



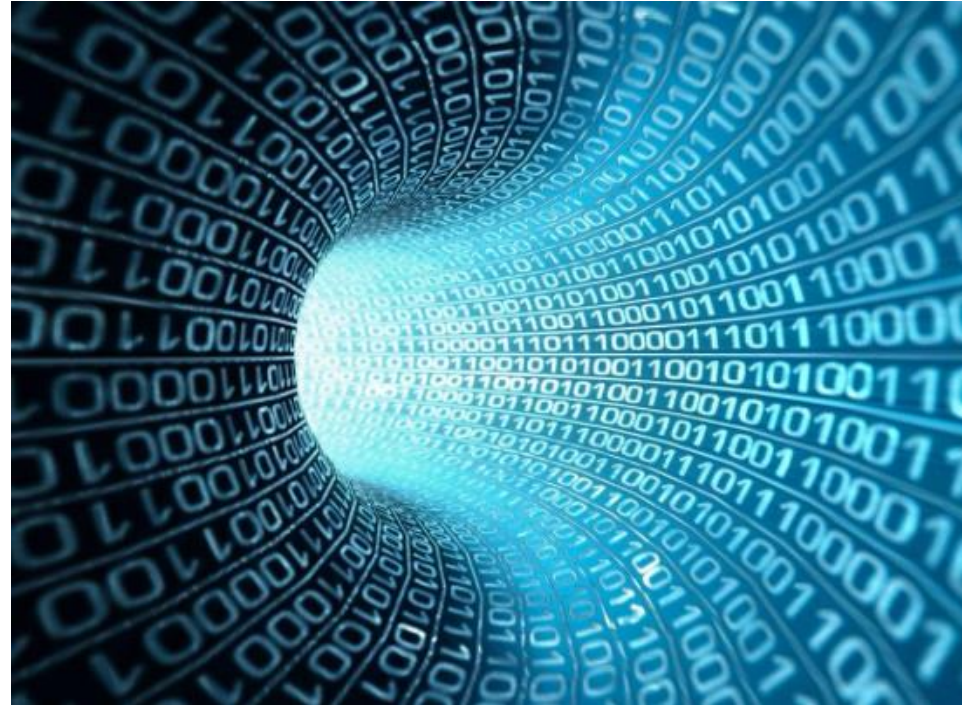
Public Health
England

How clinicians use data to make an impact on clinical outcomes

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The core objective: link data with patient outcome

- Promoting data collection
- National repository datasets
- Expert analyses
- Improve standards of care and outcomes
- Support audit and research



Main elements of clinical engagement

- Identification of key clinical issues & priorities
- ‘Ownership’ of data:
 - Dataset development & revision
 - Championing data collection
 - QA
- Clinical input into the analytical programme
- Advice on ways of reporting data
- Communication – colleagues; professional bodies, providers; commissioners
- Promoting the use of routine data in research



What do clinicians use data for?

- Audit of their practice and that of their MDT
- In discussions within their Network (Peer Pressure)
- Comparing their activity and outcomes against national 'benchmarks'
- As part of Peer Review
- To support local research
- For professional revalidation



National Lung Cancer Audit Report 2014

Report for the audit period 2013



Royal College
of Physicians

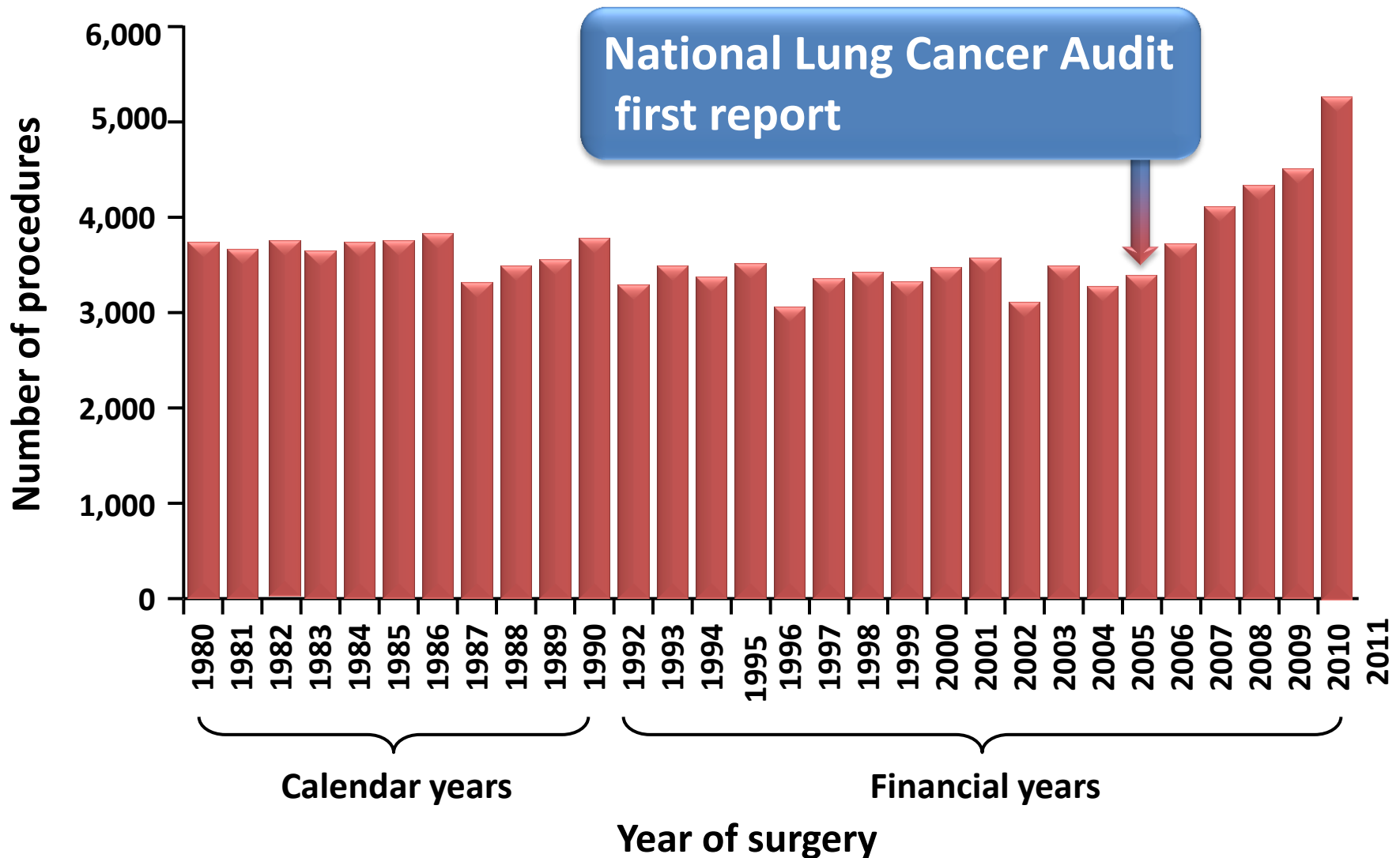


HQIP

Healthcare Quality
Improvement Partnership

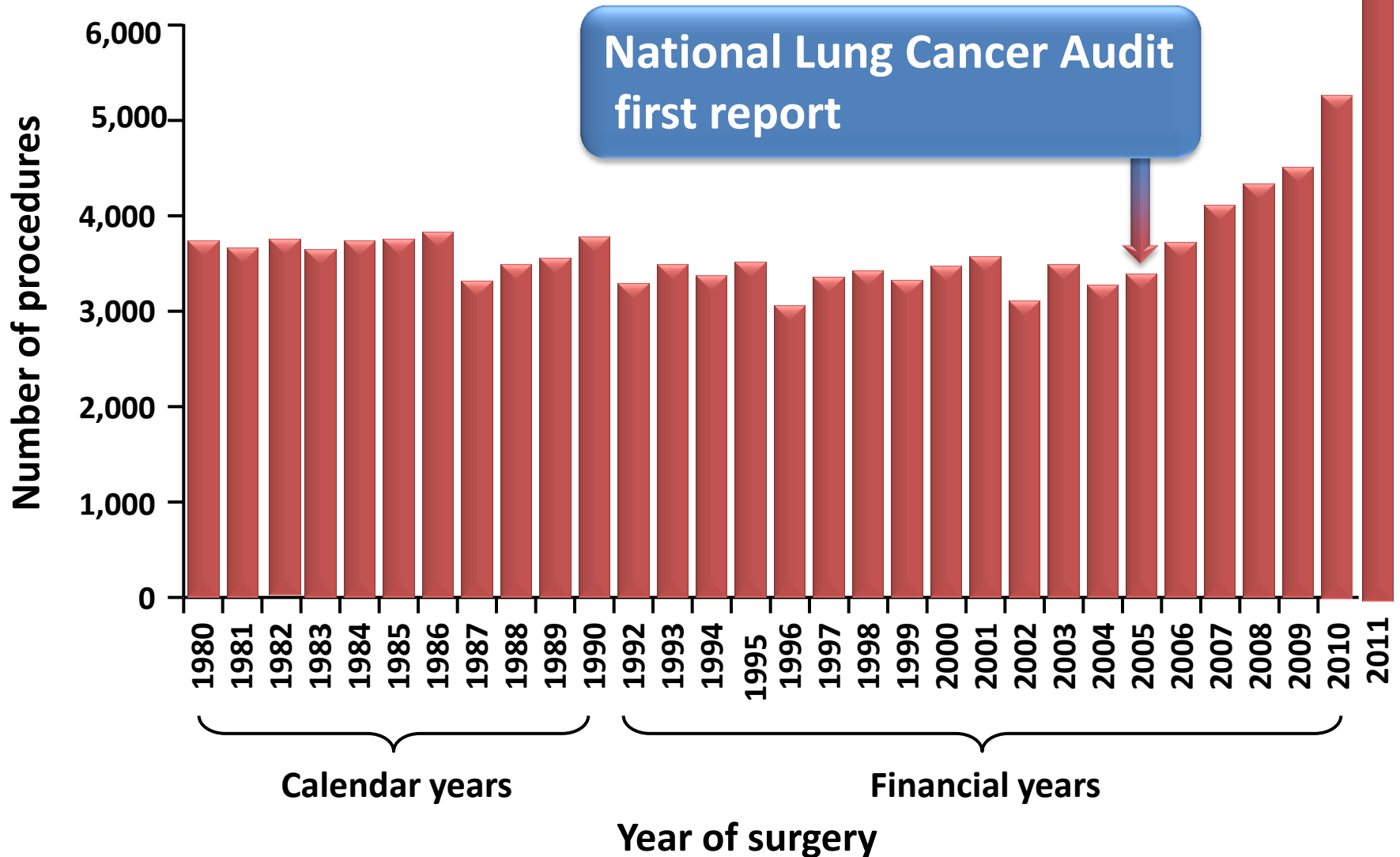
Setting higher standards

Primary lung cancer resections (n=116,148)

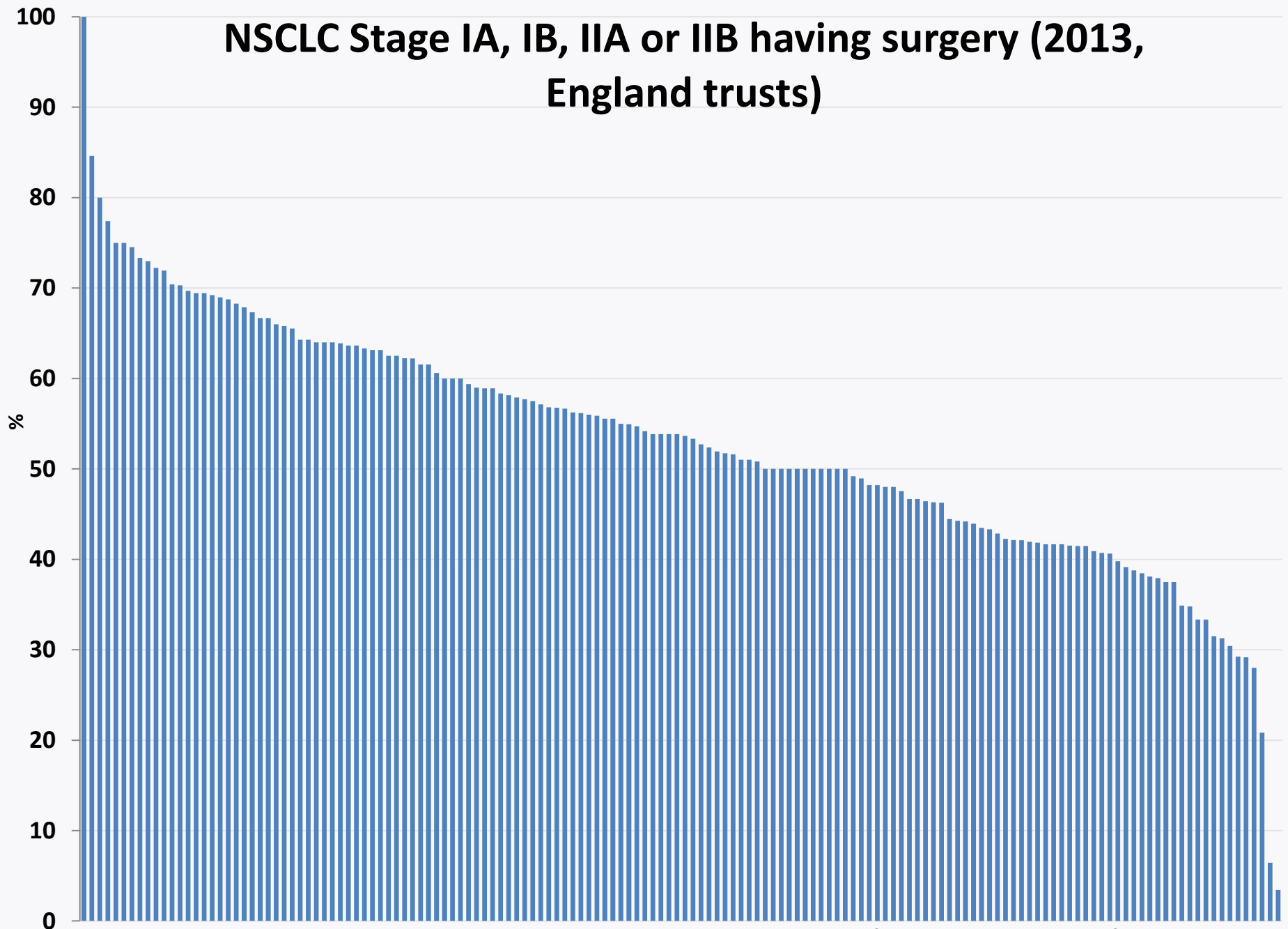


Primary lung cancer resections (n=122,408)

6360



NSCLC Stage IA, IB, IIA or IIB having surgery (2013, England trusts)



Source: National Lung Cancer Audit 2014

Case-mix (risk) adjustment

Age



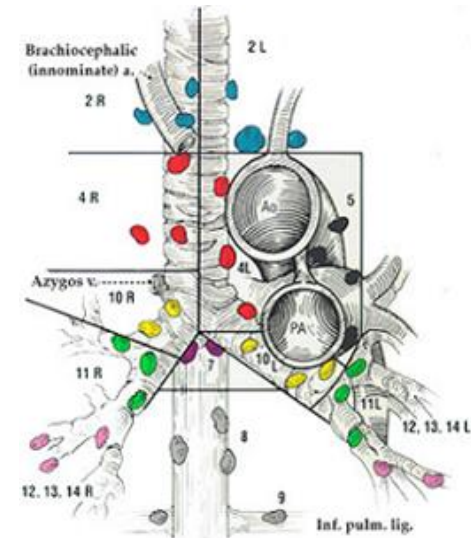
Fitness &
Co-morbidity



Social
Deprivation

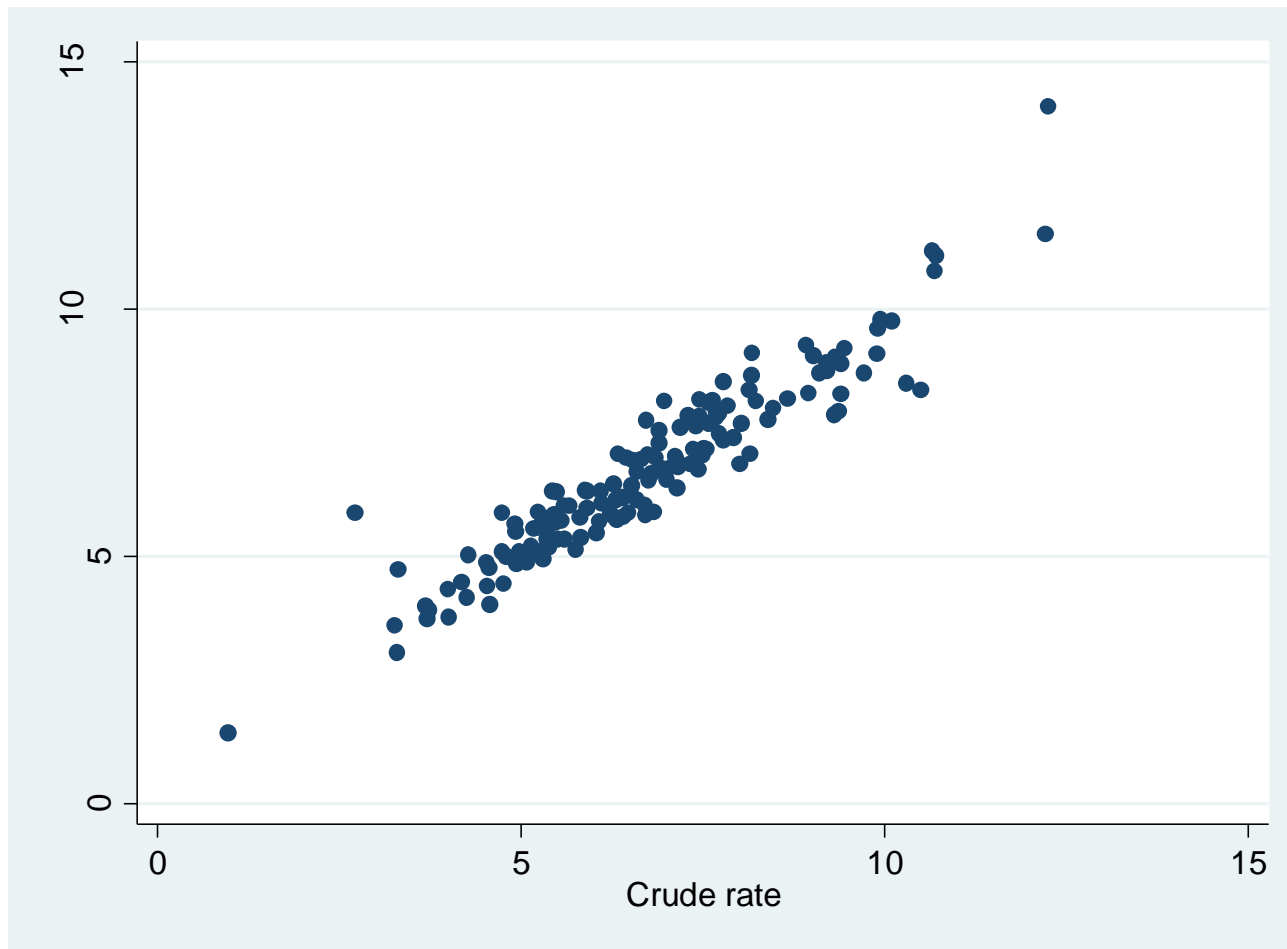


Disease
stage



Risk Adjustment

(30-day post-operative mortality colorectal cancer 2008-2010)

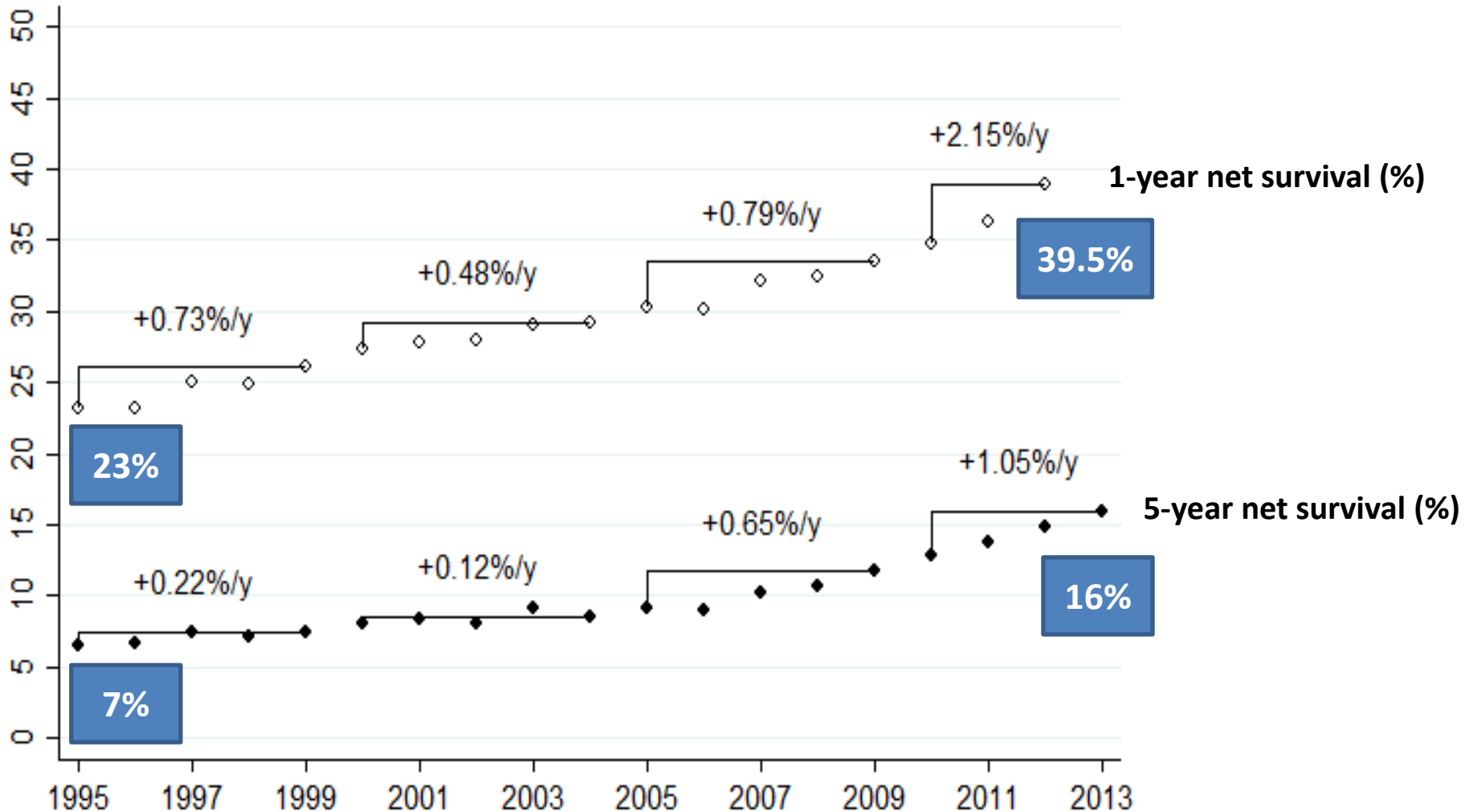


Resection rate for patients with tissue confirmation of NSCLC (2004-2008:England)

First seen in centre with thoracic surgery?	Number With a tissue diagnosis of NSCLC	Number who had surgical resection	% having surgery	Adjusted Odds Ratio for surgery*	P value
No	25,248	2,947	12%	1.00	
Yes	9,265 (27%)	1,538	17%	1.51 (1.16-1.97)	<0.001

*adjusted for sex, age, PS, stage, deprivation index and Charlson co-morbidity index

Trends in one- and five-year net survival from lung cancer in England by year of diagnosis.



Source: S Walters et al . Br J Cancer: 2015;113(5):848-60



Our cancer shame: Survival rates in UK are the worst among leading nations

By JENNY HOPE

THE Sun

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Lung cancer lottery

By JANE SYMONS

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IT is the most deadly cancer in the UK – and your chance of surviving it could be wrecked by GEOGRAPHY.

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HOW THE TREATMENTS COMPARE

BREAST				BOWEL			
		1-yr survival	5-yr survival			1-yr survival	5-yr survival
	Australia	96.7%	88.1%		Australia	84.9%	65.9%
	Canada	96.3%	86.3%		Canada	83.5%	63.7%
	Denmark	95.0%	82.4%		Denmark	77.7%	55.8%
	Norway	96.6%	85.5%		Norway	82.4%	62.0%
	Sweden	98.0%	88.5%		Sweden	83.8%	62.6%
	UK	94.2%	81.6%		UK	74.7%	53.6%
OVARIAN				LUNG			
		1-yr survival	5-yr survival			1-yr survival	5-yr survival
	Australia	73.5%	37.5%		Australia	42.8%	17.0%
	Canada	75.2%	41.9%		Canada	43.1%	18.4%
	Denmark	70.6%	36.1%		Denmark	34.9%	10.9%
	Norway	75.2%	39.7%		Norway	39.2%	14.4%
	Sweden	n/a	n/a		Sweden	43.6%	16.3%
	UK	65.0%	36.4%		UK	29.7%	8.8%

Changing the Culture

- We all are involved with cancer diagnosis, treatment, commissioning or assessment
 - Next time you see an audit or a data set
 - Pick one item where you, or your unit or hospital could improve and set about changing it.
-

Conclusions

- Ensuring the best outcomes of clinical practice and service configuration is highly dependent on robust data
- Clinicians have to take seriously their part in data collection
- We need to expand the size of the clinical community engaged with cancer data - feedback and ongoing interaction with clinicians is an essential part of the process
- Every MDT should have at least one senior clinician responsible for overseeing data collection and feedback
- High quality population-based data can clearly drive clinical behavioural change – and is now impacting on outcomes for patients