

Clinical and scientific letters

OVERVIEW

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

From Darzi to Keogh: are doctors under 'report fatigue'?

Introduction

Perhaps the last few years of the NHS should be dubbed the decade of the report. Starting in 2008 we have had Lord Darzi's call for quality for all.¹ This was followed by Sir Bruce Keogh's report² into the quality of care provided in the 14 trusts with outlying mortality data. Then not long after came the Berwick review³ into patient safety and the Francis enquiry⁴ into the failures of Mid Staffordshire Hospital. Then just this summer has come the Rose review into NHS leadership.⁵ Each report has provided wide reaching, forthright and comprehensive suggestions as to how to improve NHS services. However, the rapidity of five reports in less than eight years, combined with the fact that mean report length is 83 pages, concerned us that we were in danger of 'report fatigue'; losing sight of the major findings through being overwhelmed by data. Therefore as trainees rotated to one of the trusts featured in the Keogh report we undertook a survey of 100 doctors to review their awareness and understanding of this report published less than two years previously.

Results

Of the 100 doctors surveyed 37 were consultants, 10 were staff grades and the remaining were varying grades of junior doctors. The doctors on average had been working for the trust for 6.3 years (range 0–30) which equated to two-thirds of them being employed by the Trust during the period of Sir Bruce Keogh's report. Despite this, when asked 'There was a major report focusing on 14 trusts (including this one) approximately 1 year ago what was it called?' only 47 responded correctly. A further one-quarter claimed it was the Francis report, 17 admitted to not knowing and 5 plumed for the sham answer of the Leveson Inquiry. In light of this response it makes the results in Fig 1 less surprising. Almost 50% of those responding admitted to not attempting to read the report and only 16% managed over half.

Not surprisingly, therefore, when asked to name a single recommendation from the report just under one-quarter could do so. Furthermore, these were often vague statements such as 'more transparency' or 'encourage whistle-blowing' which may reflect a more general response to the leading messages found in the more recent Francis report. Nonetheless, our results are not entirely negative. Notwithstanding the paucity of personal

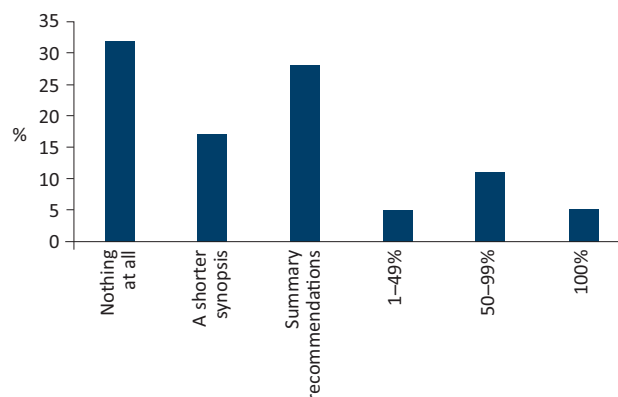


Fig 1. Percentage of responders by the amount of the Keogh report they have read.

knowledge of the contents of the Keogh report, over 80% of the responders felt that it had positively improved the trust – a point further highlighted in the more recent Care Quality Commission inspection.⁶

Discussion

Whether our results are secondary to report fatigue as postulated above, or a symptom of clinical staff already overloaded with important information, they do highlight a staggering discordance. These groundbreaking reports came at a cost of millions of pounds and with thousands of hours of expert and hard work. Yet the job seems left unfinished. Our survey shows how the difficult job of transposing hundreds of pages into effective and easily understood learning lessons has clearly not been translated to the frontline workforce. We seem to have reached a point where an enormous amount of wisdom is in danger of being squandered if we continue with the cycle of repeated large-scale reports without addressing the fundamental problem of communicating their recommendations effectively and memorably. So perhaps rather than another decade of the reports, the second half of this decade should be dubbed the decade of their dissemination and implementation. ■

ANDREW CHADWICK

ST6 respiratory and ICM, Anaesthetic Department, Stoke Mandeville Hospital, Buckinghamshire Healthcare NHS Trust, Aylesbury, UK

AMANDA MOHABIR

ST5 anaesthetics, Anaesthetic Department, Stoke Mandeville Hospital, Buckinghamshire Healthcare NHS Trust, Aylesbury, UK

References

- 1 Lord Darzi. *High quality care for all – NHS next stage review*. London: DoH, June 2008. Available online at www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf [Accessed 1 October 2015].
- 2 Keogh B. *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. Available online at www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf [Accessed 1 October 2015].
- 3 Berwick D. *Berwick review into patient safety*. London: DoH, August 2013. Available online at www.gov.uk/government/publications/berwick-review-into-patient-safety [Accessed 1 October 2015].
- 4 Francis R. *The Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: Stationary Office, February 2013. Available online at webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/ [Accessed 1 October 2015].
- 5 Lord Rose. *Better leadership for tomorrow: NHS leadership review*. London: DoH, July 2015. Available online at www.gov.uk/government/publications/better-leadership-for-tomorrow-nhs-leadership-review [Accessed 1 October 2015].
- 6 Care Quality Commission. *Buckinghamshire Healthcare NHS Trust*. London: CQC, 2015. Available online at www.cqc.org.uk/provider/RXQ/inspection-summary#overall [Accessed 1 October 2015].

Upper gastrointestinal cancer misses: could we do better?

Introduction

In the UK approximately 8,500 cases of upper gastrointestinal (GI) cancers are diagnosed annually. Many studies have indicated that survival is related closely to time and stage of diagnosis. This has prompted a move by the UK Department of Health towards encouraging innovations that promote early diagnosis such as the Be Clear on Cancer campaign.^{1–3} Endoscopy remains the gold-standard investigation for the diagnosis of gastro-oesophageal cancer. Unlike colonoscopy, where there are standardised key performance indicators and audits of all colonoscopists' practice, no parallel standards are currently in use in upper GI endoscopy.

The incidence of oesophageal malignancy is increasing and survival is poor. Upper GI cancer miss rates are reported to be approximately 5–13%.^{1,4} It is accepted that a cancer detected within three years following an endoscopy is considered to be a 'potential miss' and if detected within one year after an endoscopy is likely to be a 'definite miss'.^{4,5} In view of public health campaigns to detect cancer at an earlier stage we sought to review missed cancers in our trust over a four-year period.

Method

We conducted a retrospective, case study of patients diagnosed with oesophageal and gastric cancers between January 2011 and January 2015. Data were extracted from the cancer registry at Barnet and Chase Farm Hospital, a two-site district hospital that serves a population of approximately 500,000 patients. Information regarding any gastroscopies done within 3–36 months of cancer diagnosis was obtained for each patient using our electronic endoscopy reporting tool.

Results

In total there were 305 new cases (male, 207 (68%); mean age, 73.8 years; range, 26–100 years) of upper GI cancer, of

whom 23 (7.5%) had undergone a gastroscopy within 3–36 months of the diagnosis. Only 2 patients had undergone an endoscopy procedure in the 3–12 months prior to diagnosis. Alarm symptoms were present in 11 patients (48%; information available in 20 patients) at the time of the index 'miss' endoscopy. Oesophago-gastric cancers appear to have been missed at endoscopy in 7.5% of patients in our unit. This value parallels outcomes reported elsewhere.^{4,5}

Discussion

Given the poor prognosis associated with upper GI malignancy, this study reminds us to be vigilant when examining the mucosa, particularly at the cardia, which is most vulnerable with regard to missing a cancer. The endoscopist and referring clinician should also have a low threshold for suspicion in patients presenting with alarm symptoms. Although there are many established performance indicators for colonoscopy, endoscopists are less familiar with gastroscopy measures of quality, which are currently being addressed by the British Society of Gastroenterologists. We believe that addressing gastroscopy technique will have an impact on early detection of upper GI cancers and improve outcomes for these patients. An audit such as this also serves as a reminder to referring clinicians that alarm symptoms may warrant further evaluation even if the endoscopy is reported as normal. ■

AMIR HOSSAIN GAHANBANI ARDAKANI
FY1, Gastroenterology Department, Barnet General Hospital,
London, UK

STEVEN MANN
Gastroenterology consultant, Gastroenterology Department,
Barnet General Hospital, London, UK

References

- 1 Cancer Research UK. *Be clear on cancer. Bowel cancer campaign*. Available online at www.cancerresearchuk.org/health-professional/early-diagnosis-activities/be-clear-on-cancer/bowel-cancer-campaign [Accessed 7 July 2015].
- 2 Groene O, Cromwell D, Hardwick RH *et al*. *The national oesophago-gastric cancer audit. An audit of the care received by people with oesophago-gastric cancer in England and Wales. 2012 annual report*. Leeds: NHS Information Centre, 2012.
- 3 Richards M. The national awareness and early diagnosis initiative in England: assembling the evidence. *Br J Cancer* 2009;101:1–S4.
- 4 Chadwick G, Groene O, Hoare J *et al*. A population-based, retrospective, cohort study of esophageal cancer missed at endoscopy. *Endoscopy* 2014;46:553–9.
- 5 Gado A, Ebeid B. Gastric cancer missed at endoscopy. *Alexandria J Med* 2013;49:25–7.

Venous thromboembolism: a role for weight-stratified thromboprophylaxis?

Venous thromboembolism (VTE) encompasses a range of presentations from asymptomatic deep vein thrombosis to fatal pulmonary emboli. These common clinical problems are associated with significant morbidity, mortality and resource expenditure.¹ Routine use of thromboprophylaxis, when administered to appropriately assessed patients, reduces adverse patient outcomes and decreases overall healthcare costs, with