	Appraisal of quality of indicator for provisional CCG OIS
Indicator ref.: 1.11	**Indicator title:** Cancers detected at stage 1 or 2
<u>Key considerations for the NICE Committee</u>	- The source of this data is the National Cancer Intelligence Network (NCIN) from the Cancer Analysis System (CAS). - There is no sample data for this indicator. - No similar indicator currently exists, although this indicator will be available at local authority level in the public health outcomes framework. **Summary: the HSCIC view is that this indicator is feasible – subject to having sufficient good quality data at CCG level.**
<u>Rationale</u>	Cancer is a major cause of death, accounting for around a quarter of deaths in England. More than 1 in 3 people will develop cancer at some point in their life. In January 2011 the Government published Improving Outcomes – a Strategy for Cancer. This document sets out how the Government plans to improve cancer outcomes, including improving survival rates through tackling late diagnosis of cancer. Diagnosis at an early stage of the cancer's development leads to dramatically improved survival chances. Specific public health interventions, such as screening programmes and information/education campaigns aim to improve rates of early diagnosis. This indicator on the proportion of cancers diagnosed at an early stage is therefore a useful proxy for assessing improvements in cancer survival rates. This indicator is a subset of P1.10, which looks at whether a stage is recorded.
<u>Suitability of indicator for purpose</u>	**Data Quality dimensions:** **Completeness** All relevant cases of cancer are likely to be included, as multiple routine datasets are used to populate the cancer registries databases. **Accuracy** Multiple data sources are amalgamated and cross-checked to ensure the data is accurate. **Timeliness** Due to the current delay in publishing cancer registration data, latest available data are for tumours diagnosed in 2010. Patient level data for tumours diagnosed for 2009 and 2010 are expected to be available from the middle of 2013. This will include practice code where available and postcode, from which it should be possible to determine the patient's CCG. **Accessibility** NCIN has worked with the United Kingdom Association of Cancer Registries (UKACR) and other data owners to agree access mechanisms for these data and an overarching access policy. **Relevance** CCGs could impact on cancer staging recording by encouraging hospital trusts to record this information as soon as possible and to make sure it is passed on to the cancer registries. CCGs could insist on this as part of the services they commission.

What is measured	**Source of data** Data will be provided by NCIN from the CAS. The CAS acts as a portal into the ENCORE database, which will be under the aegis of Public Health England (PHE) Disease Registration from April 2013. **Denominator** All new cases of cancer diagnosed during the respective year, at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas and invasive melanomas of skin. **Numerator** Of the data in the denominator, the number of cases of cancer diagnosed at stage 1 or 2. This indicator measures new cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed: specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin. These cancers are those that can be staged at diagnosis. It might be expected that around 90% of these cancers are staged. There will always be cases where determining a stage is not recommended, for example, where it would be detrimental to the patient's health to carry out the necessary investigations. Data from this source has not yet been tested due to the current migration of cancer registration data to a single system. It is not yet of a sufficient quality and completeness for use as a baseline and it will continue to evolve during 2013. As it is fed with different data sources, the methodology will need to be adapted. It is expected the data will be available to develop the new methodology by September 2013. This indicator also appears in the public health outcomes framework (2.19), where it will be reported at local authority level rather than CCG level. It is expected that data for this will be available for this in "late 2013."
How data are aggregated	This indicator will be given as a percentage at CCG level. It is expected that it will be possible to identify the patient's CCG from the data. If the patient's GP and/or practice code is not available, this would have to be based on the patient's home postcode. We would have to consider options where GP or practice code is only available for some patients (and this would depend on the proportion where it was available). Both denominator and numerator will be ascribed to a CCG on the same basis.
Risk adjustment	No adjustment is anticipated for this indicator.
Scientific validity	The assignment of a CCG to a patient will be based on GP or practice code where possible and if not, then on the patient's home postcode. As the numerator is a subset of the denominator, the same method will be used for any particular patient. If the practice is not available for any of the data, a different approach may be required.
Interpretation	A high rate is desirable.

	Outliers could be identified from a suitable graph which shows appropriate confidence limits.
<u>Equality assessment</u>	The proposed indicator may show some geographic variation, although this might be due to any number of reasons, including custom by GPs, procedures of the hospital trusts, or social factors including deprivation and/or ethnicity. Examination of the underlying data, when this becomes available, may show other variations which may need to be taken into account when developing the indicator.
<u>Use, follow-up investigation and action</u>	CCGs could ensure that the data is recorded accurately and on time by the hospitals the CCGs commission services with, so it is available to be provided to the cancer registries. There will be a cost associated with extracting the data from the CAS, although this will be relatively small, as the system is required for other purposes anyway. There may be a cost associated with adding the practice to the data if this is not done automatically and it is difficult to see how this could be re-attributed to this indicator. There is no perverse incentive with this indicator.

<u>Feedback from HSCIC consultation</u>

Question	N	Response (%)				
Organisation	1	Acute Trust (100%)				
		Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**
Well defined	1	100.0%	0.0%	0.0%	0.0%	0.0%
Well constructed	1	100.0%	0.0%	0.0%	0.0%	0.0%
		Yes, significant issues	**Yes, minor issues**	**No Issues**	**Don't Know**	
Data Quality issues	1	0.0%	100.0%	0.0%	0.0%	
		Highly likely	**Quite likely**	**Quite unlikely**	**Highly unlikely**	**Don't know**
Likely service improvements	0	-	-	-	-	-
Results group dependant	1	100.0%	0.0%	0.0%	0.0%	0.0%
Likely perverse incentives	1	0.0%	0.0%	100.0%	0.0%	0.0%

<u>If you expect that there will be data quality issues associated with this indicator please provide more detail as to what you think these might be.</u>
- If staging information is not possible to get.

<u>If you would expect to see different results for particular groups please describe what differences you would expect to see and for which groups</u>
- Granularity of data available for service and delivery planning.

<u>Sample data</u>	There is no sample data for this indicator.