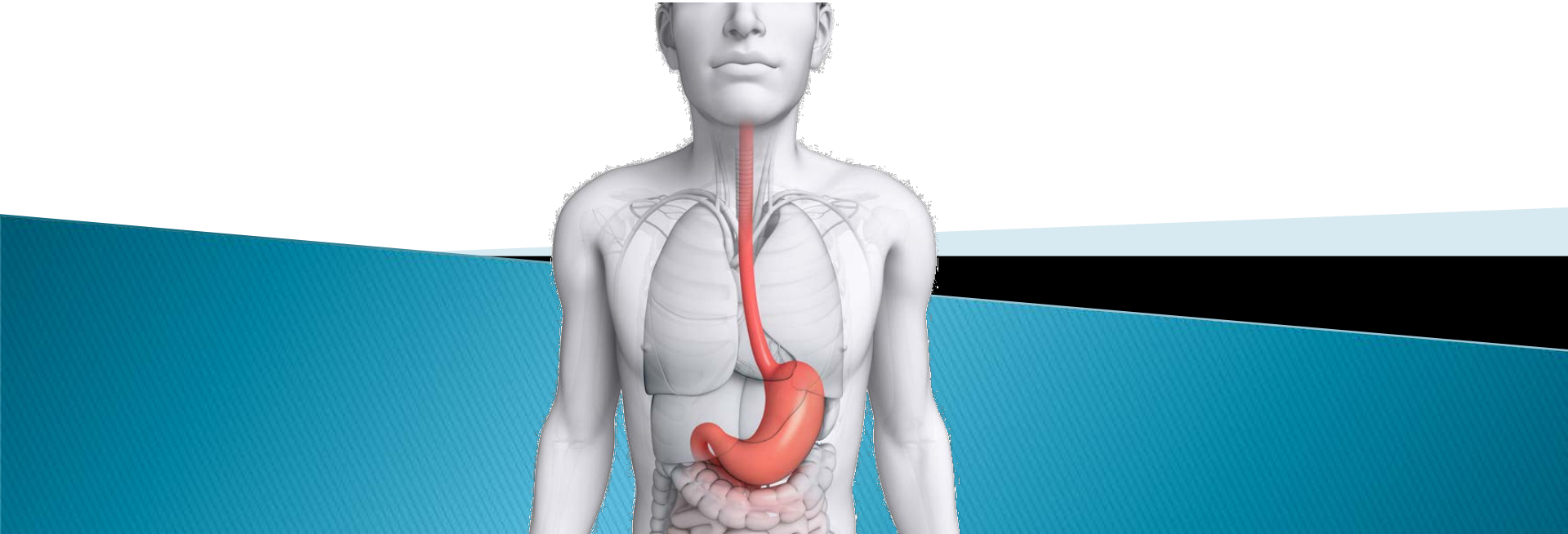
National Oesophago–Gastric Cancer Audit (NOGCA)



Team members:

The Association of Upper GI Surgeons (AUGIS)

Nick Maynard, Consultant Surgeon

Clinical Effectiveness Unit, Royal Coll Surgeons

Mira Varagunam, Statistician

Christian Brand, Assistant Professor

David Cromwell, Prof of Health Services Research

Royal College of Radiologists (RCR)

Tom Crosby, Consultant Clinical Oncologist

NHS Digital

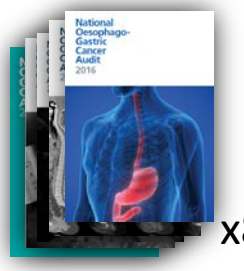
Julie Michalowski, Project Manager

Rose Napper, Audit Coordinator

The NCAPOP project journey so far

2007-present; reporting on the OG patient pathway after GP referral or emergency admission in England and Wales…from diagnosis to outcome

Annual reports



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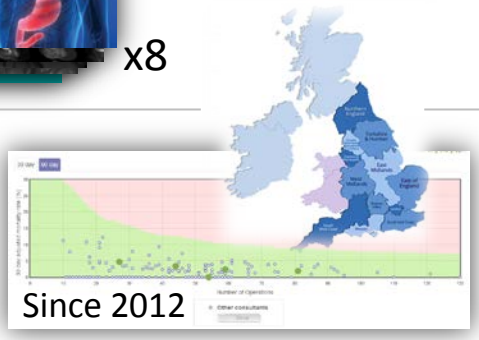
- OG-cancer & high-grade dysplasia (HGD)
- Adherence to clinical guidelines
- National variation in clinical practice
- Recommendations for local practice

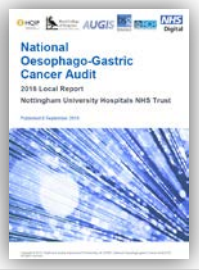
Clinical Outcomes Publication



Since 2012

- Trust and consultant outcomes
- Assessing variation in outcomes (outliers?)

Direct communication / Feedback to trusts



- Ad-hoc newsletters
- Local reports / Trust summaries
- Local action plan templates

Academic dissemination

Regular conference contributions and academic papers, e.g. on re-organisation of services, outcomes in elderly, completion rates of palliative chemotherapy, coding of high-grade dysplasia in HES…

All Teach, All Learn

1. Communicating quality improvement

- Newsletters , NHS trust summaries, NHS trust slides, local action plans etc. *It all works, but in different ways.*
- Project coordinator who is accessible to trusts to discuss QI issues. *It matters.*
- Interaction with patient associations. *Their perspective will differ from the clinicians'.*

2. Making impactful recommendations

- Focus on changes over time and the uptake of recommendations. *Keeping the eyes on what is important to staff and patients.*
- Awareness of changing clinical practice and moving goal posts (e.g. new indicator development for COP). *The world keeps changing.*

Insights from work

1. Listen to stakeholders, especially patient representatives and the clinicians at the coal-face of patient care
2. Use appropriate language (avoid complex terminology) when communicating with patients, clinicians & stakeholders
3. Be consistent in what is communicated.
    1. Keep the communications short and focused
    2. Make communications regular, avoiding long intervals of silence.

Advice to peers

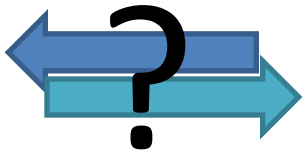
Don’t overlook the value of your communication plan

- Identify and communicate with the right people in clinical settings
- Seek feedback and advice, and try to do something with it
- Establish relationships with others to avoid duplication of effort (eg, CQC, GIRFT)
- Make time for engagement

We are keen to learn:

- How they keep up with changing clinical practice and the burning questions that need to be answered to improve patient care.

- How best to involve and communicate with patients and people affected by cancer.
  - What should we learn from them?
  - What should they learn from us?

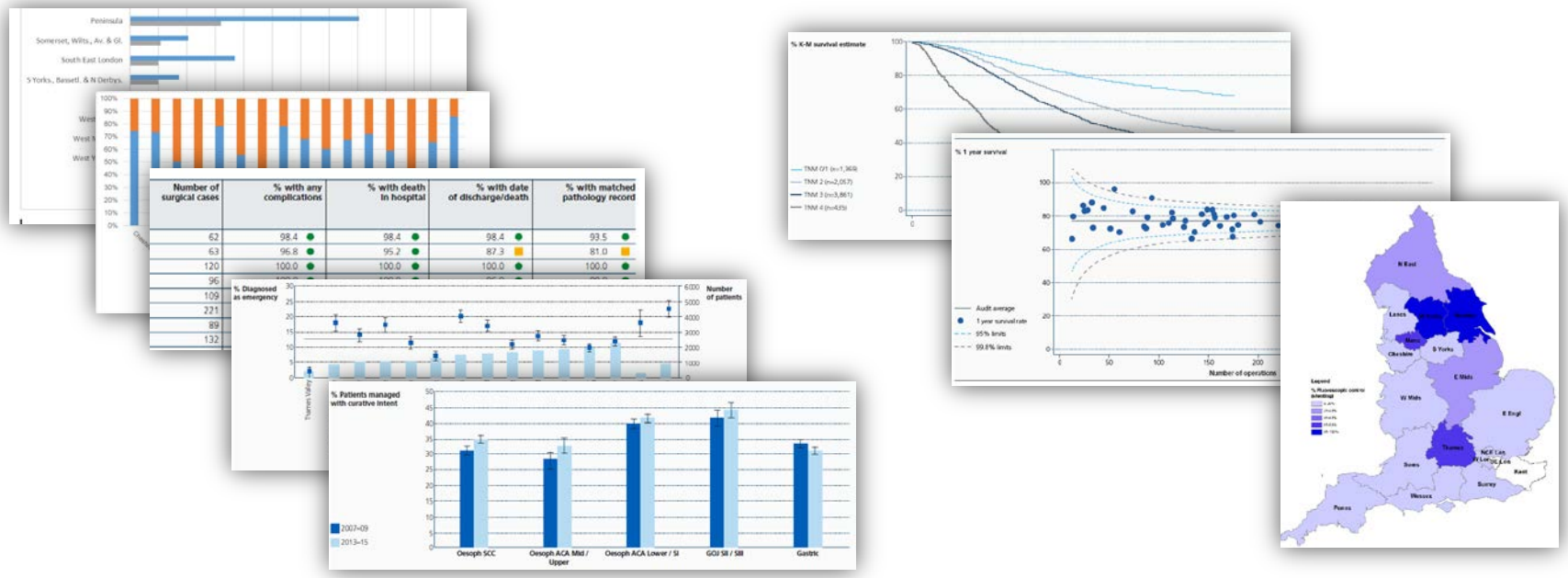


Sharing effective and impactful ways of presenting data/recommendations

EXAMPLE: Key indicators for HGD (source: BSG 2014 guideline)

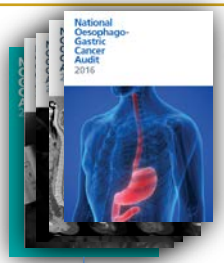
Domain	Standard	Indicator
Referral & diagnosis	All patients with a diagnosis of HGD should have the diagnosis confirmed by a second pathologist	% of patients whose diagnosis was confirmed on a second biopsy
Treatment planning	All patients with HGD for whom therapy is considered should be discussed at a specialist OG cancer MDT	% discussed at MDT
	Endoscopic treatment is preferred over oesophagectomy or endoscopic surveillance	% patients who received active treatment vs surveillance alone
	Endoscopic should be performed in high volume tertiary referral centres	Number of cases of HGD treated at each trust

EXAMPLE: Ways of presenting data / expressing relevant variation in audit data



Next Steps

Annual reports



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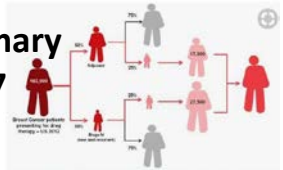
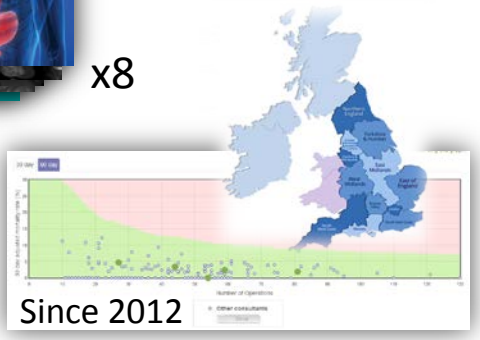
Patient summary planned 2017

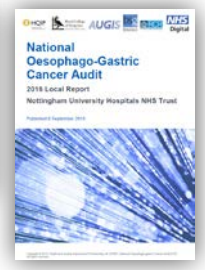


Clinical Outcomes Publication



New website development

Direct communication / Feedback to trusts



Evolution of topics E.g. …

Parity of esteem	Non-curative pathways	Best supportive care

Currently approximately 2% of patients are recorded as having a comorbidity of mental illness, based on a question in the audit data sheet. Anxiety/depression due to the illness is probably not captured.

→ Extend the audit to include quality of life questionnaires to capture the true impact of mental illness on quality of care received. E.g. does mental illness impact on whether a patient has curative treatment or palliative treatment?

How can HQIP help?

- Sharing of expertise (such as best practice in changing areas, like the use of infographics)
- HQIP can help bring into focus the need for assessing impact of disease and treatment on carers – spouses/relatives
- Funding to find out what happens outside of secondary care settings,
  - e.g. to understand experience of OG cancer patients referred for “best supportive care”