Cancer Outcomes Services Dataset – 21st February 2018

Group Discussions – Workshop, Birmingham

Hospital/Trust	Discussion-Notes
Table 1	What Works Well? • Where you have clinical engagement live data entry @MDT meetings are not always possible. Difficulties • Not all parts of patient pathway is recorded at Trusts – difficult to see completeness • Insufficient time to collect CancerStats • Service/IT issues – Cost for info flex upgrades • CWT seen as priority over COSD • Lack of input from all disciplines too many data items to collect – resource issues.
Table 2	Is the dataset too BIG? Yes! • Difficulty of collecting? – Availability of data/tertiary data/ multiple providers. • Clinical input required – non clinical staff interpreting data • Collecting live in MDT Not enough time Data not accurate Not all the data is available at the time Haematology difficulty – accuracy of data Too much duplications Hard to input a date when you only have the year of diagnosis to close the episode – now an issue when lacking at research What Can Be Done? • Integration of datasets • Value of conformance report? • *Clinicians would find other field more useful • Feedback on more data that is submitted. • Need more of the two-way process • Clinician's buy-in/Headline data. • MDT lead meetings to - software developers – assist in making system more intuitive. Future Relevant data items- why are we collecting? Somerset – Red, Green, Blue dots – where fields have all fields ticked are they necessary?
Table 3	Challenges. • Too big – unrealistic expectations! • Mortality rates at Trust level, more clinical engagement. • Start with purpose of dataset, clinicians interested in audit. Not COSD. Lost Networks so less clinical groups, less pressure at clinical events/conferences. • MDT meetings larger but no time. • Cancer resources are tight.

	What Do The Clinicians Get Back? • Population level – needs Trust level and at clinician level. What Goes Well? • MDT empowered • Standing agenda items on Cancer Board Agenda - P.status - Stage Recommended/Key points - Small datasets - Reporting back to clinicians - Expanding why and what used for. - Feedback to Trust when their data is used in reports on news etc. - Being mindful of pressures in Trust.
Table 4	• Clinical Validation • Poor engagement - Lack of understanding - Haem/Breast - Haem interest in trails datasets • Data Completeness reports • Feedback to teams – data compliance • Lack of awareness at senior level- focus on performance/CWT- no target *early stage performance • Internal IT Issue – SCR upgrades • Pathology Hub –Change of system
Table 5	• COSD Pathology section being separated good thing – reduce chance of human error. • Recurrence recording potential problems –radical / treatment record to capture? MDT time constraints. • Important to maintain momentum, keep interest. • Difficulties with MDT time constraints outcomes vs TMM/PS • Timescale too tight for volume of data • Recognition of burden of work – allocate funds – need for IT rep in cancer services.
Table 6	Not enough data booked to MDT's • Info flex reports not good enough locally • Better reports for clinicians • Not enough national reports made available to engage clinicians • PHE not good at this.
Table 7	Should we include diet and exercise levels? • How does Cancer data compare to diabetes? • Primary care data should be captured - Should link to pharmacies - Vague symptoms – Presentations before?? SCR should be part of ALL referrals - Medications, etc. - Private GP scans and reports Living with & beyond - Recorded package

Table 8	Challenges with the Trust with work structure: • Best practice - Separate MDT from Data collection If Penalties – in line with CWT would put pressures on Trust to invest into MDT Buck + Hoe • Clinical engagement – Hard to get surgical margins – They want the outcomes • Performance status – MDT Struggle to collect • M Stage: Difficult to collect in MDT meeting- Radiologist not reporting on notes • Trust MDT sending report (monthly) to request missing data- clinical team • Trusts would like all audits to be through COSD – duplications due to audits. • MDT – Team would happy to be part of a workshop- MDT can then feed back in data improved
Table 9	• MDT Co-ords – To many data items to complete everything • Auto – populating of data from links systems would help. • Data not always available histology for example - Needs more “shop floor” representation from clinicians - DI Team 1-2-1 visits are useful • Lots of different fields - Definitions need to be more explicit especially for tertiary centres ‘who is specialist first seen’? Smoking status is brilliant. To future proof should we include vaping (??) as separate options?? What about “other” things smokes (i.e. marijuana)? Should we include a diet and exercise levels? How does cancer data compare to diabetes or other lone team conditions? *Primary care data should be captured* - Should link to pharmacies - Vague symptoms – prescriptions before referral *SCR should be part of all referrals - Medication, etc. - Private GP scans + Report Text *Living with and Beyond - Treatment outcomes - Recovery Package - Stratified outcome - Lost to f/up