Primary Care Needs Assessment tool: indicator review

Google Chrome is advised to ensure this page displays/ functions as intended.

ⓘ You are now reviewing the PCNA indicator(s) for: **Incidence of cancer**

ⓘ **Caution**: The information on this page is provided for testing purposes and may be subject to amendment. It may contain errors or not be fully reflective of consensus public health advice or relevant services, therefore should only be used with care.

Strategic context

ⓘ Consider the national strategic context for prioritising improvement action in this area (in conjunction with your health board's IMTP and Regional Partnership Board's Area Plan):

- In Wales neoplasms are the leading cause (19%) of DALYs across all ages and the major cause (together with cardiovascular disease) of premature mortality in people aged 40+ (*Health and its determinants in Wales*; PHW 2018; link).
- The Welsh Cancer Intelligence and Surveillance Unit (WCISU; link) note cancer incidence rates in 2012–2016 were almost twice as high in the most deprived fifth compared to the least deprived fifth for cervical cancer; for female breast cancer the lowest incidence rates were seen in the most deprived areas of Wales and the least/ next least deprived areas had the highest rates.
- WCISU (link) note that estimates suggest that in the UK around 4 in 10 of the cancer incidence could be potentially preventable; the main preventable risk factors include tobacco, obesity, consumption of alcohol and lack of fruit and vegetables.
- Key policy on cancer is set out in the Cancer delivery plan for Wales 2016–2020; cancer incidence is one of the key population outcome indicators in the plan (link).
- The inverse care law (Hart 1971) states that the availability of good medical care tends to vary inversely with the need for it in the population served. The Inverse Care Law (ICL) Programme, established in the South Wales valleys, aims to increase ascertainment of people with or at risk of cardiovascular disease and cancer and supports them to make healthy behaviour changes.

▼ ⓘ Tell me about: DALYs

What are DALYs?

- Disability-adjusted life years (DALYs) are a combined measure of early deaths (i.e. premature mortality) and disability-weighted impact on quality of live from living with poor health.

- Because DALYs capture both what kills us and what makes us ill, they describe the overall 'burden of disease' (reported by risk or condition) more effectively than mortality or disability prevalence does alone.

▼ ⓘ Tell me about: incidence

- Incidence refers to a count of **new cases**, or rate of new cases per head of population, within a defined population (e.g. patients registered with Welsh GPs) over a specified time period (e.g. one year, or a "rolling" period of multiple years—typically when annual counts are low, so years are aggregated for statistical reasons).
- Cases diagnosed prior to the specified time period are not captured by incidence (see prevalence; link).
- Overall incidence can be broken down to assess its distribution by variables such as age band, sex, deprivation status, rurality, or stage at diagnosis; this is done to help explore potential issues around equity of access or outcomes.
- Incidence derived from counts alone may be given when the denominator population is unknown; as an absolute measure, there will be no estimate of variation around the count and comparisons cannot be made to other populations.
- Incidence rate (where the denominator population is known) may be crude (i.e. not adjusted) or standardised against a reference population to allow comparison (adjustment is typically for differing population structure, by age and or sex).
- To account for random variation, incidence rate estimates are often given with a surrounding confidence interval; this describes the likely upper limit and lower limit of variation around the single (best-guess) estimate of rate.

Improvement actions for GP practice cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Reduce cancer incidence by optimising prevention of behavioural risk factors**

- Compare local cancer incidence to local behavioural risk factor prevalence and optimise primary/ secondary preventive actions for smoking (BRF-001), unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004).

▼ **Reduce cancer incidence by optimising prevention of clinical risk factors**

- Compare local cancer incidence to local clinical risk factor prevalence and optimise primary/ secondary preventive actions for childhood (CRF-002) and adult (CRF-003) obesity.

▼ Consider cancer incidence in the light of screening uptake

- Compare local cancer incidence to uptake of screening for bowel (CAN-001), breast (CAN-002) and cervical cancer (CAN-003); seek to understand any association between cancer incidence and screening uptake by population characteristic (e.g. by age band, sex, rurality, deprivation, etc.).
- Analysis of local screening uptake may suggest a need to focus on how to encourage greater uptake in the event of inequity by age band or sex, or among those who may be experiencing social disadvantage (as measured by deprivation status).
- Analysis of local cancer pathway data (e.g. via your cancer services manager/ LHB information team) may reveal a proportion of cancers not detected via the screening route and suggest potential points for intervention.

▼ Understand local data on variation in incidence within your cluster

- National analysis of the WCISU/ Macmillan Cancer Support data indicates wide variation in cancer incidence and prevalence by sex, rurality, deprivation and stage at diagnosis (link). Note: only incidence by stage at diagnosis data are presented within the initial PCNA tool release.
- Consider carrying out equity audit to look in more detail at the distribution of cancer incidence in your cluster. This could involve looking closely at one or more dimensions of equity (e.g. age band, area deprivation, rurality, sex, cancer stage at diagnosis).
- Your local cancer service manager/ information team may be able to provide more recent data for analysis by dimensions of equity. This may reveal a need for improvements in coding (e.g. more consistent recording of stage at diagnosis to better reflect early cancer diagnoses programme efforts).

▼ Work with local cancer services to improve access to assessment and treatment

- Informed by analysis of local data, this may include focused action to improve access to diagnostic services for those living in rural areas, or optimising the acceptability and efficiency of local cancer pathways (e.g. as measured by patient experience; days from referral to assessment; days from referral to confirmation of diagnosis; days from confirmation of diagnosis to initiation of treatment, etc.).

▼ Ensure awareness and implementation of NICE guidance/ quality standards

- *Suspected cancer: recognition and referral*. NICE guideline [NG12] (Published date: June 2015;

Last updated: July 2017) includes recommendations suitable for adoption by healthcare professionals. This guideline covers identifying children, young people and adults with symptoms that could be caused by cancer. It outlines appropriate investigations in primary care, and selection of people to refer for a specialist opinion. It aims to help people understand what to expect if they have symptoms that may suggest cancer.

- *Suspected cancer*. Quality standard [QS124] (Published date: June 2016; Last updated: December 2017) sets out four quality statements, any of which could form a focus for collective local improvement action. This quality standard covers the investigation and recognition of suspected cancer, and referral to specialist cancer services for adults, young people and children. It describes high-quality care in priority areas for improvement.

Improvement actions for wider cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Reduce cancer incidence by optimising prevention of behavioural risk factors**

- Compare local cancer incidence to local behavioural risk factor prevalence and optimise primary/ secondary preventive actions for smoking (BRF-001), unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004).

▼ **Reduce cancer incidence by optimising prevention of clinical risk factors**

- Compare local cancer incidence to local clinical risk factor prevalence and optimise primary/ secondary preventive actions for childhood (CRF-002) and adult (CRF-003) obesity.

What is happening in Wales?

ⓘ Consider whether shared learning/ local experience might guide your own implementation of the evidence:

▼ **Placeholder project description**

- *What problem was being addressed?* Placeholder.
- *What was done to address it?* Placeholder.

- *How does this evidence good practice?* Placeholder.
- *What key learning can be shared?* Placeholder.
- *Who did it or who can be contacted in the event of queries?* Placeholder.

ⓘ Have something to share? Please let us know here.

ⓘ **Caution**: Any text entered into the following sections will not be saved if you navigate away from this page, or close the browser window before selecting PRINT.

What do you know about community views on this?

ⓘ Consider any relevant citizen/ community voice information (e.g. from surveys, complaints, engagement events, or your health board's well-being or population needs assessments). Summarise this into the following box:

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What assets or partnership opportunities can you identify?

ⓘ Consider any relevant local assets or potential partner organisations that might facilitate co-production. Summarise this into the following box:

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Do you need more data before making a decision?

ⓘ If relevant, consider any additional data (or information) requirements that might ensure a more informed decision on determining action. Summarise this into the following box:

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STEP H

What is your provisional decision?

ⓘ Having reviewed indicator data on local needs and considered evidence-informed quality improvement options, please record initial thoughts on proposed actions. You may also wish to record related thoughts around potential service models, capacity requirements, workforce development or financial considerations. Ideally, discuss these with both the wider cluster and with your local public health team (LPHT). Summarise your proposals for action into the following box:

Type here

ⓘ Now PRINT this page (e.g. to PDF) so you have a record of your entries (Steps E-H). You may then close the Print view browser window and return to the PCNA workbook to review another indicator.