

# General Practice Profiles for cancer

Version 1.1, December 2010

## Guidance for General Practice users



National Cancer Action Team



### Overview

The General Practice Profiles provide comparative information for benchmarking and reviewing variations at a General Practice level. They are intended to help primary care think about clinical practice and service delivery in cancer and, in particular, early detection and diagnosis. They are not for the purpose of performance management and there are no 'right or wrong' answers. The purpose of this document is to provide some guidance and things to consider when looking at the profiles and the data. A "General Practice Profiles for cancer: Meta-data for profile indicators" document is also available. This describes the datasets and methods used to generate the figures in your profile. This document is available on the NCIN website (<http://ncin.org.uk/gpprofiles>).

This is the first time such an initiative has been undertaken nationally for cancer. We have worked with a wide range of stakeholders to try and ensure the profiles are useful for your practice, including consultation with GPs, PCTs and cancer networks. However we will welcome comments and suggestions as to how to make future versions more relevant and useful for those who will use them. We hope to release a second version of the profile later this year. We plan to include cancer screening and mortality data in that version.

### Who to contact for support

Cancer networks will make available additional support to practices in the form of a GP lead for General Practice Profiles. This person will be able to help in their interpretation and can signpost additional resources for quality improvement. The contact details for your local General Practice Profile/Audit Lead is available on the NCIN and NCAT website, as well as from the local Cancer Network.

For more general queries about your profile or about accessing them, please contact our helpdesk at the following email address [cct@support.concentra.co.uk](mailto:cct@support.concentra.co.uk) (please state "General Practice Profiles and the name of your practice" in the email title).

### Accessing your profile

Access to the profiles is controlled to ensure that the data in them is used as described above – to inform primary care service delivery. The access control consists of a data sharing agreement that must be signed before accessing the profiles. Signing this agreement commits anyone accessing the data not to distribute the data further or use it outside the scope of this guidance.

There are two routes to access the profiles. Initially most GPs will get their practice information via the GP lead at the cancer network (in which case the General Practice Profile/Audit Leads administer the data sharing agreement). In time the aim is for access to be via the Cancer Commissioning Toolkit, which includes a range of cancer information, as well as the General Practice Profiles. The cancer commissioning toolkit includes a sign-up process equivalent to the data sharing agreement.

General Practice Profile/Audit Leads are working with Cancer Networks to support the introduction and use of the General Practice Profiles. They are working with key stakeholders and experts. They are ensuring that:

- GPs are aware of the General Practice Profiles;
- the information governance processes are in place for the release of data to practices;
- access is in a user friendly format;
- support with interpreting and acting on the information is offered, including targeted use of the Royal College of General Practitioners (RCGP) and the National Cancer Action Team (NCAT) Cancer Diagnosis in Primary Care Audit
- the information is being used to improve quality and outcomes.

### ***Audience***

These profiles have been designed with three major groups in mind. These are the GPs and Cancer Networks' General Practice Profile/Audit Leads; Commissioners; and other health professionals working in the National Awareness and Early Diagnosis Initiative (NAEDI) workstreams. Each of these groups will use the profiles in different ways. Some data items or features of the profiles may be more useful to one of these groups than the others.

### ***Data beyond these profiles***

Only data that are collected nationally with a high degree of completeness could be included in these national profiles. Other data items that would be desirable but could not be included in the profiles due to an absence of central collection or a low level of completeness at the national level included: radiology information, ethnicity and cancer staging. These indicators may be available locally.

We recognise that similar and useful profiles have or are being developed by other organisations e.g. by your local cancer network and a more general Practice Profile by the Association of Public Health Observatories (APHO), which will be available toward the end of the year. Our profiles are intended to be a complement to other sources of information that you may be using. We are working to ensure that as far as possible, there is consistent information and reference to these different products to help users get the most benefit.

## **Things to consider when looking at the data for your practice**

### ***How is my practice doing?***

Your practice information is presented in a way that allows comparison with PCT and national figures. Some indicators, such as colonoscopy rate, have a low level of activity and so your position in relation to the mean may vary considerably year on year. Others, such as two week wait referrals or cervical screening coverage are more stable indicators and will have a narrower range of natural variation. There is no 'good' or 'bad', but you may choose to discuss as a practice individual indicators where you are significantly different to the PCT mean. Where this is the case for a number of indicators, you may wish to get the additional support of the Cancer Network's GP Lead for Practice Profiles.

These profiles are the first publication, broken down by GP practice, of several cancer specific datasets. As such they should be considered experimental and caution should be used in interpreting them.

### ***Small numbers***

For some indicators there may be small numbers at practice level. This should be taken into consideration when interpreting the practice data and caution is needed when comparing the practice level data to the PCT and national averages. Small changes in the count can lead to wide variance in the rate, and numbers can vary significantly year on year. The absolute numbers ('number at practice' column) are provided beside each indicator and these should be taken into account. A very wide confidence interval around the practice rate or proportion can also be used as an indicator for caution (see below). Locally you may also want to be reviewing the data for larger geographic areas, for example PCTs; GP Commissioning Groups; Local Authorities; and Regions, which provide larger numbers and less year-on-year variability.

## **Interpreting specific sections in the profiles**

### ***Demographic indicators in the profile***

The percentage of the practice population aged 65 and above and the socio-economic deprivation of the practice population strongly influence the burden of cancer, these indicators give the context of cancer within the practice population. The incidence and mortality allow GPs to 'get a feel' for the numbers for their practice and can be aggregated by commissioners across multiple practices when assessing local health needs. The practice prevalence measures the number of persons recorded on the practice cancer register and can serve to inform the survivorship agenda.

### ***Cancer waiting times indicators in the profile***

These provide information on the role of the two week wait referral pathway in cancer diagnosis for your patients. The total number of referrals and the percentage of these referrals that are subsequently diagnosed with cancer give insight into the process of referral at the practice while the total cancer waiting times count gives the number of

persons who have begun undergoing cancer care. The fraction of these persons who entered the system through the two week referral pathway is a measure of the relative importance of the two week pathway compared to other routes to care.

The rate of Two Week Referrals is also shown as an indirectly age-standardised ratio. This is the number of observed referrals at the practice divided by the expected number if the practice has the same referral rates as England. The number is expressed as a percentage, so a value of 100% indicates the same referral rate as England, standardised for age. Indirectly standardised ratios are designed for comparison for small areas or organisations (i.e. the practices) to a larger area (i.e. England) for technical reasons comparisons between small areas are not valid. For this reason neither the PCT mean is calculated or a spine chart displayed.

Lastly, the total number of referrals is broken down into four major cancer groups to give a finer-grained understanding of the burden on and referrals from the practice.

### ***Presentation and diagnostics***

These provide information on procedures and referral pathways associated with some of the common cancers, together with information on cancer presenting as an emergency. The numbers of three common diagnostic procedures are given to allow the uptake of these services to be gauged.

The total number of emergency admissions is given for the practice population. This includes admissions at all points on the cancer pathway including those near the end of life.

Lastly, the route taken to diagnosis of each of the newly diagnosed cancer patients in the practice are broken down into three categories. These are routes that follow emergency presentations; that are managed by a GP referral (either two week wait or routine); or fall into another category (screening, a 'death certificate only' presentation, an elective admission to secondary care, a diagnosis at another outpatient service, or an unknown route where little data is available).

## Using the Profile

### Indicator

This column describes each indicator. The information in brackets refers to how the rates and proportions have been calculated. For more information about the indicators, please refer to the 'Meta-data for profile indicators' document. This document provides a more detailed description of the indicators, how they have been calculated, the source and the time periods they relate to.

### Practice Indicator Value

This is the number of people, referrals or procedures for the practice in relation to the relevant indicator e.g. the number of people aged 65 and over that are registered at the practice. The socio-economic deprivation indicator is slightly different as it provides the socio-economic quintile that the practice is in e.g. Quintile 1 is the most affluent. Please refer to 'Meta-data for profile indicators' document for information.

### Practice rate or proportion

This displays a % or a rate (relevant to the indicator being looked at) e.g. % of practice population aged 65 and over. A quick description of the rate or proportion is provided in the brackets in the indicator column. A fuller description of how the rate and proportions have been calculated can be found in the 'Meta-data for profile indicators' document.

Domain	Indicator (Rate or Proportion in brackets)	Practice indicator value	Practice indicator rate or proportion	Lower 95% confidence limit	Upper 95% confidence limit	PCT mean	England mean	Lowest practice	Practice rates or proportion in PCT			Source	Period
									Range	Highest practice			
Demographics	1 Practice Population aged 65+ (% of population in this practice aged 65+)	508	12.4%	11.4%	13.4%	17.0%	15.6%	10.1%		24.7%	PBC	April 2009	
	2 Socio-economic deprivation, "Quintile 1" = affluent (% of population income deprived)	Quintile 5	25.4%	24.1%	26.8%	19.7%	15.9%	10.2%		32.8%	APHO	March 2010	
	3 New cancer cases (Crude incidence rate: new cases per 100,000 population)	22	536	336	812	504	412	235		973	NCIM/UKACR	2007	
	4 Cancer deaths (Crude mortality rate: deaths per 100,000 population)	7	171	68	352	278	236	66		503	PCMD	2009	
	5 Prevalent cancer cases (% of practice population on practice cancer register)	30	0.7%	0.5%	1.0%	1.1%	1.3%	0.3%		2.1%	QOF	2008/09	
Cancer screening	6 Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	281	67.2%	62.6%	71.6%	71.5%	71.8%	49.7%		79.6%	Open Exeter	2007/08-2009/10	
	7 Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	8	40.0%	21.9%	61.3%	65.5%	74.4%	0.0%		77.4%	Open Exeter	2009/10	
	8 Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	758	74.5%	71.8%	77.1%	79.3%	75.4%	65.0%		88.5%	Open Exeter	2004/05-2009/10	
	9 Persons, 60-63, screened for bowel cancer in last 30 months (2.5 year coverage, %)	205	51.8%	46.9%	56.6%	51.6%	40.2%	35.3%		59.0%	Open Exeter	2007/08-2009/10	
	10 Persons, 60-63, screened for bowel cancer within 6 months of invitation (Uptake, %)	112	55.7%	48.8%	62.4%	56.8%	55.1%	40.4%		64.8%	Open Exeter	2009/10	
Cancer Waiting Times	11 Two-week wait referrals (Number per 100,000 population)	61	1487	1137	1810	1417	1610	157		2599	CwT	2009	
	12 Two-week wait referrals (Indirectly age standardized referral ratio)	61	105.9%	81.0%	136.1%	n/a	100.0%	10.5%		158.6%	CwT	2009	
	13 Two-week wait referrals with cancer (Conversion rate: % of all T'W'W referrals with cancer)	9	14.8%	8.0%	25.7%	14.5%	11.2%	5.7%		50.0%	CwT	2009	
	14 Number of new cancer cases treated (% of which are T'W'W referrals)	11	81.8%	52.3%	94.9%	44.5%	42.9%	12.5%		85.7%	CwT	2009	
	15 Two-week wait referrals with suspected breast cancer (Number per 100,000 population)	22	536	336	812	359	329	0		702	CwT	2009	
	16 Two-week wait referrals with suspected lower GI cancer (Number per 100,000 population)	9	219	100	416	270	251	0		771	CwT	2009	
	17 Two-week wait referrals with suspected lung cancer (Number per 100,000 population)	6	146	53	318	70	66	0		209	CwT	2009	
	18 Two-week wait referrals with suspected skin cancer (Number per 100,000 population)	6	146	53	318	146	280	0		566	CwT	2009	
Presentation & diagnostics	19 In-patient or day-case colonoscopy procedures (Number per 100,000 population)	26	634	414	929	877	513	302		1419	HES	2008/09	
	20 In-patient or day-case sigmoidoscopy procedures (Number per 100,000 population)	10	244	117	448	324	380	55		682	HES	2008/09	
	21 In-patient or day-case upper GI endoscopy procedures (Number per 100,000 population)	50	1219	904	1607	1374	999	729		2385	HES	2008/09	
	22 Number of emergency admissions with cancer (Number per 100,000 population)	16	390	223	633	583	691	239		1122	HES	2008/09	
	23 Number of emergency presentations (% of presentations)	5	45.5%	21.3%	72.0%	33.7%	23.7%	12.5%		100.0%	RtD	2007	
	24 Number of managed referral presentations (% of presentations)	3	27.3%	9.7%	56.6%	46.8%	48.6%	0.0%		87.5%	RtD	2007	
	25 Number of other presentations (% of presentations)	3	27.3%	9.7%	56.6%	19.4%	27.7%	0.0%		50.0%	RtD	2007	

### Confidence Intervals

See below

### PCT and England average

The average rate or proportion for the PCT, in which the practice is located. The England average is also provided, making it possible to see how the practice compares locally and nationally.

### Spine chart:

See below

### Source and Period Columns

The time period and data source that each indicator relates to. More information can be found in the 'Meta-data for profile indicators' document.

## Confidence Intervals

For each indicator, upper and lower confidence intervals are given. Confidence intervals provide a range around the practice rate or proportion being looked at. It is used to describe the uncertainty around the rate or proportion. This uncertainty arises as factors influencing the indicator are subject to chance occurrences that are inherent in the world around us. These occurrences result in random fluctuations in the numbers between different areas and time periods. Confidence intervals quantify the uncertainty in this estimate and, generally speaking, describe how much different the practice rate or proportion could have been if the underlying conditions stayed the same, but chance had led to a different set of data. The wider the confidence interval the greater is the uncertainty in the estimate.

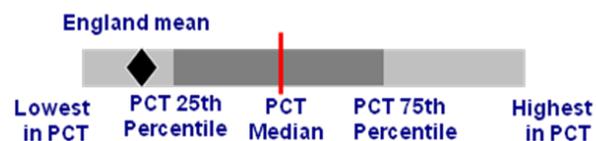
The confidence interval has been used to determine whether the practice rate or proportion is statistically significant different to the PCT average.

## Spine chart

The chart gives a visual presentation of how the practice rate/proportion compares to the local and national levels. The chart displays proportional bars which represent the range of indicator values within the PCT in which the selected practice is located. For each indicator, minimum/maximum PCT values are shown at either side of the bar column. The dark grey sections on the bar mark the range within which the middle half of the observed values lie (25<sup>th</sup> to 75<sup>th</sup> percentiles). Therefore the light grey areas on the left and right of the bar mark the lowest and highest quartiles of the range.

The central red vertical line represents the PCT average. The diamond on the proportional bar shows the England average.

- Practice is significantly different from PCT mean
- Practice is not significantly different than PCT mean
- Statistical significance can not be assessed



The round dot shows the point on the bar for the practice rate or proportion. The confidence intervals have also been used to make comparisons against the PCT average. For this purpose the confidence interval has been used to test whether the practice rate or proportion is statistically significantly different to the PCT average. If the practice confidence interval includes the PCT average, the difference is not statistically significant and the value is shown on the spine chart as a blue symbol. If the interval does not include the PCT value, the difference is statistically significant and the value is shown on the spine chart with an amber symbol.

The position of the practice with respect to the range of other practices within the PCT should be taken as possibly indicative of an effect of interest, but not conclusive. You will want to particularly consider the indicators for which your practice is significantly different from the PCT mean, to better understand the reasons and if any actions need to be taken in the practice or by others providing services or interventions on that part of the patient pathway. These statistical significance calculations take into account the small numbers present for some of the indicators. However indications of statistical significance are again not conclusive – in some cases they are caused by chance fluctuations. We anticipate many practices being significantly different to the mean on one or two indicators. In general, for any practice, the more indicators that are significantly different the stronger the argument for understanding why this should be the case. This explanation will often be grounded in the population age and socio-economic status. The General Practice Profile/ Audit leads will be available to support the interpretation and actions being taken.