# National General Practice Profiles: Frequently Asked Questions

[1. What are National General Practice Profiles? 2](#_Toc467839326)

[2. Who produces the profiles? 2](#_Toc467839327)

[3. Why is my practice not included? 2](#_Toc467839328)

[4. How can I access the profiles? 2](#_Toc467839329)

[5. Where do the data come from? 2](#_Toc467839330)

[6. Finding a practice... 3](#_Toc467839331)

[7. Intervention rates 3](#_Toc467839332)

[8. What new indicators have been included in the latest release (2016)? 3](#_Toc467839333)

[9. Where do the QOF smoking estimates come from? 4](#_Toc467839334)

[10. Comparators 4](#_Toc467839335)

[11. Clinical Commissioning Groups (CCGs) 4](#_Toc467839336)

[12. Scatter plots 4](#_Toc467839337)

[13. Trend charts 4](#_Toc467839338)

[14. How should the National General Practice Profiles be used? 4](#_Toc467839339)

[15. Can I choose my GP based on this data? 5](#_Toc467839340)

[16. A practice is an outlier for a lot of indicators (blue); what does this mean? 5](#_Toc467839341)

[17. How are outliers identified? 5](#_Toc467839342)

[18. Why aren’t we using standardised rates? 5](#_Toc467839343)

[19. What are crude rates? 5](#_Toc467839344)

[20. Why is the England average near to the top of the range for many indicators? 6](#_Toc467839345)

[21. Why do some indicators have coloured blobs and others a white one? 6](#_Toc467839346)

[22. Some indicators seem to be missing for my practice 6](#_Toc467839347)

[23. My practice doesn’t report certain indicators 6](#_Toc467839348)

### What are National General Practice Profiles?

National General Practice Profiles are a set of more than 200 general practice level indicators that have been developed for practices across England. The indicators currently cover practice population, life expectancy, deprivation, patient satisfaction, the Quality and Outcomes Framework (QOF), cancer, antibiotic prescribing, and child and maternal health.

### Who produces the profiles?

The National General Practice Profiles are produced by Public Health England, led by Public Health Data Science and with contributions from other teams.

### Why is my practice not included?

The inclusion criteria have changed for the 2016 refresh. In order to be included in the profiles practices now have to meet the following criteria:

* Practice located in England
* Practice code exists in QOF AND practice list size is > 800

These revised criteria mean that very few practices have been excluded.

### How can I access the profiles?

The profiles can be accessed at: <http://fingertips.phe.org.uk/profile/general-practice>

### Where do the data come from?

The data are drawn from a number of data sources, using 2015/16 data or the latest available version at November 2016. These sources include:

* Numbers of patients registered at a GP practice – April 2016 (http://www.hscic.gov.uk/catalogue/PUB17356)
* The Index of Multiple Deprivation 2015 (IMD2015) – population weighted GP practice averages calculated with April 2016 population figures (<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>)
* Census 2011 (ethnicity estimates)

NOTE: Ethnicity estimates for GP practices were calculated by the Department of Primary Care and Public Health Sciences, King’s College London. Guarantor: Dr Mark Ashworth, Reader in Primary Care
* The NHS Patient Satisfaction Survey - July 2016 publication, collected during July-September 2015 and January-March 2016 (<https://gp-patient.co.uk/> )
* The Quality and Outcomes Framework 2015/16 (<http://www.content.digital.nhs.uk/catalogue/PUB22266> )

### Finding a practice...

In addition to the standard drop down boxes for navigating to a practice via a Clinical Commissioning Group (CCG), you can enter geographical terms into the search box. This will also show the practice location on a map. Please note that if you are unsure of the practice postcode just use the first part of the postcode to identify all practices in the area.

### Intervention rates

In line with other PHE products, the National GP profiles show the intervention rate where the denominator includes all the patients to whom the indicator applies regardless of the exceptions (denominator includes exceptions) instead of the underlying achievement because from a public health perspective we are more interested in the actual proportion of patients receiving the intervention, i.e. the proportion of all patients with this condition who were treated. The HSCIC (QOF FAQs, <http://content.digital.nhs.uk/catalogue/PUB18887/qof-1415-annex3-DQandFAQ.pdf> , p.16) stated this point: "Percentage of patients receiving the intervention, gives a more accurate indication of the rate of the provision of interventions as the denominator for this measure covers all patients to whom the indicator applies, regardless of exception status."

We consider this also to be the better comparable indicator because, while there are very good reasons why a patient might not be treated (such as terminal illness), a generous interpretation of exception rules can also be used to improve practice performance.

The tool is intended to highlight variation and encourage conversation about causes of variation and whether it is warranted or not. We are not suggesting that every practice should or can achieve a 100% intervention rate for every indicator - clearly there are patients it would not be desirable to be included - however it is clear that there is unwarranted variation in Exception rates as well as rates vary considerably and the data is not available for us to make adjustments.

Triangulation with other sources of primary care data such as the National Diabetes Audit (NDA) supports this approach. For those QOF indicators which match NDA indicators, a higher degree of correlation was found with intervention rates than with achievement scores, so intervention rates seem a better measure of true performance.

### What new indicators have been included in the latest release (2016)?

Where QOF indicators have changed, the current equivalents have been used and new QOF indicators added. QOF indicators which were included in 2014 and 2015 but were retired from QOF since were left in the profiles with a marker ‘retired’. A set of new cancer service indicators was added, and the topic is now split into Cancer (general) and a two-week-waiting time domain. Antibiotic prescribing data was added in April 2016.

Where technically possible, new life expectancy estimates were calculated (2010-14), using a population weighting from the life expectancy figures for the MSOAs where the practice population lives.

### Where do the QOF smoking estimates come from?

This is based on the methodology published in Honeyford et al (2014)

<http://bmjopen.bmj.com/content/4/7/e005217.full>

The assumption is that the denominator of indicator SMO004 (proportion of smokers who received cessation advice) is close to the total number of smokers (15+) in the practice population and, this number divided by the whole practice population (15+) is a good estimate for the smoking prevalence.

### Comparators

Comparisons can be made with practices in the same CCG and deprivation decile. Deprivation decile comparisons are across England. The deprivation decile in which a practice falls can be found in the Population panel using a ‘heat scale’.

### Clinical Commissioning Groups (CCGs)

Where CCG values are available the profiles display the published figures. For indicators and time periods where CCG values are not readily available, CCGs have been calculated and pre-loaded into the profiles wherever possible. This saves time and helps to make the tool more responsive.

CCG values are calculated for most indicators. If the profiles do not include practice values for one or more practices within a CCG a CCG value is still calculated as long as the included practices account for ≥ 90% of the CCG population.

Many CCG values are now displayed with an indication of statistical significance using the same colourings as elsewhere in the tool.

### Scatter plots

It is possible to create scatter plots for any two indicators for which there are practice level data. The scatter plots contain all profiled practices in England but the currently selected practice and CCG are shown within the scatter plot. The scatter plot does not produce correlation coefficients.

### Trend charts

The charts show the trend for a current indicator over as many years as it has been included in the profiles, which is up to six years.

Please note that many indicators do not have such a long time line because they are new in a technical sense, due to substantial changes in the definition.

### How should the National General Practice Profiles be used?

Feedback so far suggests that the profiles are especially helpful in giving practice staff a clear overview of their practice and an insight into the possible health needs of the population that they serve. This can then help with making commissioning decisions and in deciding when to provide new or different services.

An important part of understanding the profiles is to understand the context. Part of the context is seeing how the practice compares with others. The spine charts help with making comparisons. Users can also compare a practice against others with similar levels of deprivation.

Feedback over the last years suggests that the profiles have been used by practices, CCGs, LAs, academics and others. Ultimately, the profiles can be used in whatever way is helpful to the user.

### Can I choose my GP based on this data?

The profiles provide a wide range of information at a practice level and so may well be of use in choosing whether to register at a particular practice. However, the profiles have not been designed for the purpose of choosing a practice and a great deal of care needs to be taken with the interpretation of the profiles – some of the other answers in these FAQs highlight the challenge of interpreting the profiles. There are many other factors that are not in the profiles but which should be taken into consideration in choosing a practice.

### A practice is an outlier for a lot of indicators (blue); what does this mean?

The colour of the blobs on the spine chart signifies statistical significance and suggests that it is worth seeking an explanation as to why there is a difference compared with the national mean. It does not imply that being different is wrong.

It is important to consider all the information in the profile when making comparisons; for example a practice may appear to have very low levels of cardiovascular disease but the demographic data may show that it has an unusually young population (for example, it could be a university practice).

### How are outliers identified?

There is a technical issue concerning the fact that much of the data we use (especially the QOF data) are over dispersed (which is a technical term for when there is greater variation than might be expected within the statistical model used). We are working with academic colleagues to perfect the approach to correcting for over dispersion. In the meantime the profiles use 3 standard deviation statistical process control limits (i.e. 99.8 % confidence limits) to identify outliers.

### Why aren’t we using standardised rates?

QOF data are not age standardised and the level of detail in the public QOF dataset is insufficient to allow us to standardise the QOF indicators.

### What are crude rates?

A crude rate is calculated by dividing a numerator by a denominator and expressing the result in units over a given time. For example, an annual admission rate would be calculated by dividing admissions in the population over a year (numerator) by the population during that year (denominator) and expressing that per 1000 population.

The important thing to understand about crude rates is that there is no account taken of the age structure of the population. For example, a university practice may have a very low crude rate of admissions for COPD because they have very few patients with COPD.

### Why is the England average near to the top of the range for many indicators?

Some QOF indicators have a very skewed distribution, with the majority of practices attaining close to the maximum number of points available for that indicator. This means that the average (arithmetic mean) for practices across England is also close to the maximum and not in the middle of the range.

### Why do some indicators have coloured blobs and others a white one?

The circles/blobs represent the practice value. For many indicators it is possible to calculate the window of certainty around a value. White blobs reflect indicators for which it is not possible to do this, and coloured blobs reflect indicators for which this is the case.

Where confidence limits are available the value may be statistically significantly different from the mean or not. If the value is not significantly different, then blobs are coloured amber; if it is, then blobs are blue.

### Some indicators seem to be missing for my practice

There may be several reasons for this:

* Publication of small numbers (less than 6) or rates derived from small numbers from identifiable data sources such as Hospital Episode Statistics (HES) is not permitted; therefore any such values have been suppressed;
* Some practices may not have submitted QOF data for certain indicators;
* Life expectancy could now be calculated if the source data was missing for one or more of the small areas that contribute to the practice’s catchment area.

### My practice doesn’t report certain indicators

The QOF dataset will include a 0 denominator for practices that do not report particular indicators. If the QOF dataset shows a particular practice has a 0 denominator for an indicator then that indicator is not shown within the profile for that practice.