

User Survey 2017

Method – Descriptive Results – Thematic Analysis – Audit Development

Method

All known NOGCA contacts - i.e. trust/health board staff who have registered as NOGCA data users and providers – were invited in July 2017 to participate in an online survey about recent audit output and their views on and experiences of submitting data to the audit. The total number of unique contacts (email addresses) in trusts and health boards was 1,388 and an invitation email with a link to the survey on Citizen Space was sent to all of them. Several reminders were sent in August 2017. In total there were **131 responses (9.4%) representing 106 organisations (75.7%)**. As the survey was announced as a “user” survey with a focus on collecting and uploading data, it was anticipated that only a considerably smaller pool of known contacts would be eligible respondents. However, the contact database did not allow for pre-selection of those individuals. An estimated 40% of contacts have job titles that suggest potential involvement in the audit in data management or MDT coordination functions. These were expected to be the most likely active users of NOGCA’s clinical audit platform and therefore the survey’s actual target population.

Analysis

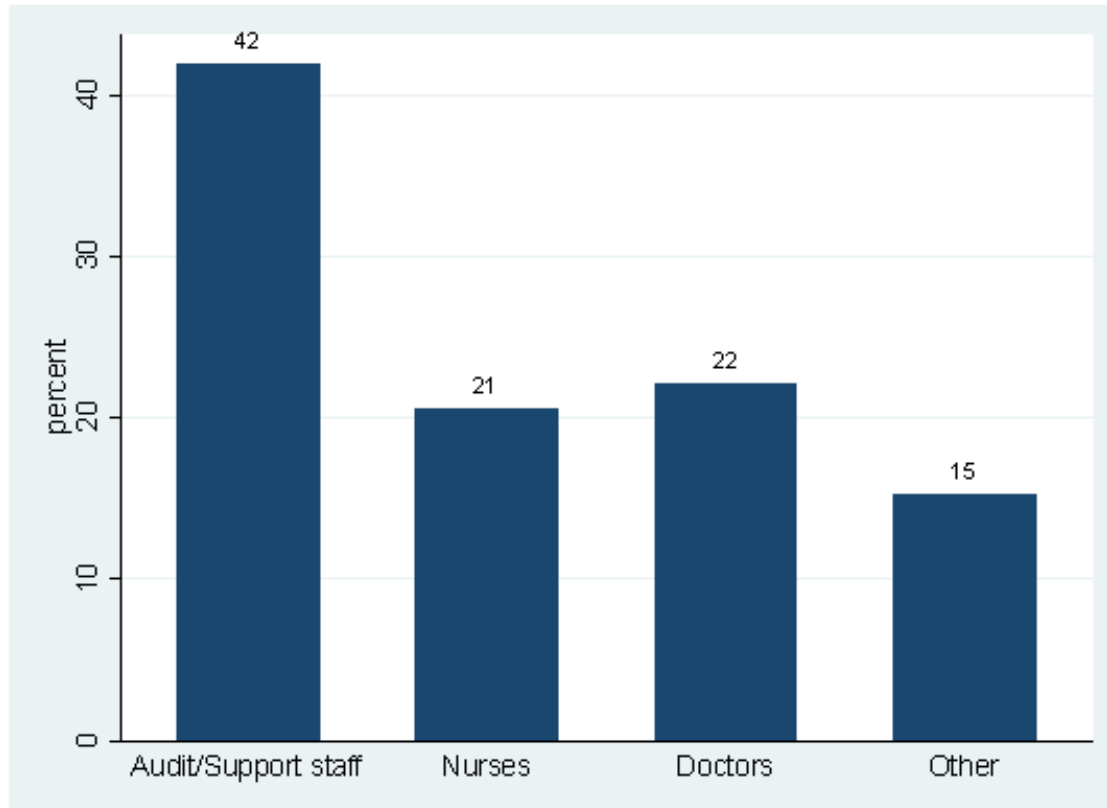
Frequency distributions of all response items are shown. Subgroup analyses (e.g. by staff type) were generally not feasible due to apparently low levels of variation in response patterns and small numbers.

The survey had a strong focus on open questions:

- What did you find helpful about the Summary PDF? Is there anything you would remove or add?
- Which are the main enablers of the audit?
- Which are the main constraints of the audit?
- If one thing could be changed, which one should it be?

Open responses were – if possible – categorised into thematic groups and representative voices of NOGCA users are reported.

1. Job category that best describes the current role in the audit (%)



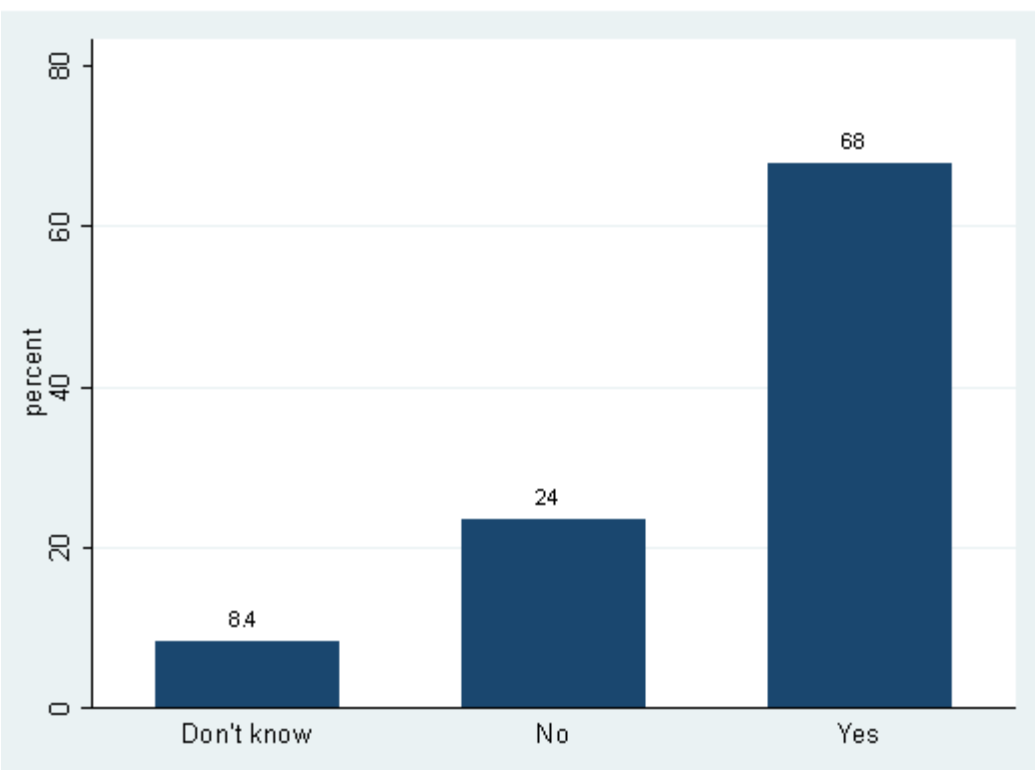
Audit/Support staff: Clinical audit staff and non-clinical support staff combined

Doctors: Physicians and surgeons combined

Our commentary

The distribution of reported job categories is similar to the distribution of job titles in the contact database. Unfortunately, we cannot know whether this means that the survey has captured a small but basically representative sample of all NOGCA contacts or whether it has captured the most active, 'hands-on' individuals. However, we are pleased to have responses from a diverse group of individuals including a large proportion of clinicians, and this gives us confidence that all groups have contributed.

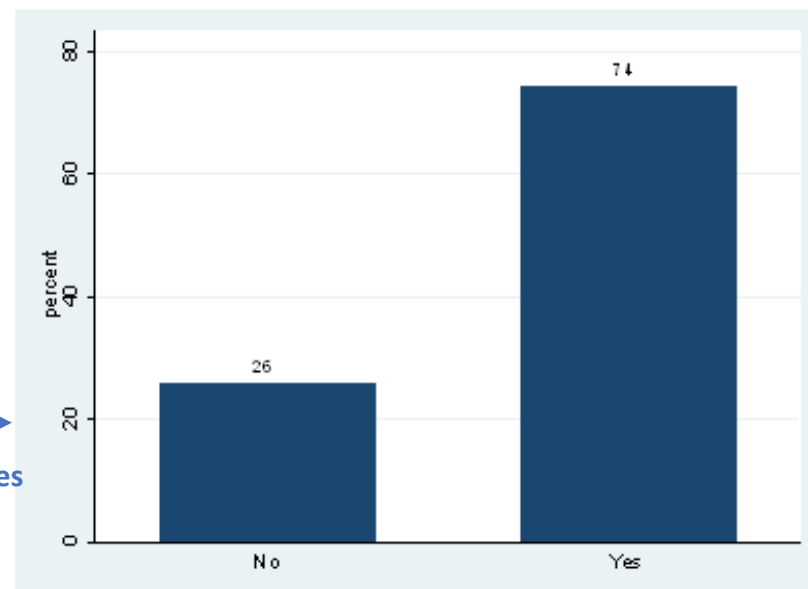
2. Whether the "Trust summary" PDF sent to the trust after the 2016 report has been seen (%)



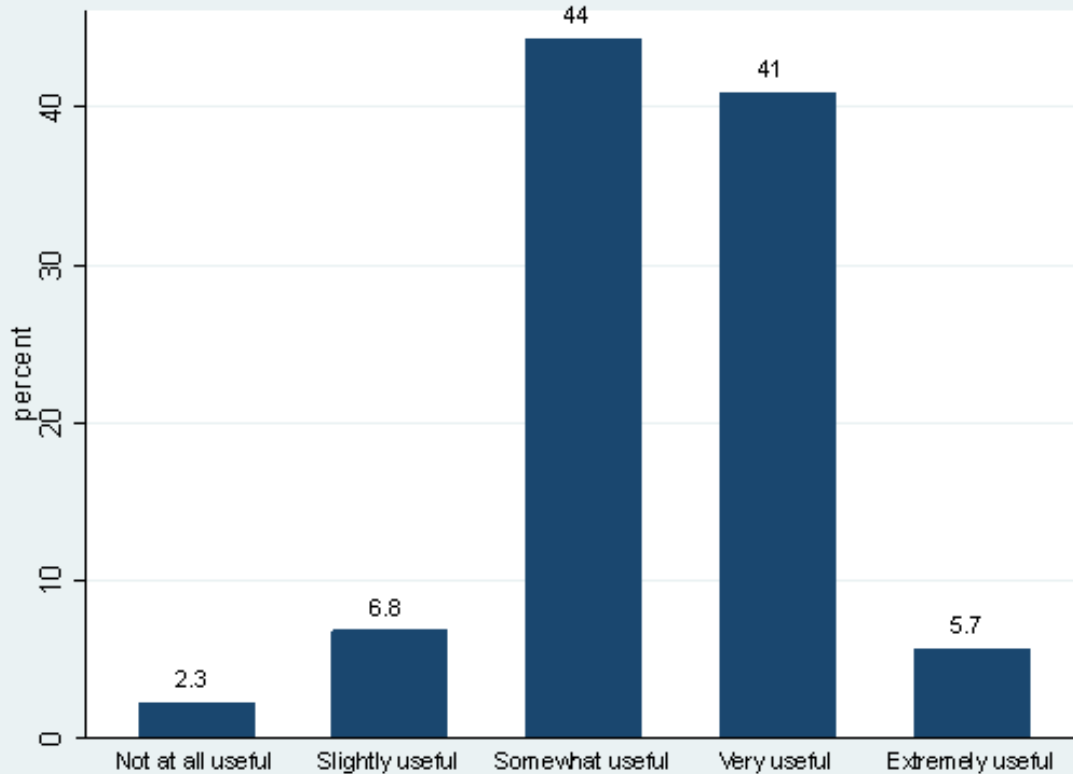
Our commentary

A large proportion of respondents knowing about the trust summaries is good news. Audit results are apparently finding their way back to trusts or health boards.

ignoring the don't know responses



3. Usefulness of trust summary – if known (%)



Our commentary

Combining the top 3 categories (assuming that 'somewhat useful' is at least a satisfactory outcome) implies a 90% approval rating of this particular form of trust feedback, among those who know of it.

4. Additional feedback on trust summaries (open responses)

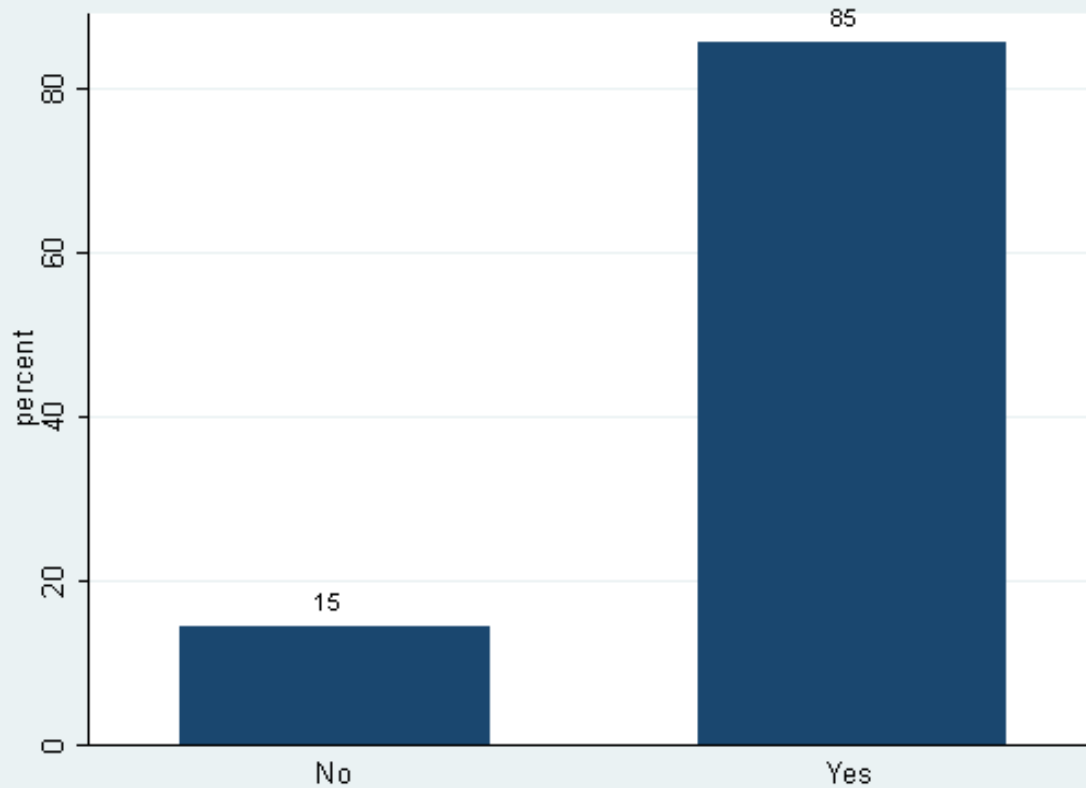
Only 18 valid responses were received. Of those it was possible to extract 10 unambiguously positive comments,

- 5 of which focussed on the value trusts attach to being able to **benchmark local figures nationally** (*'It was useful to see our position in comparison with national standards'*).
- Two respondents noted a positive impact on **data quality** (*'It gives an idea of how well this authority is doing with data submission and where we can improve'*)
- and a further two reported that it helps them **know their trust's actual figures** (*'It is useful to know how many patients were diagnosed and treated within the trust'*).
- The remaining positive response noted that the summary was helpful in formulating a **local action plan**.

There were also 10 unambiguous critical statements or suggestions for improvement, but these do not fall into easily identifiable themes and are therefore reported verbatim:

- *As my role is to run the extract and upload the data on behalf of the Trust, it is useful to compare the numbers of records actually uploaded compared to those included in the Summary - there are usually **differences** and it is **not always possible to understand why**.*
- **Data is old** so some improvements have been made.
- *Some figures don't feel correct*
- *It would have been very helpful to have **breakdown of our region** (all 5 trust submitting patients to our MDT).*
- **Not applicable** as surgery is performed elsewhere
- *The statistics are **presented against 'expected' data which is not realistic**. It would be far more helpful to have more detailed relevant data. It would also be helpful to have **data divided into 'surgical only' patients and 'oncological treatment only' patients** as, eg. pathology reports, are not applicable to both groups yet reported against both groups in 'completion' stats.*
- *Given that there are **a number of separate reports assessing data quality, completeness and outcomes I would welcome one single report which highlighted all metrics in one place** so that Trusts have full visibility of the information being used in the audit, accepting that mortality information may not be available until closer to the time of publishing and national averages would change until all Trusts had finalised their results.*
- *(provide) Tumour site breakdown, Operation breakdown, Nodal yield, Co-morbidity specifics, Tumour staging*
- *We audit our results and we are already aware about them before NOGCA*
- *We work together with which is our surgical centre. Unfortunately their **data is not adequately submitted** which reflects badly on our Trust performance*

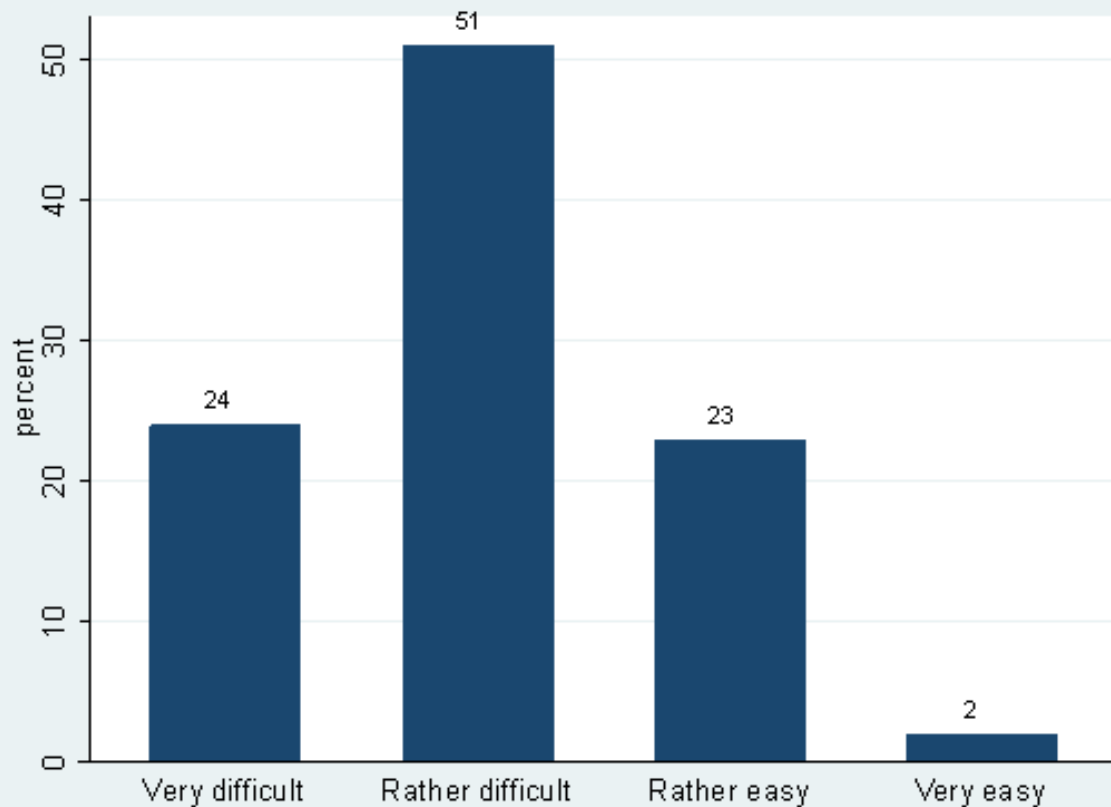
5. Whether the respondent is involved in collecting data for NOGCA (%)



Our commentary

This large proportion would seem to support the assumption that the survey did indeed appeal to the most active core group of NOGCA participants.

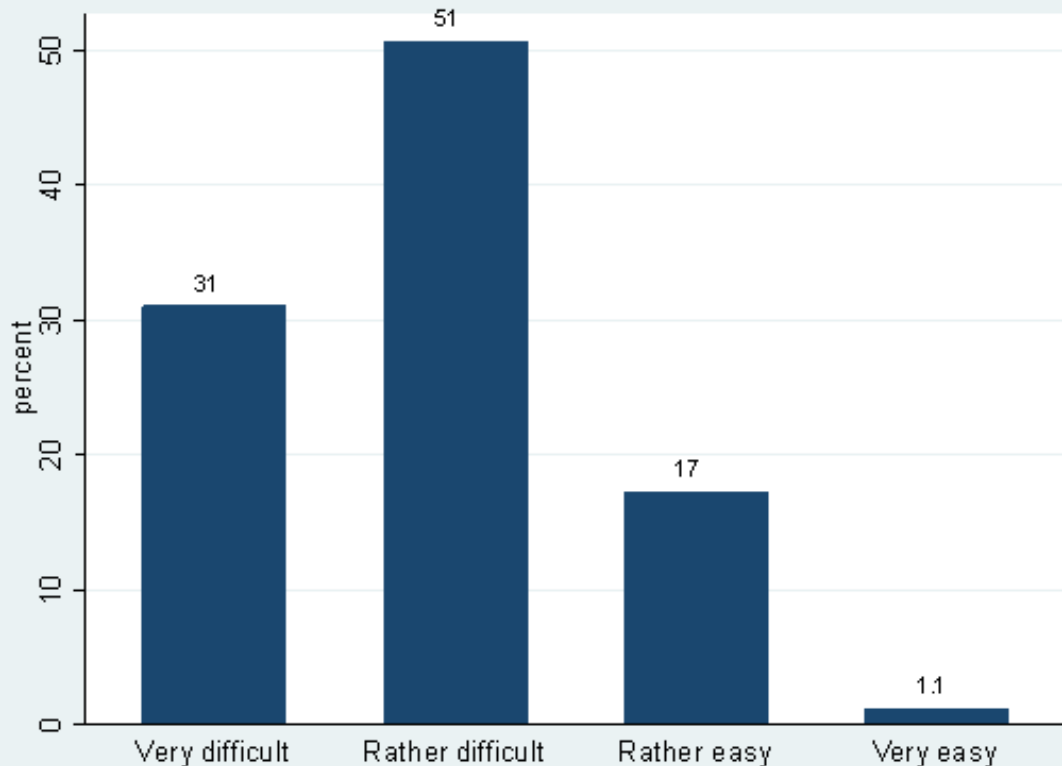
6. Ease-of-use collecting HGD data – if involved in HGD data collection (%)



Our commentary

Three out of four users find collecting data on high grade dysplasia (HGD) patients difficult. We know from other sources that NHS trusts tend to struggle with the HGD component of the audit.

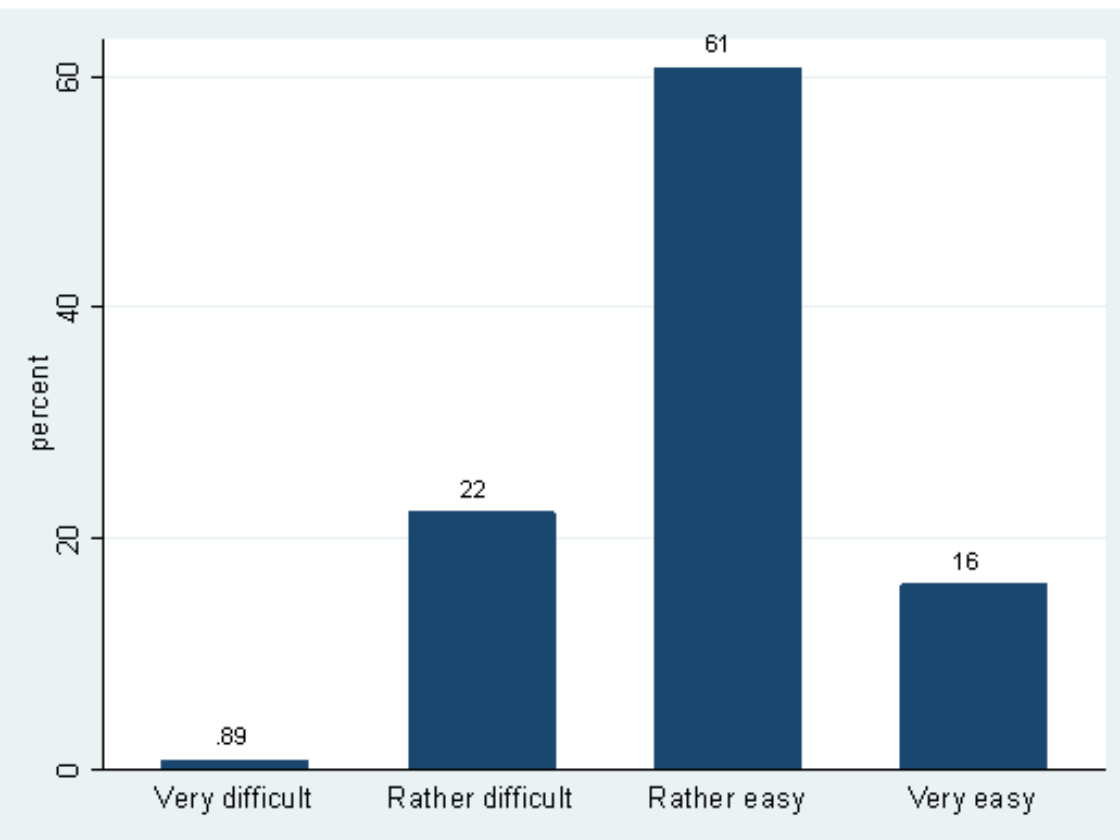
7. Ease-of-use coordinating HGD data collection with other organisations (%)



Our commentary

An even bigger proportion of users find coordinating the collection of HGD data with other organisations difficult. Again, we are aware of some of the issue facing trusts in this context. Unfortunately, HGD patients often follow care pathways through different organisations and different data items along these pathways are required by the audit. The NHS Digital CAP data collection system is currently not ideally set up for facilitating cooperation between organisations. Instead, communication and self-directed coordination are necessary to fulfil the audit's HGD data requirements.

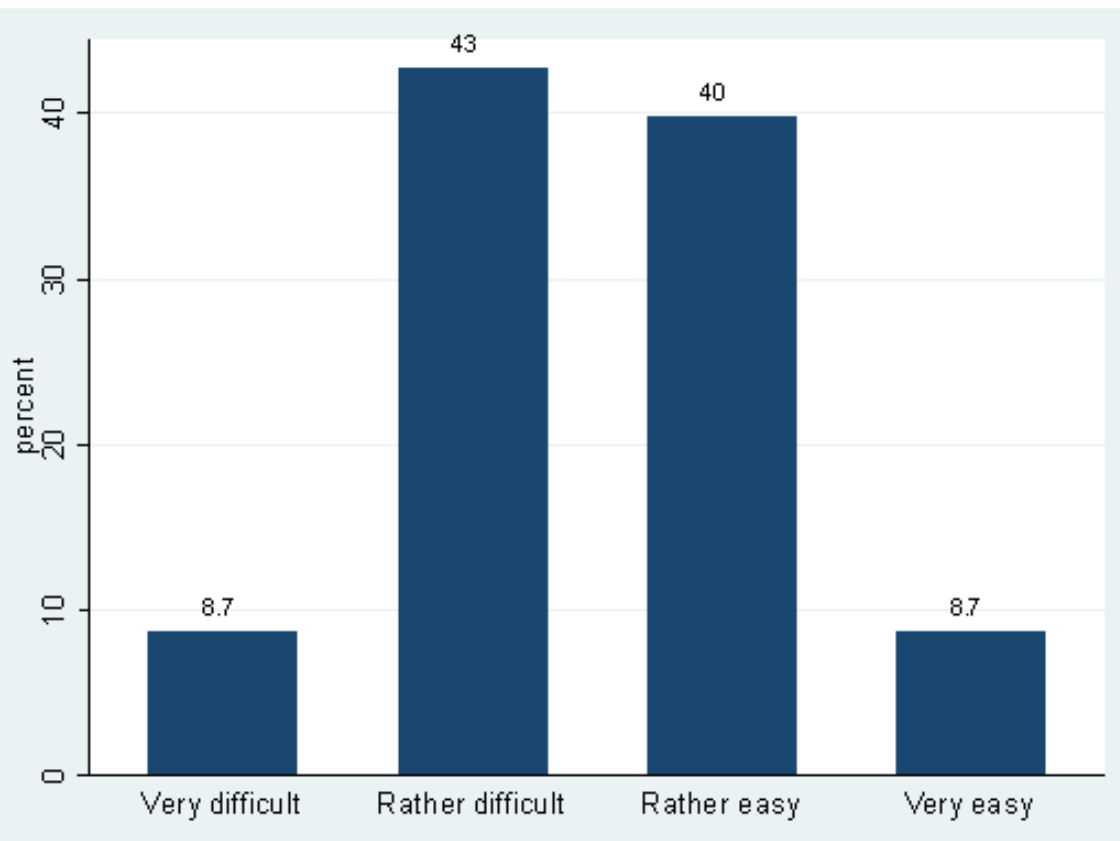
8. Ease of collecting Oesophago-Gastric (OG) cancer data for NOGCA (%)



Our commentary

This stands in (welcome) contrast to the relatively big problems trusts seem to experience when collecting HGD data.

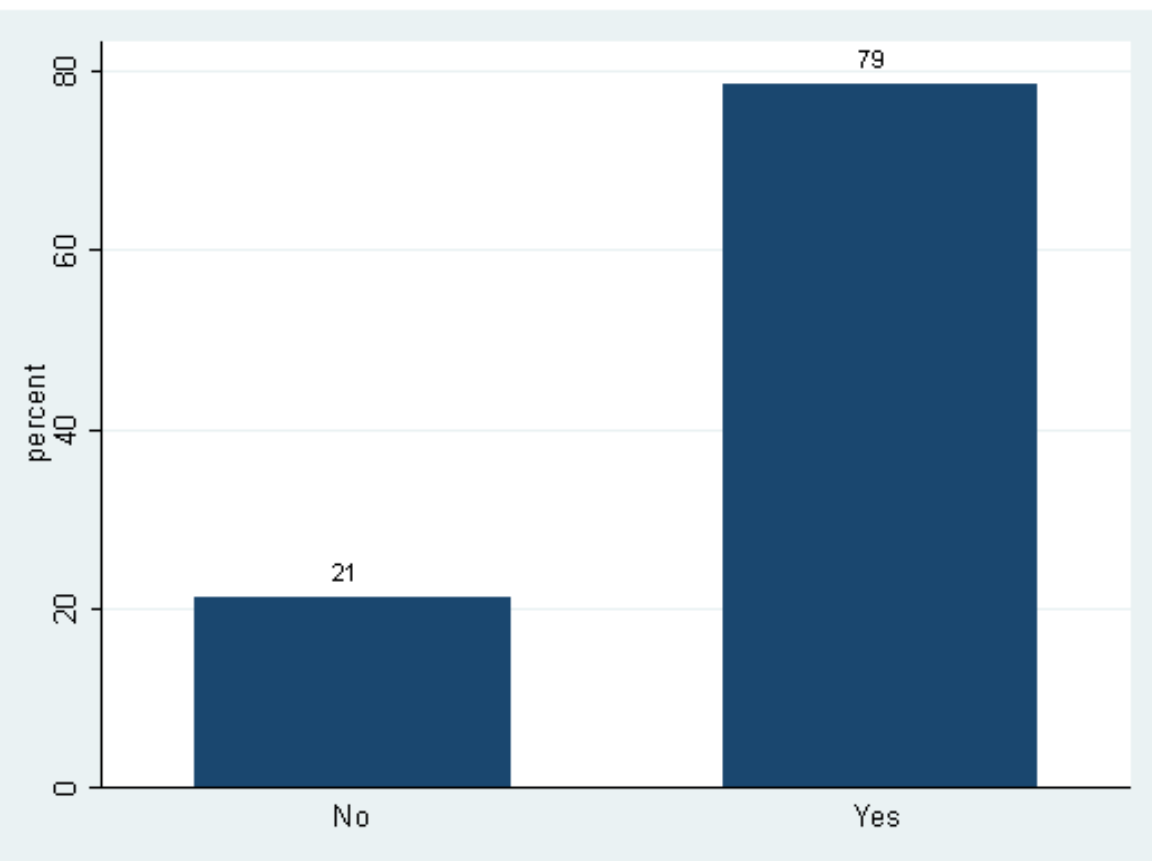
9. Ease-of-use coordinating OG data collection with other organisations (%)



Our commentary

The split into almost equal parts of difficult and easy is interesting. It is likely that the perception is strongly influenced by how complex it is to coordinate data collection across individual trusts.

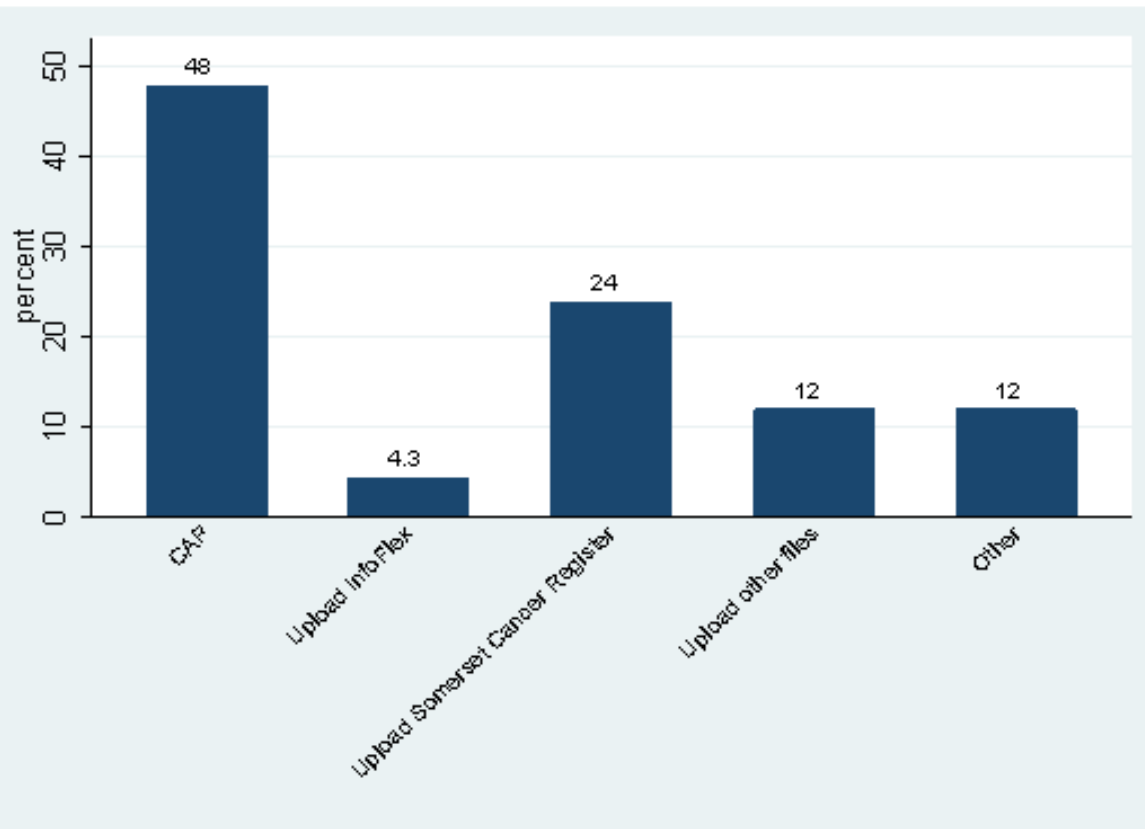
10. Involved in submitting data to NOGCA (%)



Our commentary

Again, the respondents tend to be the active providers of data to the audit.

11. Mode of submission HGD (%)



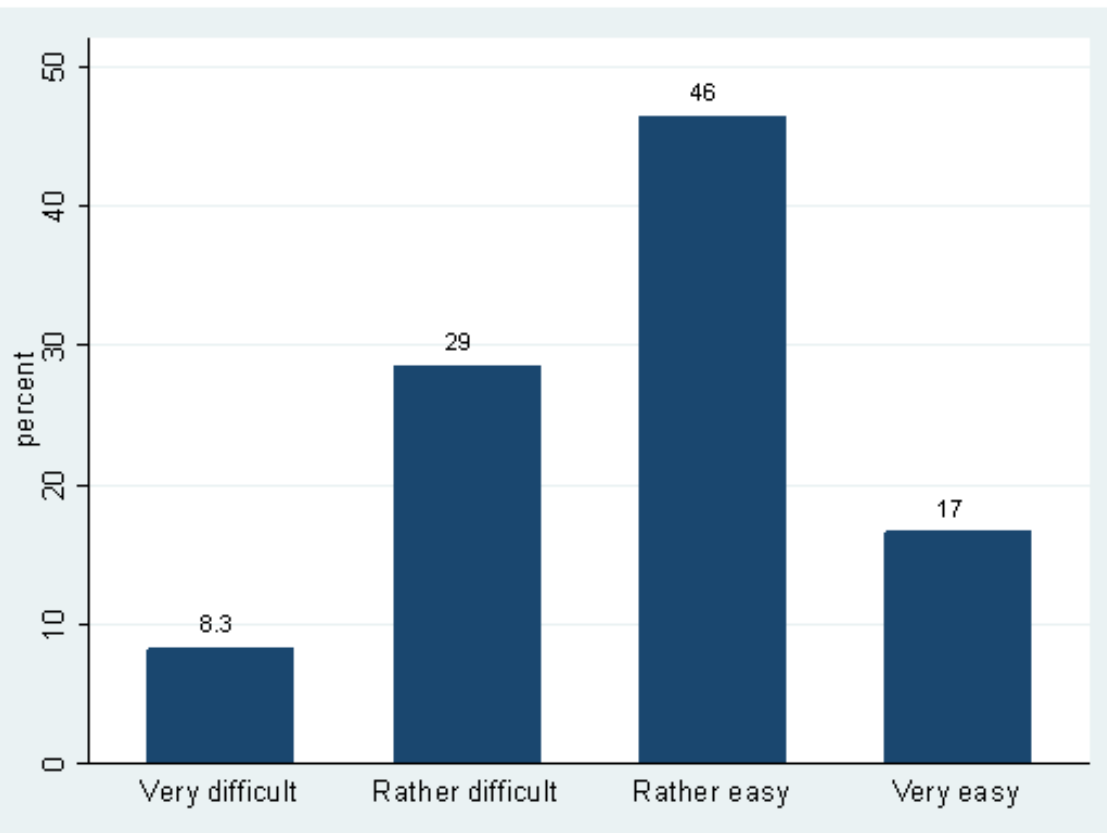
Our commentary

It is surprising that 24% seem to manage with Somerset Cancer Registry (SCR)-produced csv-files. As was established in 2017 in cooperation with the SCR data team, it is not straightforward to submit non-cancer-diagnosis HGD cases via SCR and the documentation was changed to encourage users to do what the majority already does: enter directly in CAP (48%). A further 12% create csv-files manually (“upload other files”).

NB: the “other” category also identifies scenarios whereby the data is actually created or uploaded manually, although on occasion after deriving data from other sources such as internal IT systems.

NB: CAP refers to entering data directly in the CAP system. Upload refers to csv-files, which can be created by Somerset Cancer Register, InfoFlex or manually (“other files”).

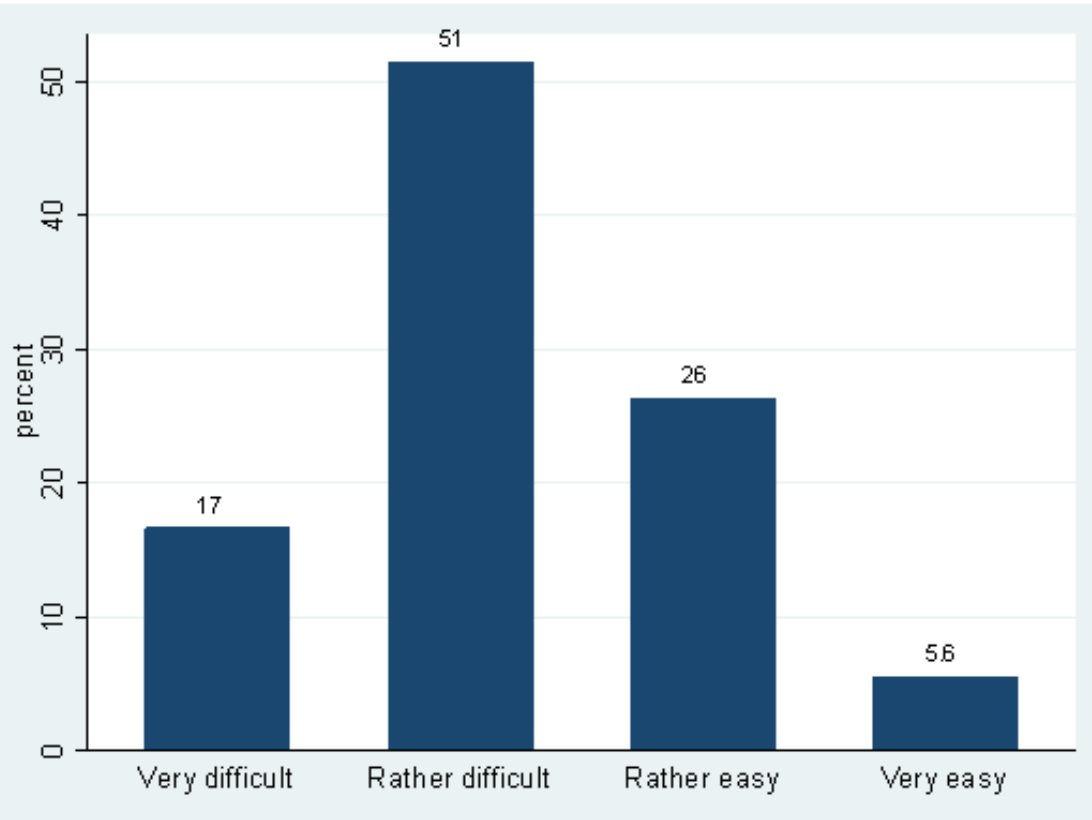
12. Ease-of-use HGD data submission (%)



Our commentary

This is good news. After HGD data has been collected – the relatively hard bit according to the responses shown above – more than half of trusts seem to find submitting the data relatively easy.

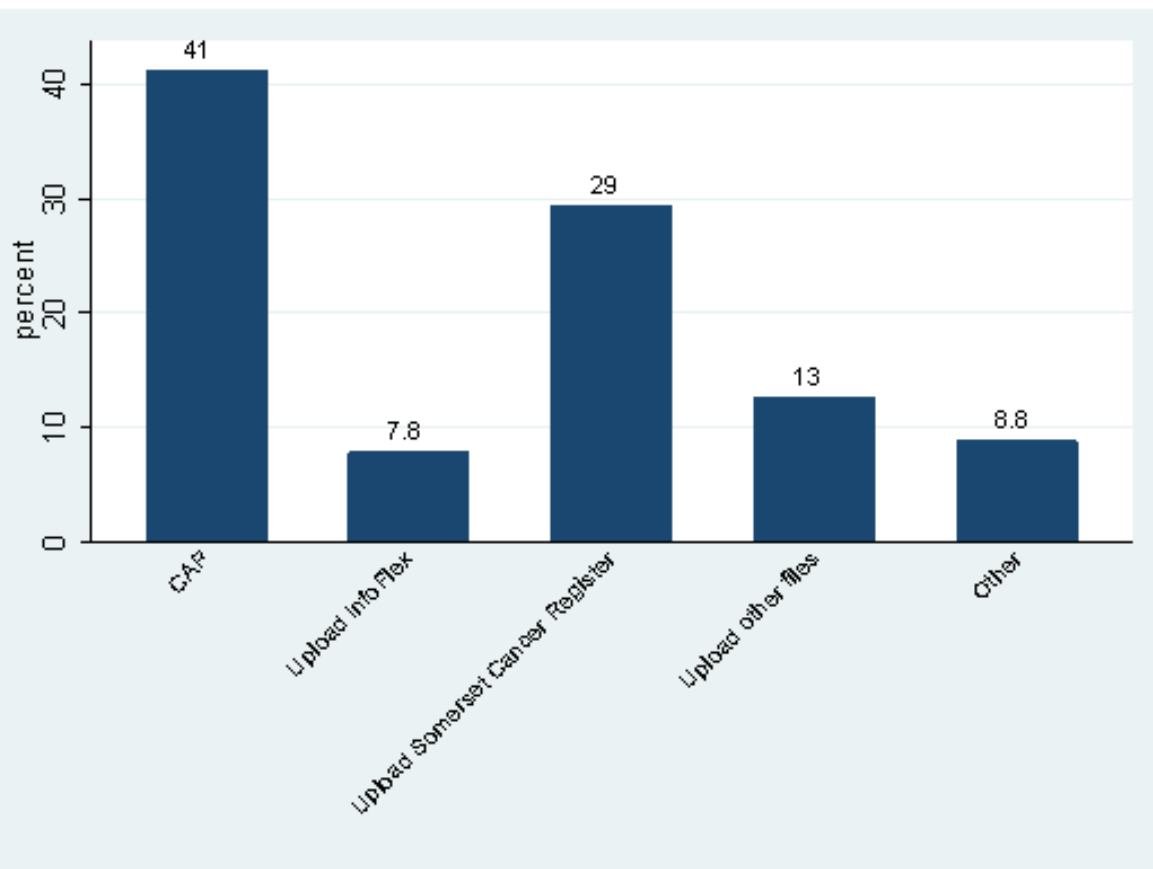
13. Ease-of-use coordinating HGD data submission with other organisations (%)



Our commentary

We know from other sources that joint data submission for patients with shared care pathways can be challenging. The difficulties that NHS trusts face when submitting or when collecting the data are essentially the same; data is not always available where it is needed and CAP data collection system does not currently allow for easy cross organisation working on HGD cases.

14. Mode of data submission OG (%)

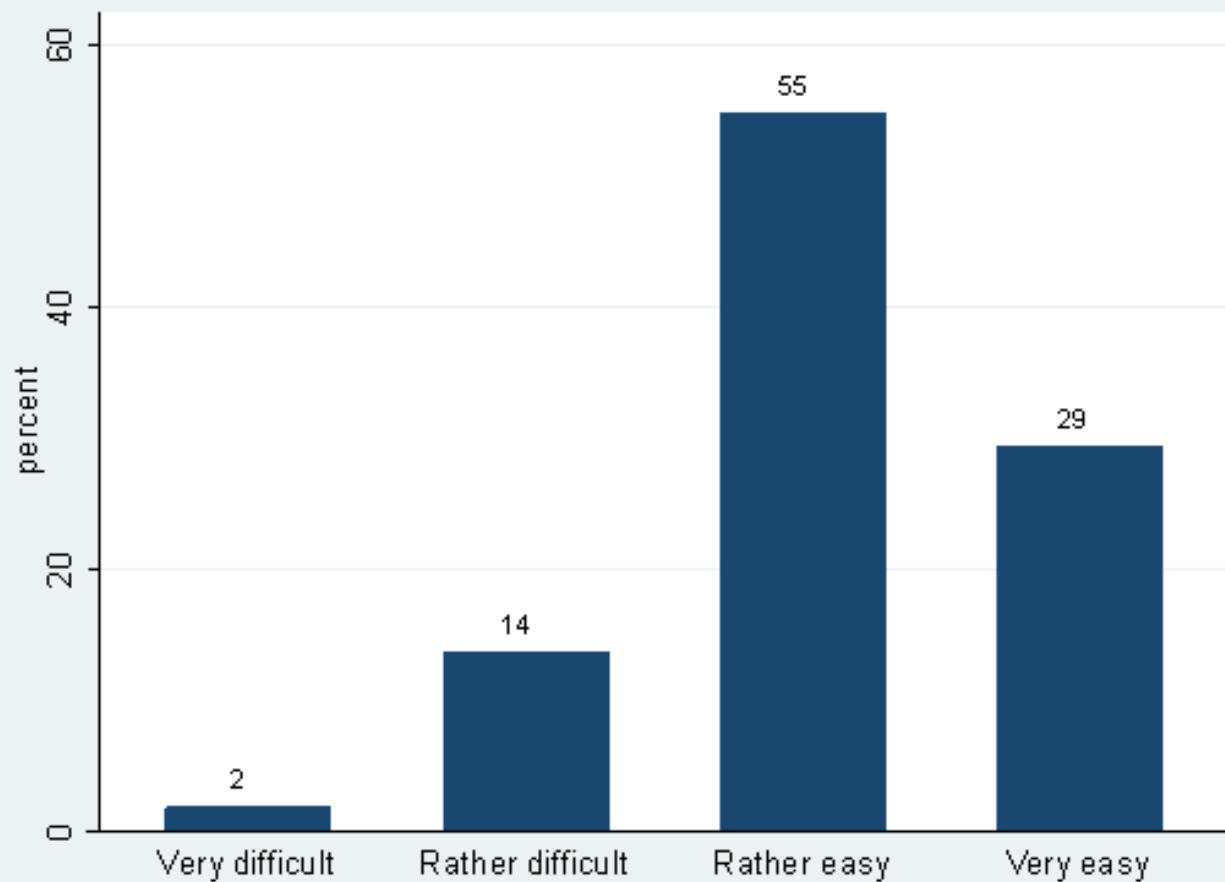


Our commentary

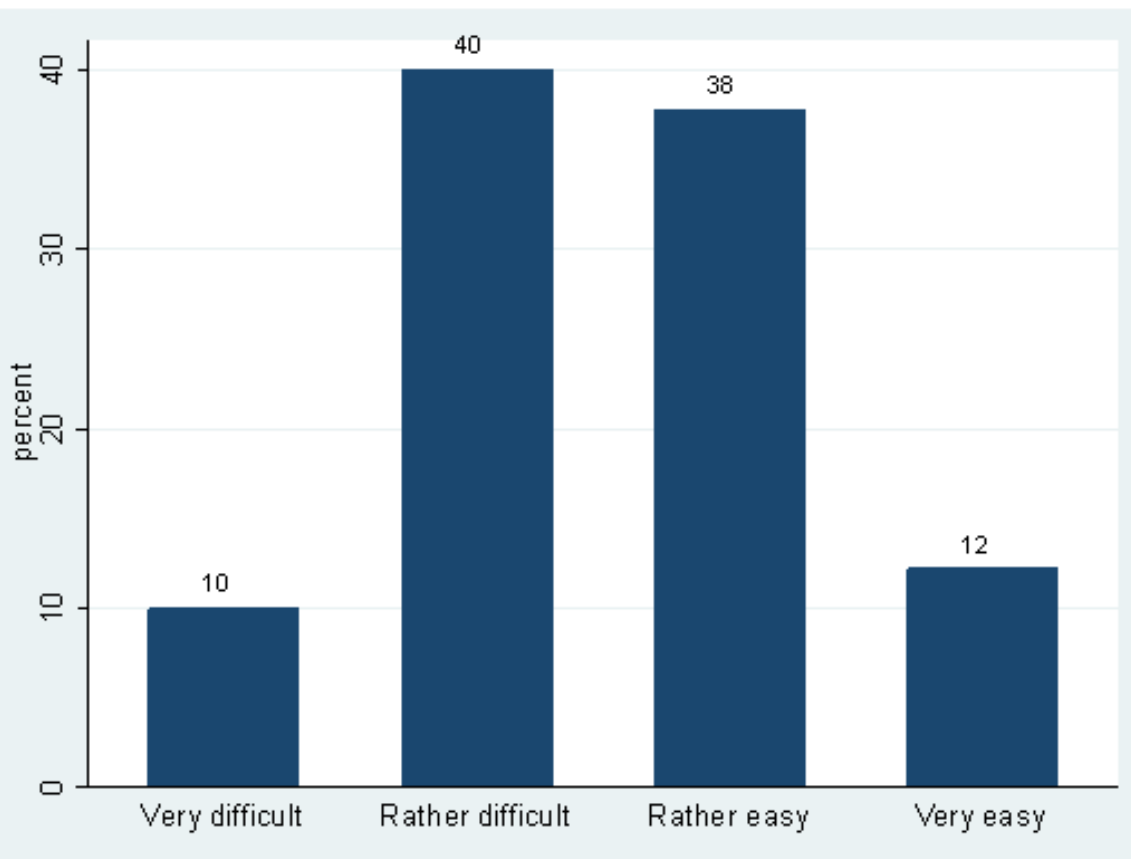
41% entering data onto CAP directly comes as a surprise to the audit team, given that this might involve double entry of data into IT systems. This warrants further investigation.

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15. Ease-of-use OG data submission (%)



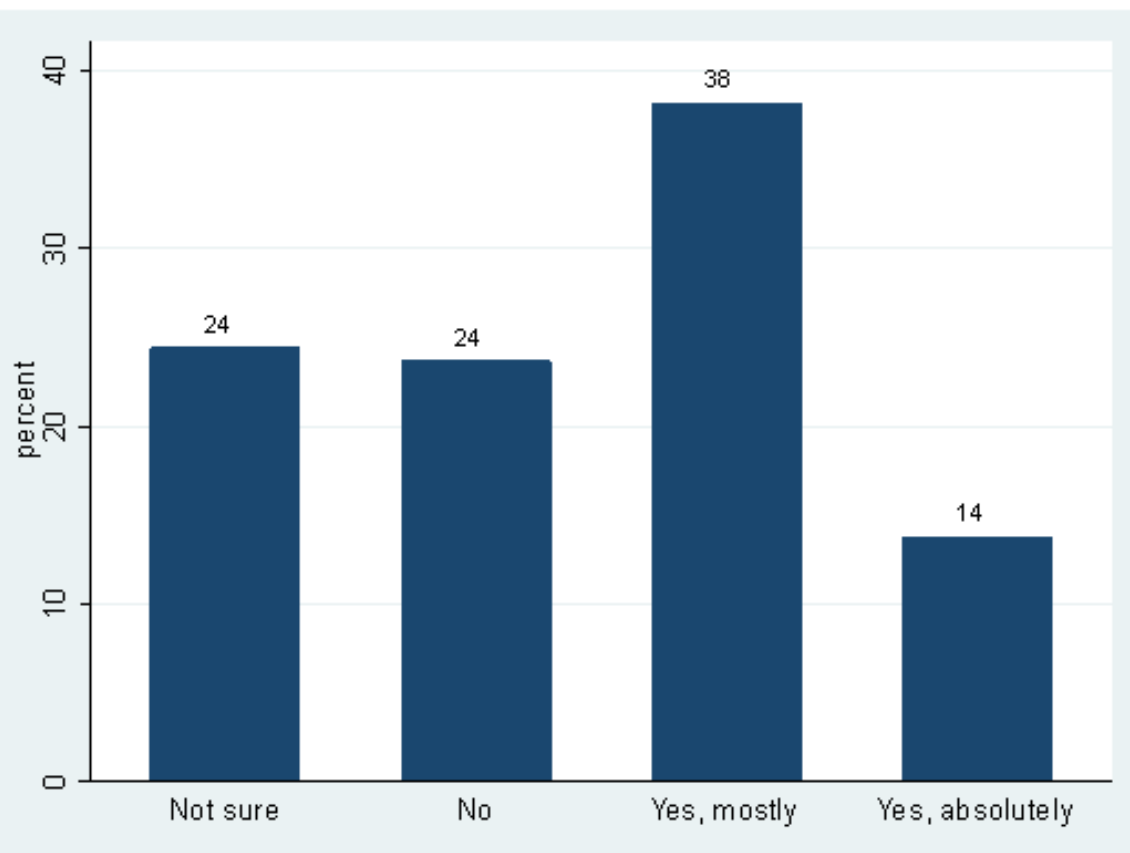
16. Ease-of-use coordinating OG data submission with other organisations (%)



Our commentary

There is an apparent polarisation between users who find it relatively easy and relatively difficult to coordinate data collection, possibly reflecting the complexity of care pathways in individual trusts.

17. Is the audit worth the effort? (%)



Our commentary

The primary approval rating stands at 52%. If we looked only at those respondents with a clear opinion (i.e. ignoring 'not sure'), then the approval rating stands at a more positive 69%. However, 24% thinking it is not worth the effort and 24% being unsure means the Audit team needs to explore ways to limit the audit burden and maximise its benefits.

18. Enablers of the audit (name up to 3)

71 respondents (**54%**) provided **110** clearly identifiable mentions of enablers. There were two main themes.

Theme 1: Dataset, Clinical Audit Platform, Third party providers

 **73% of enablers**

Theme 2: Support from audit team, clinical teams/leads, MDT coordinators

 **25% of enablers**

Theme 1: Dataset, Clinical Audit Platform, Third party providers

CAP (easy to use, direct upload, good reporting)

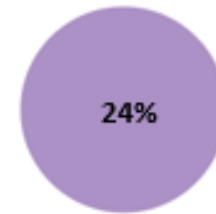
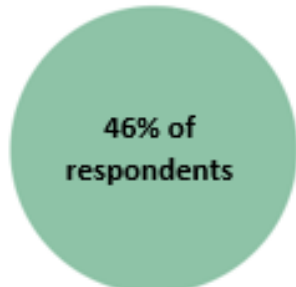
Dataset (clear, small, logical)

Data (available, MDT access, electronic access, clinical notes)

COSD (alignment with)

Somerset Cancer Registry (direct upload, reporting, ease-of-use)

InfoFlex (ease-of-use)



33

15

11

2

17

1

Voices (representative examples):

*Fairly easy to upload *.csv files via the web interface*

The platform is easy to use. I collect the data and enter the information onto the platform so recognise and know the patients

Reliable, fast web platform.

User friendly data upload platform

Database is simple, OG cancer data is simple. easily available

Dataset pretty simple, which enables non-clinical staff to easily collect information.

Easy, clear data items to complete

*Small amount of data collected
Structure of the audit is logical - patient, tumour, surgical etc.*

OG cancer data is easy to collect as the majority of data is documented in the minutes or in the notes. If I do struggle to get any data i.e. TN staging because it's not documented anywhere, we have a process where I send the form and notes to a clinician and they complete any missing data which I have highlighted.

Minimal NOGCA HGD records for our Trust makes the upload simple and time effective.

Direct uploading of information from Somerset - when this works, saves time.

Somerset Cancer Registry extract. Somerset Cancer Registry check report

Reporting from Somerset makes it easy to identify missing information

Using Somerset can make entering audit data easier

Theme 1: Dataset, Clinical Audit Platform, Third party providers

CAP (easy to use, direct upload, good reporting)

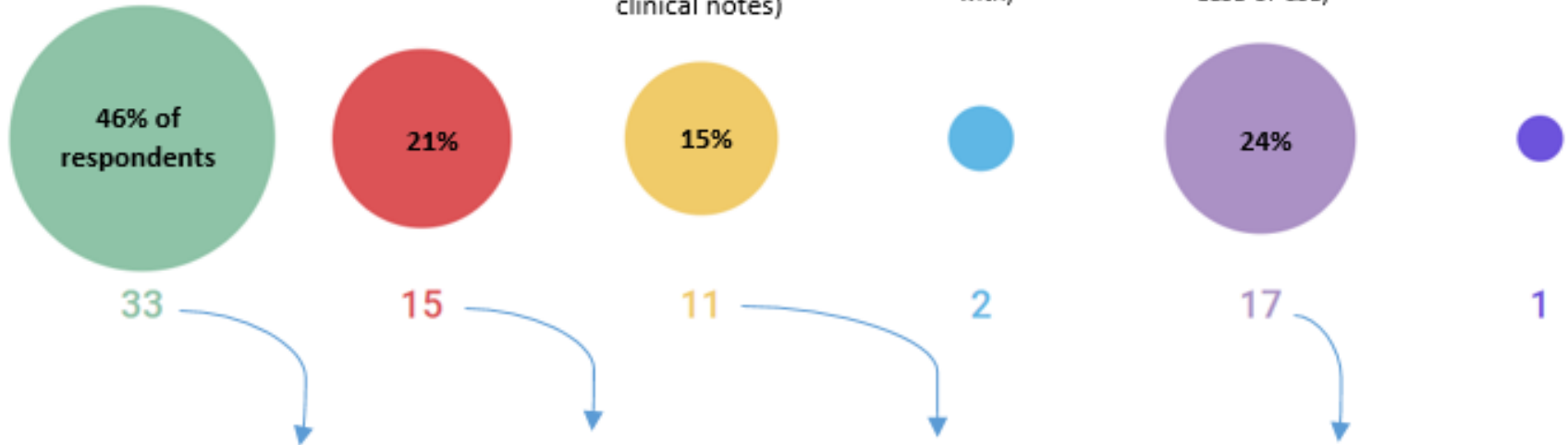
Dataset (clear, small, logical)

Data (available, MDT access, electronic access, clinical notes)

COSD (alignment with)

Somerset Cancer Registry (direct upload, reporting, ease-of-use)

InfoFlex (ease-of-use)



Voices continued:

The system is easy to use - self explanatory. The system is quick and allows quick movement from page to page

Ability to download data submitted is good - feedback etc.

Can save and come back any time to a patient on the CAP system

The pathology reporting is standardised.

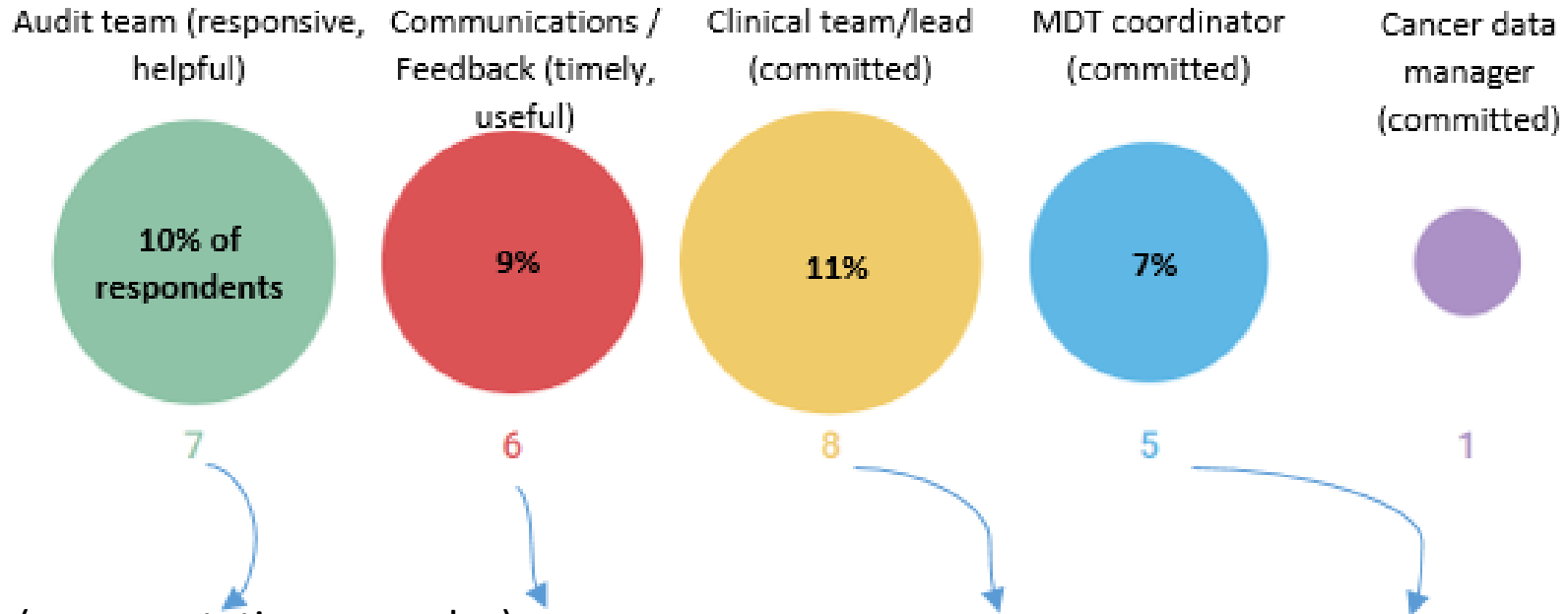
The surgical details are straightforward to collect.

Using our own database to track our patients prospectively is integral to our work - and we can upload to NOGCA from that. The information is important so we want to collect it.

Easy to identify all patients from MDT lists. All information is available from electronic records

Somerset is an easy registry to use

Theme 2: Support from audit team, clinical teams/leads, MDT coordinators



Voices (representative examples):

Central support available from NOGCA team

Clear guidance from NHS Digital Communication with HSCIC/ NHS

Digital is good, we are provided with good updates, and any queries we have are responded to in a timely manner.

Reminder emails are helpful

Excellent communication with respect to deadlines for audit, and sharing of information prior to finalising audit

Feedback reports

Excellent support from the Clinical Lead

The willingness and support of the clinical team to record the data in the first place. The time the clinicians provide to assist me in validating the data prior to extract/upload so as to ensure as many records as possible are uploaded and all missing/erroneous data is addressed.

Good clinical team involved

Uploading done by our MDT coordinators

Good MDT coordinator

Other enablers and additional comments

One respondent identified their own experience in doing the audit as a key enabler and two others noted a low workload for NOGCA, based on much of the audit data being supplied by other (surgical) trusts.

Furthermore, four respondents included suggestions for change or concerns among their enablers:

- *The specification file helps with submissions but for each submission file the data items are listed out of order to those actually on the submission file. If they were in the same order it would make that little bit easier to check submissions.*
- *Would be better if single sections with all fields added were accepted and only sections where the data was missing not be accepted. Would be better if all fields matched with cosd field definitions. A report that shows all entered fields so that you can better dq what is missing*
- *Time consuming to collate data. Changes in data collection mean revisiting previous patient details. Volume of data required*
- *Integration with other database data collection eg IDSE ESODATA would be beneficial*

19. Constraints of the audit (name up to 3)

67 respondents (**51%**) provided **121** identifiable mentions of constraints, which reflected well the two main themes already identified above.

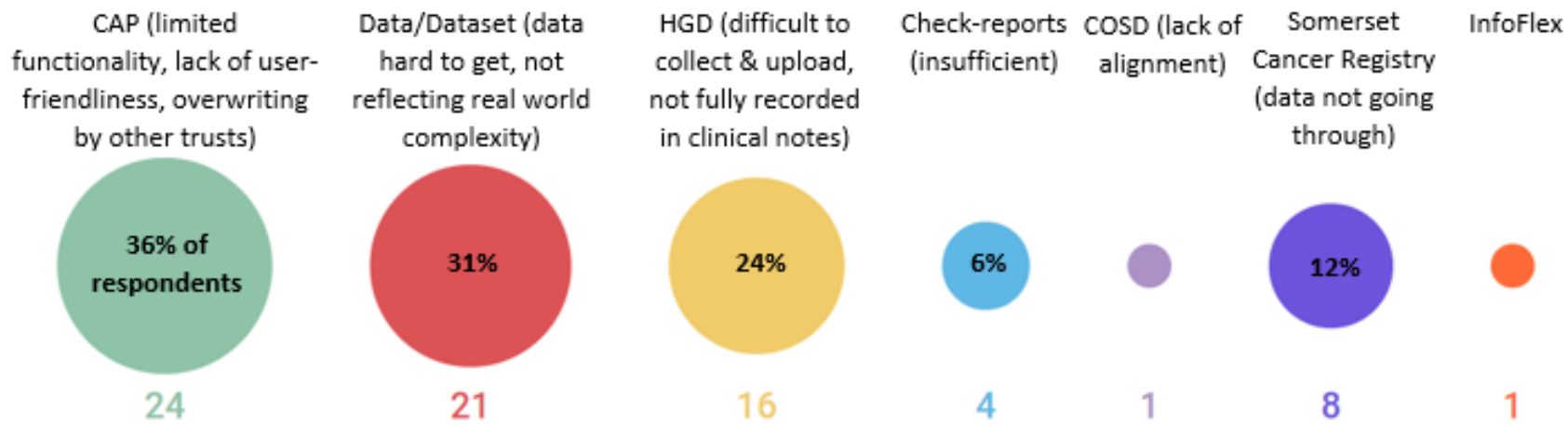
Theme 1: Dataset, Clinical Audit Platform, Third party providers

 **63% of constraints**

Theme 2: Support from own NHS trust, cooperation between trusts, support from clinical team, feedback/communication from audit team

 **38% of constraints**

Theme 1: Dataset, Clinical Audit Platform, Third party providers



Voices (representative examples):



Need to complete all data before being able to save - would be useful to be able to save some of the data and go back to it rather than completing the whole section

Use of CSV files - some data fields require you to manually alter the data in the CSV files before it will upload. If you fail to correct all the errors in the file at once, you then have to re-edit the file again meaning you have to make note of all the data items you edited previously and then re-do the entire thing prior to re-uploading. Unnecessarily time consuming.

Error messages on NOGCA website are not user friendly

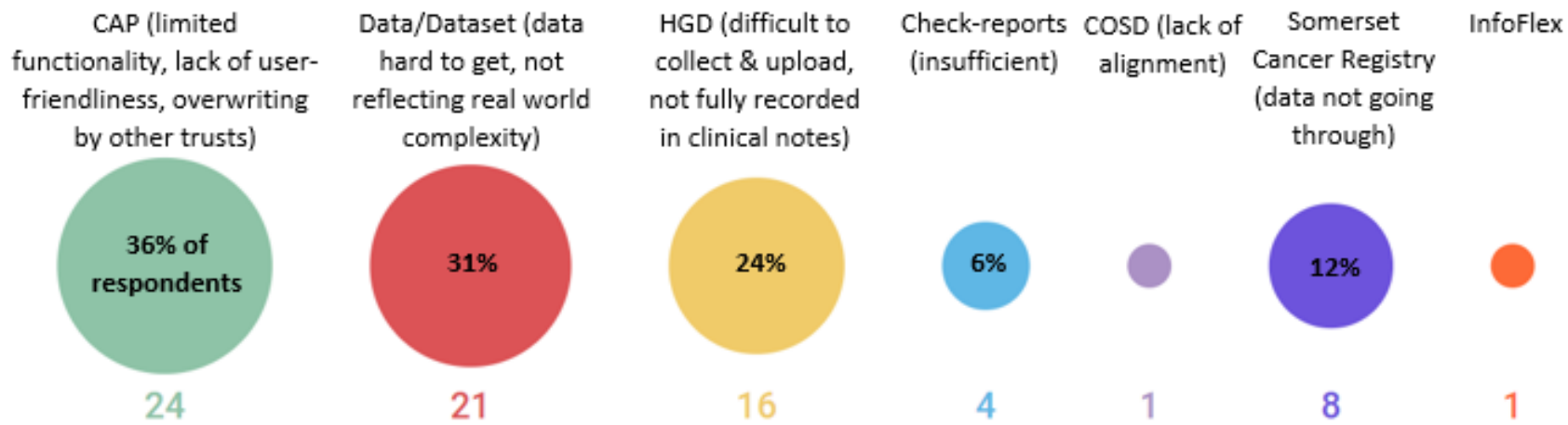
Having to translate the data from our database to NOGCA isn't always straightforward.

Other NHS trusts can overwrite good data if they upload after we do, particularly irritating as we are the Centre and feeder units not doing most of the treatment

overwriting of data from other Trusts

Although I haven't experienced this problem with this particular audit, I do worry about other Trust overwriting data I have submitted, especially if they are submitting data via extract. I think Trusts should be alerted if somebody else has already submitted data for a particular patient and given their contact details if they need to make an addition/change.

Theme 1: Dataset, Clinical Audit Platform, Third party providers



Voices (continued):



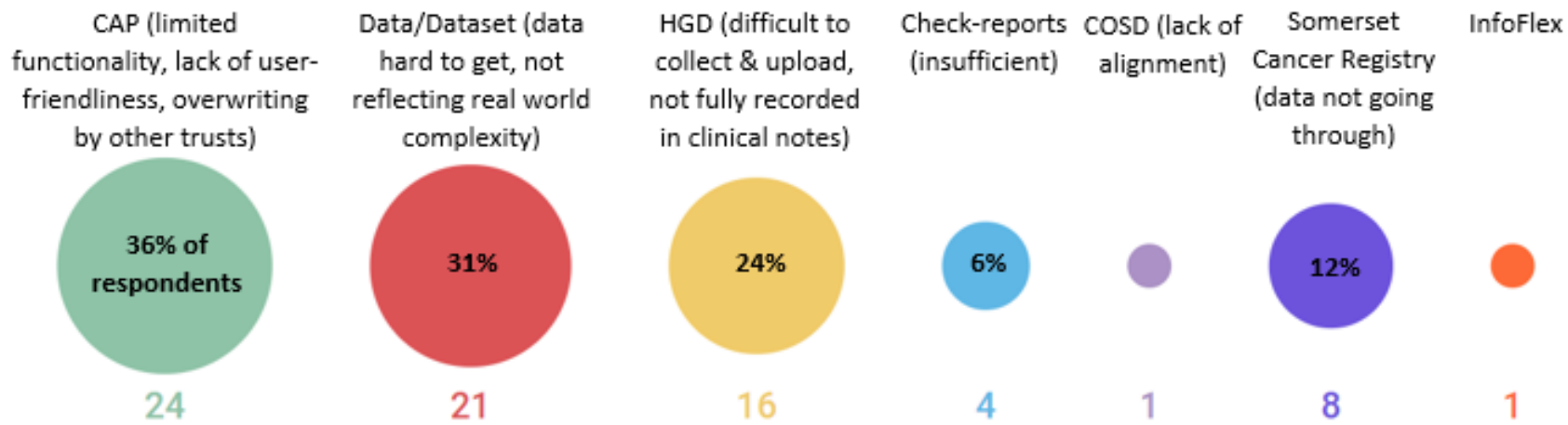
Overwriting is a huge problem especially when there is more than one hospital involved with the patients care. Overwriting is also a problem when the data is submitted electronically via CSV files etc. No alerts when overwriting has occurred

The upload validation files are not very "user friendly", as they do not include patient identifiers forcing the users to have to reference the original upload file to find the row with the issue. The audit dataset submission time frame and submission deadlines should be available on the audit submission platform rather than having to search for separate site.

If I am half way through input on a patient, the phone rings. If I start adding more data the systems obviously has timed-out when I go to submit. Which is annoying, why doesn't a message pop up before you added all the data stating timed out. It waits until you have added it all and then doesn't accept it, as its time-out a while ago.

Unable to submit more than one record for a patient - we are missing activity, often the more important data as this would show progression, recurrence etc.

Theme 1: Dataset, Clinical Audit Platform, Third party providers



Voices (representative examples):



Interface between our Access surgery database and clinical audit is difficult because we do not have access to the date of diagnosis.

No automatic link with other data systems used by the surgeons.

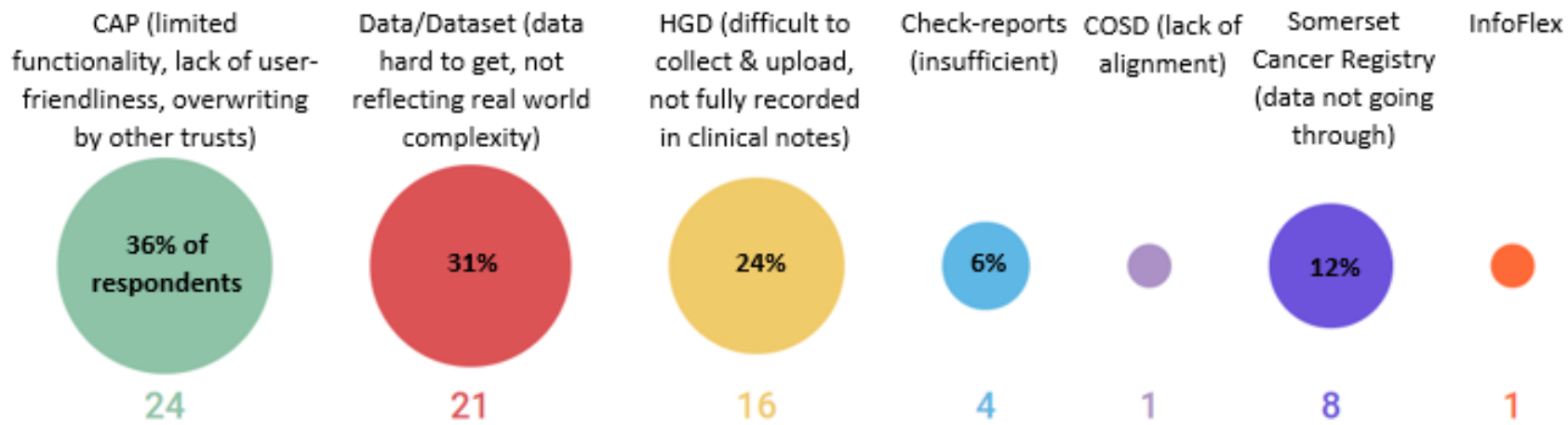
We may not have done the first biopsy, may have been picked up privately or on holiday, but the patient is seen by us in outpatients immediately following this and then referred on to specialist centre or treated by us as well. However no way to indicate this on the data set.

Because some records are excluded from the audit because of maybe just one data item being missing (perhaps because the patient died mid-pathway), the audit gives an unfair view of the actual activity taking place at a Trust.

Not all patients will have CT staging, this is a clinical decision because the patient would not be fit for treatment other than palliative care. This information cannot be transferred across.

It would make entering data a lot easier if on some of the questions there was a NOT KNOW option, if all information is not entered, and sometimes it is difficult with dates for instance, then it doesn't allow us to register the patient.

Theme 1: Dataset, Clinical Audit Platform, Third party providers

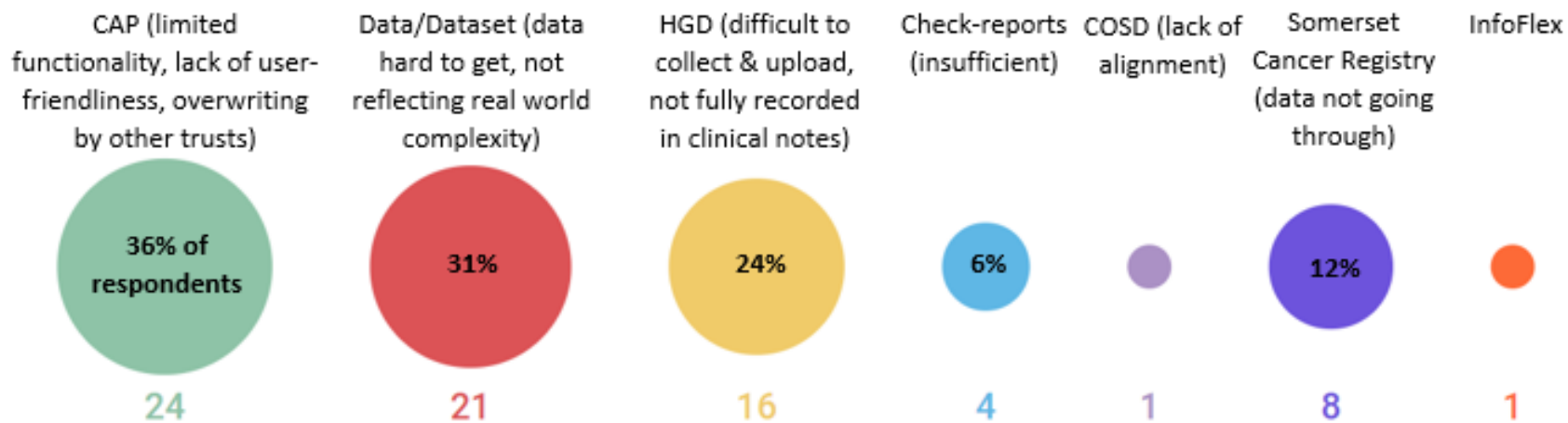


Voices (continued):

The drop down boxes do not consider every case. For example, if a patient has had a CT and there is a definite cancer mass. The patient is not fit for endo/biopsies. Cancer type cannot be determined. The drop-down box wants a cancer type input, this is difficult.

As I try and enter the data onto the audit platform prospectively (usually after the patient has been discussed at MDT), I find that the oncology section is difficult to complete. This is because the data set requires the patient to have finished treatment before submitting a record.

Theme 1: Dataset, Clinical Audit Platform, Third party providers



Voices (representative examples):

Trusts submitting HGD data which then does not allow our treatment data to be accepted.

HGD is difficult to collect

HGD is difficult to obtain and to upload with conflict of OG cancer

HGD data can be difficult to find and interpret sometimes

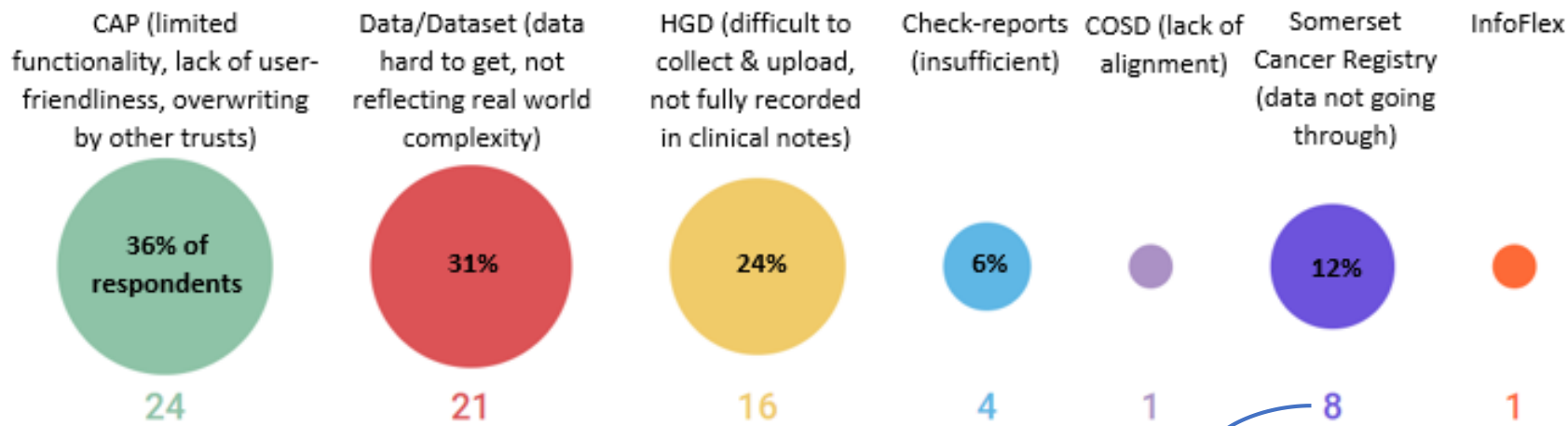
Issues with HGD as we will do a first biopsy and then refer on to specialist trust if HGD, so don't have second biopsy results and can't therefore enter any data as you can't enter part of the record. Reliant on Trust we referred to, to do so and cases therefore not attributed to us as initial diagnosis.

Notification of HGD by our pathology department to our team is difficult to extract

HGD checks have to be run separately to ensure we have captured all HGD cases as not part of the normal CWT work.

The HGD/Cancer record logic does not make any sense and feels wrong not to report cancers.

Theme 1: Dataset, Clinical Audit Platform, Third party providers



Voices (representative examples):

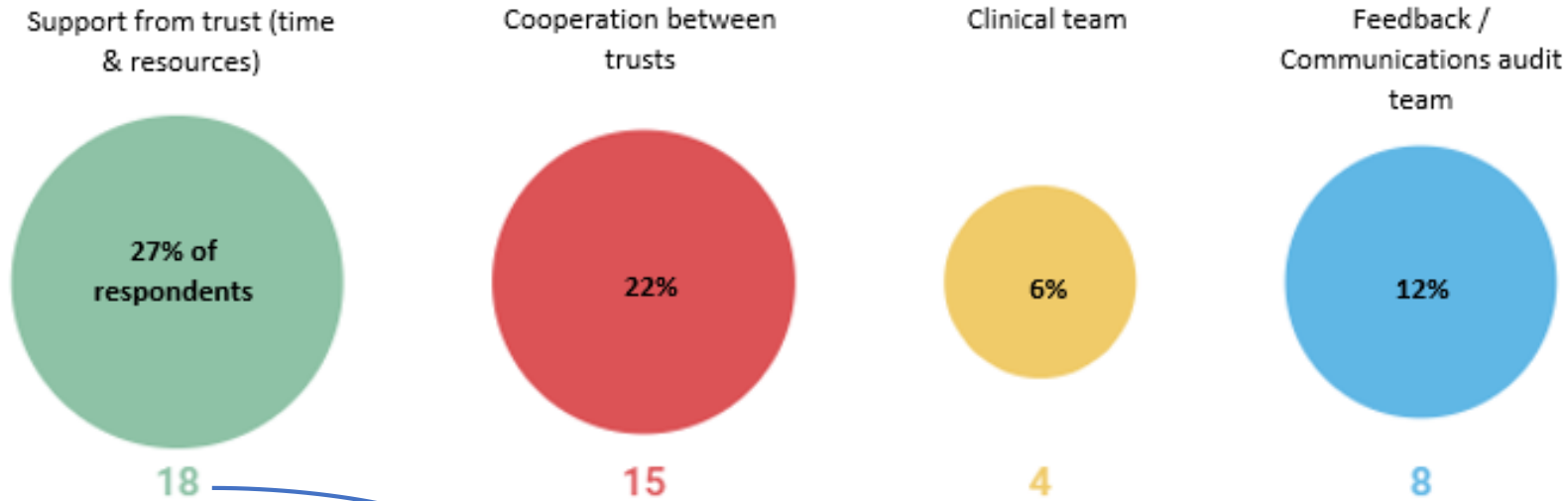
Sometimes the error messages on Somerset can be a hindrance when we cannot work out why patients are excluded.

Attempting to understand why data does not pull through via Somerset

Clinical engagement with entering surgical data - Consultants opinion that some surgeries do not fit into the available options on Somerset Cancer Register.

Sometimes entering the 'right' data into Somerset can be difficult. Understanding what fields need to be completed and having dates in the right order.

Theme 2: Support from own trust, cooperation between trusts, support from clinical team, feedback/communication from audit team



Voices (representative examples):

Despite their willingness to help, there is always a demand on the clinicians time during the data validation process which impacts their clinical responsibilities.

Lack of support staff due to cost cutting exercise by the Trust to reduce administrative staff in the Cancer Services Department. With the increasing focus on Cancer in the NHS, it seems daft that Trust Boards do not share the vision of having a Cancer Services team to co-ordinate clinical services and data management.

Not having enough staff to coordinate and collect data

No time. No designated data staff- CNS staff trying to fit around workload- unable to complete all data reliably.

There are no constraints other than I am the only one who collects and submits the data so when I am off this isn't done.

Time constraints collecting all of the data required for audit. Training new staff to be able to collect the data.

Tertiary centre does not work with us to submit shared records

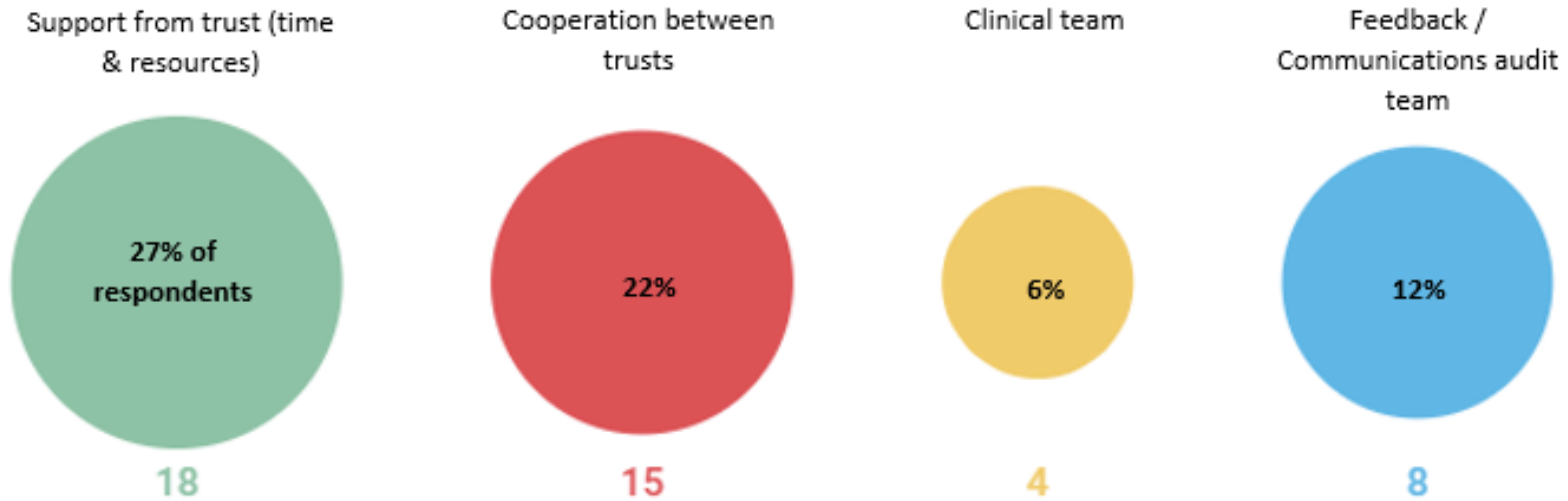
I do have to rely on XXX to complete the entries for each patient who is referred to them for treatment and there is often no way of receiving confirmation that this has been done until the reports come out.

Diagnosing Trusts not uploading their patient details prior to our submitting treatment details

*Lack of contact details for relevant staff at other Trusts
Other Trust not validating their data until near to submission time*

Complex shared pathways across Trusts can make data collection difficult.

Theme 2: Support from own trust, cooperation between trusts, support from clinical team, feedback/communication from audit team



Voices (representative examples):

*Not having the surgical information from all of our clinicians
Liaising with consultants.*

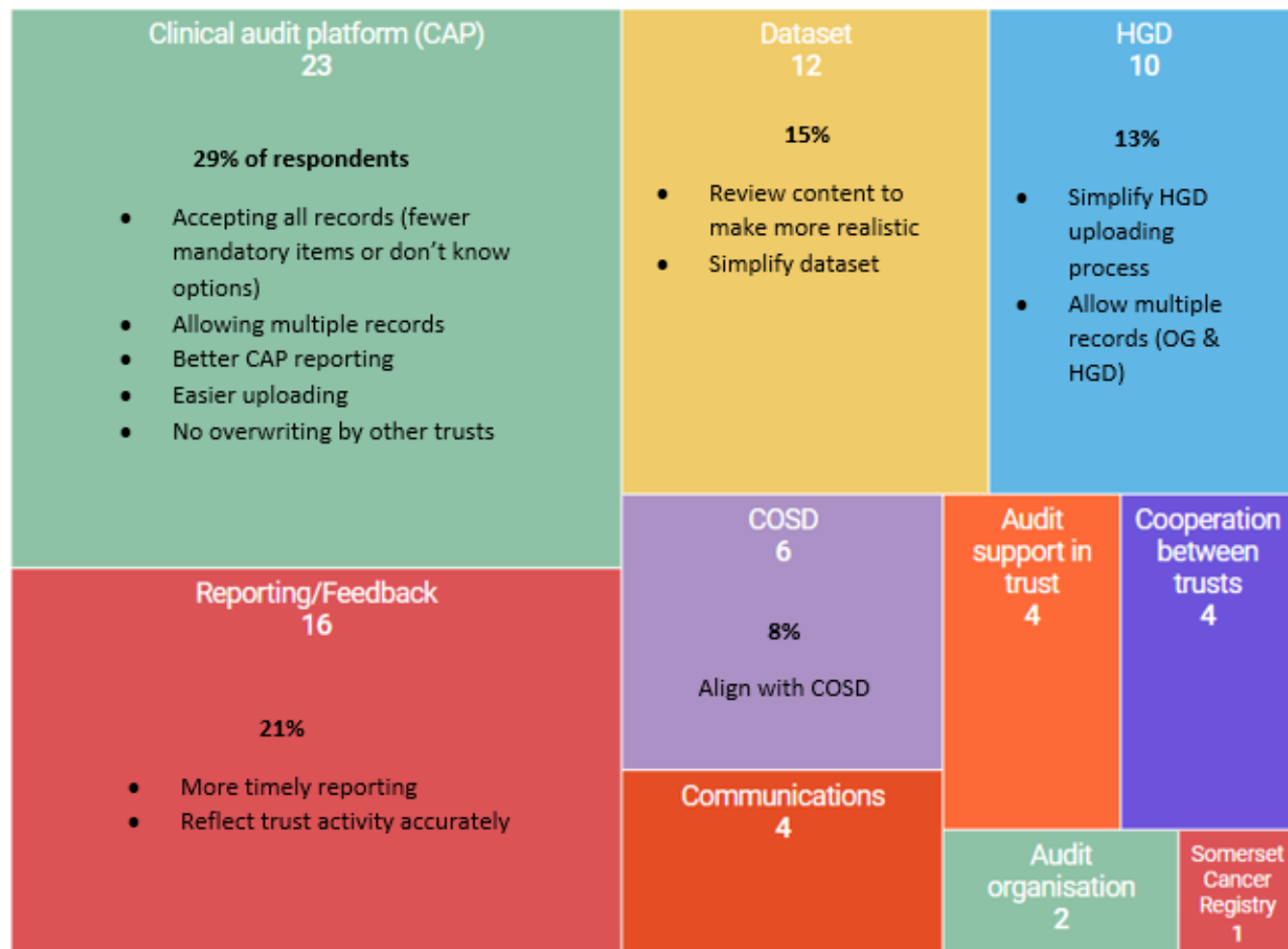
Earlier feedback to pass on to Surgical team - allowing more time to improve quality of data.

We are constantly criticised by our clinical team that the number of patients included in the audit is less than the actual number treated, especially for HGD patients. We think that this is due to the fact that patients are selected by the Trust they were originally diagnosed at. Being a regional centre, a large number of patients are referred to us from other hospitals but they cannot be included in the NOGCA submission via Somerset. We hope this can be addressed as currently the audit does not take this into account for Trusts like ourselves. It is not truly reflective.

Lack of national reporting / updates back to the Trusts

20. What should change?

78 respondents (**60%**) made **85** specific suggestions for improvement. The following conceptual maps shows the thematic groups as ordered by absolute number of suggestions and percent of respondents making a suggestion.



All voices of NOGCA users are listed below. As they contain a wide range of specific suggestions for audit development, they are presented in full.

What should change? Clinical audit platform (CAP)

To allow all activity to be included whether data was missing or not and perhaps supported by a free text field or drop down options to explain why data was missing i.e. patient died before treatment etc

We use a combination of uploads from Infoflex, however since the clinical audit platform rejects records with missing or inconsistent information a lot of information needs to be added manually directly on to the clinical audit platform. I think the level of restrictions needs to be reviewed. My personal view is that all records should be accepted with relevant reports available to identify missing information or inconsistent information with logic rules (eg surgery date after discharge date).

Too many key data items need to be completed before submitting a record. It's frustrating getting all the way through a diagnostic record just to find that you can't save because you missing one item (like treatment plan - this isn't always decided at the first MDT)

The reporting system on NHS digital could be improved upon

being able to put in the information you have available instead of blocking a whole section if 1 mandatory field item is missing.

One extract to upload, rather than 5

I would also like to be able to create more than one record for a patient, this would solve the issue above but would also allow for recurrences to be submitted.

To stop other Trusts being able to override our patient data. This is why we manually input to the audit platform as we have fallen foul of this in the past.

Ability to save data as you identify it. Ability to indicate patient has died before treatment plan agreed.

I'D MAKE IT EASIER TO SHOW DIFFERENT REPORTS AND TRENDS TO PROVE WHAT COLLECTING DATA ACHIEVES

System to be easier to use and more user friendly.

Add more unspecified options into mandatory fields

What should change? Clinical audit platform (CAP) ...continued...

Being able to save and come back to complete sections

Prevent overwriting of data

THE SYSTEM IN CLINICAL AUDIT PLATFORM IS DIFFICULT, IF INCOMPLETE DATA INFORMATION HASNT BEEN ADDED IN SOMERSET.

If you could see exactly what is uploaded of the patients you are working with.

As I work in Wales it would be to have a clinical audit platform that was fit for purpose

Data collection is probably not complete and there is a selective element to data submitted.

Making it easier for our data managers to upload, check and validate the data

Reduce the number of mandatory fields and dependencies - a lot of good data never reaches the audit because of single minor discrepancies or date issues.

Sometimes it can be very confusing - I think it needs to be made simpler

What should change? Reporting/feedback

Review the inclusion criteria to better reflect the number of patients treated. As mentioned previously, we are a regional centre and we have lots of patients which are referred to use for treatment from other trusts. At present these patients cannot be included in our submissions due to how patients are included in the audit i.e. by diagnosis. The numbers we get out of the annual reports are never reflective of our true practise. The National Prostate Cancer audit reports data on a Trust level and an MDT level to take into account this difference. Perhaps NOGCA team can review this and introduce something similar.

More contemporary data and over more than 3 years collection period. Longer term mortality data.

Make all the audits the same data range and the same time periods, also make the national data base more user friendly still difficult signing in and finding what you want

As a Trust that has merged with another Trust, the data that is reported is often 'merged' when it would be nice to know/have the individual hospitals data.

Better turn around time for data / reports.

A more integrated real time input of Audit, directly linked in from the AUGIS database

Advice and support in developing robust action plans from the reports. Often the results are similar year on year with very little or no key learning is identified and so participation sometimes can feel not worthwhile although it is recognised that this data does provide information for other purposes including quality accounts.

90 day mortality which is not surgically related should be identified and reported as such . Eg progressive disease/early recurrence.

easy to follow longer term outcomes

I would continue to accumulate data, rather than present 3 yr snap shots.

In more real time. Current 2016 report is for data that was collected April 2013 and March 2015

What should change? Reporting/feedback ...continued....

make the outcomes team based rather than surgeon specific

The issue for our Trust is that we are a diagnosing centre, and the report is very much geared towards the treatment of patients - therefore although the data collection process is relatively easy, it is difficult to get buy in from clinicians who don't particularly see any results from the audit. The consultant outcomes programme element of the project does not affect clinicians not providing surgical treatment and as such, engagement is not as good as it could be.

The majority of the outcomes are regarding surgery which is not performed at this trust so is therefore not relevant to our trust.

They don't reflect completely the practice. Some surgeons may have brilliant results (dong only distal gastrectomies) and be chosen for the general public for these reason not knowing they don't do IE an oesophagectomy (higher mortality).

To be more specific to local Trust.

What should change? Dataset

Review of surgical procedure names to ensure they cover all appropriate surgeries undertaken at trusts.

Minimise data required

Create a data set which is more succinct.

To include RIP date.

Ability to save data as you identify it. Ability to indicate patient has died before treatment plan agreed. Ability to add first section of HGD data set and save it to indicate diagnosed patient referred on.

Able to identify that patient hasn't had biopsy but radiologically diagnosed. Some patients too ill and are too advanced to undergo biopsy

Just to improve on the data collection and to provide more options with the answers

CLINICAL JUDGEMENT IS NOT RECORDABLE

Each individual box should be reviewed and asked if it is really specifically useful. Is it worth auditing and why is it collected. Is it useful information.

The audit assumes that all treatment will be carried out at one hospital therefore asks for the date and details of final treatment plan. However, many of our patients have two MDTs, one at XXX and, if referred to XXX, another carried out there, which may change the treatment plan. It would be easier if there were an option on the form for it to be stated that treatment will be carried out at another trust.

TNM staging there is not an Tx on the staging and sometimes this is required.

Include all resections ie non curative, GISTS etc

What should change? HGD

Submitting HGD records via Somerset Cancer Registry should be much easier.

High grade dysplasia cases may be better placed as direct upload from relevant consultants

The logic for cases with HGD and cancer. We are not able to submit some cancer cases, which in my mind would take priority over HGD, due to there being an existing HGD record.

I would look into collecting HGD as part of the audit and possible separating it from the process as many trusts are only able to submit handful of records/patients.

Simplify the dataset for HGD

Ability to save data as you identify it. Ability to indicate patient has died before treatment plan agreed. Ability to add first section of HGD data set and save it to indicate diagnosed patient referred on.

Remove HGD audit part.

The HGD submission, allow referral and endoscopic reports to be submitted separately to the treatment.

It's difficult to get access to some of the information required. For example getting HGD information from other hospitals and HGD information generally as the information you ask for is not listed on our reports.

Make the HGD audit easier to complete

What should change? COSD

Please run the audit from COSD uploads

contemporary data based on COSD with a chance to validate/extract as with the Clinical Audit Platform

The audit moved to NCRAS like the NLCA and data was submitted as part of COSD

Complete alignment with the COSD OG tumour specific dataset

To move the audit to COSD and run it through the routine COSD submissions.

Use the data already collected for COSD and CWT submissions rather than an additional data collection and upload

What should change? Communications

Keep the Trusts informed as to why the audits keep slipping from their intended timescales. It becomes more difficult as time goes on to monitor the status of any given audit period.

Force Trust Management to act on the results of the audit and hold them accountable for actions within defined time frames. There is no point auditing practice if Trust Boards take no notice of the data and results

Is this data taken forward? for example if a hospital has lots of complications is it highlighted? is that hospital informed? and is there a forward plan. Does the data we produce change processes? or is it just collected for the public to show how we are performing? I would prefer to think all of this is to improve and to highlight problems and therefore be acted upon. Is there a review panel?

The instructions for the audit could be clearer.

What should change? Audit support in trust

Need dedicated data person to support the process who understands how to find the clinical data - therefore a clinical consultant is not relied upon to do the whole submission

There was someone to do it!

I value the audits and fully understand their importance. My problem is resourcing the staff to collect the data.

A dedicated audit administrator for the Trust

What should change? Cooperation between trusts

units being able to change centre data

Patient information pulling through from cancer data base for local patients that have been treated at tertiary centres

Make the file upload process for shared provider pathways useable

OUR SERVICE IS SHARED WITH ANOTHER HOSPITAL, AND THEY MAY BE FULLY ENGAGED WITH THIS, BUT I HAVE NO ACCESS TO THEIR DATA

What should change? Audit organisation & Somerset Cancer Registry

Instead of year upload have quarterly up load with a yearly validation

Deadline for audit to be different to NBOCA audit

Collecting the data from Somerset which is not good

Further thematic analysis...

The following **word map** shows all 85 specific suggestions reduced to small phrases of no more than three or four words. Size indicates relative frequency (here ranging from max. 10 to min. 1 mention of a topic).

This map is meant to **pinpoint potential priority areas for quality improvement**, in the sense of readily available courses of action that could be taken.

However, it also highlights a limitation of the thematic map shown above. Although the dominant area singled out for improvement by users was the Clinical Audit Platform, the word map illustrates that this large group actually contains a variety of potential actions (e.g. Accept all records, Better CAP reports, Allow multiple records), all of which on their own do not represent the number one single most important thing that can be acted upon immediately. On the other hand, suggestions to improve the dataset can often be seen simply as calls to review the audit's content (What is needed? What can go? What should be added?), and several suggestions in other thematic areas could be addressed in the same way.



It follows from the word map that the audit’s priority actions for quality improvement could be (1) a content review, (2) simplifications of the HGD component, (3) making CAP accept all records (regardless of missing or unknown values), (4) simplifying the upload process (e.g. by working on the interface, considering the csv-file structure) and (5) better aligning the audit with COSD.

What will we do next?

Not all aspects raised by our user community can be addressed directly by the audit team. As a next step we will separate your feedback into three categories:

1. Aspects that can be directly improved by the audit team
2. Aspects that unfortunately we cannot change because we feel it would harm the quality of the audit, but we will try to explain better why these aspects are needed
3. Aspects that are beyond our control, but we will attempt to lobby the right audiences on your behalf

The National OG Cancer Audit will be re-commissioned in 2018, together with the current National Bowel Cancer Audit, as the three-year National Gastrointestinal Cancer (Oesophago-gastric and Bowel) Audit Programme.

This will provide an opportunity to engage in audit development work and the results of this survey – especially the voices of our users – will be drawn on to inform this process.

We thank the staff members of
NHS trusts and local health
boards who gave their time to
complete this survey.

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