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**Indicator Supporting Documentation**

**IAP00344 Mortality from breast cancer in females**

Applications for consideration

Methodology Review Group,

Indicator Assurance Service

Meeting date: 5th June 2014

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# Applicant Updates

The following updates have been provided by applicants in response to previous MRG recommendations:

## 1.1 Mortality from Breast Cancer in females aged 35 and over (CCG OIS)

*Presented by: Matt Curley*

***Denominator:***

*CCG level count of people aged 35 years and over registered with the constituent General Practices in England.*

***Numerator:***

*Deaths of people aged 35 years and over from breast cancer (ICD-10: C50), classified by the underlying cause of death registered in the respective calendar years.*

A revision has been presented in response to the following MRG recommendation:

**“It was recommended that the particular issue around the approach to standardisation used for this indicator should be re-considered by MRG based on the outcome of the workshop.”** (MRG, 19/01/2014)

It is recommended that the title be updated to reflect what is included in the indicator, based on the revisions implemented on the basis of comments from MRG:

‘Mortality from Breast Cancer in females aged 35 and over.’

The below figure displays the number of deaths from breast cancer in females in the period 2011-13, highlighting the differing age demographics breast cancer mortality. The number of deaths increases with the age of the patient until the age of 85, after which the volume falls. These differing rates suggest that standardisation will be necessary in order to account for the differing demographics of CCGs, allowing for a fairer comparison.

In the reference period 2011-13, 204 of 25,538 (0.8%) women who died from breast cancer were aged 34 and under. It is recommended therefore to exclude this age group. This in addition to grouping women aged 95 and over into a single group will minimise the number of ‘0’ cell values which could impact the standardisation calculation.

The below table presents the counts of numerator cell values when the data is split into 5 year age bands for the period 2013, 2011-13, and 2009-13, the following 5 year age bands were used: 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95+.

**Count of cell values in numerator**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **0** | **1-5** | **6-19** | **20+** | **Total** |
| **2013** | 372 | 1,832 | 525 | 14 | 2,743 |
| **(1yr)** | 13.6% | 66.8% | 19.1% | 0.5% |  |
| **2011-13** | 74 | 811 | 1,540 | 318 | 2,743 |
| **(3yr)** | 2.7% | 29.6% | 56.1% | 11.6% |  |
| **2009-13** | 25 | 452 | 1,375 | 891 | 2,743 |
| **(5yr)** | 0.9% | 16.5% | 50.1% | 32.5% |  |

The table demonstrates that data for 2013 includes a number of ‘0’ cell values (372 of 2,743, 13.6%), this is beyond the recommended 10% threshold and may therefore impact the direct standardisation calculation. In 2013, 37 CCGs have an overall numerator volume of less than 25, a directly standardised rate (DSR) will not be calculated for these CCGs.

If the reference period is increased to three or five years, the proportion of ‘0’ cell values in the numerator decreases. For the three-year period 2011-13, the number of ‘0’ cell values is reduced to 74 of 2,743 (2.7%), in this time period only one CCG has an overall numerator volume of less than 25, for which a DSR will not be calculated. For the five-year period 2009-13, the number of ‘0’ cell values is further reduced to 25 of 2,743 (0.9%) and no CCGs have an overall numerator volume of less than 25. These activity volumes are more acceptable for direct standardisation.

Based on the volumes presented above, it is recommended that data is presented for the period 2011-13 using five-year age bands in the standardisation calculation with the Mid-2011 Registered Population Estimates will be used as the denominator for this data. This will allow for a balance between the focus of the reference period and factors that could influence the standardisation calculation.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CCG** | **Numerator** | **Denominator** | **Rate per 100,000** | **DSR per 100,000** | **95% confidence interval DSR*lower*** | **95% confidence interval DSR*upper*** |
| CCG1 | 18 | 18,034 | 99.8 | - | - | - |
| CCG2 | 68 | 71,794 | 94.7 | 124.0 | 94.7 | 159.1 |
| CCG3 | 47 | 36,525 | 128.7 | 129.8 | 95.3 | 172.7 |
| CCG4 | 84 | 80,571 | 104.3 | 131.5 | 104.2 | 163.7 |
| CCG5 | 53 | 51,369 | 103.2 | 135.1 | 100.3 | 177.9 |
| CCG6 | 55 | 60,275 | 91.2 | 136.2 | 100.7 | 179.5 |
| CCG7 | 44 | 46,376 | 94.9 | 136.9 | 97.6 | 186.2 |
| CCG8 | 76 | 66,093 | 115.0 | 139.7 | 109.6 | 175.5 |
| CCG9 | 62 | 46,692 | 132.8 | 142.1 | 108.8 | 182.3 |
| CCG10 | 152 | 105,580 | 144.0 | 143.7 | 121.8 | 168.5 |
| CCG202 | 181 | 73,614 | 245.9 | 216.0 | 185.4 | 250.1 |
| CCG203 | 122 | 61,252 | 199.2 | 216.8 | 179.8 | 259.1 |
| CCG204 | 90 | 40,244 | 223.6 | 219.2 | 176.2 | 269.6 |
| CCG205 | 69 | 29,025 | 237.7 | 220.3 | 171.3 | 278.9 |
| CCG206 | 94 | 43,243 | 217.4 | 220.3 | 178.0 | 269.7 |
| CCG207 | 106 | 41,269 | 256.9 | 221.4 | 180.6 | 268.5 |
| CCG208 | 123 | 51,503 | 238.8 | 222.2 | 184.6 | 265.3 |
| CCG209 | 251 | 101,331 | 247.7 | 223.6 | 196.6 | 253.3 |
| CCG210 | 106 | 45,055 | 235.3 | 227.9 | 186.5 | 275.6 |
| CCG211 | 123 | 43,795 | 280.9 | 241.7 | 200.5 | 288.9 |
|  |  |  |  |  |  |  |

**Updated potential issues:**

Mortality indicators in the CCG OIS normally refer to a single year, due to the activity volumes in this indicator the reference period has been increased to three years. As such, this is inconsistent with other mortality indicators in the set and has the potential to be misinterpreted.

In order to have sufficient volumes for direct standardisation, females aged 34 and under are excluded. This is also inconsistent with other mortality indicators.

## 1.2 Alcohol-specific emergency readmissions in people aged 19 and over, within 30 days of discharge following an alcohol-specific admission (CCG OIS)

*Presented by: Matt Curley*

***Denominator:***

The number of finished admission episodes in people aged 19 years and over which contains a primary diagnosis code of an alcohol-specific condition.

***Numerator:***

The number of emergency admission episodes in people aged 19 years and over which contain a primary diagnosis code of an alcohol-specific condition where the patient was discharged, within the last 30 days, after an admission which also had a primary diagnosis relating to an alcohol-specific condition.

The indicator has been referred back to MRG from IGB with the following recommendation:

**“The indicator (CCGOIS 3.15) is to be referred back to MRG for consideration of how the proposed standardisation of this indicator will relate to other indicators that may come through the assurance process in the future, and regarding consistency between the alcohol specific admission and re-admission indicator. Additionally, a chair’s action is raised for the rationale to be reviewed and re-stated to clarify the purpose of the indicator as raised during MRG Discussions.”**

The table below displays the number of alcohol-specific readmissions in the period March 2010 to February 2013 (allowing up to March 2013 for a 30 day period in which to readmit), highlighting the differing age demographics.

|  |  |
| --- | --- |
| **Age Band** | **Readmissions** |
| 0-18 | 70 |
| 19-29 | 1,281 |
| 30-39 | 4,270 |
| 40-49 | 6,433 |
| 50-59 | 4,615 |
| 60+ | 2,808 |
| **Total** | **19,471** |

In the reference period 2010-13, only 70 of 19,471 (0.4%) readmissions were of people aged 18 and under. It is proposed therefore to exclude this age group. This, in addition to grouping adults aged 60 and over into a single group, will minimise the number of ‘0’ cell values which could impact the standardisation calculation.

The table below presents the counts of numerator cell values when the data is split into 10 year age bands: 19-29, 30-39, 40-49, 50-59, 60+. 29 CCGs (13.7%) have an overall numerator volume of less than 25; a directly standardised rate (DSR) will not be calculated for these CCGs.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Count of cell values in numerator** | **0** | **1-5** | **6-19** | **20+** | **Total** |
| **2010-13** | 282 | 870 | 683 | 275 | 2,110 |
| **(3yr)** | 13.4% | 41.2% | 32.4% | 13.0% |  |

The table demonstrates that data for 2010-13 includes a number of ‘0’ cell values (282 of 2,110; 13.4%), which is beyond the recommended 10% threshold. 111 of the 282 ‘0’ cells are contained within the 29 CCGs that have overall numerator volumes of less than 25 and will not have DSRs calculated; this means that there are 9.4% of cells with a ‘0’ value in the CCGs for which a DSR can be calculated.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CCG** | **Numerator** | **Denominator** | **Rate per 100** | **DSR per 100** | **95% Confidence Interval DSR*lower*** | **95% Confidence Interval DSR*upper*** |
| CCG1 | 44 | 834 | 5.3 | 5.1 | 3.7 | 6.9 |
| CCG2 | 26 | 455 | 5.7 | 5.5 | 3.5 | 8.2 |
| CCG3 | 30 | 463 | 6.5 | 6.4 | 4.3 | 9.1 |
| CCG4 | 35 | 542 | 6.5 | 6.5 | 4.4 | 9.1 |
| CCG5 | 91 | 1,409 | 6.5 | 6.6 | 5.3 | 8.1 |
| CCG6 | 27 | 358 | 7.5 | 6.6 | 4.2 | 9.8 |
| CCG7 | 53 | 719 | 7.4 | 6.7 | 5.0 | 8.7 |
| CCG8 | 102 | 1,537 | 6.6 | 6.7 | 5.4 | 8.1 |
| CCG9 | 61 | 914 | 6.7 | 6.7 | 5.1 | 8.6 |
| CCG10 | 46 | 615 | 7.5 | 6.7 | 4.8 | 9.1 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CCG** | **Numerator** | **Denominator** | **Rate per 100** | **DSR per 100** | **95% Confidence Interval DSR*lower*** | **95% Confidence Interval DSR*upper*** |
| CCG202 | 171 | 1,069 | 16.0 | 15.4 | 13.1 | 17.9 |
| CCG203 | 71 | 421 | 16.9 | 15.4 | 11.8 | 19.7 |
| CCG204 | 523 | 3,100 | 16.9 | 15.5 | 14.1 | 17.0 |
| CCG205 | 155 | 943 | 16.4 | 15.8 | 13.4 | 18.5 |
| CCG206 | 141 | 827 | 17.0 | 15.9 | 13.3 | 18.9 |
| CCG207 | 188 | 1,160 | 16.2 | 16.0 | 13.8 | 18.5 |
| CCG208 | 382 | 2,185 | 17.5 | 16.8 | 15.2 | 18.7 |
| CCG209 | 228 | 1,275 | 17.9 | 17.2 | 15.0 | 19.6 |
| CCG210 | 259 | 1,440 | 18.0 | 17.4 | 15.2 | 19.8 |
| CCG211 | 183 | 924 | 19.8 | 19.6 | 16.8 | 22.7 |

**Updated potential issues:**

In order to have sufficient volumes for direct standardisation, people aged 18 and under are excluded. This is now inconsistent with the CCG OIS 3.14 Alcohol-specific admissions indicator, although CCG OIS 1.8 Emergency admissions for alcohol related liver disease is limited to adults only. In order to align the indicators, MRG may wish to consider whether it is appropriate also remove people aged 18 and under from the alcohol-specific admission indicator.

Following on, it is proposed that the title be updated to reflect the current indicator:

‘Alcohol-specific emergency readmissions in people aged 19 and over, within 30 days of discharge following an alcohol-specific admission.’

## 1.3 Unplanned readmissions to Mental Health Services within 30 days of a Mental Health inpatient discharge in people aged 17 and over (CCG OIS)

*Presented by: Kye Forrester*

A revision has been presented in response to the following MRG recommendation (9/01/14):

**“Further consideration is to be given to the methodology with regards to the output of the guidance on approaches to standardisation workshop that is being arranged following discussions earlier in the meeting.”**

|  |  |
| --- | --- |
| Indicator Title | Unplanned readmissions to Mental Health Services within 30 days of a Mental Health inpatient discharge in people aged 17 and over. |
| Data source | MHMDS |
| Construction | ***Summary description of the calculation:***  A directly standardised rate per 1,000 discharges of people aged 17 and over at CCG level.  ***Calculation type:***  Direct standardised rate by age and sex per 1,000 discharges at CCG level.  ***Denominator:***  The number of inpatient discharges for those aged 17 and over from a general psychiatric hospital in the reporting period.  Where a patient has more than one discharge in the reporting period, each discharge is counted separately  WHERE MHD\_Age between 17 and 90  AND MHD\_EpiType = 'PROSP'  AND ep.MHD\_EpiEnd\_Date IS NOT NULL  ***Numerator:***  Of people in the denominator, the number of emergency admissions that were preceded by an inpatient discharge from the same Mental Health inpatient service within 30 days.  Exclusions:   * Patients with a booked or planned admission (admission types 11, 12, 13, 81) * Patients transferred to another provider * Where the patient was under the age of 17 at the end of the RP * Where the inpatient discharge occurred more than 30 days before the emergency admission * Where the inpatient discharge was from another provider * Where the method of discharge was 'patient died'. * There must also be an episode of type REF that is open or ends in the reporting period or the previous reporting period and not discharged due to transfer to another provider. * The date of hospital discharge must not be the same as the date of referral discharge. * Based on the month before the reporting period (RP-1) because of the potential 30 day overlap between reporting periods.   ***Statistical Methods / Risk adjustment variables:***  It is proposed that direct standardisation by age and sex be used for this indicator, this would align to other indicators within the CCG OIS.  The directly age-standardised rate (DSR) is the rate of events that would occur in a standard population if that population were to experience the age-specific rates of the subject population. The age-specific rates of the subject population are applied to the age structure of the standard population.  formula for calculation of directly standardised rate by age  where:  *Oi* is the observed number of events in the local or subject population in age group *i*;  *ni* is the number of individuals in the local or subject denominator population in age group *i*, or the population × period at risk (e.g. 'person-years');  *wi* is the number (or proportion) of individuals in the reference or standard population in age group *i*.  The standard population used for the direct method is the number of discharges from a general psychiatric hospital. The age-groups used are: 17-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75+.  The DSR is given as a rate per 1,000 discharges from a general psychiatric hospital.  95% confidence intervals are calculated using Dobson's1 and Byar's2 methods. Byar’s method is recommended for larger counts and the exact method based on the Poisson distribution for small counts, where Byar’s method is not quite as accurate. The formulae are:  where: *O* is the total number of observed deaths in the subject population  Dobson A et al. Confidence intervals for weighted sums of Poisson parameters. Stat Med 1991;10:457-62  2 Breslow NE, Day NE. Statistical methods in cancer research, volume II: The design and analysis of cohort studies. Lyon: International Agency for Research on Cancer, World Health Organization; 1987: 69. |

***Sample Data:***

DSR for the period April 2011 to February 2014, people aged 17 and over.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CCG** | **Numerator** | **Denominator** | **Rate per 1,000** | **DSR per 1,000** | **95% Confidence Interval DSR*lower*** | **95% Confidence Interval DSR*upper*** |
| CCG1 | 13 | 736 | 17.7 | 0.0 | 0.0 | 0.0 |
| CCG2 | 16 | 489 | 32.7 | 0.0 | 0.0 | 0.0 |
| CCG3 | 15 | 446 | 33.6 | 0.0 | 0.0 | 0.0 |
| CCG4 | 6 | 172 | 34.9 | 0.0 | 0.0 | 0.0 |
| CCG5 | 15 | 418 | 35.9 | 0.0 | 0.0 | 0.0 |
| CCG6 | 20 | 479 | 41.8 | 0.0 | 0.0 | 0.0 |
| CCG7 | 24 | 492 | 48.8 | 0.0 | 0.0 | 0.0 |
| CCG8 | 21 | 391 | 53.7 | 0.0 | 0.0 | 0.0 |
| CCG9 | 15 | 254 | 59.1 | 0.0 | 0.0 | 0.0 |
| CCG10 | 30 | 851 | 35.3 | 36.5 | 24.4 | 52.5 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CCG** | **Numerator** | **Denominator** | **Rate per 1,000** | **DSR per 1,000** | **95% Confidence Interval DSR*lower*** | **95% Confidence Interval DSR*upper*** |
| CCG202 | 326 | 2,544 | 128.1 | 121.5 | 108.5 | 135.7 |
| CCG203 | 245 | 1,985 | 123.4 | 121.8 | 106.7 | 138.3 |
| CCG204 | 321 | 2,552 | 125.8 | 126.2 | 112.6 | 141.0 |
| CCG205 | 211 | 1,530 | 137.9 | 136.1 | 117.9 | 156.2 |
| CCG206 | 185 | 1,281 | 144.4 | 139.1 | 119.3 | 161.2 |
| CCG207 | 237 | 1,587 | 149.3 | 142.1 | 123.8 | 162.2 |
| CCG208 | 372 | 2,055 | 181.0 | 165.9 | 149.0 | 184.0 |
| CCG209 | 1,173 | 6,558 | 178.9 | 169.1 | 159.1 | 179.5 |
| CCG210 | 148 | 746 | 198.4 | 191.0 | 160.8 | 225.1 |
| CCG211 | 1,635 | 7,902 | 206.9 | 204.9 | 195.0 | 215.1 |

|  |  |
| --- | --- |
| Updated Potential Issues | This indicator does not capture cases where a readmission occurs at a different Mental Health service than the one that discharged the patient. This will potentially exclude activity elsewhere and underestimate a services true readmission rate.  No adjustment is put in place for more severe mental illness that may have a higher readmission rate than a more mild mental illness; this could unfairly punish Mental Health services that deal with more serious cases.  The updated methodology used to obtain mental health readmissions will be inconsistent with other readmission indicators in the CCG OIS. However, if the original methodology is used, it will be inconsistent with a measure produced on a monthly basis as part of the Mental Health Bulletin. If the monthly figure produced in the Mental Health Bulletin were to be aggregated to an annual figure, it will not match the one presented by this indicator, even though they are purporting to measure the same thing. We recommend using the method that is consistent with the Mental Health Bulletin to minimise the risk of inconsistent indicators being produced. |

## Health related quality of life for people with long term mental health conditions (CCG OIS)

*Presented by: Matt Curley*

**Background information (Initial Submission Previously discussed by MRG 15/11/13) - *shaded in grey***

|  |  |
| --- | --- |
| Rationale / usefulness | This indicator seeks to capture how successfully the NHS is supporting people with a long-term mental health condition to live as normal a life as possible. It will help people to understand whether health related quality of life is improving over time for adults with a long-term mental health condition. The indicator uses EQ-5D, which is a validated direct measure of health status or health-related quality of life used internationally.  The indicator provides a CCG level figure that is concerned with adults with a long-term mental health condition.  CCGs could help to look after the physical needs of their patients with long-term mental health conditions by ensuring they commission appropriate secondary mental health services that pay attention to patients’ physical health needs.  CCGs could also make sure that patients’ physical healthcare needs are provided for in primary care. |
| Data source | GPPS (NHS England/Ipsos Mori) <http://www.gp-patient.co.uk> |
| Construction | ***Summary description of the calculation:***  The average weighted health status (EQ-5D) score for adults with a long-term mental health condition, given by CCG.  ***Calculation type:*** Mean EQ-5D score.  ***Denominator:***  The sum of all weighted responses from people who identify themselves as having a long-term mental health condition.  This is the sum of the ‘wt\_new’ field for people who identified themselves as having a long-term mental health condition in Q31, answer 14 (GPPS, Year 8, July – Sept 2013).  ***Numerator:***  The sum of weighted EQ-5D scores for all responses from people who identify themselves as having a long-term mental health condition.  The GPPS has a section headed Your State of Health Today. The health status (EQ-5D) scores are derived from responses to Q34 in the GPPS (Year 8, July – September 2013), which asks respondents to describe their health status using the five dimensions of the EuroQuol 5D (EQ-5D) survey instrument:  • Mobility  • Self-care  • Usual activities  • Pain/discomfort  • Anxiety/depression  EQ-5D™ is a registered trademark of EuroQol. It assesses whether health-related quality of life is increasing over time for the population with long-term conditions, while controlling for measurable confounders (age, gender, disease mix, etc.). Further details are available from <http://www.euroqol.org>.  A single measure of health related quality of life for each survey respondent is derived using a standard tariff, which is itself elicited from a representative sample of the general population. (For the derivation, see Dolan, Gudex, Kind and Williams “A Social Tariff for EuroQol: Results from a UK General Population survey”, Discussion Paper 138, Centre for Health Economics, University of York, September 1995. Available online at: <http://www.york.ac.uk/media/che/documents/papers/discussionpapers/CHE%20Discussion%20Paper%20138.pdf>.) The derived value takes a maximum score of 1 (full health) and is anchored at 0 (a state of no intrinsic value, for example, unconscious).  This indicator uses a similar definition to NHS Outcomes Framework indicator 2: health related quality of life for adults with long-term conditions but is only concerned with adults with a long-term mental health condition. It is also similar to health related quality of life for carers, a forthcoming indicator for the NHS Outcomes Framework.  ***Statistical Methods / Risk adjustment variables:***  *The data are not standardised***. (Subsequently updated, see applicant update below)**  The GPPS data are weighted to ensure results are representative of the national population. People likely to respond to the survey are not necessarily representative of the population as a whole, so the data include a weight for non-response bias (a field called ‘wt\_new’). This weights the data to account for potential differences between the demographic profile of all eligible patients in a practice and those who actually return the questionnaire. The weighting accounts for gender, age and practice.  The weighting scheme from the 2011-2012 survey onwards has been adjusted to make the data better represent the views of the population as a whole. It now takes into account local factors (such as deprivation, crime levels, ethnicity, marital status, overcrowding in households, household tenure and employment status).  As the weighting scheme has changed, as well as changes to questionnaire design and survey frequency, it is not possible to make direct comparisons with previous years’ data, even in cases where the same questions have been asked.  Results of the GPPS are available both weighted and unweighted.  Confidence intervals are to be calculated for this indicator. The method to be used will be determined in conjunction with the Clinical Indicators team to ensure a consistent methodology across similar indicators. In the meantime, a 95% confidence interval based on the standard error and the t-distribution has been presented with the sample data (below).  ***Other (Quality assurance/interpretation/known limitations):***  The question in the GPPS has developed over time in order to elicit the most accurate response. However, as it is a self-completed questionnaire, interpretation could vary between respondents. The survey does not include a definition of either “long-term” or “mental health condition” so there may be variation as to how these terms are interpreted and how this question is approached. Note that the mental health condition does not necessarily have to been diagnosed by a doctor.  The assignment of a patient to a CCG will be based on the GP practice code, which is 100% complete in the GPPS.  A high rate is desirable. The higher the rate the higher the average health status of the relevant population. |
| Potential Issues | Of the people reporting a long-term mental health condition, 30496 respondents (88%) completed the question which allowed their health status to be calculated (GPPS, July 2011 to March 2012). The smallest number in a CCG was 23 people.  A patient’s average health status could be influenced by numerous factors, including the severity of their condition and how long they have suffered from it. The survey does not give respondents the opportunity to specify which mental health condition (or conditions) they have. Additionally, this indicator does not take account of whether respondents also have a long-term physical health condition, which may or may not be related to their mental health condition. A long-term physical health condition may have a greater impact on respondent’s physical health than a long-term mental health condition.  The weighting scheme for non-response bias does not take the experience mix into account, i.e., whether people with a bad experience are more likely to respond to the survey. This indicator is dependent on people’s readiness to self-report a long-term mental health problem in the GPPS. It is not clear whether those affected with a long-term mental health condition are more or less likely to respond to the survey. Over or under reporting of long-term mental health conditions could distort the measure.  There is the potential of a perverse incentive or gaming with this indicator. If people with severe mental illness/complex conditions have poor EQ-5D scores, there could be a risk that some GPs would be disinclined to take them onto their list. |

**Updates to recommendations**

|  |  |
| --- | --- |
| Ref code  IAP00354-01  Made: 31/10/13 | **The standardisation methods used should be brought in line with other indicators using the EQ-5D score as much as possible, which will influence the confidence interval methodology used.** |

The standardisation methodology for this indicator was considered and agreed by MRG on 17th January 2014 along with the following Health Related Quality of Life indicators:

* Health related quality of life for people with long term conditions (NHS OF indicator 2 and CCG OIS 2.1)
* Proportion of people who feel supported to manage their condition (NHS OF 2.1 and CCG OIS 2.2)
* Health related quality of life for carers, aged over 18 years (NHS OF 2.4 and CCG OIS 2.15)

As agreed by MRG, the indicator will be standardised by age and gender using 4 age bands, rather than 8, reducing the number of CCGs with zero cells from 162 to 30.

|  |  |
| --- | --- |
| Ref code  IAP00354-02  Made: 31/10/13 | **Response rate of people with mental health conditions should be explored and evidenced.** |

We have explored potential proxy measures regarding the response rate of people with mental health conditions. We are unable to determine the overall response rate compared to the general population.

We have investigated any potential difference between those with long term mental health conditions and the general population in terms of completion of the EQ-5D score by those responding to the GPPS. As a proxy measure, this indicated an insignificant difference in completion rates between the groups.

As a proxy measure to determine the likely response rate of those with long term mental health problems, we investigated discrepancies between response rates of the Community Mental Health Survey (29%) and the National Inpatient Survey (49%). The surveys have a sizable difference in response rate, but the applicability of this result as a proxy measure of response rates is questionable.

|  |  |
| --- | --- |
| Ref code  IAP00354-03  Made: 31/10/13 | **Exploration of any bias caused by including the anxiety/depression dimension for people with mental health conditions should be explored.** |

Euroqol documentation states that excluding an element of EQ-5D means the method can no longer be claimed to have been used with limitations imposed for the way that EQ-5D can be analysed. Removing a dimension would invalidate the calculation as the scores are based on trade-offs between different combinations of the health status in the 5 dimensions.

We do not receive the individual EQ-5D dimensions in a scored format and only have access to the written responses provided. This has meant that we have not been able to explore removing a dimension and how it would affect the overall weighted EQ-5D.

There is also the issue of comparability with other similar CCG OIS indicators that use EQ-5D. This indicator is a sub-set of CCG OIS indicator 2.1 and will no longer be comparable if the method used to assess overall health is changed. A reference in the Indicator Quality Statement can be included to highlight any possible bias caused by the use of certain dimensions in the EQ-5D.

The existing NHS OF indicator 2 and CCG OIS indicator 2.1 (Health related quality of life for people with long-term conditions)include people who identify themselves as having ‘Arthritis or long-term joint problem’ or a ‘Long-term back problem’ (as well people with a ‘Long-term mental health condition’) but still include the mobility and pain/discomfort elements of the EQ-5D in their overall health calculation where the responses may be influenced by their condition.

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| Ref code  IAP00354-04  Made: 31/10/13 | **Produce a scatter graph showing the number of respondents against the average EQ-5D score to show variation in score is not due to response rate.** |

As shown in the above scatter-graph, there is no notable correlation between the average EQ-5D score and CCG response rates.

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| Ref code  IAP00354-05  Made: 31/10/13 | **Reference the contextual indicator which provides the average EQ-5D score of all respondents to the GPPS.** |

The Indicator Quality Statement has been amended to include a reference to CCG OIS indicator 2.1 which provides the average EQ-5D score of all respondents at national and CCG level.

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| Ref code  IAP00354-06  Made: 31/10/13 | **Provide a link in the Quality Statement to the GPPS website to explain the response rate to the survey.** |

The Indicator Quality Statement has been amended to provide a link to the GP Patient Survey annual technical annex report, detailing the technical details of how the survey is administered including response rates:

<http://www.gp-patient.co.uk/results/annual/technicalannex/>

# Applicant Initiated Reviews

The following papers have been submitted to the service to provide updates to existing indicators for assurance.

## 2.1 NHS OF Deprivation Breakdown Methodology Proposal

*Presented by: Sindy Holschumacher*

**Proposal for inclusion of deprivation breakdowns within the NHS Outcomes Framework – an interim approach**

We propose to include new deprivation breakdowns for certain indicators within the NHS Outcomes Framework. This proposal affects the following indicators:

* 1a Potential years of life lost (PYLL) from causes considered amenable to health care – Adults and children
* 1a.i Potential years of life lost (PYLL) from causes considered amenable to healthcare – Adults
* 1.1 Under 75 mortality rate from cardiovascular disease
* 1.2 Under 75 mortality rate from respiratory disease
* 1.3 Under 75 mortality rate from liver disease
* 1.4 Under 75 mortality rate from cancer
* 2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions
* 2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
* 3a Emergency admissions for acute conditions that should not usually require hospital admission
* 3.2 Emergency admissions for children with lower respiratory tract infections

Rationale for introduction of an interim approach

The introduction of deprivation breakdowns for the above indicators has been requested by colleagues at the Department of Health and NHS England. These breakdowns, which would use the Indices of Multiple Deprivation (IMD) 2010 scores for 2011 lower super output area (LSOA) boundaries, would provide useful information relating to inequalities.

Following the census in 2011, updated LSOA boundaries (known as LSOA 2011) came into existence from 1st April 2012. The majority of boundaries did not change between the LSOA 2001 and LSOA 2011 configurations. In summary, the changes were:

* 31,672 LSOAs did not change between 2001 and 2011 (97.5%)
* 366 LSOAs split
* 294 LSOAs merged
* 150 LSOAs have had a more complex change

The Department of Communities and Local Government (DCLG), who produce the official indices of deprivation, have not yet released updated IMD 2010 values based on LSOA 2011 boundaries, resulting in a mis-match between current geographies, populations and the IMD data. Although DCLG have recently announced that they have commissioned an update and review of the existing methodology the planned release date for these updated indices is summer 2015:

<https://www.gov.uk/government/collections/english-indices-of-deprivation>

Due to this delay, an interim approach which uses an unofficial reference file produced by the Association of Public Health Observatories (APHO) is being proposed. Given the appetite for deprivation breakdowns within the NHS Outcomes Framework we are concerned that by waiting for the official DCLG file to be released we would be restricting the use of our statistics and encouraging other organisations to produce these breakdowns. In addition, the APHO reference file is used by Public Health England in a number of Public Health Outcomes Framework indicators and by the Office for National Statistics (ONS) in their publications (both National Statistics publications and bespoke data requests).

Proposed Method

The proposed method would use the APHO reference data which includes IMD 2010 scores based on 2011 LSOA boundaries. This file is available at:

<http://www.apho.org.uk/resource/view.aspx?RID=125886>

It is acknowledged by Public Health England, which APHO are now part of, that these adjusted indices have not been quality assured by or endorsed by DCLG and that the 2010 English Indices of Deprivation based on 2001 LSOA boundaries are still the official source of IMD 2010 scores.

As previously mentioned, 97.5% of LSOAs have the same boundaries in both 2001 and 2011 configurations so these have not changed.

For the 366 LSOAs which split between 2001 and 2011, the current 2010 IMD score has been assigned to the new LSOAs. For example, if one 2001 LSOA split into three 2011 LSOAs, each of the three LSOAs would have the same IMD score as the original 2001 LSOA as they cover the same geographical area.

For the 294 LSOAs which merged between 2001 and 2011, a population weighted average of the current IMD 2010 score was assigned to the new LSOA. For example, if two 2001 LSOAs merged to form one 2011 LSOA, the original scores were averaged to create a single score for the new 2011 LSOA.

The remaining 150 LSOAs were classed as having a more complex change and these were dealt with on a case by case basis, depending on the type of change. An example of one of these changes is a slight boundary changes between the two versions of LSOAs which used population weighted averages to derive a new value for the new LSOAs.

For further information please the link above.

Support for change of calculation methodology

The NHS Outcome Framework Team at NHS England agree with the rationale for the change in methodology and support this proposed change.

Indicator Governance Board Meeting – 22nd July 2014

*Paper (4)*

Indicators for Appraisal - Pack 2

* **IAP00344** Mortality from breast cancer in females
* **IAP00346** Percentage of cancers diagnosed via emergency routes
* **IAP00347** Record of cancer stage at diagnosis
* **IAP00350** Cancers detected at stage 1 or 2
* **IAP00351** Record of lung cancer stage at decision to treat

Record of Assurance provided by **Indicator Governance Board**

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| **Indicator Title** | **Mortality from breast cancer in females** | IAS Ref Code: | IAP00344 |
| Indicator Set | CCG Outcomes Indicator Set |  |  |

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| Description | Deaths from breast cancer registered in the calendar year, directly standardised by age group, females only, given as a rate per 100,000 CCG population. |

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| Initial IGB discussion | 22/07/14 | Further discussed |  |

**Strategic Considerations & Implications**

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| Applicant / Sponsor Organisation | NHS England  \*Costing for assurance appraisal included in development cost | Assurance process funded? | **Yes\***    **No** |  |

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| Indicator rationale | Breast cancer is the most common cancer in women in England (and also affects a very small number of men). New cases diagnosed in women each year have increased from under 30,000 in 1993 to more than 41,000 in 2010. During the same period, the number of deaths from breast cancer in women has fallen from 12,500 to just over 9,600.  There is a trend of increasing incidence because of lifestyle factors and improved detection, and decreasing mortality because of earlier detection and improvements in the quality and availability of effective treatments.  CCGs could impact on breast cancer mortality in a number of ways. They could encourage women to attend breast screening when invited and commissioning appropriate treatment services, etc. However, it could be several years before any effect is noticed, particularly given the existing general downward trend in breast cancer mortality. |
| Basis for rationale  [Details of quality statement, policy etc.] | This indicator is based on NICE Quality Standard 12 (Breast Cancer), linked to Clinical Guidelines 80 and 81. |
| Calculation Summary | Calculation type: 3 year rolling indicator, directly age standardisation, standardised using 5 year age bands.  ***Denominator:***  CCG level count of females registered with the constituent GP Practices provided by NHAIS (Exeter) Systems.  ***Numerator:***  The number of deaths of females from breast cancer (ICD-10: C50), classified by the underlying cause of death registered in the respective calendar years. |
| Risks & assumptions | * The registered population is derived from practice populations. All current practices in England are part of a CCG. It is acknowledged that the registered population may be an overestimate of the true population. The registered population is larger than the postcode-based resident population; it is 6.6% larger throughout England, based on 2010 population estimates. . * To remain in line with the Office of National Statistics, male breast cancer deaths are not included in the indicator. * The data used is based on the original cause of death recorded on the death certificate rather than any final amended causes. |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | *Data Source(s):*  *Denominator:*   * National Health Application & Infrastructure Services (NHAIS, commonly known as the Exeter System) for the CCG populations. * *Also: ONS mid-year population estimates (for England ‘standard’ population).*   *Numerator:*   * Primary Care Mortality Database (PCMD) from HSCIC:   *The numerator is derived from data in the ONS mortality database, which does not contain the GP practice code required to report these data at CCG level. The PCMD contains the ONS mortality data with the addition of the GP practice code.*   * Discussions between the HSCIC, ONS and General Register Office (GRO) are on-going around PCMD access and it needs to be made sure that the appropriate legal gateway is used for the indicator. |
| Potential impacts on other business areas [inc outstanding generic issues] | There are a number of indicators relating to Breast Cancer reported on the HSCIC Indicators Portal (Compendium of Population Health Indicators), including:   * Incidence of breast cancer:   indirectly standardised ratio, <75 years, 3-year average, Female   * Mortality from breast cancer:   directly standardised rate, all ages, 3-year average, Female   * Mortality from breast cancer:   number, by age group, annual, Female   * Years of life lost due to mortality from breast cancer:   directly standardised rate, 1-74 years, 3-year average, Female   * Survival following diagnosis of breast cancer:   one year age-standardised relative survival rate (%), 15-99 years, 3-year average, Female  These indicators are reported at National, Trust and SHA level.  The proposed indicator is the only indicator measuring at CCG level  A general question was raised during the appraisal as to whether HSCIC (or NHS England) should be looking to commission something producing “an Attribution Dataset (ADS)” which can be used at CCG level and would serve to increase consistency with the ONS populations. |
| Implementation Method  [inc production funding] | * NHS England has commissioned HSCIC to produce and disseminate the CCG OIS indicators; this is funded via the Grant in Aid funding to HSCIC. * Dissemination and presentation of the CCG OIS will be via a number of routes:   + The indicators and their underlying data will be made publicly available via the HSCIC website and the Indicator Portal.   + The data will also be provided to NHS England for use in their internal Intelligence Tool.   + Subject to confirmation by NHS England, the calculated indicator, numerator and denominator for CCGs will be supplied by messaging to the Calculating Quality Reporting Service (CQRS) for use by CCGs as part of their management information. |

**Development Advice / Peer Review (undertaken as part of assurance process)**

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| Range of input during development | - |
| Assurance Service  Peer Reviewers: | Paul Jennings – HSCIC Clinical Indicators Team |
| Peer Review summary: | * (Original )Title may need some elaboration in order to differentiate it from a number of existing indicators. * As there is understood to be an overall downward trend in breast cancer mortality, changes as the result of organisational actions may take several years to become apparent. |

**Record of MRG Discussion**

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| Discussion dates: | 07/10/13, 09/01/14,  05/06/14 |

By:

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| --- | --- | --- |
| Julie Stroud (chair) | HSCIC | Head of Population Health and Social Care |
| Chris Dew (vice-chair) | HSCIC | Section Head, Clinical Indicators |
| Irena Begaj | UHB | Statistical Intelligence Analyst |
| Paul Fryers | PHE | Deputy Director, East Midlands Knowledge and Intelligence Team |
| Jonathon Hope | HSCIC | Principal Information Analyst, Clinical Audit |
| Paul Iggulden | HSCIC | Interim Head of Clinical Analysis, Research & Development |
| John Sharp | HSCIC | Head of Data Quality |
| Andy Sutherland | HSCIC | Statistics Head of Profession |
| Alyson Whitmarsh | HSCIC | Programme Manager, Clinical Audit |

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| Summary of MRG discussions: | MRG Appraisal against Criteria:  **Clarity**   * Based on further analysis following the MRG meeting (5/6/14), the indicator will contain all ages and the title updated to – “Mortality from breast cancer in females”. * In the view of the applicant the indicator title and the location of publication are consistent with other CCG OIS mortality indicators and as such they would like to keep it the same. The differentiation suggested by the peer review would be achieved through publication in the CCGOIS section of the indicator portal.   **Rationale / Purpose**   * It is noted that there are a number of indicators measuring the subject area, however MRG acknowledged this is the only indicator measuring at CCG level. * MRG questioned as to whether NICE Quality Standard 12 excludes men, and what the justification was to exclude men from the indicator. * NCIN provided the following advice on the exclusion of men from the indicator: Due to the anatomical differences in males and females leading to the differences in presentation of disease, male breast cancer is routinely separated from analysis of breast cancer as a whole. In addition, with 211 CCGs, there are insufficient cases to robustly measure breast cancer mortality for men. To remain in line with the Office of National Statistics, male breast cancer deaths are not included in the indicator.   **Data :**   * Justification provided regarding the choice of data source(s) * Use of the Primary Care Mortality Database (PCMD) as the data source is consistent with other CCG OIS mortality indicators. * In order to record CCG, data from the PCMD is used. The numerator is derived from data in the ONS mortality database, which does not contain the GP practice code required to report these data at CCG level. The PCMD contains the ONS mortality data with the addition of the GP practice code. * The reasoning for the selection of the data source is included in the metadata. * With regards to the denominator, it was noted that there are issues with using GP registered population as there are more patients on GP practice registers than counted in the Census by the ONS. * It was suggested that Attribution Dataset (ADS) be looked into to see if it could be adapted for use as a possible denominator. * However, having consulted with the HSCIC Population Geography team, the applicant was advised that the ADS would be unable to provide the necessary data for the indicator denominator. The latest ADS was produced for 2011 data at SHA and PCO levels but there are no plans to commission the service for CCG populations. The ADS was commissioned by Connecting for Health and carried out by an external contractor. * The applicant confirmed that the proposed population being used from NHAIS has been used before and are the same as the populations being generally used at CCG level. * Further clarification was sought detailing the on-going discussions between the HSCIC, ONS and General Register Office (GRO) around PCMD access, and the implications for accessing data.   + A review of all of the mortality feeds into the HSCIC from ONS is being initialised.   + HSCIC Population and Geography team are not aware of any planned changes to PCMD which would affect the CCG OIS indicators.   + It is confirmed that HSCIC has the legal gateway approval to use the PCMD to produce the CCG OIS indicators and there are no changes to this anticipated at present. * The Chair suggested that the response be accepted for the moment, with it being re-assessed if there is an issue.   **Construction:**   * Analysis presented based on 1 year data showed 40 CCGs (19%) had a count in the numerator of less than 25, which is considered significant (in Public Health Outcomes Framework directly standardised rates that are based on numerators of less than 25 are supressed). * The applicant suggested the indicator could be re-presented using indirect age standardisation in order to deal with the small numbers at CCG level, however MRG put forward that options around suppression or widening the 1 year data to 3 years in order to have more in the numerator be considered before indirectly standardising.   Following further analysis, the final proposal presented is as follows:   * It is recommended that data is presented for the period 2011-13 using five-year age bands in the standardisation calculation with the Mid-2011 Registered Population Estimates used as the denominator for this data. This will allow for a balance between the focus of the reference period and factors that could influence the standardisation calculation. * Initially, those aged under 35 were to be excluded from the indicator. However following advice from MRG on the impact that zero cells will have on the standardisation, this age group was re-included. * In order to align to other indicators, this indicator will now use 5 year age bands up to 89, those aged 90 and above will be counted in a single group. * MRG members indicated they were content with the proposed change.   **Interpretation:**   * No further comments raised by MRG   **Risks and Usefulness:**   * No further comments raised by MRG |

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| *Outcome of MRG consideration:* | 1. **No significant issues identified** |  |  |
|  | 1. **No significant issues on basis of completion of outstanding actions** |  |  |
|  | 1. **Some concerns expressed as caveats or limitations** |  |  |
|  | 1. **Significant reservations** |  |  |
|  | 1. **Unresolved issues** |  |  |

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| MRG statement of recommendation: | * Based on the response to questions raised and follow up analysis regarding standardisation presented by the applicant, MRG members indicated they were content with the evidence presented. |

Review:

**Review**

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| Review Timescale |  |
| **1 year** |  |
| **3 years** |  |
| **Other:** |  |

Rationale [Issues to consider – Changes to process, policy data source, coding definitions HES definitions ]

The indicator is recommended for review in three years on the rationale that no changes to methodology are anticipated.

IGB Sign-off:

**Indicator Assurance Process Output**

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| *Final Appraisal Status* | 1. **Assured** |  |  |
|  | 1. **Assured with Comments** |  |  |
|  | 1. **Failed Assurance** |  |  |

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| Basis of Sign-off  [Detail caveats and limitations ] |  |
| Sign-off Date |  |

Record of Assurance provided by **Indicator Governance Board**

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| **Indicator Title** | **Percentage of cancers diagnosed via emergency routes** | IAS Ref Code: | IAP00346 |
| Indicator Set | CCG Outcomes Indicator Set |  |  |

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| Description | This indicator shows the percentage of cases of cancer diagnosed during the respective year where the first presentation to secondary care is traced back to an emergency route, given by CCG. Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. |

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| Initial IGB discussion | 22/07/14 | Further discussed |  |

**Strategic Considerations & Implications**

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| Applicant / Sponsor Organisation | NHS England  \*Costing for assurance appraisal included in development cost | Assurance process funded? | **Yes\***    **No** |  |

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| Indicator rationale | Research into the way in which patients are first diagnosed with cancer shows that about a quarter of cancer patients are diagnosed via emergency routes and that the survival rates for those diagnosed via emergency routes are considerably lower than for other cancer patients.  The National Cancer Intelligence Network (NCIN) has produced the first study to look at how patients first enter secondary care on their way to being diagnosed with cancer. The methodology has been peer-reviewed in the British Journal of Cancer and the results include detailed comparison by type of cancer and results by equality groups. Also included is an analysis of incidence by broad route for breast, colorectal, lung and prostate cancer at PCT level.  The study showed that those patients diagnosed following an initial emergency presentation to secondary care had worse outcomes across all cancer types. By identifying the proportion of patients who first present as an emergency, it’s possible to investigate why these patients present as emergencies and how some patients could present earlier through a different route. An increase in the proportion of patients who present through a more managed process will correspond with improved outcomes. An indicator on the proportion of cancers diagnosed via an emergency route is, therefore, a useful proxy for assessing improvements in early diagnosis.  CCGs could impact on cancer diagnosis routes in a number of ways, including encouraging compliance with screening programmes among their patients and encouraging people to see their GP with potential symptoms of cancer when these first become noticeable, even if the symptoms do not represent an immediate major health issue. However, it could be several years before any effect is noticed and it may be difficult to isolate the effect of local interventions over national awareness programmes. |
| Basis for rationale  [Details of quality statement, policy etc.] | 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. |
| Calculation Summary | ***Denominator:***  The number of invasive cases of cancer, excluding non-melanoma skin cancer, diagnosed during the respective year. This is for both males and females, all age groups.  *Note: non-melanoma skin cancer is a non-basal cell carcinoma which is regularly excluded from cancer indicators as its impact on health is much less than other cancers and there are comparatively large numbers of cases which could significantly impact any statistic that includes it.*  *ICD-10 diagnosis codes are C00-C97, excluding C44.*  ***Numerator:***  Of cases of cancer in the denominator, the number with a route to diagnosis of “Emergency Presentation”.  *A route to diagnosis can be calculated for each tumour using a variety of sources. The methodology for this has been published in the British Journal of Cancer.*  *The assignment of a route to diagnosis is based on combining datasets to assign the most likely route. The route is not captured in any one dataset.* |
| Risks & assumptions | * The methodology for assigning the route to diagnosis as part of the registration system will be developed in early 2014 and may not be ready until late 2014, which means it will correspond with the availability of cancer registration data for 2013. * 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. Where the patient’s practice and postcode are both unavailable, the responsible CCG is the location of the hospital or trust. As the numerator is a subset of the denominator, the same method will be used for any particular patient. |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | *Data Source:* National Cancer Intelligence Network (NCIN) from the Cancer Analysis System (CAS).   * Data for this indicator will be extracted from the NCIN’s CAS. The CAS contains an extract of cancer registration data for analytical purposes once data have been signed off as complete by the cancer registries. Currently, the most recent year’s data available are for 2011. Data for 2013 will not be available until October or November 2014. |
| Potential impacts on other business areas [inc outstanding generic issues] | * There are no regularly produced indicators which look at the route to diagnosis of people diagnosed with cancer. * The National Cancer Intelligence Network (NCIN) produced similar indicators at a national level and for breast, colorectal, lung and prostate cancers at PCT level. These are part of the work for “Routes to Diagnosis” |
| Implementation Method  [inc production funding] | * NHS England has commissioned HSCIC to produce and disseminate the CCG OIS indicators; this is funded via the Grant in Aid funding to HSCIC. * Collection of the data required for the CCG OIS is via existing data collections, in this case by the NCIN from the Cancer Analysis System (CAS). Testing and specification of this indicator was carried out by the Specification Development Service in conjunction with the NCIN. The construction of the indicators will be carried out by the NCIN. * Dissemination and presentation of the CCG OIS will be via a number of routes:   + The indicators and their underlying data will be made publicly available via the HSCIC website and the Indicator Portal.   + The data will also be provided to NHS England for use in their internal Intelligence Tool.   + Subject to confirmation by NHS England, the calculated indicator, numerator and denominator for CCGs will be supplied by messaging to the Calculating Quality Reporting Service (CQRS) for use by CCGs as part of their management information. |

**Development Advice / Peer Review (undertaken as part of assurance process)**

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| Range of input during development | Advice and input was received on indicator definitions from Dr Mick Peake, National Clinical Lead for NHS Cancer Improvement and Clinical Lead for the NCIN. |
| Assurance Service  Peer Reviewers: | Andrea Johnson – Clinical Indicator HSCIC |
| Peer Review summary: | * Perhaps change title to ‘Percentage of cancers diagnosed via emergency routes’. * Include definition of secondary care. * ICD 10 codes included, along with the exclusion of C44 and that it covers all ages and genders need to be explicitly stated in the indicator definition. * Further explanation of how a patient comes to be registered on the NCIN CAS database would be useful. * The indicator as it stands offers an overall figure to CCGs on performance. However, due to the typical later presentation of males into services, a breakdown by gender, age or deprivation may be beneficial to highlight inequalities and allow CCGs the ability to more efficiently targets resources if required. * Contextual indicators into the main types of cancer, particularly those covered by screening programmes would help CCGs assess where work may need to be targeted. * The completeness of the NCIN CAS system is not detailed, only that ‘England is widely recognised as having one of the most comprehensive cancer registration systems in the world.’ |

**Record of MRG Discussion**

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| --- | --- |
| Discussion dates: | 07/10/13, 09/01/14 |

By:

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| --- | --- | --- |
| Julie Stroud (chair) | HSCIC | Head of Population Health and Social Care |
| Chris Dew (vice-chair) | HSCIC | Section Head, Clinical Indicators |
| Irena Begaj | UHB | Statistical Intelligence Analyst |
| Paul Fryers | PHE | Deputy Director, East Midlands Knowledge and Intelligence Team |
| Julie Henderson | HSCIC | Programme Head, Clinical Analysis |
| Jonathon Hope | HSCIC | Principal Information Analyst, Clinical Audit |
| Paul Iggulden | HSCIC | Interim Head of Clinical Analysis, Research & Development |
| Andy Sutherland | HSCIC | Statistics Head of Profession |
| Alyson Whitmarsh | HSCIC | Programme Manager, Clinical Audit |

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| Summary of MRG discussions: | Appraisal against Criteria:  **Clarity**   * The recommendation to amend the title to include the “percentage of…” was acted upon. * It was suggested that further evidence of the methodology used to determine whether cases are diagnosed by emergency routes would be useful, e.g. as described in the British Journal of Cancer. * The methodology used for this indicator has been peer-reviewed and published in the British Journal of Cancer. * A link to the BJC study has been provided in the indicator quality statement alongside the table presented in MRG detailing the eight routes, and showing diagnosis groups, descriptions, priority and relevant codes. This is also included in the specification. * It was noted that in within the list of emergency codes for inpatients, the third category code 24 (emergency referral from outpatient to inpatient) is missing. For other emergency admissions it is usually included, therefore it will be inconsistent with the definition of emergency used elsewhere. Conformation was sought as to whether it was certain it shouldn’t be excluded. * The developer put forward that   + the intent with the routes was work back from the end point and in going through this, to find out what the emergency presentation was that got the patient to first present to secondary care.   + finding out how people first came into secondary care is of interest. If someone is an emergency transfer for outpatient to inpatient, they have already had an outpatient appointment. The outpatient data would have to be looked at to see if the first presentation was an emergency or not. This would be slightly different to a patient who had entered into secondary care and then been considered an emergency and transferred to inpatient (as opposed to presenting as an emergency into secondary care in the first place). This had been discussed at length as part of the development process. * MRG questioned how this aligned with the inclusion of emergency admissions following A&E attendance. A&E is the first presentation but the indicator includes the inpatient bit following a presentation at A&E. * The developer put forward that there was a considerable difference as presenting at A&E is actually their first attendance into secondary care and is an emergency rather than already being in the system and becoming an emergency. * The exclusion of the category code 24 is explained in the Indicator Quality Statement as it represents a different approach for emergency admissions for other indicators. * The developer accepted as a good idea the suggestion to look as to whether the outcomes (survival) for those people who present as an outpatient and then get an emergency referral through to an inpatient significantly different to other people who first present as an outpatient, * However, this wouldn’t be done until late 2014.   **Rationale / Purpose**   * No further comments were raised by MRG   **Data :**   * The applicant put forward that cancer registration data has been used for this indicator, as it is the definitive source for cancers diagnosed via emergency routes at a national level. * A description identifying that for some cancers better data sources are available (e.g. the NLCA for lung cancer) is included in the metadata.   **Construction:**   * Further clarification as to whether patients diagnosed at death should be included in the numerator and the denominator or excluded from the indicator. * NCIN provided the following advice on this recommendation:   + This indicator measures the proportion of all tumours that were diagnosed as an emergency. The source of this indicator also displays the other seven Routes that tumours can be assigned to. A Death Certificate Only (DCO) is a Route; indeed, it is important to identify cancer sites with a high proportion of DCOs in order to understand why the person had not presented with symptoms. This indicator and results should also align with the source of the data and therefore needs to adhere to the same methodology.   + Professor Sir Mike Richards, Clinical Advisor to the Routes to Diagnosis project, supports these results being consistent with the Routes to Diagnosis methodology.   **Interpretation:**   * It was confirmed DCOs are included in the denominator but not the numerator, however it was queried as to whether there might be an issue in that DCOs are a bad outcome, but a higher level of DCOs can be interpreted as good on this indicator. In this case should they be excluded from the denominator. * In response the developer put forward excluding DCOs from the denominator would produce a slightly different set of results to anything else that is published using the risk and diagnosis methodology, and on the basis of a small amount of numbers, is there a benefit of producing this inconsistency. * A suggestion put forward was the preferable outcome was to include DCOs in the numerator (as if people were diagnosed at death then this represents a failure of the system), however the developer responded that as it was not classified as an emergency it couldn’t be included in the numerator, as there was no information if they presented as an emergency or not. * MRG concluded that the issue of including / excluding DCO’s would impact on the interpretation of the indicator, as mixing of “good and bad things” isn’t generally a good way of defining an indicator. However, if it is a negligible issue and is the historic way it is done then the group might not want to see it being slightly different from other versions of the indicator elsewhere. * To ensure that there is not any perverse behaviour happening around DCOs results showing emergency plus DCOs will be provided as contextual information. This will enable users to see if there were any large changes in the DCOs that would affect the emergency rates.   **Risks and Usefulness:**   * No further comments were raised by MRG   **Other:**  Further clarification was provided as to those patients presenting at secondary services via routes other than A&E and emergency GP referrals. |

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| *Outcome of MRG consideration:* | 1. **No significant issues identified** |  |  |
|  | 1. **No significant issues on basis of completion of outstanding actions** |  |  |
|  | 1. **Some concerns expressed as caveats or limitations** |  |  |
|  | 1. **Significant reservations** |  |  |
|  | 1. **Unresolved issues** |  |  |

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| MRG statement of recommendation: | The indicator is recommended for appraisal by IGB subject to the issues discussed during the meeting. The pragmatic approach the MRG have adopted to cover the concerns raised around this indicator’s methodology regarding the inclusion of DCOs should be noted. |

Review:

**Review**

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| --- | --- |
| Review Timescale |  |
| **1 year** |  |
| **3 years** |  |
| **Other:** |  |

Rationale [Issues to consider – Changes to process, policy data source, coding definitions HES definitions ]

The indicator is recommended for review in three years on the rationale that no changes to methodology are anticipated.

IGB Sign-off:

**Indicator Assurance Process Output**

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| --- | --- | --- | --- |
| *Final Appraisal Status* | 1. **Assured** |  |  |
|  | 1. **Assured with Comments** |  |  |
|  | 1. **Failed Assurance** |  |  |

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| Basis of Sign-off  [Detail caveats and limitations ] |  |
| Sign-off Date |  |

Record of Assurance provided by **Indicator Governance Board**

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| --- | --- | --- | --- |
| **Indicator Title** | **Record of cancer stage at diagnosis** | IAS Ref Code: | IAP00347 |
| Indicator Set | CCG Outcomes Indicator Set |  |  |

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| Description | The percentage of all cases of cancer for which a valid stage is recorded, given by Clinical Commissioning Group (CCG).  ‘Validity’ of stage is assessed according to United Kingdom Association of Cancer Registries (UKACR) rules. As not all cancer types can be validly staged by any staging system, the UKACR adopts a threshold of 70% completeness for this indicator. |

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| Initial IGB discussion | 22/07/14 | Further discussed |  |

**Strategic Considerations & Implications**

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| --- | --- | --- | --- | --- |
| Applicant / Sponsor Organisation | NHS England  \*Costing for assurance appraisal included in development cost | Assurance process funded? | **Yes\***    **No** |  |

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| --- | --- |
| Indicator rationale | Cancer is a major cause of death, accounting for around a quarter of deaths in England. Currently, it is estimated that more than 40% children born today will develop cancer at some stage in their life. The stage of the tumour at diagnosis is a major determinant of patient outcomes from cancer. A high proportion of cancers with a valid stage recorded allow much deeper and more actionable analyses of outcomes by treatment type, patient pathway, and case-mix.  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. An 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 on the overall proportion of cancers for which a stage is recorded will allow assessment of the completeness of staging data for these purposes. |
| Basis for rationale  [Details of quality statement, policy etc.] | 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. |
| Calculation Summary | ***Denominator:***  The number of new invasive cases of cancer, excluding non-melanoma skin cancer, diagnosed during the respective year.  *Note: non-melanoma skin cancer is a non-basal cell carcinoma which is regularly excluded from cancer indicators as its impact on health is much less than other cancers and there are comparatively large numbers of cases which could significantly impact any statistic that includes it.*  ***Numerator:***  Of cases of cancer in the denominator, the number with a valid stage at diagnosis recorded, as defined by the former United Kingdom Association of Cancer Registries (UKACR) registration rules. |
| Risks & assumptions | * Data for this indicator will be extracted from the National Cancer Intelligence Network (NCIN) Cancer Analysis System (CAS). The CAS contains an extract of cancer registration data for analytical purposes once data have been signed off as complete by the cancer registries. Currently, the most recent year’s data available are for 2011. Data for 2013 will not be available until October or November 2014. * 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. Where the patient’s practice and postcode are both unavailable, the responsible CCG is the location of the hospital or trust. As the numerator is a subset of the denominator, the same method will be used for any particular patient. |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | *Data Source:* Data will be provided by the NCIN from the CAS  The CAS contains a fully signed off extract of cancer registrations supplied by the National Cancer Registration Service.  Data for calendar year 2012 is due to be published in September 2014 as a baseline. |
| Potential impacts on other business areas [inc outstanding generic issues] | - |
| Implementation Method  [inc production funding] | * NHS England has commissioned HSCIC to produce and disseminate the CCG OIS indicators; this is funded via the Grant in Aid funding to HSCIC. * Collection of the data required for the CCG OIS is via existing data collections, in this case by the NCIN from the Cancer Analysis System (CAS). Testing and specification of this indicator was carried out by the Specification Development Service in conjunction with the NCIN. The construction of the indicators will be carried out by the NCIN. * Dissemination and presentation of the CCG OIS will be via a number of routes:   + The indicators and their underlying data will be made publically available via the HSCIC website and the Indicator Portal.   + The data will also be provided to NHS England for use in their internal Intelligence Tool.   + Subject to confirmation by NHS England, the calculated indicator, numerator and denominator for CCGs will be supplied by messaging to the Calculating Quality Reporting Service (CQRS) for use by CCGs as part of their management information. |

**Development Advice / Peer Review (undertaken as part of assurance process)**

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| --- | --- |
| Range of input during development | Advice and input was received on indicator definitions from Dr Mick Peake, National Clinical Lead for NHS Cancer Improvement and Clinical Lead for the NCIN. |
| Assurance Service  Peer Reviewers: | Andrea Johnson – Clinical Indicators HSCIC |
| Peer Review summary: | * Indicator title ‘Cancer stage at diagnosis’ could be changed. It actually measures the percentage of new cases per year with a valid stage recorded. ‘Percentage of new cancer cases with a valid stage recorded’ or similar perhaps? * It isn’t explained how a patient comes to be registered on the NCIN CAS database. Is it at the point of initial cancer diagnosis from whichever location? How long does it take to appear on the NCIN system following diagnosis? * It is noted on the application form that a 70% completeness rate is considered to be a valid completeness level for this indicator by the UKACR as not all cancers can be validly staged by any staging method. A note could be placed on the data to recognise that 100% may not be achievable through no fault of the CCG. |

**Record of MRG Discussion**

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| --- | --- |
| Discussion dates: | 07/10/13, |

By:

|  |  |  |
| --- | --- | --- |
| Heather Dawe (chair) | HSCIC | Programme Manager, Clinical Indicators |
| Chris Dew (vice-chair) | HSCIC | Section Head, Clinical Indicators |
| Paul Fryers | PHE | Deputy Director, East Midlands Knowledge and Intelligence Team |
| Julie Henderson | HSCIC | Programme Head, Clinical Analysis |
| Andy Sutherland | HSCIC | Statistics Head of Profession |
| Alyson Whitmarsh | HSCIC | Programme Manager, Clinical Audit |

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| Summary of MRG discussions: | Appraisal against Criteria:  **Clarity**   * The indicator title has been updated to “Record of cancer stage at diagnosis’ in order to clarify that it is measuring record completeness, as opposed to the average cancer stage at diagnosis.   **Rationale / Purpose**   * It was suggested by MRG that if old age is a common cause for staging not to be conducted, that an age cut off could be used (for instance it may be undesirable for clinicians to conduct invasive procedures in order to stage the cancer in an elderly patient with prostate cancer) * In response the applicant felt this would reflect poorly on the indicator and raise concerns about elderly patients not getting the same standard of care due to their age. Furthermore, that the aim of 70% of cancer patients being staged at diagnosis takes into account this population.   **Data :**   * No further comments were raised by MRG   **Construction:**   * The extent to which staging is appropriate differs with different cancers, therefore when CCGs are being compared, it was queried as to whether any standardisation would account for this. * The applicant felt that one purpose of the indicator was to drive better staging at diagnosis, therefore it is hoped that records would be more complete as a result. However, in terms of standardisation, the applicant felt there was no way of doing this.   **Interpretation:**   * Although it is understood by MRG that one of the main purposes of this indicator is support the push to increase staging of cancer when possible at diagnosis, the group queried how a CCG with a low rate of staging should be compared to others which perhaps have many cases of cancer which either cannot be staged or it is deemed undesirable to do so, and thus how this fits into the purpose of CCG OIS. * Another concern raised is that CCGs may be able to claim a variable not taken into consideration by the indicator is the reason behind the results, for example deprivation or population age. It was felt by MRG that in the future, contextual indicators should be published with the outcomes of this indicator. * In the interim the indicator quality statement associated with the indicator directs users to contextual information:   + *“This indicator requires careful interpretation and should not be viewed in isolation, but instead be considered alongside information from other indicators and alternative sources. The NCIN’s service profiles provide information on other indicators and are available from https://www.cancertoolkit.co.uk/. When evaluated together, these will help to provide a holistic view of CCG outcomes and provide a more complete overview of the impact of the CCGs’ processes on outcomes.”*   **Risks and Usefulness:**   * No further comments were raised by MRG |

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| *Outcome of MRG consideration:* | 1. **No significant issues identified** |  |  |
|  | 1. **No significant issues on basis of completion of outstanding actions** |  |  |
|  | 1. **Some concerns expressed as caveats or limitations** |  |  |
|  | 1. **Significant reservations** |  |  |
|  | 1. **Unresolved issues** |  |  |

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| MRG statement of recommendation: | This indicator was recommended for discussion by IGB on the basis that the indicator quality statement reflects that the indicator should not be used in isolation, and that as part of the future development of this indicator, contextual indicators should be produced e.g. around deprivation, age etc. |

Review:

**Review**

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| --- | --- |
| Review Timescale |  |
| **1 year** |  |
| **3 years** |  |
| **Other:** |  |

Rationale [Issues to consider – Changes to process, policy data source, coding definitions HES definitions ]

The indicator is recommended for review in three years on the rationale that no changes to methodology are anticipated.

IGB Sign-off:

**Indicator Assurance Process Output**

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| --- | --- | --- | --- |
| *Final Appraisal Status* | 1. **Assured** |  |  |
|  | 1. **Assured with Comments** |  |  |
|  | 1. **Failed Assurance** |  |  |

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| --- | --- |
| Basis of Sign-off  [Detail caveats and limitations ] |  |
| Sign-off Date |  |

Record of Assurance provided by **Indicator Governance Board**

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| --- | --- | --- | --- |
| **Indicator Title** | **Cancers detected at stage 1 or 2** | IAS Ref Code: | IAP00350 |
| Indicator Set | CCG Outcomes Indicator Set |  |  |

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| Description | This indicator calculates the percentage of new cases of cancer which were diagnosed at stage 1 or 2 for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphoma and invasive melanomas of skin, given by CCG.  This indicator relates to a subset of the cancers covered by CCG indicator 1.16 Percentage of cancers diagnosed via emergency routes, and 1.17 Record of stage of cancer at diagnosis. |

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| Initial IGB discussion | 22/07/14 | Further discussed |  |

**Strategic Considerations & Implications**

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| --- | --- | --- | --- | --- |
| Applicant / Sponsor Organisation | NHS England  \*Costing for assurance appraisal included in development cost | Assurance process funded? | **Yes\***    **No** |  |

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| Indicator rationale | Cancer is a major cause of death, accounting for around a quarter of deaths in England. Currently, it is estimated that more than 40% children born today will develop cancer at some stage in their life. The stage of the tumour at diagnosis is a major determinant of patient outcomes from 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. An indicator on the proportion of cancers diagnosed at an early stage is, therefore, a useful proxy for assessing improvements in cancer survival rates.  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 stipulate this as part of the services they commission. |
| Basis for rationale  [Details of quality statement, policy etc.] | 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. |
| Calculation Summary | ***Denominator:***  The number of 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 lymphoma and invasive melanomas of skin.  *The full list of UKACR registration rules is available in a separate document.*  ***Numerator:***  Of cases of cancer in the denominator, the number diagnosed at stage 1 or 2. |
| Risks & assumptions | * Data for this indicator will be extracted from the National Cancer Intelligence Network (NCIN) Cancer Analysis System (CAS). The CAS contains an extract of cancer registration data for analytical purposes once data have been signed off as complete by the cancer registries. Currently, the most recent year’s data available are for 2011. Data for 2013 will not be available until October or November 2014. * 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. Where the patient’s practice and postcode are both unavailable, the responsible CCG is the location of the hospital or trust. As the numerator is a subset of the denominator, the same method will be used for any particular patient. * This indicator shows the percentage of new cases of cancer which were diagnosed at stage 1 or 2 for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphoma 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 may 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. |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | *Data Source:* Data will be provided by the NCIN from the CAS.   * The CAS contains a fully signed off extract of cancer registrations supplied by the National Cancer Registration Service. * Data for calendar year 2012 is due to be published in September 2014 as a baseline. |
| Potential impacts on other business areas [inc outstanding generic issues] | * A similar indicator exists in the Public Health Outcomes Framework:   *PHOF 2.19 - The proportion of invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin, diagnosed at stage 1 or 2* |
| Implementation Method  [inc production funding] | * NHS England has commissioned HSCIC to produce and disseminate the CCG OIS indicators; this is funded via the Grant In Aid funding to HSCIC. * Collection of the data required for the CCG OIS is via existing data collections, in this case by the NCIN from the Cancer Analysis System (CAS). Testing and specification of this indicator was carried out by the Specification Development Service in conjunction with the NCIN. The construction of the indicators will be carried out by the NCIN. * Dissemination and presentation of the CCG OIS will be via a number of routes:   + The indicators and their underlying data will be made publically available via the HSCIC website and the Indicator Portal.   + The data will also be provided to NHS England for use in their internal Intelligence Tool.   + Subject to confirmation by NHS England, the calculated indicator, numerator and denominator for CCGs will be supplied by messaging to the Calculating Quality Reporting Service (CQRS) for use by CCGs as part of their management information. |

**Development Advice / Peer Review (undertaken as part of assurance process)**

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| Range of input during development | Advice and input was received on indicator definitions from Dr Mick Peake, National Clinical Lead for NHS Cancer Improvement and Clinical Lead for the NCIN. |
| Assurance Service  Peer Reviewers: | The indicator was sent for peer review in a pack of five cancer indicators. No comments were received for this indicator. |
| Peer Review summary: | n/a |

**Record of MRG Discussion**

|  |  |
| --- | --- |
| Discussion dates: | 07/10/13, |

By:

|  |  |  |
| --- | --- | --- |
| Heather Dawe (chair) | HSCIC | Programme Manager, Clinical Indicators |
| Chris Dew (vice-chair) | HSCIC | Section Head, Clinical Indicators |
| Paul Fryers | PHE | Deputy Director, East Midlands Knowledge and Intelligence Team |
| Julie Henderson | HSCIC | Programme Head, Clinical Analysis |
| Andy Sutherland | HSCIC | Statistics Head of Profession |
| Alyson Whitmarsh | HSCIC | Programme Manager, Clinical Audit |

|  |  |
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| Summary of MRG discussions: | Appraisal against Criteria:  **Clarity**   * MRG felt it was not clear from the title that only certain cancers were measured and it was assumed that the list of cancers was the same as the other cancer indicators. * Clarity of which cancers are included in the indicator is included in the Specification. In the detailed descriptor and the introduction, it also makes reference to the fact that this indicator differs to the other two specific CCG OIS cancer indicators. * The applicant updated the group that the list of cancers used is the same as those used for the Public Health Outcome Framework indicator, with the same name. A wider issue of whether the PH indicator should be changed too was raised.   **Rationale / Purpose:** No further comments were raised by MRG  **Data :** No further comments were raised by MRG  **Construction:**   * It was questioned whether it was planned to aggregate all cancers on the list at CCG level, and the applicant confirmed this was the case. * It was clarified by the applicant that the numerator is measuring the cases that are both diagnosed and recorded; therefore, there will be patients who did not have a stage recorded which will be in the denominator but not in the numerator. However, all cancers in the denominator have the potential to be recorded.   **Interpretation:** No further comments were raised by MRG  **Risks and Usefulness:** No further comments were raised by MRG |

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| *Outcome of MRG consideration:* | 1. **No significant issues identified** |  |  |
|  | 1. **No significant issues on basis of completion of outstanding actions** |  |  |
|  | 1. **Some concerns expressed as caveats or limitations** |  |  |
|  | 1. **Significant reservations** |  |  |
|  | 1. **Unresolved issues** |  |  |

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| MRG statement of recommendation: | This indicator was recommended for discussion by IGB on completion of the above recommendations. |

Review:

**Review**

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| --- | --- |
| Review Timescale |  |
| **1 year** |  |
| **3 years** |  |
| **Other:** |  |

Rationale [Issues to consider – Changes to process, policy data source, coding definitions HES definitions ]

The indicator is recommended for review in three years on the rationale that no changes to methodology are anticipated.

IGB Sign-off:

**Indicator Assurance Process Output**

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| --- | --- | --- | --- |
| *Final Appraisal Status* | 1. **Assured** |  |  |
|  | 1. **Assured with Comments** |  |  |
|  | 1. **Failed Assurance** |  |  |

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| --- | --- |
| Basis of Sign-off  [Detail caveats and limitations ] |  |
| Sign-off Date |  |

Record of Assurance provided by **Indicator Governance Board**

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| --- | --- | --- | --- |
| **Indicator Title** | **Record of lung cancer stage at decision to treat** | IAS Ref Code: | IAP00351 |
| Indicator Set | CCG Outcomes Indicator Set |  |  |

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| Description | The percentage of cases of lung cancer for which a valid stage field is recorded, given by Clinical Commissioning Group. |

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| Initial IGB discussion | 22/07/14 | Further discussed |  |

**Strategic Considerations & Implications**

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| --- | --- | --- | --- | --- |
| Applicant / Sponsor Organisation | NHS England  \*Costing for assurance appraisal included in development cost | Assurance process funded? | **Yes\***    **No** |  |

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| Indicator rationale | Lung cancer has one of the lowest survival outcomes of any cancer because over two-thirds of patients are diagnosed at a late stage when curative treatment is not possible. Earlier diagnosis and referral to specialist teams would make a significant difference to survival rates. |
| Basis for rationale  [Details of quality statement, policy etc.] | This indicator is based on the NICE Quality Standard 17: Lung cancer for adults, issued March 2012  http://guidance.nice.org.uk/QS17.  This indicator aims to be consistent with the NICE Clinical Guideline 121: The diagnosis and treatment of lung cancer, issued April 2011  <http://publications.nice.org.uk/lung-cancer-cg121>.  The following statements are taken from CG121:  *1.3.2 Patients with known or suspected lung cancer should be offered a contrast-enhanced chest CT scan to further the diagnosis and stage the disease. The scan should also include the liver and adrenals.*  *1.3.12 Choose investigations that give the most information about diagnosis and staging with least risk to the patient. Think carefully before performing a test that gives only diagnostic pathology when information on staging is also needed to guide treatment* |
| Calculation Summary | ***Denominator:***The number of patients first seen in the respective Lung Cancer Audit year.  ***Numerator:*** Of the denominator, the number of patient records where the stage field at the time of decision to treat is completed (according to staging rules). |
| Risks & assumptions | * When testing the indicator for the NICE Advisory Committee in May 2013, the data had been mapped to CCG using the ‘latest’ GP Practice code registered for each patient. * GP Practice code at ‘date first seen’ would be preferable as it is more reflective of the patient’s home location of secondary care. NHAIS (Exeter) have confirmed that they are able to trace GP Practice code at date first seen, however this will involve a cost. |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | *Data Source:* The National Lung Cancer Audit.  The National Lung Cancer Audit Report is published at trust and network level on an annual basis. Use for CCG level indicators will be subject to a Data Sharing Agreement.  The National Lung Cancer Audit (the Lung Cancer Data project LUCADA) is approved by ISB ref ISB0064. |
| Potential impacts on other business areas [inc outstanding generic issues] | - |
| Implementation Method  [inc production funding] | * NHS England has commissioned HSCIC to produce and disseminate the CCG OIS indicators; this is funded via the Grant in Aid funding to HSCIC. * Collection of the data for the CCG OIS is via existing data collections, in this case the National Lung Cancer Audit. Testing and specification of this indicator is carried out by the Specification Development Service in conjunction with the National Lung Cancer Audit. The construction of the indicators will be carried out by Clinical Indicators via the CI Platform at HSCIC. * Dissemination and presentation of the CCG OIS will be via a number of routes:   + The indicators and their underlying data will be made publically available via the HSCIC website and the Indicator Portal.   + The indicators will also be provided to NHS England for use in their internal Intelligence Tool.   + Subject to confirmation by NHS England, the calculated indicator, numerator and denominator for CCGs will be supplied by messaging to the Calculating Quality Reporting Service (CQRS) for use by CCGs as part of their management information. * The National Lung Cancer Audit is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and currently funded to December 2013. It is expected to be granted an extension to December 2014; however, this is yet to be approved. |

**Development Advice / Peer Review (undertaken as part of assurance process)**

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| Range of input during development | - |
| Assurance Service  Peer Reviewers: | The indicator was sent for peer review in a pack of five indicators. No comments were received for this indicator. |
| Peer Review summary: | n/a |

**Record of MRG Discussion**

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| --- | --- |
| Discussion dates: | 07/10/13, |

By:

|  |  |  |
| --- | --- | --- |
| Heather Dawe (chair) | HSCIC | Programme Manager, Clinical Indicators |
| Chris Dew (vice-chair) | HSCIC | Section Head, Clinical Indicators |
| Paul Fryers | PHE | Deputy Director, East Midlands Knowledge and Intelligence Team |
| Julie Henderson | HSCIC | Programme Head, Clinical Analysis |
| Andy Sutherland | HSCIC | Statistics Head of Profession |
| Alyson Whitmarsh | HSCIC | Programme Manager, Clinical Audit |

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| Summary of MRG discussions: | Appraisal against Criteria:  **Clarity**   * The applicant highlighted an issue with the current title, that the lung cancer stage is recorded at decision to treat rather than at diagnosis, therefore the title has been updated to ‘Record of lung cancer stage at decision to treat’   **Rationale / Purpose:** No further comments were raised by MRG  **Data :**   * It was questioned as to why the NLCA was used as a data source for this indicator, when NCIN includes lung cancer. The applicant explained that this data was of a higher quality, and if data of this standard was available for all cancer types, it would be used as opposed to the NCIN.   **Construction:** No further comments were raised by MRG  **Interpretation:** No further comments were raised by MRG  **Risks and Usefulness:** No further comments were raised by MRG |

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| --- | --- | --- | --- |
| *Outcome of MRG consideration:* | 1. **No significant issues identified** |  |  |
|  | 1. **No significant issues on basis of completion of outstanding actions** |  |  |
|  | 1. **Some concerns expressed as caveats or limitations** |  |  |
|  | 1. **Significant reservations** |  |  |
|  | 1. **Unresolved issues** |  |  |

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| --- | --- |
| MRG statement of recommendation: | This indicator was recommended for discussion by IGB on completion of the above recommendations |

Review:

**Review**

|  |  |
| --- | --- |
| Review Timescale |  |
| **1 year** |  |
| **3 years** |  |
| **Other:** |  |

Rationale [Issues to consider – Changes to process, policy data source, coding definitions HES definitions ]

The indicator is recommended for review in three years on the rationale that no changes to methodology are anticipated.

IGB Sign-off:

**Indicator Assurance Process Output**

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| --- | --- | --- | --- |
| *Final Appraisal Status* | 1. **Assured** |  |  |
|  | 1. **Assured with Comments** |  |  |
|  | 1. **Failed Assurance** |  |  |

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| --- | --- |
| Basis of Sign-off  [Detail caveats and limitations ] |  |
| Sign-off Date |  |

See our [accessibility statement](https://www.nice.org.uk/accessibility#what-to-do) if you’re having problems with this document.