NOGCA
National Oesophago-Gastric Cancer Audit

NATCAN
National Cancer Audit Collaborating Centre

National Oesophago-Gastric Cancer Audit Quality Improvement Plan 2026

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NOGCA

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HQIP Healthcare Quality Improvement Partnership

The National Cancer Audit Collaborating Centre (NATCAN) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). NATCAN delivers national audits in bowel, breast (primary and metastatic), kidney, lung, non-Hodgkin lymphoma, oesophago-gastric, ovarian, pancreatic and prostate cancers.

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Executive Summary

The National Oesophago-Gastric Cancer Audit (NOGCA) has been commissioned to evaluate the quality and outcomes of care for people diagnosed with oesophageal or gastric (OG) cancer in England and Wales. The Audit supports NHS organisations to benchmark OG cancer care against measurable standards, identify unwarranted variation, and drive improvements in the quality and outcomes of care.

The NOGCA 2026 Quality Improvement (QI) Plan sets out a framework for Audit reporting and action, including the Audit's scope, five quality improvement goals, eight performance indicators, and key pathway and survival indicators for future reporting. The QI Plan is developed by the NOGCA Project Team in consultation with the Audit's Clinical Reference Group (CRG), Patient and Public Involvement (PPI) Forum, and the wider OG cancer care community.

The NOGCA includes all NHS patients with a histologically confirmed diagnosis of invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach in England and Wales. The Audit evaluates care across the OG cancer pathway, from diagnosis through to completion of primary hospital-based treatment, including surgery, systemic anti-cancer therapy, radiotherapy and endoscopic therapies, with both curative and non-curative intent.

The following quality improvement goals have been identified for 2026 reporting:

1. Reduce the time from diagnostic endoscopy to the start of disease-targeted treatment
2. Improve access to clinical nurse specialist (CNS) support and care coordination
3. Improve access to potentially curative treatment, where appropriate
4. Improve short-term outcomes for people receiving treatment for OG cancer
5. Improve survival following diagnosis of OG cancer

NOGCA has identified eight performance indicators and key pathway and survival indicators mapped to these five quality improvement goals. The indicators are intended to support targeted, measurable improvement at service level, alongside national benchmarking. This QI Plan sets out improvement methods, improvement activities and the approach to evaluating progress and impact of these goals and activities.

1. Introduction

1.1 Aim and objectives of the Quality Improvement Plan

The National Oesophago-Gastric Cancer Audit (NOGCA) Quality Improvement Plan aims to support improvements in the quality and outcomes of care for people with oesophageal and gastric (OG) cancer in England and Wales. This plan builds on previous Quality Improvement Plans, which have defined the Audit's scope and coverage of the care pathway, and identified key quality improvement priorities.

The QI Plan sets out and prioritises the Audit's five quality improvement goals and eight performance indicators, which are designed to support benchmarking, identify unwarranted variation, and enable targeted improvement at service level, and also includes additional pathway and survival indicators that support interpretation of performance and provide contextual insight into patient care and outcomes. The QI Plan outlines key improvement activities that will support implementation of the plan, in addition to the approaches to evaluate progress and impact.

The NOGCA Quality Improvement Plan was developed in consultation with key stakeholders, including people with lived experience of OG cancer, and was last reviewed in 2026.

1.2 The National Cancer Audit Collaborating Centre

The NOGCA is part of the National Cancer Audit Collaborating Centre (NATCAN), a national centre of excellence which aims to strengthen NHS cancer services by analysing patterns of care, treatments and patient outcomes across England and Wales. It was set up on 1 October 2022 to deliver six new national cancer audits, including kidney, ovarian, pancreatic, breast cancer (two separate audits in primary and metastatic disease) and non-Hodgkin Lymphoma. In addition, existing audits in prostate, lung, bowel, and oesophago-gastric cancers moved into NATCAN in 2023-24. The centre is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government.

The aims of the ten NATCAN Audits are to:

1. Provide regular and timely evidence to cancer services of where patterns of care in England and Wales may vary.
2. Support NHS services to increase the consistency of access to treatments and help guide quality improvement initiatives.
3. Stimulate improvements in cancer detection, treatment and outcomes for patients, including survival rates.

Further information about NATCAN and the key features of its approach to audit can be found in the appendix.

2. Background: oesophageal and gastric (OG) cancer

Oesophageal and gastric cancers are the fifth most common type of cancer in the UK. Despite advances in diagnosis and treatment, survival remains poor compared with many other common cancers, and care pathways are complex.

2.1 Main issues in OG cancer care and outcomes

Recommendations on the delivery of high-quality care by OG cancer services have been published by NICE in its clinical Guidance [NG83][1] and Quality Standards [QS176][2], and by professional medical associations.[3, 4, 5] Service development is also informed by the strategies published by NHS England[6] and NHS Wales.[7] These national policies and standards set expectations for timely, coordinated, and high-quality care across the OG cancer pathway.

Recent NOGCA reports have identified several improvements in the quality of care delivered to people with OG cancer, including improved survival after curative surgery, since the Audit began in 2012. However, important challenges remain:

- Long waiting times through care pathways after diagnosis to the start of treatment, which may adversely affect patient experience and outcomes.
- Regional variation in access to clinical nurse specialists, raising concerns about equity of support and care coordination.
- Variation in rates of curative treatment among people diagnosed with OG cancer, suggesting potential differences in access to potentially life-prolonging therapies.
- Regional variations in treatment and outcomes among people undergoing palliative chemotherapy.

2.2 Care pathways

Several routes can lead to a diagnosis of OG cancer. An individual may be referred after presenting to their general practitioner (GP) with symptoms or referred by a hospital consultant following outpatient review. Diagnosis can also follow an emergency admission to hospital, with individuals experiencing acute symptoms that are often the result of late-stage disease. The route to diagnosis is closely linked to disease stage, treatment options and outcomes, and emergency presentation is consistently associated with poorer prognosis.

Following a diagnosis of OG cancer, a person may undergo a number of different staging investigations, depending on the site and extent of disease (see Box 1). These investigations are essential for determining treatment intent but can introduce complexity and delay within the pathway, requiring coordination across multiple services.

Box 1: Recommended staging investigations for oesophageal and gastric cancer

NICE Guideline on OG cancer: Assessment and management in adults (2018):

- CT scan of chest, abdomen and pelvis to provide an initial local assessment, and look for evidence of nodal and metastatic spread.
- Offer a PET-CT scan to people with oesophageal and gastro-oesophageal junctional tumours that are suitable for curative treatment (except for T1a tumours).
- Do not offer endoscopic ultrasound only to distinguish between T2 and T3 tumours in people with oesophageal and gastro-oesophageal junctional tumours.
- Only offer endoscopic ultrasound (EUS) to people with oesophageal and gastro-oesophageal junctional cancer when it will help guide ongoing management.
- Offer staging laparoscopy to all people with potentially curable gastric cancer.

RCR Guideline on Evidence-based indications for the use of PET-CT in the UK 2022:

- Consider a PET-CT scan in people with gastric cancer if it will help guide ongoing management, including for staging and re-staging of confirmed gastric cancer if there is curative intent.

[1] Overview | Oesophago-gastric cancer: assessment and management in adults | Guidance | NICE
[2] Overview | Oesophago-gastric cancer | Quality standards | NICE
[3] Provision-of-Services-June-2016.pdf (augis.org)
[4] Radiotherapy dose fractionation, Fourth edition | The Royal College of Radiologists (rcr.ac.uk)
[5] Evidence-based indications for the use of PET-CT in the United Kingdom 2022 | The Royal College of Radiologists (rcr.ac.uk)
[6] NHS England Cancer Plan
[7] executive.nhs.wales/functions/networks-and-planning/cancer/cancer-improvement-plan-docs/summary/

Treatment options for people with OG cancer depend on several factors, including clinical stage, patient fitness and individual preferences. For people with localised disease who are relatively fit, the recommended treatment is generally surgery, with or without oncological therapy (see Box 2). For those with squamous cell carcinoma of the oesophagus, definitive chemo-radiotherapy is also an option. Endoscopic treatment may be suitable for those whose tumours are limited to the mucosa, with little risk of spread to the lymph nodes. Timely staging, multidisciplinary team (MDT) decision-making and access to specialist services are therefore critical to ensuring appropriate delivery of potentially curative treatment.

For people with metastatic OG cancer, or those who are too unwell for curative treatment, chemotherapy can improve survival. Therapies for managing symptoms such as dysphagia include endoscopic or radiological interventions, such as stents, and radiotherapy. Variation in access to and outcomes of palliative treatments remains an important quality improvement concern.

Box 2: Recommended curative treatment options for OG cancer **[NICE 2018]**

Oesophageal squamous cell carcinomas:

- Definitive chemoradiation for proximal oesophageal tumours.
- For tumours of the middle or lower oesophagus, either chemoradiotherapy alone or combined with surgery.

Oesophageal adenocarcinoma and GOJ tumours:

- Preoperative chemotherapy or chemoradiation is recommended to improve long term survival after surgery, compared to surgery alone.
- Perioperative chemotherapy (pre and post-operative) can also be recommended as it increases survival for junctional tumours.
- Nivolumab is recommended for adjuvant treatment of completely resected oesophageal or GOJ cancer in adults who have residual disease after previous neoadjuvant chemoradiotherapy (NICE 2021).

Gastric cancer:

- Perioperative chemotherapy is recommended to improve survival compared to surgery alone.
- In patients at high risk of recurrence who have not had neoadjuvant chemotherapy, adjuvant chemoradiotherapy may be considered, although evidence is largely derived from non-Western populations.

2.3 Guidelines on the management of OG cancer

Several guidelines relating to the management of OG cancer are available. Key UK clinical guidelines are summarised in Table 1.

Table 1: UK clinical guidelines relating to management of OG cancer

Organisation	Guideline	Year
NICE	NG83: “Oesophago-gastric cancer assessment and management in adults”	2018 [updated 2023]
NICE	NG12: “Suspected cancer: recognition and referral”	2015 [updated 2023]
NICE	QS176: “Oesophago-gastric cancer Quality Standard”	2018
AUGIS	The Provision of Services for Upper Gastrointestinal Surgery	2016
RCR	Radiotherapy Dose Fractionation. Fourth Edition.	2024

3. Approach to developing the Quality Improvement Plan

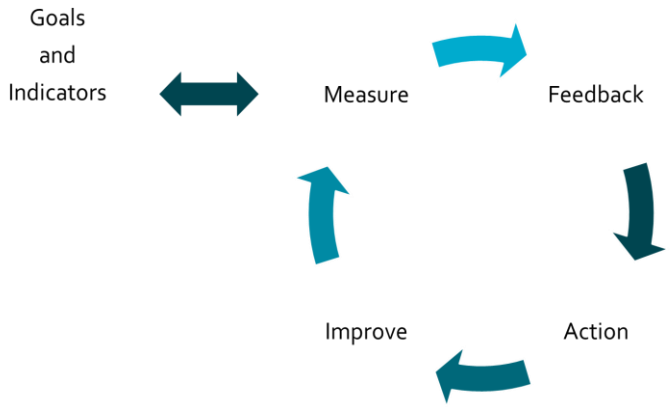
3.1 Approach to developing the Audit scope

The scope of the NOGCA Audit has been informed by structured scoping exercises, review of routinely collected OG cancer data, and ongoing consultation with key clinical, policy and patient stakeholders. This work has been undertaken to ensure that the Audit scope remains clinically relevant, feasible using available data, and aligned with national priorities for cancer quality improvement. Details of the scoping exercise can be found in the NOGCA Scoping Document.

3.2 Approach to prioritising performance indicators

Clinical Performance Feedback Intervention Theory (CP-FIT)[8] states that developing improvement goals and performance indicators are the first steps in the audit and feedback cycle (Figure 1). This framework underpins NOGCA's approach to selecting indicators that are most likely to support meaningful improvement in care.

Figure 1: The audit and feedback cycle



Based on the scoping exercise and previous Quality Improvement Plans, NOGCA developed a list of candidate performance indicators. Prioritisation of eight performance indicators from this list of candidates was informed by the following set of key principles. To enhance NOGCA's ability to inform improvements in care, performance indicators were required to meet the following criteria:

- **Measurable** so that they can be the basis of credible feedback about performance. This property means that the indicators can be defined with available data in a valid, reliable, and fair manner that allows performance to be attributed to a specific unit.[9]
- **Actionable** so that feedback translates into action to improve care. Indicators should therefore be important and address a specific pathway of care that is clear to all stakeholders. Stakeholders should understand the drivers of variation in performance within this pathway and control the levers for change. These changes should be evidence-based and address policy priorities.
- **Improvable** so that actions have the desired effect on patient care. There should therefore be clear scope for improvement (low baseline levels or large unwarranted variation) in a large population and a receptive context, with no unintended consequences. Some interventions may have demonstrated improvements to certain indicators in existing literature.

In addition to the eight performance indicators, NOGCA will report select pathway indicators that provide contextual information on patient care and outcomes and support interpretation of performance.

[8] Brown B, Gude WT, Blakeman T, van der Veer SN, Ivers N, Francis JJ, et al. Clinical Performance Feedback Intervention Theory (CP-FIT): a new theory for designing, implementing, and evaluating feedback in health care based on a systematic review and meta-synthesis of qualitative research. Implement Sci 2019;14:40.

[9] Geary RS, Knight HE, Carroll FE, Gurol-Urganci I, Morris E, Cromwell DA, van der Meulen JH. A step-wise approach to developing indicators to compare the performance of maternity units using hospital administrative data. BJOG 2018;125:857-65.

3.3 Data provision

The NOGCA uses routine national healthcare datasets. These datasets capture details on the diagnosis, management and treatment of every person who is diagnosed with OG cancer in England and Wales, enabling population-level benchmarking and comparison across services. Use of routinely collected national data supports consistent, sustainable audit reporting over time. Further details on data acquisition can be found in the appendix.

3.4 Data limitations

For accurate and timely benchmarking, it is essential that data used by NOGCA:

1. Include all the data items required to measure and risk-adjust performance indicators
2. Are timely
3. Have high level of case-ascertainment
4. Have high levels of data completeness
5. Are accurate

For people treated in England, Rapid Cancer Registration Data (RCRD) linked to other national healthcare datasets is used for reporting. This dataset is mainly compiled from Cancer Outcomes and Services Dataset (COSD) records and is made available more quickly than the gold standard National Cancer Registration Data (NCRD). This improved timeliness supports more rapid feedback to services, but the speed of production means that case ascertainment and data completeness are lower, and fewer data items are available in the RCRD compared to the NCRD.

For patients treated in Wales, reporting uses data submitted to the National Cancer Team, NHS Wales Performance and Improvement. These data are linked to other national datasets including hospital admissions and treatment data.

3.5 Stakeholder involvement

NOGCA is delivered through a partnership that combines clinical leadership, methodological expertise, project management and a secure environment for data analysis, representing the following organisations: Association of Upper Gastrointestinal Surgery of Great Britain and Ireland (AUGIS), Royal College of Radiologists (RCR), British Society of Gastroenterology (BSG), UK & Ireland Oesophagogastric Cancer Group (UKIOG) and NATCAN.

The Audit team is supported by twice-yearly meetings of stakeholders in its Clinical Reference Group (CRG), which includes clinicians from across the patient pathway, patient representatives, data controllers, commissioners and funder representatives. The CRG provides clinical oversight and advises on audit scope, indicator selection, interpretation of findings and improvement priorities. NOGCA also has a Patient and Public Involvement (PPI) Forum, whose members represent people with lived experience of OG cancer and several patient organisations.

Further details about stakeholder representation in the CRG and PPI Forum can be found here.

3.6 Service provision

OG cancer services in England and Wales are organised on a regional basis to provide an integrated model of care. In England, 20 Cancer Alliances are responsible for coordinating cancer care and improving local outcomes, with 31 specialist centres providing surgery for OG cancer. In Wales, three centres provide specialist surgical and oncology services for OG cancer across three regions.

4. Audit scope

4.1. Patient inclusion criteria

All NHS patients with a histologically confirmed diagnosis of invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach (C15 or C16) in England and Wales are included in the Audit.

4.2. Care pathway

The Audit evaluates OG cancer care from the point of diagnosis to the completion of primary treatment.

The Audit covers treatments with curative intent as well as non-curative therapies. The treatment modalities included in the Audit are: surgery, systemic anti-cancer therapy, radiotherapy and endoscopic therapies (endoscopic mucosal resection, stent insertion, etc). Information on the diagnostic and staging process include: the route to diagnosis and use of staging investigations. This scope enables consistent assessment of care delivery and outcomes across the OG cancer pathway, supporting benchmarking and targeted quality improvement.

5. Quality Improvement Goals and Indicators

Quality Improvement Goal	Indicators*	National Recommendations
1. Reduce the time from diagnostic endoscopy to the start of disease-targeted treatment	PI 1: Median time (days) and IQR from diagnostic endoscopy to first disease-targeted treatment for OG cancer	NHS England, National Cancer Plan for England: cancer pathways will be improved to ensure cancer waiting time standards are met.
2. Improve access to clinical nurse specialist (CNS) support and care coordination	PI 2: Percentage of people with a diagnosis of OG cancer who have a record of being seen by a CNS	The National Cancer Plan for England: Action 23: Every patient will have a Clinical Nurse Specialist or other named lead to support them through diagnosis and treatment. NHS Wales Cancer Improvement Plan: Every person diagnosed with cancer should have a named Key Worker [...] a role undertaken ordinarily by a Clinical Nurse Specialist
3. Improve access to potentially curative treatment, where appropriate	PI 3: Percentage of people with a diagnosis of OG cancer who initiated potentially curative treatment (stages 1-3)	NICE guideline 83: All people with confirmed OG cancer should be reviewed within an MDT that includes an oncologist and radiologist with an interest in OG cancer, and people with non-metastatic disease are additionally discussed at a specialist OG cancer MDT.
4. Improve short-term outcomes for people receiving treatment for OG cancer	PI 4: Adjusted 90-day survival after curative surgery for OG cancer	N/A
	PI 5: Percentage of people undergoing curative surgery for OG cancer with postoperative length of stay >15 days	N/A
	PI 6: Percentage of people readmitted to hospital with an overnight stay within 30 days of discharge following curative surgery	NICE guideline 94 Chapter 35 Discharge Planning: 30-day readmission is an important outcome measure linked to discharge processes and transitional care.
	PI 7: Percentage of people beginning palliative systemic anti-cancer therapy (SACT) for OG cancer who complete at least four cycles of treatment	N/A
	PI 8: Percentage of people with stage 4 OG cancer who died within 90 days of starting SACT	N/A
5. Improve survival following diagnosis of OG cancer	Survival indicator: Adjusted 1-year survival from diagnosis	NHS England, National Cancer Plan for England: by 2035, three-quarters of people diagnosed with cancer will survive five years

*Details of the five Quality Improvement Goals and the associated indicators are outlined in the table above. Where appropriate, the indicators will be presented for specific patient groups as well as for the whole patient population. PI – performance indicator. The Audit will publish the performance indicators, key pathway indicators and survival indicators in its annual State of the Nation report and, where appropriate, in quarterly reports. The publication of indicators is aligned with data availability and the completion of robust, methodological development work including appropriate risk-adjustment models.

Pathway Indicators

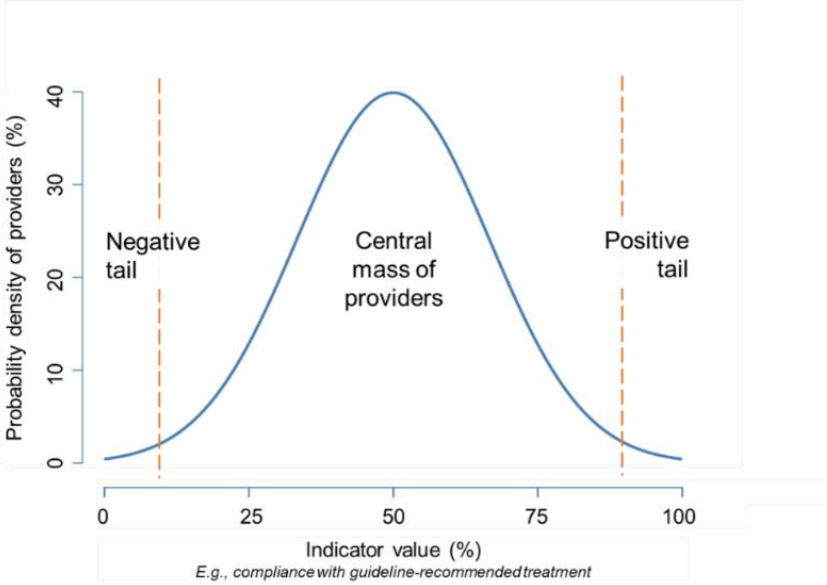
Pathway Indicators^	National Recommendation
1. Percentage of people with a diagnosis of OG cancer who are diagnosed after an emergency admission	NHS England, National Cancer Plan for England: improve early diagnosis of cancer Wales Cancer Network, A Cancer Improvement Plan for NHS Wales: reducing emergency presentation and 1st presentation with advanced disease
2. Percentage of people with a diagnosis of OG cancer who are diagnosed with stage 4 disease	

^Details two Pathway Indicators that support interpretation of performance and provide contextual insight into patient care and outcomes.

6. Quality Improvement Methods

The figure below shows a hypothetical example of how a performance indicator may be distributed across NHS providers nationally at a single time point. For quality improvement purposes, this distribution can be considered in three domains: the negative tail (suggestive of worse performance), the central mass (where most providers cluster), and the positive tail (suggestive of better performance).

Each domain is associated with a different set of methods for improving healthcare.



Negative tail

Example methods: Regulation and public reporting of outliers

- Clinical audit has traditionally focused on the negative tail to improve healthcare. This approach is primarily concerned with identifying providers at risk of delivering substandard care and ensuring that minimum standards are met. Such intervention may be necessary to assure minimum standards of care and to reduce inequality between the best and worst performing NHS providers.

Central mass

Example methods: Statistical process control and iterative testing of interventions

Most providers exist in the central mass of the distribution (by definition) which may present the greatest scope for improving average levels of care nationally. Methods in this domain suggest that all providers can improve their performance, regardless of baseline levels. Longitudinal monitoring provides feedback about whether improvements occur or not. This domain is therefore central to NOGCA's approach to system-wide quality improvement.

Positive tail

Example methods: Positive deviance

- Some NHS providers perform exceptionally well despite similar constraints to others, which presents opportunities to learn how this is achieved. 'Positive deviance' approaches assert that generalisable solutions to better performance already exist within the system. Such solutions are therefore more likely to be acceptable and sustainable within existing resources. These approaches aim to identify local innovations and spread them to other settings. Within NOGCA, this may include identifying high-performing providers, exploring contributory practices, and supporting shared learning across services.

NOGCA will select which methods to implement to improve oesophago-gastric cancer care after investigating the distributions of its performance indicators (outlined in section 5). This includes the distribution of performance indicators between providers at a given time point and within providers over time. It also includes investigation of variation at the patient, hospital, and regional levels to see where most variation exists and which variables help to explain it.

7. Improvement activities

7.1 National and Regional

NOGCA undertakes activities that directly support system-level improvement in the delivery of OG cancer services. These activities use audit outputs to inform policy, assurance, and coordinated improvement action at national and regional levels. These include:

Stakeholder	NOGCA activity
NATIONAL	
NHS England / Welsh Cancer Network	Identify issues and make recommendations on the organisation and delivery of OG cancer services, including where national leadership, investment or service reconfiguration may be required.
Care Quality Commission (CQC)	Provide CQC with information to support local inspections of NHS providers and including areas of concern identified after an organisation is flagged as a potential outlier on a NOGCA performance indicator.
Professional societies	Identify issues and make recommendations regarding the delivery of OG cancer services that fall within the remit of the professional associations.
National multi-professional groups	Engage with national groups such as the United Kingdom and Ireland Oesophago-gastric Cancer Group (UKIOG) to disseminate recommendations and promote improvement activities.
REGIONAL	
Cancer Alliances	Support the monitoring role of Cancer Alliances publishing Cancer Alliance- and network-level results, enabling benchmarking, shared learning and targeted improvement across providers.

At a national level, the NOGCA team will also provide the National Cancer Registration and Analysis Service (NCRAS) Data Improvement Leads (in England), and the Wales Cancer Network with information to help them support their NHS organisations to improve the quality of their routine data submissions.

7.2 Local

NOGCA supports local NHS cancer services in the provision of quality care to people with OG cancer through structured performance feedback and improvement support, including:

NOGCA feedback activity	Description
Annual “State of the Nation” reports	State of the Nation reports that allow NHS organisations in England and Wales to benchmark themselves against clinical guideline recommendations and the performance of their peers, supporting identification of priority areas for improvement.
Web-based data dashboard	Presents results for individual NHS organisations that allows the user to view the results of selected indicators and providers.
Local Action Plan template	Allows NHS organisations to document how they will respond to the State of the Nation report recommendations.
Outlier reporting	Reporting of NHS provider values that are more than three standard deviations from the expected level of performance (i.e. deemed a potential outlier). NOGCA will support outliers to understand the findings and identify areas for improvement.

7.3 Improvement tools and shared learning

The NATCAN website includes a Quality Improvement Resources page that directs healthcare providers to quality improvement tools including:

- 'How to' guides including quality improvement methodology
- Links to existing resources
- Links to training courses for quality improvement
- Good practice repository with contact information where possible.

NOGCA will continue to share findings and support learning through relevant national professional meetings and quality improvement initiatives, helping to spread effective practice and engage clinical teams.

7.4 National Quality Improvement Intervention

NOGCA is delivering a national quality improvement (QI) intervention to support Cancer Alliances and NHS trusts in improving timely access to treatment for people with oesophago-gastric (OG) cancer. This intervention focuses on the performance indicator **time from diagnostic endoscopy to the start of disease-targeted treatment**, which aligns with the NHS England Treatment Variation Group recommendation for OG cancer and is a key priority within the 2025 National Cancer Plan for England.

The intervention is underpinned by analysis of routinely collected cancer data that shows substantial variation in waiting times across England, particularly among patients undergoing curative-intent treatment. Reducing delays during this period is critical to maintaining patient fitness for treatment and optimising outcomes.

As part of the intervention, NOGCA is providing Cancer Alliance-specific reports that present recent performance benchmarked against the national median, alongside detailed trust-level results within each Alliance. These reports are intended to support local review of pathway performance, identification of potential bottlenecks and equity gaps, and discussion between Cancer Alliances and trusts to agree and implement targeted improvement actions.

This intervention supports the translation of audit findings into coordinated, system-level quality improvement activity.

7.5 Patient and Public Involvement

Patient representatives are regularly consulted on the design of the Audit and the communication of its results, via the NOGCA Patient and Public Involvement (PPI) Forum. Members of several patient organisations are represented: Heartburn Cancer UK, Oxfordshire Oesophageal and Stomach Organisation, Action Against Heartburn, Guts UK. Elected members of the PPI Forum also act as patient representatives on the Clinical Reference Group, ensuring that patient perspectives inform Audit priorities, and participate in the development and review of key Audit outputs.

The PPI Forum plays an integral role in ensuring that NOGCA's audit and quality improvement activity remains patient-centred and accessible. The PPI Forum:

- Has a key advisory role in developing the design and function of the Audit website to ensure that patients and the public can easily access the information they are seeking,
- Contributes to the design and content of patient information materials and NOGCA reports for the public,
- Provides input into the development of the Audit's quality improvement goals, activities and outputs to ensure they reflect priorities from the patient perspective, and
- Supports dissemination of NOGCA findings and outputs through patient networks and charitable organisations.

7.6 Communication and dissemination activities

NOGCA uses a range of communication and dissemination activities to support awareness, interpretation and uptake of audit findings among stakeholders, providers, patients and the public, including:

- The Audit website, which is regularly updated to provide access to publications, key findings and resources, including tools to support quality improvement.

- Regular distribution of newsletters via the Audit's mailing list.
- Communications via the networks of the professional bodies and patient associations working in partnership with the Audit, such as AUGIS, BSG, RCR, UKIOG, Heartburn Cancer UK, Action Against Heartburn and Guts UK, to support engagement and shared learning.
- Presentation of Audit results at national conferences of relevant professional bodies, to facilitate professional discussion and dissemination of best practice.
- Publication of articles in medical journals and other media.

Together, these activities support dissemination of NOGCA findings, engagement with key audiences, and the spread of learning to inform quality improvement across OG cancer services.

8. Evaluation

NOGCA will report year-on-year progress against improvement goals to the Audit's Clinical Reference Group and in the State of the Nation reports on an annual basis. Evaluation will focus on assessing change over time in performance indicators at national, regional and provider levels where appropriate, and on understanding patterns of variation and improvement.

The impact of the national quality improvement intervention will be undertaken through ongoing monitoring of the relevant performance indicator within routine NOGCA reporting. Changes in performance over time will be examined at national and Cancer Alliance level, with particular attention to trends and variation before and after introduction of the intervention. Given the use of routinely collected cancer registry data, improvements resulting from local action are expected to emerge over time rather than immediately.

Early evaluation will also consider engagement with the Cancer Alliance reports as an indicator of implementation and reach.

Findings from this evaluation will be used to support interpretation of audit results, inform refinement of quality improvement activity, and guide prioritisation of future improvement efforts.

Appendix

1. National Cancer Audit Collaborating Centre (NATCAN)

NOGCA is part of the National Cancer Audit Collaborating Centre (NATCAN), a national centre of excellence launched on 1 October 2022 to strengthen NHS cancer services by looking at treatments and patient outcomes in multiple cancer types across England and Wales. The centre was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government with funding in place for an initial period of three years.

NATCAN is based within the Clinical Effectiveness Unit (CEU), the academic partnership between the Royal College of Surgeons of England (RCS Eng) and the London School of Hygiene & Tropical Medicine. The CEU is recognised as a national centre of expertise in analytic methodology and the development of administrative and logistic infrastructure for collating and handling large-scale data for assessment of healthcare performance.

The aim of the ten NATCAN Audits is to:

1. Provide regular and timely evidence to cancer services of where patterns of care in England and Wales may vary.
2. Support NHS services to increase the consistency of access to treatments and help guide quality improvement initiatives.
3. Stimulate improvements in cancer detection, treatment and outcomes for patients, including survival rates.

Key features of NATCAN's Audit approach

The design and delivery of the Audits in NATCAN has been informed by the CEU's experience delivering national Audits, built up since its inception in 1998. Key features of all Audit projects within the CEU include:

- Close clinical-methodological collaboration
- Use of national existing linked datasets as much as possible
- Close collaboration with data providers in England (National Disease Registration Service [NDRS, NHSE] and Wales (Wales Cancer Network [WCN], Public Health Wales [PHW])
- A clinical epidemiological approach, informing quality improvement activities
- "Audit" informed by "research".

All these features will support NATCAN's focus on the three "Rs", ensuring that all its activities are clinically relevant, methodologically robust, and technically rigorous.

2. Data provision

The NATCAN Executive Team has worked closely with data providers in England and in Wales to establish efficient "common data channels" for timely and frequent access to datasets, combining data needs for all cancers into a single request in each Nation and only using routinely collected data, thereby minimising the burden of data collection on provider teams.