

# Ovarian cancer service evaluation at a UK gynaecological cancer centre

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## Objective

To evaluate ovarian cancer treatment at a UK gynaecological cancer centre and ensure reported data were complete ahead of a national audit.

## Background

New Quality Performance indicators (QPIs) were proposed by the British Gynaecological Cancer Society (BGCS) in May 2021<sup>1</sup>

**QPI 1:** Patients to be discussed at diagnosis at a specialist MDT prior to a decision for treatment. Target 95%.

**QPI 2:** Patients diagnosed with Stage 2-4 or unstaged Ovarian cancer to receive anticancer treatment of any type. Target 80%.

**QPI 3:** Patients with Stage 2-4/ unstaged ovarian cancer to receive cytoreductive surgery. Minimum target 55%; Optimal target 70%.

**QPI 4a:** Patients with ovarian cancer should have recording of FIGO stage, WHO performance status, at diagnosis. Target 95%.

**QPI 4b:** Patients with ovarian cancer undergoing primary or interval debulking surgery should have recording of residual disease. Target 95% .

**QPI 5a:** Patients with non-mucinous epithelial ovarian cancer on histology to be tested for germline BRCA1/2 testing. Target 90%.

**QPI 5b:** Patients with advanced high grade serous and clear cell cancer on histology to be tested for tumour BRCA1/2 testing. Target 90%.

**QPI 6:** Patients to be enrolled into an NCRI portfolio study at diagnosis. Minimum Target 5%.

## Design

This report was conducted as a service evaluation of demographics and survival and an audit to evaluate specific parameters of patient care against the proposed BGCS standards.

## Method

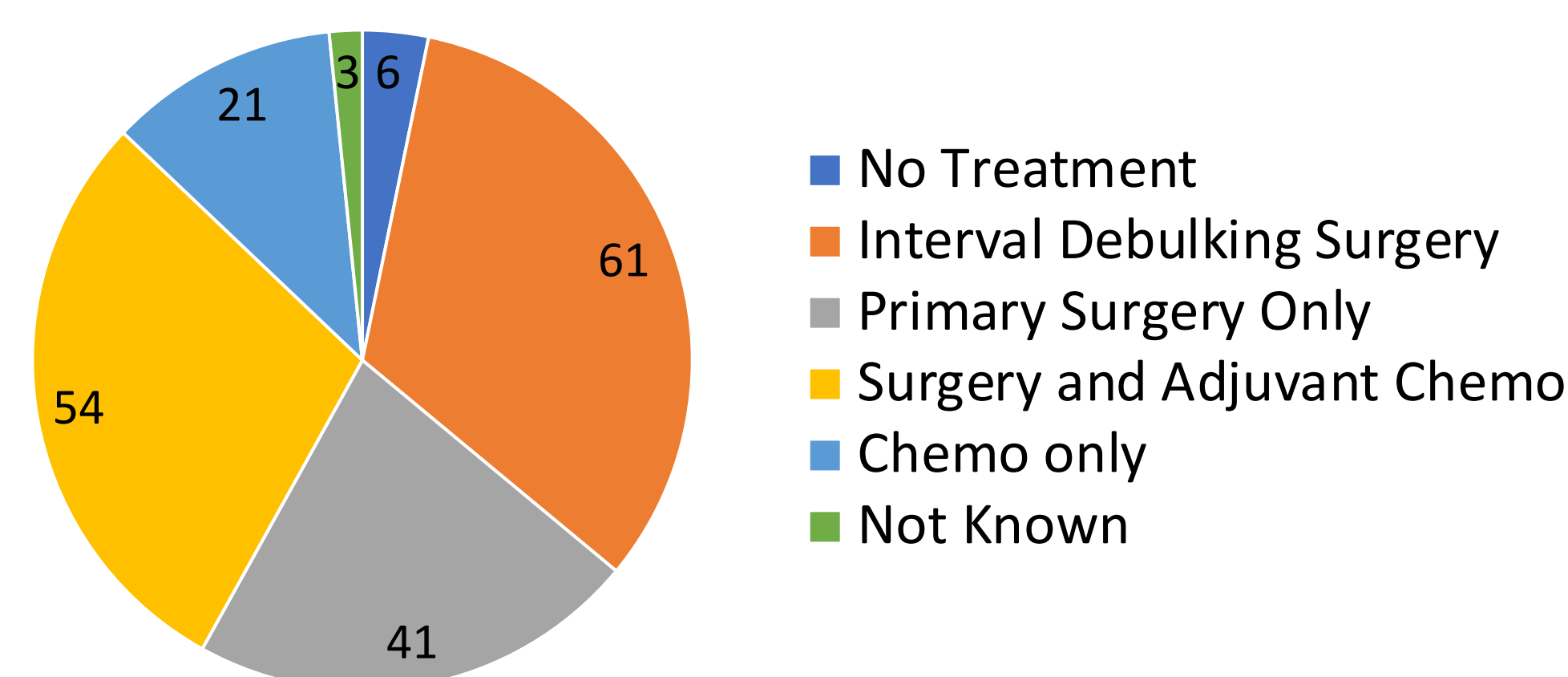
Data intelligence services selected all patients diagnosed with ovarian cancer from the 1st January 2016 to the 23rd March 2021 (n=220). This included all patients with ovarian, primary peritoneal carcinomas and fallopian tube cancers with ICD-10 codes C56, C57, C48, or D39.1. 186 of the 220 identified patients fulfilled the inclusion criteria. Data was extracted from the Somerset Cancer Registry (SCR) and simultaneously collected from clinical systems (Millennium and Aria).

Discrepancies in information between the two data sets were investigated and corrected. Surgeon grade, final FIGO stage, residual disease, and performance status were included from the clinical systems (not previously reliably recorded on the SCR).

The results from the pre-existing SCR data and newly correct data were audited against BGCS quality performance indicators 2, 3, 4a, 4b.

Kaplan-Meier curves were generated for the assessment of 1 and 3 year survival rates to compare with national averages.

**Chart showing patient treatment-group allocations for Ovarian Cancer (2016-2021)**



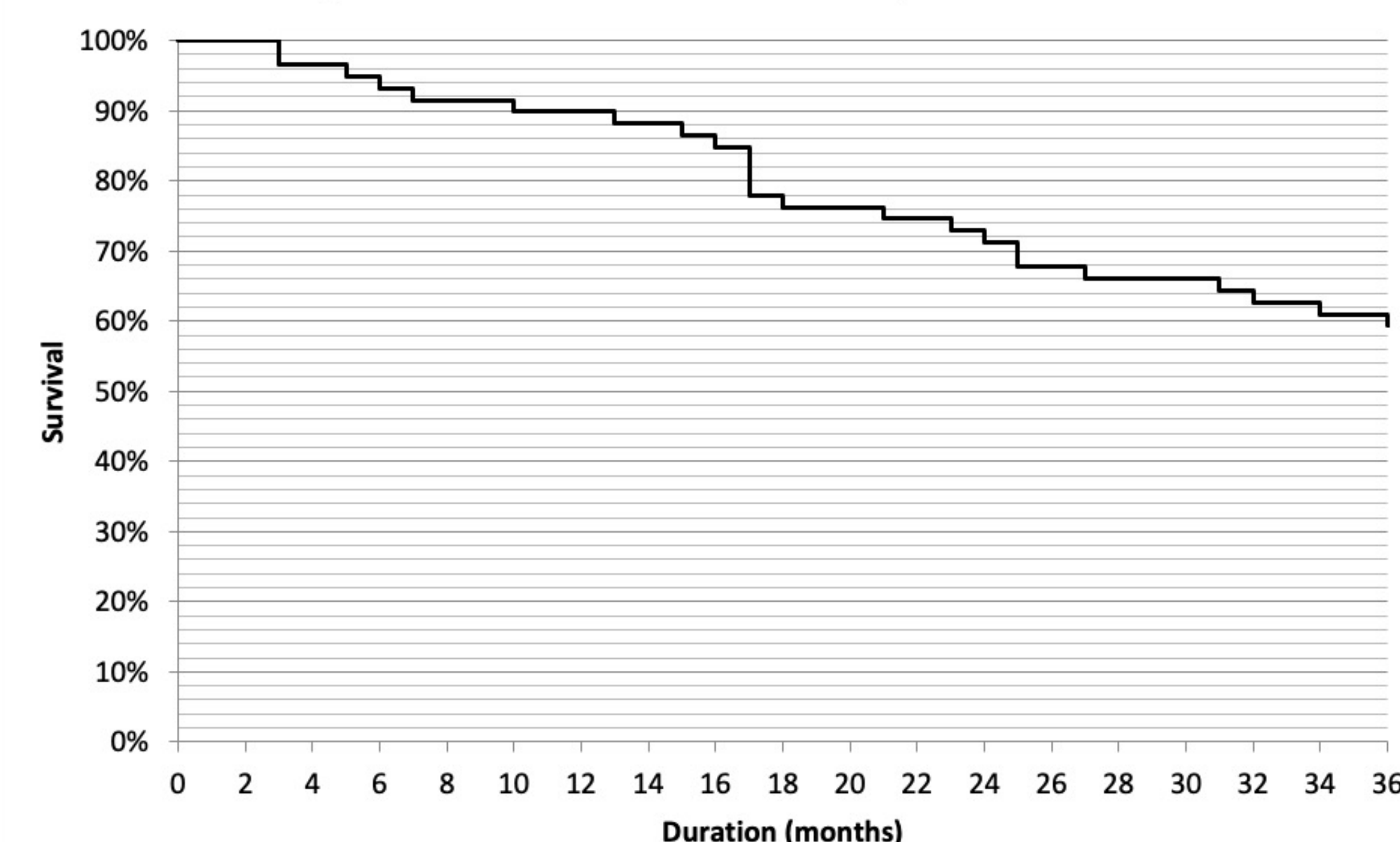
## Results

The average age of patients in this cohort was 64.1 years old and the mean departmental caseload was 36.2 patients per year.

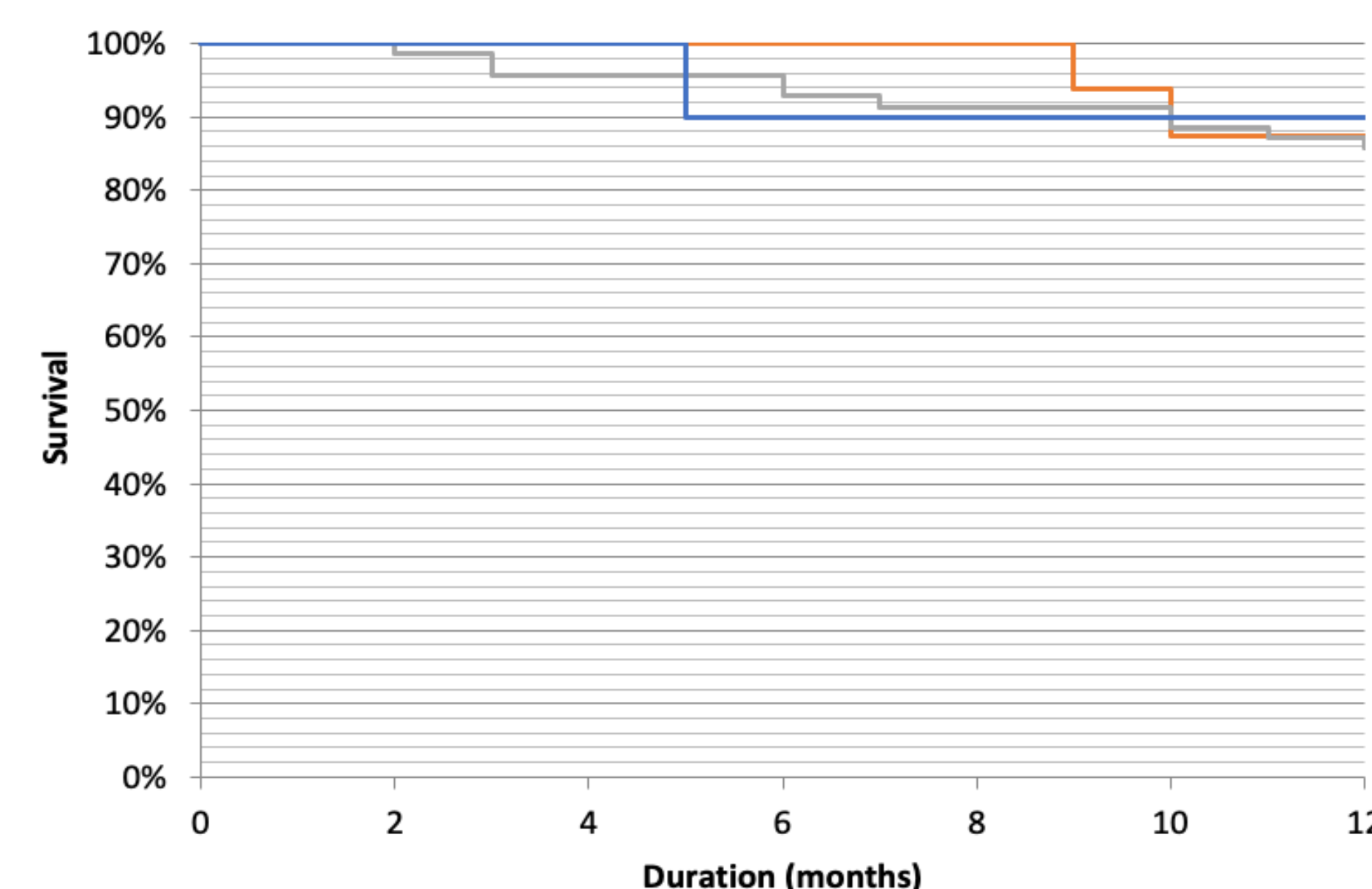
The Ovarian Cancer Audit Feasibility Pilot found one-year net survival rate to be 68.0% at 1 year and 34.6% at 5 years (Ovarian cancers in England stage 2-4 from 2013-2017)<sup>2</sup>. This cohort had a 1-year survival rate of 90% and a 3-year survival rate of 59% (stages 2-4), 5-year survival could not be assessed as insufficient time had elapsed.

When the departmental performance is audited against proposed standards set out by the BGCS, the department consistently achieve above the targets, the only exception being the reporting of FIGO ovarian cancer stage (93% reported failing to meet the stipulated 95% target).

**Stages 2-4 ovarian cancer 3 year survival**



**1 year survival by FIGO stage**



**3 year survival by FIGO stage**

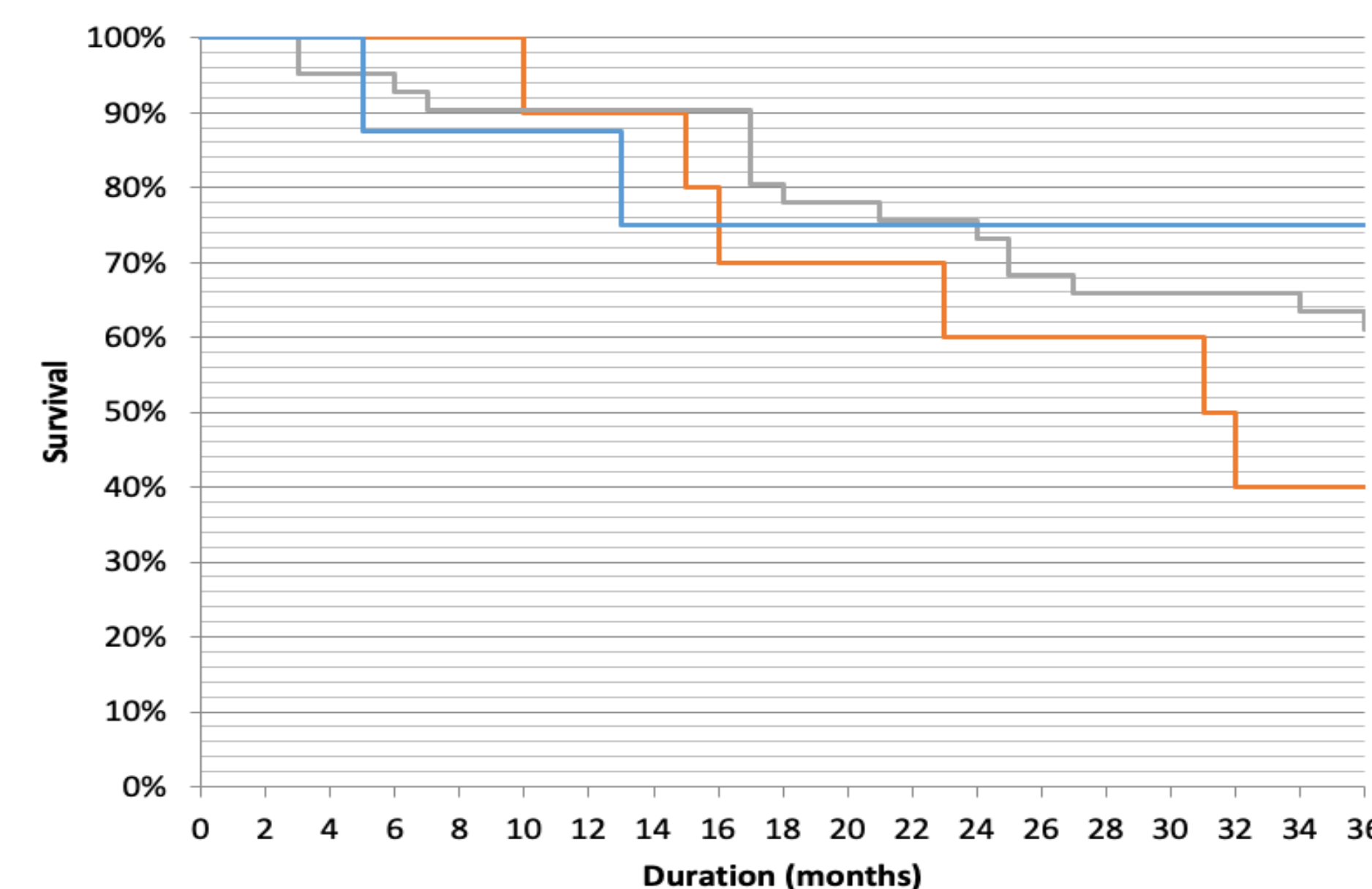


**Table summarising actual performance and previously recoded data from the SCR against BGCS QPIs 2, 3, 4a, and 4b**

| Standard      | BGCS recommended target    | Performance from SCR                           | Actual performance                             |
|---------------|----------------------------|------------------------------------------------|------------------------------------------------|
| <b>QPI 2</b>  | 80%                        | 95.3%                                          | 95.3%                                          |
| <b>QPI 3</b>  | Minimum 55%<br>Optimal 70% | 78.7%                                          | 78.7%                                          |
| <b>QPI 4a</b> | 95%                        | FIGO Stage- 56.5%<br>Performance status- 36.6% | FIGO Stage- 93.0%<br>Performance status- 98.9% |
| <b>QPI 4b</b> | 95%                        | 13.5%                                          | 97.4%                                          |

## Recommendations for further action

- If the department wishes to record and monitor the points of the patient journey where the CNS team are involved, there should be a standardised way of recording this interaction.
- Weekly MDT meetings should discuss and record residual disease and final FIGO stage following all operations. This information from the operation note should be uploaded to the Somerset cancer registry (SCR). The surgical team should agree on standardised phrasing for reporting residual disease. Patients' diagnoses should be updated on SCR when finalised and not left unspecified.
- Performance status should be formally recorded by the gynaecological oncology consultant during the initial consultation, as close to the time of diagnosis as possible (pre-operatively). This performance status should be discussed at the MDT meeting and uploaded to the SCR for all patients.
- Further investigation into the coding of surgical procedures including all elements of larger surgeries with multiple codes is required. There is potential for errors in coding to have large impacts on departmental funding and remuneration as well as incorrect information in cancer registry databases.
- Care should be taken to ensure correct date of surgery is documented in all clinical letters.
- Data should be revisited to calculate 5-year survival once sufficient time has passed.
- The audit cycle should be completed with a re-audit against BGCS standards after discussion, agreement, and implementation of these recommendations. Future evaluation could also include measures against the remaining BGCS QPIs not included in this report.

## Conclusions

The process of updating and correcting data for this cohort on the SCR has highlighted significant issues in the maintenance of health records. In most parameters there was sufficient documentation of clinical information however this was not reliably transferred to the cancer registry, representing major discrepancies between actual and reported performance.

This report highlights the gynaecological oncology department appears to achieve appropriate treatment targets and survival rates. There was improvement required in the correct documentation of patient data, this has implications for patient care, perceived departmental performance, remuneration, and quality of national data. New processes were introduced to ensure the accurate recording of audit data and updated retrospective data was uploaded to the national ovarian cancer audit database.

## References

- British Gynaecological Cancer Society, 2021. *Version 1 19 May 2021*. BGCS Call to Action – Response to findings from National Ovarian Cancer Audit Feasibility Pilot.
- Public Health England, 2020. *Disease Profile in England: Incidence, mortality, stage and survival for ovary, fallopian tube and primary peritoneal carcinomas*. Ovarian Cancer Audit Feasibility Pilot. [online] Public Health England. Available at: <[http://www.ncin.org.uk/cancer\\_type\\_and\\_topic\\_specific\\_work/cancer\\_type\\_specific\\_work/gynaecological\\_cancer/gynaecological\\_cancer\\_hub/ovarian\\_cancer\\_audit\\_feasibility\\_pilot\\_outputs](http://www.ncin.org.uk/cancer_type_and_topic_specific_work/cancer_type_specific_work/gynaecological_cancer/gynaecological_cancer_hub/ovarian_cancer_audit_feasibility_pilot_outputs)> [Accessed 4 May 2021].