NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATOR DEVELOPMENT PROGRAMME

Cost impact statement: Dementia

QOF indicator area: Dementia

Date: July 2013

Indicators

NM64: The percentage of patients with dementia with the contact details of a named carer on their record.

NM65: The percentage of patients with dementia (diagnosed on or after 1 April 2014) who have a record of attendance at a memory assessment service up to 12 months before entering onto the register

Introduction

This report covers 2 new indicators relating to dementia. The indicators are part of the NICE menu of potential Quality and Outcomes Framework (QOF) indicators for 2014/15, following the recommendations of the independent QOF advisory committee in June 2013. The indicators have been piloted as part of the NICE QOF indicator development process.

This report considers the likely cost impact of incentivising the interventions associated with the proposed indicators in terms of the number of additional interventions provided and the cost of each intervention. Costs to NHS commissioners are outlined where relevant, along with the cost of additional activity at general practices.

The rationale of NM64 is to recognise the role of general practitioners in supporting people with dementia and their carers. For example, to support

care planning in primary care around the physical and mental health of people with dementia, and their carers, and the planning and provision of palliative care.

The rationale of NM65 is to improve the accuracy and timeliness of the diagnosis of dementia, enabling people with dementia to make choices about their care.

Current 2013/14 QOF guidance on maintaining registers of patients diagnosed with dementia states: “it is expected that diagnosis will largely be recorded from correspondence when patients are referred to secondary care with suspected dementia or as an additional diagnosis when a patient is seen in secondary care. However it is also important to include patients where it is inappropriate or not possible to refer to a secondary care provider for a diagnosis and where the GP has made a diagnosis based on their clinical judgement and knowledge of the patient.”

Cost implication

Number of people affected

The incidence of dementia in England is estimated at 0.3% per year for people aged 65 and over. Table 1 details the incidence by age group and sex (Matthews et al 2005).

Table 1 Estimated number of newly diagnosed dementia per year (England)

Age	Population		Incidence of dementia		Number of new diagnoses of dementia		Total
	Male	Female	Male	Female	Male	Female	
65-69	1,360,598	1,418,468	0.40%	0.40%	5,442	5,674	**11,116**
70-74	987,852	1,086,385	0.90%	0.60%	8,891	6,518	**15,409**
75-79	784,103	930,278	1.40%	1.70%	10,977	15,815	**26,792**
80-84	540,617	751,000	2.30%	4.40%	12,434	33,044	**45,478**
Over 85	405,533	814,647	4.50%	6.00%	18,249	48,879	**67,128**
Total	**4,078,703**	**5,000,778**			**55,994**	**109,930**	**165,924**

Current care

NM64

GPs are not responsible for implementation of dementia care plans however they do have to be aware of plans and review them at least annually, which is in line with QOF indicator DEM002.

GP's obtaining names of carer and family members isn't current practice and is seen to be related more to the dementia plan and so carried out by social services. The pilot also indicates that there are issues around people not recognising themselves as carer's for people diagnosed with dementia and therefore they don't respond to invitations to add contact details.

NM65

Currently only about one-third of people with dementia receive a formal diagnosis at any time in their illness. When diagnoses are made, it is often too late for people with the illness to make choices. Furthermore, diagnoses are often made at a time of crisis; a crisis that could potentially have been avoided if diagnosis had been made earlier.

Once suspicion of dementia is established, either through patients presenting with memory issues or relatives raising concerns, GPs perform a number of tests for cognitive impairment in-house as well as physical tests (as set out by current indicator DEM0031) to rule out any organic causes of memory loss. Patients are then referred on to their local memory assessment service (MAS) for diagnosis.

MAS are already readily available for GPs to refer suspected dementia patients to and all GP practices in the pilot scheme had access to MAS, with many having more than one to refer to.

[1] DEM003: The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register

Proposed care

NM64

Because GPs have to review dementia care plans annually in line with QOF indicator DEM002, it would be reasonable to assume that making sure named carer's contact details are recorded could be done as part of this review.

NM65

Referring to MAS prior to diagnosing dementia is already part of the current pathway in most practices. However it is anticipated that more GPs will refer suspected dementia to MAS to help identify earlier, allowing patients to make choices about care.

There is potentially increased workload for the MAS if all cases of suspected dementia are now referred. Table 1 estimates cost of implementing indicator NM65 and uses the incidence of new cases of dementia per year. It is estimated that only one-third of patients receive a formal diagnosis of dementia so we have assumed that an additional third of patients will receive a formal diagnosis as a result of implementing MN65.

The average cost of dementia initial assessment has used average reference costs for 2011/12 of mental health outpatient attendances and the weighted average care clusters initial assessments. The annual cost impact has been estimated at £10.51 million.

Table 1 Estimated cost of implementing indicator NM65

	Men	Women	Total
People aged between 65 and above	4,078,703	5,000,778	9,079,481
% incidence of new cases of dementia per year	1.4%	2.2%	1.8%
Number of new cases of dementia per year	55,994	109,930	165,924
% of people who currently receive a formal diagnosis of dementia	33.3%	33.3%	33.3%
Number of people who received a formal diagnosis	18,665	36,643	55,308
% of additional people who will receive a formal diagnosis as a result of NM65	33.3%	33.3%	33.3%
Number of additional people who will receive a formal diagnosis as a result of NM65	18,665	36,643	55,308
Average cost of dementia initial assessments			£190
Total cost impact			**£10,508,520**

As a result of early diagnosis not only will it allow people to make choices about their care, it is assumed that this could reduce the number of hospital admissions and hospital bed days related to dementia.

The pilot scheme highlighted a coding issue as uptake was poor. This indicator required a change in practice regarding coding, with a 'seen in' code having to be inputted into the clinical system, rather than a 'refer to' code, which is more common practice. This indicator could add to workload at the general practice level because it entails additional coding activity.

Resource impact

NM64

The indicator is not thought to have significant cost impact as confirming named carer's contact details can be done as part of the annual dementia care plan review.

NM65

The resource impact of implementing indicator NM65 is estimated to be around £10.51 million dependent on the increase in referrals to memory

assessments clinics and how such services are provided. However a decrease in the number of hospital admissions and hospital bed days as a result of early diagnosis is likely to reduce the cost impact.

Sensitivity analysis

NM65

If the number of additional people who will receive a formal diagnosis of dementia as a result of implementing NM65 is varied to 20% and 50% of the incident population the estimated costs vary from £6.31 million to £15.76 million.

If the unit cost of dementia initial assessments is varied between £154 (cost of outpatient mental health attendance) and £225 (weighted average cost of mental health care clusters – initial assessments) the estimated costs vary from £8.52 million to £12.44 million.

Conclusions

There is estimated to be no significant cost impact as a result of implementing indicator NM64.

The estimated initial cost impact of indicator NM65 is £10.51 million. It is anticipated that a decrease in the number of hospital admissions and hospital bed days as a result of early diagnosis is likely to reduce the cost impact.

Related QOF indicators

Current QOF indicator	Numerator	Denominator	Underlying achievement (2011/12)
DEM2 (reworded as DEM002 in 2013/14): The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months	214,903	270,879	79.3%
DEM002: The percentage of patients diagnosed with dementia whose care has been	Not in QOF in 2011/12	Not in QOF in 2011/12	Not in QOF in 2011/12

reviewed in a face-to-face review in the preceding 12 months			
DEM3 (reworded as DEM4 in 2012/13 and as DEM003 in 2013/14). The percentage of patients with a new diagnosis of dementia (from 1 April 2011) with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register	29,940	35,852	83.5%
DEM003: The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register	Not in QOF in 2011/12	Not in QOF in 2011/12	Not in QOF in 2011/12

References

Health and Social Care Information Centre (2012) QOF 2011/12 data [online].

University of Birmingham (NICE External Contractor), Development feedback report on piloted indicators, 2013.

University of Birmingham and University of York Health Economics Consortium (NICE External Contractor), Health economic report on piloted indicator, 2013.

Source: Matthews F et al. (2005) The Incidence of Dementia in England and Wales: Findings from the Five Identical Sites of the MRC CFA Study. PLoS Medicine, Vol 2, Issue 8, e193, 1-11

National dementia strategy (Department of Health, 2009)

2013/14 general medical services (GMS) contract quality and outcomes framework (QOF)