**How to Improve Data Completeness and Data Quality**

The following are the notes that were recorded following the group discussions at each of the 8 COSD Roadshows held within January and February 2017. Some region Trusts were happy to identify themselves through this process, whilst within other group sessions some topics were grouped by discussion type.

These were very popular and created a lot of positive discussion. I am not a great believer in re-inventing the wheel, and a strong believer of sharing ideas to improve services/best practice.

Where a Trust has been identified, they were all happy for anyone to contact them to discuss this further locally. I hope that this continues to provide additional support far beyond the roadshows.

I have also included the names of the delegates who attended each meeting too, in appendix 1, at the end of this document. There will also be all the presentation available as a series of pdf downloads as well for your use locally.

If you have any questions you are always most welcome to contact either myself direct or your local NCRAS Liaison Manager

* Andrew Murphy Head of Cancer Datasets
* Karen Graham Head of Data Liaison
* Marianne Mollett Liaison Manager (Eastern)
* Dr Emily Griffiths Liaison Manager (East Midlands & North West)
* Katrina Sung Liaison Manager (London & South East)
* Laura Prenton Liaison Manager (Northern & Yorkshire)
* Matt Lynch Liaison Manager (Oxford & West Midlands)
* James Withers Liaison Manager (South West)

Warmest regards

Andy

Andrew Murphy
Head of Cancer Datasets
The National Cancer Registration and Analysis Service.

Public Health England

**Cancer Outcomes Services Dataset – 12 January 2017**

**Group Discussions – Workshop, London (1)**

|  |  |
| --- | --- |
| **Hospital/Trust** | **Discussion-Notes** |
| **Kings/PRUH** | * Clinical Lead speaks to MDT leads and re-enforces importance amongst clinicians
 |
| **Guys** | * Increased profile
* Operational group including looking at how COSD interacts with structure of Trust finding interested clinicians, can present performance and make it a trust priority
 |
| **Guys** | * Using cancer statistics to show relative performance between similarly structures trusts, creating competition
 |
| **Kings** | * Sharing information between trusts
* Automatically spending MRT outcomes
 |
| **GOSH** | * Review of data prior to spending, having the appropriate people in place to do some recent recruitment of analysts
 |
| **Guys** | * Giving clinical teams a clear picture of what needs to be completed by making your admin team member a high profile member of the team
 |
| **Marsden** | * Meet clinicians
* Live MDT – minimum increase, timing documented
* Encourage MDT coordinators to request staging in TN and M (rather than interpret clinical information
 |
| **Hillingdon** | * Live MDT – Local
* Live recording done by clinicians, not co-ordinators
 |
|  | * Constantly checking the Data being collected
* Clinicians include Performance status on clinical letters
* Involve C.N.S with MDT team
* Pop-up validations on Infoflex
 |

**Cancer Outcomes Services Dataset – 18 January 2017**

**Group Discussions – Workshop, London (2)**

|  |  |
| --- | --- |
| **Hospital/Trust** | **Discussion-Notes** |
| Kent | * Making sure have appropriate technical support in addition to administrative clinical support
* Ensure good links of inter-trust communication, administrative and clinical
* monthly data manager meetings
 |
| RNOH | * Working on a time flow appropriate to the MDT weekly data capture and review to fit MDM schedule
* Making sure MDM co-ordinators see impact of lack of data quality
* Clinical procedures to ensure the correct data is captured – policy for Data to be in first letter/consultation
 |
| East Kent | * Establishing competencies for MDM coordinators
* Making sure they have the tools to validate and have appropriate training in place
 |
| Maidstone | * Sharing good practice – recurrence policy now Kent wide
 |
| Live stage capture at MDT | * On a screen
* Radiologist & Pathologist
* Run report every month for missing items
* Actually meet clinicians to go through and pick up missing items
* Clinicians sign to say they have not taken part
* Clinicians being stronger on not moving on until items have been collected
* Encouraging MDT co-ordinators to do the same
* Live collection – vocal coordinators
* Weekly checklist of stage group, CNS, performance status
* CNS list of weekly diagnosis
* Local validations, gaps
 |
| Brighton | * Varies within MDTS – lung is very good with performance, difficulties in improving change
* Live MDT – met with restraint
* Gaps – going back to look at data gaps, referrals
 |
| Barts | * Spreadsheet to merge, three Somerset systems
* Two weeks to review
* staging
 |

**Cancer Outcomes Services Dataset – 25 January 2017**

**Group Discussions – Workshop, Newmarket**

|  |  |
| --- | --- |
| **Hospital/Trust** | **Discussion-Notes** |
| Staff training | * Includes feedback on validation
* Double training
* MDT proformas include main COSD items for care plan and have clinical involvement/sign off
* System review, back to basics (is IT system logical/easy to use?)
* (Is the change progress managed and co-ordinated well?)
* Engagement from staff and a willingness to work proactively
* Audit Resources
 |
| Bedford | * MDT will not move forward until all data is discussed and collected
* Use a COSD weekly report by Tumour Site (of missing data)
* Goes to MDT coordinators for completion
* Work with clinicians to set accurate information
 |
| Clinical | * Use a PT discussion list with all data BMI/staging and performance status
* All these have to be completed by clinicians before moving to next PT
 |
|  | * Use MDT as point of Data Collection for Accuracy
* MDT coordinators track PTS as well as manage MDTs
* Pre-populate as much as possible prior to MDT
* Good relationship between clinicians and MDT Coordinators
 |
| Issues | * High turnover of staff disrupting understanding/collection
* Long time to train new staff
* Electronic pro-forma for some MDTs
* Can’t move on without completing a section
* Other sites now asking for the pro-forma
* Pro-forma is site-specific
* Laminated staging sheets/Assertive MDT Co-ordinator
* Internal League table – comparing sites
* Better working relationships with Clinicians re: COSD
* Staging collection
* Empowering MDT Co-ordinators
* Relationship with NCRAS
* Clinical engagement (key)
* Regular feedback (from Cancer registry)
* Extending MDTs
* Clinicians entering data live at MDT
* Educating and meeting those entering data (making sure data is in correct field)
* Recruitment of data and Audit clerks (ensure there is enough admin staff)
* Training Programme
* Roadshows for clinical staff
* Challenge data
 |

**Cancer Outcomes Services Dataset – 2 February 2017**

**Group Discussions – Workshop, Sheffield**

|  |  |
| --- | --- |
| **Hospital/Trust** | **Discussion-Notes** |
| Mid-Yorks | Initial Issue:-* Using old version of Infoflex
* Lack of understanding of COSD requirements

What they did:-* Updated Infoflex July 2016
* Initial visit from Karen Graham Aug 2016
* Presentation – COSD awareness staging
* MDT Co-ordinators
* Shared with Clinical Teams – good buy in
* Second visit Nov 2016
* Aimed at MDT Co-ordinators
* 1 to 1s with each co-ordinator

Issues:-* Breast – Recurrence v progression
* Skin – No staging, also mapping issue (not pulling through)
* Urology – General confusion multi-sit cancers reportable v non-reportable
* Laura – Producing flow/process/decision chart
* MDT co-ordinators – all done understanding Cancer training
* Big push from Katrina (Cancer Manager)
* Visit in March
* All coordinators have a printed version of COSD
* Weekly validation
 |
| Derby Nottingham | **Data Improvement**Non-Clinical Staff* Provide as much information as possible
* Reports
* Encourage ownership
* Dedicated Data Team
* Highlight missing information
* Only ask for realistic information

Clinical Teams* Clinical Data Lead
* CNS
* Key data on clinical letters
* Junior Clinicians
* Validation MTGs
* Engage take ownership
* Change of focus of MDT
* Prep before meetings, reduce burden
* Pre-populate data
* Are MDT referrals appropriate
* Competition between clinicians (name & shame)
 |
|  | * Hard working staff-building expectations
* Patient proformas with core data
* Live data capture
* Involvement by clinical staff & working relationships
* System/database development i.e. clinical nursing records recorded on cancer databases
* User friendly – Infoflex easy to follow and use
* Conformance reports to MDT leads review, standing agenda item on cancer governance meeting
* Doncaster – Lung clinicians directly input into system
 |

**Cancer Outcomes Services Dataset – 10 February 2017**

**Group Discussions – Workshop, Leeds**

|  |  |
| --- | --- |
| **Hospital/Trust** | **Discussion-Notes** |
| Harrogate | * Bespoke XML
* Improved engagement with CNS
* Previously putting unknown
* Introductions & relationships with CNs
* Input Data from CNS
 |
| Mid Yorkshire | * Upgrade to InfoFlex July (Chameleon info management)
* Now CIMMS manage
* Ensure current exportation of DATA
* Laura came to talk to MDTs which has improved communication
* Pathology
* Saving time as Don’t need to input everything
* Work in progress – live inputting into InfoFlex
 |
|  | * Clinical validation after MDT directly onto the system
* Live data entry at MDT
* Healthy competition between trusts!
* Circulation of reports to all clinical teams
* Engagement and involvement of PCO’s, wall of data, all have access to cancer stats
* Dedicated manager for COSD, audits, SACT *etc.*
* Reports for clinicians showing their Data completeness
* Clinicians putting Performance status in letters
* Gynae is clinician lead MDT registrar recording the Info
* Assertive MOT Co-ordinators
* Live Data Collection at MDT
 |
|  | * DQ reports help (and time to react to them)
* Transparency – *e.g.* open Exeter/CWT can view after
* How data is presented, Trust allocation currently unhelpful (2 views: diagnosis, treatment)
* Be able to scrutinise pre-publication
* Slower pace of change
* Allow submission of outdated codes, get feedback
* Move to MDT reporting will help
 |
| York | * Using bespoke system – develop slightly separately from info & SCR
* Karen visit – staging system changes – came in last week
* Data collection of the 3 principles of staging, making sure all the co-ordinators see where the data goes, confidence in using the systems
* Collect a lot of staging at MDT – pinning down what is the priority
 |
| Northumbria | * Project dataset onto the wall – is any data missing
* They add direct onto SCR during MDT’s – use the MDT section of SCR
* Lung co-ordination prepares beforehand to see where the gaps are
* Importance of clinical buy in helps
 |
| Sheffield | * Lung MDT improvements – validation reports around the KPI’s
* They are getting the patient level behind them
* Cross checking with the registry
* Lung are a very motivated team – not the same across the board
* Using the Cancer stats performance to compare to other trusts
* Busy MDT schedules
 |
|  | * Staging colorectal and PS (Pre-treatment) ASA – Hull/NLAG
* MDT coordinators added key items to MDT List reminded the clinicians/MDT to complete
* NLAG live use of Somerset in MDT. Now embedded in routine Hall live
* Lead clinician validates input
* Visit and support to MDT co-ordinators to empower and “slap” clinicians
* Feedback to clinicians on MDT performance. Now wait for MDT to complete
* Peer review implications have helped. Stresses importance of MDT Coordinators 12-18 months but worth it
* Engage with Lead Clinician
* Calderdale + Hadds – live PPM been doing the same a long time, can vary by MDT
* Breast TNM – hard as clinically not relevant
* Report with missing data items monthly and pass to lead clinician to fill in himself [Lung especially]
* MDT part of team, consistency, relationships
* (NS using systems more engaged but not all do)
* Virgin Care – skins – MDT only since May. MDT leading discussion now Get MDT to turn up with systems and empty table and see how they would cope without MDT coordinators
* Bring Clinicians down to earth
 |

**Cancer Outcomes Services Dataset – 16 February 2017**

**Group Discussions – Workshop, Manchester**

|  |  |
| --- | --- |
| **Hospital/Trust** | **Discussion-Notes** |
|  **Mid-Cheshire** | * Have proforma on all sites
* Engage clinicians
* Concentrate core
 |
| **St-Helens** | * No paper collected
* Types into SCR driving MDT
* Projected onto the screen
 |
| **Royal Bolton** | * Somerset improvement/updates, time line *etc.*
* Improve key areas like performance strategy and particularly stage improve input, inputting data in the correct place
* Have a preform – fill in very quickly, doing before will be better
* Proforma goes with the patient notes
* Cancer meeting – twice weekly, predictor, micro manage and improve performance
 |
| **Stockport** | * Co-ordinators not confident to add during meeting on screen, have gone back to using a proforma
* Staging improvement – weekly validations, identify gaps, learning for future
* Clinical engagement – area for improvement
* Turnover sites with audits always come out better
 |
| **Southport** | * Discussion into how to improve things – looking to get ideas *i.e.* Interested in the proforma idea
 |
|  | * Having one system to collect data
* Have a Non-compliant
* Record live at MDT
* CEO Involvement
* Data is a part of Board meeting
* Benchmarking against region
* Dashboard
* Sharing scripts
* Share S.C.R across the region
* Have all the people in the room
* Fill in the data directly and not to paper
* Make clinical lead work with MDT co-ordinator
* Provide fuller reports and updates to each clinical lead
* Provide weekly reports of patients missing stage
* Have information available and ready for the meetings and to the people before the meetings
* Agenda sent 2-3 days before meeting electronically
 |
|  | * Go directly to pathway and import images of skin like for MRI scans, remote access needed
* Somerset not responsive enough
* Small MDTs ok but large ones done work
* Incorporate a consultant into moving away from paper notes
* Finding a clinical champion to drive improvements
* Read-only of other hospitals submissions so that they can update centres
* “pink form” proforma circulated around CNS, consultant, coordination and data analyst outside MDT and entered by dedicated data staff after
* CNS work in same office as coordinators or have extra meetings outside busy MDT
* Capture the simple basics in busy MDTs and catch extra data items after
* Proformas going paperless, virtual MDTs
* Separate “advanced” MDT for particular pts
* Need to decide responsibility for data to be collected by each
* Take COSD reports to network speciality meetings so consultants compete across the trusts
* Multiple trusts noticed that CNS box not feeding through (identified how to correctly report)
* Insist on data from referring centre before discussed at territory MDT
* Discuss data with a clinical team member
 |

**Cancer Outcomes Services Dataset – 23 February 2017**

**Group Discussions – Workshop, Birmingham**

|  |  |
| --- | --- |
| **Hospital/Trust** | **Discussion-Notes** |
| **Wolves, Northampton, Dudley** | * acknowledge the need for improvement
* engagement/Buy-in
* senior Leadership/cancer board
* clinicians
 |
|  | * **Know what COSD is:-**
* understand COSD is as important as CWT
* allocate time to COSD
* pro-active Data collection
* housekeeping reports (3 x per month)
* blank key data items
* reduce clinician burden for data collection
* data meetings, fortnightly – validation outside MDT
* Involve clinicians especially CNS
* name and shame – competition between MDT Leads
* quality & Completeness
* clinical ownership
* make staging, PS & CNS indicator mandatory
* Review MDT minutes after MDT to ensure all data is collected correctly
* MDT Co-ords must have excellent knowledge of the CMS. Know where all key fields are
* regular training would be beneficial
 |
|  | * CNS responsible for stage, PS & CNS @ MDT
* live data collection
* more likely to get engagement from other clinical staff
 |
| **WYE Valley Trust** | **Good practice at Lung MDT + for COSD validation*** clinical support at MDT from Lead
* weekly patient meetings with MDT Co-ordinator and clinician
* summary sheet from MDT, completed by clinician for every patient discussed at MDT
* monthly validation for COSD with MDT Co-ordinator and clinician
* Tertiary information re: post op staging – what is required?
 |
|  | **Our Trusts improvement:-*** to run out through to other specialities for each MDT
* more clinical engagement with MDT co-ordinator
* CNS to collect performance status and CNS indicator and enter into InfoFlex
* live input of COSD data at MDT – Capture sheet
* monthly data meetings to share COSD Data on Cancer stats
 |
|  | **Improvements:-*** intensive data improvement process – training sessions
* clinically led – MDT proforma
* Information inputted prior to MDT where possible
* MDT coordinator seen as a core member – prompts for staging
* live data entry at MDT
* training/review meetings with pathologists on COSD path data items
* weekly COSD reports sent to MDT coordinator to complete missing fields
* weekly COSD reports sent to MDT coordinator, complete missing fields
* audits – specialities data completeness influenced by audit
* Introduced competition with COSD conformance reports between speciality MDT coordinators
* good CNS involvement using SCR
 |
|  | * Gynae – Figo stage – clinical lead – championed this, MDT co-ordinator requesting in MDT Data drop - so any missing stage goes back to the weekly clinical lead to update, 40% - 90%
* automatic report for CNS – if the code has been updated to if patient has been seen
* positive – Live MDT Data input – clinical buying – date feedback reports
* breast – have
* recruited staff to focus on collected COSD
* methodical MDT – don’t move on until fields are filled, live MDT
* more regular engagement with the leads – feeding back on data
* presenting the data
* alter MDT form to incorporate question being asked at MDT
* emailing to get relevant information
* live data entry at MDT with lead Doctor/Clinical team member doing this

Some barriers* local reporting/data problems
* XML – not being able to provide data to consultant before being submitted
 |

**Cancer Outcomes Services Dataset – 28 February 2017**

**Group Discussions – Workshop, Taunton**

|  |  |
| --- | --- |
| **Hospital/Trust** | **Discussion-Notes** |
|  | DCH – Improved Clinical Engagement with NLCA:-* No Hierarchy, peer or peer challenge
* Changed MDT room layout (Friendly competition between coordinators)
 |
| **NDDH** | * Increased clinical engagement, increased training dashboards
 |
| **Cornwall** | * Getting assumptions out of clinicians heads
* Improved understanding by MDT coordinators
 |
| **South Devon** | * Clinical engagement
* Competition
* Feedback to clinicians
 |
|  | * Collecting radiology stage @ MDT, previously was not done
* Paddles with “stage” and “Perf Status” on that MDT co-ordinators hold up
* Have monthly – 3 monthly meetings with consultants to fill in Gaps
* Have Data items (who score, height )
* Added to first letter so MDT Co-ordinators knows where to find it
* Same for Haematology stage
* MDT held at different site
* View only access to other trusts Somerset systems
* Weekly report of patients that haven’t come in on week pathway
* Meet with surgical diagnostic teams
 |
|  | * Clinician buy in collecting data e.g., staging, recommended staging system
* Pre-popularity MDT system
* Save time during meeting
* COSD Champions
* Key data items
* Live Tracking (performance dashboards)
* Reporting (internal) to track completeness
* Understanding how NCRAS record data
* How do other trusts archive good results
 |
| **Portsmouth** | * Pre-populate data before MDT
* Stop the action until crucial information is recorded
* Impossible to capture all info in MDT (only if MDT fits)
* Build strong relationships with members
* Co-ordinators responsible for tracking down all information, track down, validate etc.,
 |
| **Exeter** | * Main focus on MDT – Outcomes
* Pre-populate preformas as much as possible
* Difficult to stop conversation – mid flow
* Go through oncology front sheet
* Started training lung consultants in data recording
* How to make it easier for clinicians to make information explicit
* Created dataset for CNS (teams) to complete for e.g., populate performance status in Excel
* Ownership of the whole patient pathway
* The right person needs to be in charge of patient tracking, (delegated that to secretaries 1000 people to be trained)
 |
| **Portsmouth** | * Regular validation/agree
 |
| **Bristol** | * MDT managed by surgical services at Cancer Services – context
* Root cause analysis
* Lung audit – every month
* Check – every 6 months
 |