# National General Practice Profiles: Frequently Asked Questions

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### What are National General Practice Profiles?

National General Practice Profiles are a set of more than 150 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 service, and antibiotic prescribing.

### 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?

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 in QOF is > 750, OR
* Practice code in Open Exeter (April 2020) AND Open Exeter practice list size is >750 AND the practice has valid data in the GP patient survey 2020.

For details please see [Rules of Inclusion and Included Practices](https://fingertips.phe.gov.uk/documents/Inclusionlist2020.xlsx)

### 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 2019/20 data or the latest available version at November 2020. These sources include:

* Numbers of patients registered at a GP practice – April 2020
* The Index of Multiple Deprivation 2019 (IMD2019) – population weighted GP practice averages calculated with April 2016 population figures (<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>)
* 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, using 2015 practice populations
* The NHS Patient Satisfaction Survey - July 2020 publication (<https://gp-patient.co.uk/> )
* The Quality and Outcomes Framework 2019/20  
  (<https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20> )

### Finding a practice...

There is an area search box on the Introduction page where a postcode or place name can be entered. The search results are shown as list and also as pins on the map. The same area search is accessible from within the tool when the Map tab is selected. 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.

Alternatively, you can use the geography selector in the grey area at the top of the tool, selecting Area type: GP, Area grouping: CCG or PCN; then choose the CCG or PCN of interest and the practice of interest.

### 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 (since 2019/20: the Personalised care adjustments (PCAs)) 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 ( [https://webarchive.nationalarchives.gov.uk/20170726164154/https://digital.nhs.uk/media/27660/QOF-2014-15-Annex-3-Data-Quality-and-Frequently-Asked-Questions/Any/qof-1415-annex3-DQandFAQ](https://webarchive.nationalarchives.gov.uk/20170726164154/https:/digital.nhs.uk/media/27660/QOF-2014-15-Annex-3-Data-Quality-and-Frequently-Asked-Questions/Any/qof-1415-annex3-DQandFAQ), p.16, downloaded on 23 November 2020) 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/PCA 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 for whom it would not be desirable to be included - however it is clear that there is unwarranted variation in Exception/PCA 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.

### 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 SMOK004 (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 is a good estimate for the smoking prevalence.

### Comparators

Comparisons can be made with practices in the same CCG, PCN and England.

### 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.

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

### Primary Care Networks (PCNs)

Since 2019, groups of GP practices have built Primary Care Networks (PCNs). PCNs are still changing quite frequently and care must be taken when values for PCNs are shown which practices are assumed to be contributing to the value. QOF published 2019/20 PCN values, valid at the end of the financial year 2019/20, however Fingertips updated the GP-to-PCN lookup table to a more recent version and aspires to continue doing so. To avoid a situation where uploaded QOF values are potentially based on a different set of practices than shown in Fingertips (as belonging to the PCN) we are not showing the original QOF PCN values but calculate them based on the current lookup table.

### 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 with the currently selected practice and CCG are shown within the scatter plot. Alternatively, you can switch to a view that shows the practices of the currently selected CCG. In this view the regression line and correlation coefficients are also available.

### 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 eleven 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.

Feedback over the last years suggests that the profiles have been used by practices, CCGs, PCNs, 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).

### 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 blue or yellow blobs and others have blobs in shades of one colour?

The circles/blobs represent the practice value. For many indicators it is possible to calculate the window of certainty around a value (the range between the confidence limits). 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 yellow; if it is, then blobs are blue.

If we cannot determine statistical significance we can still rank and group the values into groups. We apply five shades of blue from the darkest shade for the lowest 20% to the lightest for the top 20%. when no good-bad judgement is appropriate and five shades of purple (darkest = worst) when a judgement is possible.

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

There may be several reasons for this:

* Publication of small numbers or rates derived from small numbers from person 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 data or don’t occur for another reason in one or more of the underlying source data sets for certain indicators. E.g., due to technical problems QOF had only data for about half of the practices in NHS Kernow CCG for 2018/19.
* 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.
* Indicators that couldn’t be updated due to missing new input data have not been calculated for newly added practices.

### What does the note ‘There is a data quality issue with this value. Potential underestimate of the value due to double counting of patients in QOF’ in the 2018/19 prevalence indicators mean?

Where practices have merged or closed during the year, QOF was in some cases still listing the now closed practices with the number of patients they used to care for, and also the practice that took over the patients, showing them with the now bigger patient number. However, for the now closed practice no activities are shown and so the patients are only counted once e.g. for having a disease but twice for the population which is used as denominator. When practices are grouped and sums are built for CCGs and other aggregates this will lead to an underestimate. This effect will be very small at an England level but this effect is concentrated in some places where it can be of some relevance. In order to stay in line with the officially published QOF figures we decided not to correct the numbers but to add a note to alert users that there is a quality issue with some figures.