the last annual QOF publication.

Practices are matched in the datasets by their practice code, the difference in coverage can be attributed to practice closures, openings and mergers, as well as changes in practice codes.

Relevance:

This analysis looks at Quality Outcomes Framework (QOF) recorded dementia prevalence for 2012/13 and provisional data for 2013/14.

The Department of Health (DH) launched the Dementia Strategy in 2009 (https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy). The strategy highlighted the issue of under-diagnosis; data from 2007 quoted in the strategy estimated that only one third of people with dementia received a formal diagnosis . One of the key objectives of the dementia strategy was:

Good-quality early diagnosis and intervention for all. All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.

Prime Minister David Cameron launched the Dementia Challenge in 2012 (http://dementiachallenge.dh.gov.uk/), to build on the Dementia Strategy. A key component of the challenge is to improve diagnosis rates for dementia; so that more patients suffering from dementia are given a formal diagnosis so that they can receive the appropriate care and support.

NHS England has a commitment to increase the dementia diagnosis rate to 67 per cent by March 2015 (http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf). By this measure two thirds of people with dementia would receive a formal diagnosis.

To support monitoring of progress for this ambition, DH and NHS England requested that the Health and Social Care Information Centre (HSCIC) release the QOF dementia register data for 2013/14 early, ahead of the full publication of QOF Achievement, prevalence and exceptions data scheduled for October 2014.

Timeliness & Punctuality:

QOF information relates to achievement over a financial year. QOF achievement can take some months after financial year-end to be agreed between practices and ATs. The HSCIC takes a QMAS extract three or four months after year-end (June/July) to maximise the numbers of practices whose achievement is signed-off, whilst still allowing publication in October.

For this bulletin, a provisional dataset was extracted in April, to provide

	more timely data on the numbers of patients diagnosed with dementia.
Coherence & Comparability:	QOF information is collected primarily to support QOF payment calculations under GP contracts, and that data collection from practices is (for clinical information) based on detailed coded business rules. Information on QOF clinical registers may not precisely match disease definitions used by epidemiologists. It is extremely important to take account of QOF definitions (including coding contained in QOF business rules) before comparing QOF information with other data sources – for example comparing QOF disease prevalence with expected prevalence rates (based on public health models). Specific issues and caveats concerning the interpretation of these data are contained in the bulletin.
Accessibility & Clarity:	This publication is accessible via the HSCIC internet as PDF documents. More detailed, local level information is provided in Excel format.
Performance, Cost & Respondent Burden:	QOF information is collected primarily to support QOF payment calculations under GP contracts, and that data collection from practices is (for clinical information) based on detailed coded business rules. The QOF data published by HSCIC is secondary use of the data used to support QOF payments to GPs. There is not extra burden on providers in the HSCIC collation and publication of these data.
Confidentiality, Transparency and Security	Published QOF information is derived from data collected via CQRS and GPES. QOF publications are subject to risk assessments around disclosure. However, no patient identifiable data is available from the QOF. Standard HSCIC protocols around information governance are followed in the production of QOF publications.