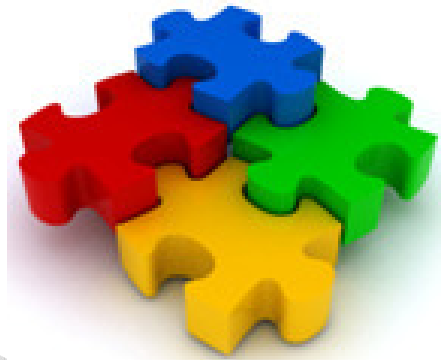




# Data Quality Manual



**5-Byte**

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SAMPLE

## **Introduction**

Information about your patients plays a vital role in the management of health care provision for those patients. It can be used to plan and commission services, monitor trends and measure performance. The information therefore needs to be accurate, reliable and credible if we are to trust the picture that it paints.

Practice disease register counts are used for final payment calculations in QMAS / CM Web / PCAS. If your disease registers are not accurate you could be either under or over claiming payment. In the former instance your practice is not being paid for the amount of work that you do. In the latter you are making false, and possibly, fraudulent payment claims.

Under the eight principles of the Data Protection Act 1998 practices have a duty of care to hold only data that is accurate, relevant and not excessive, whilst being up to date.

As practices move forward into the paperlight and paperless ways of working, more and more reliance is put onto the information recorded on the GP clinical systems. If we are to believe what this tells us without the reliance on paper based backup, we need to ensure that the information is as accurate as it can be. Taking the time and making the effort in the first instance to review the data held on your clinical system, making any corrections or amendments, and continuing this on a regular basis will reap benefits in the long term. Your practice will have the trust and belief that whatever uses your data may be called to report on; you will have the confidence to rely on it.

The following list of suggested searches can be used as a guide to improving the quality of the data held in your clinical system.

### **Read code versions**

This manual provides Read codes for clinical systems using 5 byte Read codes. Practices should identify which Read code set their clinical system uses and then write the searches using the corresponding set of codes provided in this guide.

### **Description of the symbols and characters used in this manual:**

%	Includes the code itself plus all the hierarchical children codes
-	Includes the listed codes plus all the codes between the two codes
1	Is the number one
0	Is the number zero
l	Is the lower case letter L
O	Is the upper case letter o
I	Is the upper case i

Vision	Note in your system you will need to precede Read code entries with the hash (#) sign
Synergy System 6000	Note in your system you will need to precede Read code entries with a dot (.)
ISoft Premiere	Note in your system if a Read code consists less than 5 characters, you will need to add a number of full stops to the end of the code padding it out to 5 characters e.g. H33 would have been entered as H33..

### **Emis drug searches**

EMIS software does not use Read codes for drugs. Therefore the 'lower case' codes used in the manual do not apply. Instead when EMIS sites carry out the drug searches listed in the manual, these need to be performed in the normal way using the BNF drug chapters within the 'drugs' feature in EMIS searches.

## **Disclaimer:**

Insight Solutions have prepared this document as a guide for practices to use to help them identify data quality issues. The Read codes lists are not designed to be exhaustive, but provide guidance to the types of Read codes that could be used. Whilst every effort has been made to make this document as accurate and reliable as possible, it is in the practice's best interest to consult a qualified professional in their local primary care organisation before implementing any changes based on this document.

This document has been written to give practices a variety of searches that should be built on their own clinical systems. We have deliberately designed it so it is "generic" in terms of which clinical system you use. The functionality of all the different systems has not been taken into account, and in some cases some of these searches may already be available on your clinical system and produce the appropriate lists. We have made every effort to include as many different searches as possible, some will identify more patients than others. Whenever patients are identified after building a recommended search, we do not suggest that all patients will have incorrect entries, but that these patients should be checked as it is likely that some of them may have errors in their records.

We have called on many many years of practice experience from all our consultants and directors when creating this document and envisage that over time it may be added to when either changes to the nGMS contract are made or we identify other searches that may be of benefit to practices. If you feel that there is a search we could add to this document then please feel free to notify us at **[info@insightsol.co.uk](mailto:info@insightsol.co.uk)**

We hope that this document will be a great help to practices in their endeavour to maintain the highest standards of patient data on their clinical system. If any practice has difficulty in building the searches due to lack of skills within the practice then please talk to us at Insight and we will be able to suggest a training programme for your needs.

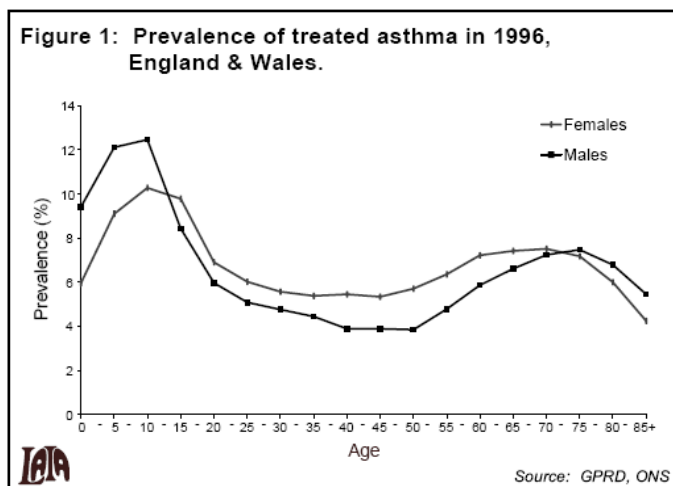
## Age and Sex of practice

Obtain an age/sex breakdown or a count of the practice population as a baseline to work out percentage recordings of other disease areas.

## Data Validation Searches QoF Registers

### Asthma

The Lung and Asthma Information Association fact sheet provides data on the prevalence of asthma treated in General Practice taken from the GPRD 1994-96.



The proportions of all registered patients who received asthma treatment in 1996 were highest in children, lowest in middle age and rose again in the elderly, with the prevalence in men almost doubling between ages 50 and 75.

Analysis found that there was relatively little geographical variation in prevalence of treated asthma.

Since that fact sheet was produced, there have been further rises in the prevalence of wheezing illness in both adults and children. The prevalence of asthma is probably at least 15 per cent

in children and about half that proportion in adults. Given the difficulties in obtaining reliable estimates of the prevalence of asthma, these figures are approximate.

Data from the European Respiratory Health Survey suggest that in the UK about one quarter of adults between 20 and 44 suffer from wheeze; in 15 per cent there was wheeze with breathlessness and the prevalence of doctor-diagnosed asthma was around 7 per cent.

The business rule set applies to patients with a diagnosis who have been prescribed asthma-related drugs in the previous twelve months. The three indicators ask that newly diagnosed asthma patients should have a measure of variability or reversibility recorded; 14-19 year olds should have a smoking status recorded and an asthma review is carried out within the contract period for each patient.

## Searches

### Age sex

Obtain a count of patients with asthma who have been prescribed asthma-related drugs in the previous twelve months. Use the diagnosis codes shown below along with the medication codes detailed in the next search.

***Work out the practice's percentage of asthmatic patients***

#### **5 byte Read codes**

H33..% Asthma  
(excluding H333., H33z1)

### Medication but no diagnosis

Obtain a list of patients taking asthma medication without a recording of the asthma diagnosis codes noted above.

***Investigate why patients have the medication without a diagnosis recorded***

Note: The following medication may be prescribed to a patient with other conditions.

Note: Depending on your clinical system the searches may be built with or without the associated Read codes.

#### **5 byte Read codes**

c1...% Selective beta-adrenoceptor stimulant  
c2...% Other adrenoceptor stimulants  
c3...% Anticholinergic bronchodilators  
c4...% Xanthine bronchodilators  
c5...% Compound bronchodilators  
c6...% Corticosteroids [respiratory use]  
c7...% Asthma prophylaxis  
cA...% Leukotriene receptor antagonist

### Diagnosis but no medication

Obtain a list of patients with a diagnosis of asthma without a medication recorded using the above Read codes for diagnosis and medication.

***Investigate why patients have no medication, are they intolerant to the medication or should the diagnosis be questioned?***

***Where appropriate these records may need a change: If a patient no longer suffers from the condition and the diagnosis was considered accurate, you may wish to add a condition resolved code, however should the condition recur the resolved code would need removing or a new diagnosis for asthma adding with the associated variability or reversibility testing.***

***If a patient no longer suffers from the condition and the diagnosis was considered accurate, add a condition resolved code.***

***Where it has been identified that a diagnosis is incorrect this should be edited or deleted in line with a robust practice deletion policy.***

## **Associated codes but no diagnosis**

Obtain a list of patients with asthma associated codes shown below without a recording of an asthma diagnosis code as noted above.

***Investigate why patients have the associated code, was the code added in error, has the condition been resolved or should the diagnosis be added?***

### **5 byte Read codes**

- 6633 – Oral steroids last used, intermittent drugs used more, increasing exercise wheeze, inhaler technique shown, inhaler technique observed, home nebuliser
- 6638
- 663F – Oral steroids started, Oral steroids stopped
- 663G
- 663H – Inhaler technique – good, inhaler technique – poor, airways obstruction reversible
- 663J
- 663L – Bronchodilators used > 1 /day, bronchodilators used 1/day max, asthma disturbing sleep, asthma not disturbing sleep, asthma limiting activities, asthma not limiting activities, peak flow meter at home, no peak flow meter at home, asthma management plan given, asthma severity, asthma prophylaxis used, irritable airways, steroid dose inhaled daily, respiratory disease monitoring nos
- 663Z
- 663a – Oral steroids since last appmt, home nebuliser since last appmt, nebulisation since last appmt, emergency asthma admission since last appmt, asthma restricts exercise, asthma never restricts exercise, inhaled steroids use, asthma - currently dormant, asthma - currently active
- 663j
- 663l Spacer device in use
- 173A Exercise induced asthma
- 8791 Further asthma – drug prevention
- 8793 – Asthma control step 0, asthma control step 1, asthma control step 2, asthma control step 3, asthma control step 4, asthma control step 5
- 8798
- 8H2P Emergency admission, asthma
- 9N1d Seen in asthma clinic
- 9OJ% Asthma monitoring admin.
- 9Q21 Patient in asthma study
- 14B4 H/O: asthma
- 1O2.. Asthma confirmed
- 66Y5. Change in asthma management plan
- 66Y9. Step up change in asthma management plan
- 66YA. Step down change in asthma management plan
- 66YC. Absent from work or school due to asthma
- 66YJ. Asthma annual review
- 66YK. Asthma follow-up
- 66YQ. Asthma monitoring by nurse
- 66YR. Asthma monitoring by doctor
- 66YP. Asthma night-time symptoms
- 8CE2. Asthma leaflet given
- 8B3j. Asthma medication review

This preview document has been created to give you a sample of the structure and contents of the full document

Pages 14 – 162 are included in the full version