National Oesophago-Gastric Cancer Audit
Clinical Outcomes Publication 2017
Frequently Asked Questions

Question	Answer
Inclusion criteria	
What are the inclusion criteria for the 2017 Clinical Outcomes Publication (COP)?	Patients diagnosed with oesophageal and gastric cancer between 1 April 2013 to 31 March 2016 who went on to undergo curative surgery are included. Patients with palliative surgical intent, open-and-shut procedures, and bypass procedures are excluded.
What grade of surgeons will be included in public reporting?	Please only enter the GMC codes (CXXXXXXX) for surgeons at consultant level. Only the first two surgeon codes submitted will be used in COP.
Are HGD patients excluded from COP data?	Yes
Indicators	
Length of Stay	The median length of stay for patients undergoing an oesophagectomy or gastrectomy for cancer was 12 days (COP 2016). This will be reported at both trust and consultant level
Volume of care	The volume of care is the number of procedures conducted by a surgeon or a trust In the most recent three year period, the median surgeon volume of curative oesophagectomies or gastrectomies for OG cancer was 29 procedures. Half of the surgeons will perform more procedures and the other half will perform fewer. All eligible procedures are included in volume of care but outcomes for trusts and consultants with fewer than 10 procedures are not reported as they can be affected by chance findings alone. Volume of care will be reported at both trust and consultant level

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30 day mortality postoperative surgery following oesophagectomy or gastrectomy (risk-adjusted)	The mean national 30 day postoperative mortality rate reported in COP 2016 was 2.0 per cent. This will be reported at both trust and consultant level
90 day mortality postoperative surgery following oesophagectomy or gastrectomy (risk-adjusted)	The mean national 90 day mortality rate reported in COP 2016 was 3.8 per cent. This will be reported at both trust and consultant level.
Proportion of patients with adequate lymph nodes examined	This is a new indicator that will be reported only at trust level. Guidelines suggest that the minimum number of lymph nodes required for staging the disease is at least 15 for both oesophagectomies and gastrectomies. Adequate lymph node resection is required to determine whether further oncological treatment is required after surgery and to allow accurate staging. This indicator will allow the surgical units to monitor their process of care and adherence of guidelines
Proportion of patients with positive resection margins	This is a new indicator that will be reported only at trust level. Guidelines recommend monitoring whether the tissue removed during an operation has evidence of the tumour along its edge (known as the margin). Patients are rarely cured if their resection specimen has tumour at the margins. This measure will be assessed separately for oesophagectomies and gastrectomies.
How are 30 day and 90 day mortality ascertained?	We link the audit data to data from the Office for National Statistics (ONS). Based on the vital status returned by ONS (either death date or 'alive') we calculate 30 and 90 day mortality. ONS tracing is robust and accurate in over 99 per cent of cases. Note that recording of 'death in hospital' takes priority over ONS data. For example, if a patient is erroneously coded as 'death in hospital' the death will still be included in the 30 and 90 day mortality rate, even though the ONS tracing does not return a death date.

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How are risk-adjusted outcomes calculated?	The risk-adjusted data take into account information on the following patient characteristics: age, sex, ASA grade, performance status, overall TNM stage, site of cancer and number of comorbidities. **Risk adjustment in practice:** Large differences between observed and adjusted outcomes are uncommon, and usually explained by data quality issues and low volume.
Is it intent at treatment plan or intent at surgery which renders a patient curative or palliative?	Surgical intent.
How are deaths for 'dual surgery' dealt with for the assessment of outcomes at the consultant level where two consultants are recorded?	In these cases both consultants have a death recorded in calculating their outcomes. This follows guidance from HQIP on dual reporting. Similarly, if a patient survives post-operatively the patient outcome is allocated to both consultants. Where this rule seems problematic, we suggest that only one surgeon is recorded.
If a consultant has operated in more than one trust in the three year period, which trust will the consultant be affiliated to?	The consultant will be affiliated to the most recent trust that he/she worked in for that COP publication, but all the cases attributed to the consultant in the three year period will be included in the assessment.
Why does the case load at my trust not equal the total case load of the consultants at my trust?	The case load of a trust will only equal the total case load of the consultants working in the trust if all the patients in the trust had been operated on by only one consultant and the consultants working in the trust have been working only in that trust for the three year period covered by the outcome data.