NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Consultation report

Indicator area: Cancer

Consultation period: 8 February – 8 March 2017

Date of Indicator Advisory Committee meeting: 6 June 2017

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Summary of indicators included in the consultation

ID	Indicator	Evidence source
GP6	The proportion of women eligible for screening and aged 25 – 49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3.5 years.	Cervical screening: programme overview (2015) National Screening Committee – Cervical screening programme guidance.
GP7	The proportion of women eligible for screening and aged 50 – 64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the last 5.5 years.	Cervical screening: programme overview (2015) National Screening Committee – Cervical screening programme guidance.
CCG14	The proportion of eligible people aged 60-74 years whose records shows a bowel screening test has been performed within the last 2 years.	Bowel cancer screening: programme overview (2015) National Screening Committee – Bowel cancer screening programme guidance.
CCG15	The proportion of women aged 50-70 years whose record shows a breast screening test has been performed within the last 3 years.	Breast screening: programme overview (2015) National Screening Committee – Breast screening programme guidance.

GP6: Cervical cancer screening – women under 50

The proportion of women eligible[1] for screening and aged 25 – 49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3.5 years

Rationale

Cervical cancer often has no symptoms in its early stages and the exact cause of cervical cancer is not known. Cervical screening is a method of preventing cancer by detecting and treating abnormalities of the cervix.

There is an existing indicator in the QOF for cervical screening:

> CS002: The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years.

However, this indicator does not align with The NHS Cervical Screening Programme (NHSCSP) in England in terms of age and frequency. The NHSCSP invites:

- Women aged 25-49 years for screening every 3 years
- Women aged 50-64 for screening every 5 years

Summary of consultation comments

Stakeholders welcomed this indicator, and commented that the indicator is consistent with the National Screening Programme; may allow opportunistic intervention to improve responses to screening invites; and may reduce variations in screening uptake in respect of race and religion.

Stakeholders advised that data for this indicator are already available.

Considerations for the advisory committee

The committee is asked to consider if the indicator should progress.

[1] Eligible women are those **not** ceased from recall due to clinical reasons i.e. absence of cervix

GP7: Cervical cancer screening – women aged 50 years and above

The proportion of women eligible[2] for screening and aged 50 – 64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the last 5.5 years

Rationale

Cervical cancer often has no symptoms in its early stages and the exact cause of cervical cancer is not known. Cervical screening is a method of preventing cancer by detecting and treating abnormalities of the cervix.

There is an existing indicator in the QOF for cervical screening:

> CS002: The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years.

However, this indicator does not align with The NHS Cervical Screening Programme (NHSCSP) in England in terms of age and frequency. The NHSCSP invites:

- Women aged 25-49 years for screening every 3 years
- Women aged 50-64 for screening every 5 years

Summary of consultation comments

Stakeholders welcomed this indicator, and commented that the indicator is consistent with expected clinical practice and may reduce variations in screening uptake in respect of race and religion.

Stakeholders advised that data for this indicator are already available.

Considerations for the advisory committee

The committee is asked to consider if the indicator should progress.

[2] Eligible women are those **not** ceased from recall due to clinical reasons i.e. absence of cervix

CCG14: Bowel cancer screening

The proportion of eligible people aged 60-74 years whose records shows a bowel screening test has been performed within the last 2 years.

Rationale

Colorectal cancer (also known as bowel cancer) is the second most common cause of cancer deaths in the UK, with approximately 16,100 deaths each year. This makes prevention and early detection a healthcare priority because if bowel cancer is found early, it is easier to treat. Ensuring earlier diagnosis presents great potential for transformational improvements in patient outcomes.

The NHS bowel cancer screening programme (NHSBCSP) offers screening every 2 years to all men and women aged 60 – 74. The NHSBCSP is delivered through programme hubs and local screening centres. Bowel screening uptake is not as high as uptake of other cancer screening programmes, and there are variations between areas and demographics.

Summary of consultation comments

Stakeholders described the indicator as positive, but suggested that GP practices need to think about how they would act on the results.

Stakeholders raised concerns that staff time and resources will be needed for GP practices to code the results.

Stakeholders highlighted that the data may already be available from screening registry data.

Considerations for the advisory committee

The committee is asked to consider:

- if the indicator would contribute to increased uptake of bowel cancer screening and reduced variation in uptake
- the respective roles of CCGs and GPs in improving uptake
- whether the indicator would result in increased workload for GP practices.

CCG15: Breast cancer screening

The proportion of women aged 50-70 years whose record shows a breast screening test has been performed within the last 3 years.

Rationale

The NHS Breast Screening Programme (NHSBSP) is a population screening programme which is currently offered to women aged 50-70 in England and is estimated to save 1,300 lives each year. If breast cancer is diagnosed at the earliest stage, the majority of women will survive for 5 years or more, compared to 3 in 10 women if diagnosed at a later stage (Cancer Research UK, 2015).

The aim of breast screening is to reduce mortality by finding breast cancer at an early stage often when any changes in the breast are too small to feel. Of all women with cancers detected in 2013-14, 39.9 % (7,175 women) had invasive but small cancers (less than 15mm in diameter), that are usually too small to detect by hand.

Summary of consultation comments

The indicator was generally described as useful and positive. It would allow GP practices to consider their role in maximising uptake of national screening programmes.

Stakeholders suggested that potential unintended consequences are over diagnosis and consequent treatment which can result in significant harm. Creating an indicator could imply greater benefit and block balanced discussions, leading to skewed information for patient choice.

Stakeholders raised concerns that staff time and resources will be needed for GP practices to code the results.

Stakeholders highlighted that the data may already be available from screening registry data.

Considerations for the advisory committee

The committee is asked to consider:

- if the indicator would improve uptake
- the role of CCGs and GPs
- whether the indicator would result in increased workload for GP practices
- if the indicator could adversely affect patient choice.

Appendix A: Consultation comments

ID	Proforma question no.	Stakeholder organisation	Comment
Question 6.1: Do you think there are any barriers to implementing the care that would impact on this indicator?			
GP6	6.1	The Royal College of General Practitioners	No
GP6	6.1	Royal College of Nursing	No
GP6	6.1	Royal College of Pathologists	No
Question 6.2: Do you think there are potential unintended consequences to implementing / using this indicator?			
GP6	6.2	The Royal College of General Practitioners	No
GP6	6.2	Royal College of Nursing	No
GP6	6.2	Royal College of Pathologists	No
Question 6.3: Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
GP6	6.3	The Royal College of General Practitioners	No
GP6	6.3	Royal College of Nursing	No
GP6	6.3	Royal College of Pathologists	Yes. It has a potential differential impact in respect of race and religion. It has a positive impact on Asian (Muslims) women. This group tend to default and feel reluctant to have a smear and sometimes the ultimate say is not in the woman's hand but in the hands of their partners. By making sure that adequate smear was recorded in the previous 3.5 years would influence the screening programme positively.
Question 6.4: Do you have any general comments on this indicator?			
GP6	6.4	NHS Medway Clinical Commissioning Group	And are we also doing for immunisations routinely given in primary care?

ID	Proforma question no.	Stakeholder organisation	Comment
GP6	6.4	The Royal College of General Practitioners	This is a good indicator, which is consistent with National Screening Programme. There may be benefits for bowel and breast screening allowing opportunistic intervention for poor responders to the invite.
GP6	6.4	British Medical Association	These figures are already available
GP6	6.4	Royal College of Nursing	A positive indicator
GP6	6.4	Royal College of Pathologists	You need a good fail safe mechanism in place for this indicator to succeed.
Question 7.1: Do you think there are any barriers to establishing and maintaining this register indicator?			
GP7	7.1	The Royal College of General Practitioners	No
GP7	7.1	Royal College of Nursing	No
GP7	7.1	Royal College of Pathologists	No
Question 7.2: Do you think there are potential unintended consequences to implementing / using this indicator?			
GP7	7.2	The Royal College of General Practitioners	No
GP7	7.2	Royal College of Nursing	No
GP7	7.2	Royal College of Pathologists	No
Question 7.3: Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
GP7	7.3	The Royal College of General Practitioners	No
GP7	7.3	Royal College of Nursing	No
GP7	7.3	Royal College of Pathologists	Yes as above (see comment from Royal College of Pathologists for question 6.3 above)
Question 7.4: Do you have any general comments on this indicator?			
GP7	7.4	NHS Medway Clinical Commissioning Group	And are we also doing for immunisations routinely given in primary care?
GP7	7.4	The Royal College of General Practitioners	It seems a sensible change as it more accurately mirrors expected clinical practice
GP7	7.4	British Medical Association	These figures are already available

ID	Proforma question no.	Stakeholder organisation	Comment
GP7	7.4	Royal College of Nursing	A positive indicator
GP7	7.4	Royal College of Pathologists	Again, good fail safe mechanism is needed for the indicator to succeed.
Question 25.1: Do you think there are any barriers to implementing the care described by this indicator?			
CCG14	25.1	The Royal College of General Practitioners	GP practices will need to code the results which will require staff time and resources
CCG14	25.1	Royal College of Nursing	No
CCG14	25.1	Royal College of Pathologists	No
Question 25.2: Do you think there are potential unintended consequences to implementing / using this indicator?			
CCG14	25.2	The Royal College of General Practitioners	Increase in workload due to the need to code results
CCG14	25.2	Royal College of Nursing	No
CCG14	25.2	Royal College of Pathologists	No
Question 25.3: Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
CCG14	25.3	Royal College of Nursing	No
CCG14	25.3	Royal College of Pathologists	No
Question 25.4: Do you have any general comments on this indicator?			
CCG14	25.4	NHS Medway Clinical Commissioning Group	Presumably this is being taken direct from the screening registry data. I think this is already available.
CCG14	25.4	The Royal College of General Practitioners	The GP practices will need to think about how they might act on the results
CCG14	25.4	Royal College of Nursing	A positive indicator
CCG14	25.4	Royal College of Pathologists	No
Question 26.1: Do you think there are any barriers to implementing the care described by this indicator?			
CCG15	26.1	The Royal College of General Practitioners	Time spent coding the results for the practice staff
CCG15	26.1	Royal College of Nursing	No
Question 26.2: Do you think there are potential unintended consequences to implementing / using this indicator?			

ID	Proforma question no.	Stakeholder organisation	Comment
CCG15	26.2	Crossfell Health Centre - GP	There are significant harms from overdiagnosis and the consequent treatment which outweigh the modest (if any) decrease in overall mortality. Inclusion as an indicator implies greater benefits and blocks balanced discussions around risks so leading to skewed information for patients' choice.
CCG15	26.2	The Royal College of General Practitioners	Time needed for coding
CCG15	26.2	Royal College of Nursing	No
Question 26.3: Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
CCG15	26.3	The Royal College of General Practitioners	No
CCG15	26.3	Royal College of Nursing	No
Question 26.4: Do you have any general comments on this indicator?			
CCG15	26.4	NHS Medway Clinical Commissioning Group	Presumably this is being taken direct from the screening registry data. I think this is already available
CCG15	26.4	The Royal College of General Practitioners	Useful for GP practices to think about what role they play in maximising the uptake of National screening programmes but they do need to allocate staff time to coding results
CCG15	26.4	Royal College of Nursing	A positive indicator

Appendix B: Equality impact assessment

Protected characteristics		
• Age • Disability • Gender reassignment	• Pregnancy and maternity • Race • Religion or belief	• Sex • Sexual orientation
Note: 1) The characteristic of marriage and civil partnership is protected only from unlawful discrimination. There is no legal requirement to consider the need to advance equality and foster good relations. 2) The definition of direct discrimination includes less favourable treatment of someone associated with a person with a protected characteristic, such as the carer of a disabled person.		
Socioeconomic factors		
The relevance and nature of socioeconomic factors will vary according to the quality standard topic. They may include deprivation and disadvantage associated with particular geographical areas, or other geographical distinctions (for example, urban versus rural).		
Other definable characteristics		
Certain groups in the population experience poor health because of circumstances distinct from – though often affected by – sharing a protected characteristic or socioeconomic factors. The defining characteristics of groups of this sort will emerge from the evidence (although a quality standard topic will sometimes explicitly cover such a group). Examples of groups identified are: • looked-after children • people who are homeless • prisoners and young offenders.		

Indicator Equality Impact Assessment form

Development stage: Consultation

Topic: Cancer

1.1 Have any potential equality issues been identified during consultation, and, if so, what are they?
No equality issues have been identified at this stage.

1.2 Have any population groups, treatments or settings been excluded from coverage by the indicators at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?
Indicators GP6 and GP7 are related. In combination, they exclude women aged under 25, women aged 65 and over, and all men. The exclusions ensure that the population covered by the indicators matches the population covered by the NHS cervical screening programme. Indicator CCG14 excludes people aged under 60 years of age and those aged 75 or over. The exclusions ensure that the population covered by the indicator matches the population covered by the bowel cancer screening programme. Indicator CCG15 excludes women aged under 50, women aged over 70 and all men. This ensures the indicator matches the population covered by the breast screening programme.

1.3 Do any of the indicators make it more difficult in practice for a specific group to access services compared with another group? If so, what are the barriers to, or the difficulties with, access for the specific group?
No – comments from consultation do not suggest that the indicator will make it impossible or unreasonably difficult in practice for a specific group to access a test. Comments suggest that indicators GP6 and GP7 may result in improved access to screening services from people who do not currently respond to invitations; and that there may be reduced variation in uptake with respect to religion and race.

1.4 Is there potential for the indicators to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No – comments do not suggest an adverse impact on people with disabilities.

Completed by lead technical analyst: Paul Daly

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Approved by NICE quality assurance lead: Julie Kennedy

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