

Cancer Outcomes Services Dataset – 18 January 2018

Group Discussions – Workshop, London (2)

Hospital/Trust	Discussion-Notes
Round Table, COSD discussion	<p>Future Changes</p> <ul style="list-style-type: none"> • Remove Pathology from COSD MDT • Care plan date, agreed date, validation in SCR? • Compliance – Quarterly/monthly • Inc in conference resort • PT level data <p>CancerStats</p> <ul style="list-style-type: none"> • Start at Trust/tumour site level • Identify PT: Missing data <p>What works?</p> <ul style="list-style-type: none"> • CancerStats is good, patient level data would be great • DX Trust a welcome change • Identify responsibility
COSD Round table discussion	<p>Is the dataset too big? /should it be reduced?</p> <ul style="list-style-type: none"> - Overheads, clinical ownership - Time - Knowing the most important data items/high return - No benefits/no incentives to impact data across 12 tumour sites. Difficult to engage clinical staff - Difficult to collect data - Not in one place, different systems to get data - No staging on Radiology reports - Right time to collect - Depends on Taunton group - Information not always available @ MDT <p>What data are difficult to collect?</p> <ul style="list-style-type: none"> - Clinical data by MDT co-ordinator - Extra data for audits/duplication - Performance status – different places to enter data – only want to enter it in one place - CNS data – but now mapping (was system issue) <p>What should we remove?</p> <ul style="list-style-type: none"> - Duplication <p>What should we add?</p> <ul style="list-style-type: none"> - Information on importance of data items - Maybe info about what work the data items have been used for?
What works?	<ul style="list-style-type: none"> - Dataset never too big, but doesn't cover whole pathway - Staging – collected live in MDT - TX Planning – PS/Stage/CNS - Data in notes/MDT minutes - Needed to ascertain options - Multiple MDT presentations - Info collected eventually, BUT only 1st MDT sent to COSD
What doesn't work?	<ul style="list-style-type: none"> - Dataset collection, responsibility falls to MDT <u>NOT</u> other operational departments

	<ul style="list-style-type: none"> - Usage depends on Cancer MGMT system! - Skillset to use system/understanding of dataset not there always - Little support from DH on systems - Lack of IT support in Trusts - Dataset changes frequently but financial cost for Trusts to implement - Lack of training on CMS/Dataset-what teams must vs need to record - CWT more important as financial penalties if not submitted - Lack of resource – knee jerk reactions for resource allocation
Dataset is too big	<ul style="list-style-type: none"> - Good some things removed - Need automated systems to populate e.g. pathology - What impact is data on Cancerstats having - Tangible effect on patient care - Hard to gather clinical info from large MDTs - Not sure clinicians coordinators understand how best to give data - Need more education/resilience for MDT coordinators - Support from National team clinical admin - What data difficult to collect - Haematology – need to understand data requirements - Mesothelioma staging – lung - Disparities about how to record – might mean lost data - Should it be reduced? - New field – sexual orientation - Why included? Will there be more like this? - What does it mean? - New things to see in COSD:- - Vaping status - Joining all other audits, NBOCAP, NOGCA, HANA, NABCOP, Prostate
	<ul style="list-style-type: none"> - Resources - Cancer Funding - Info teams - MDT Coordinators - DQ Improvements - Training/Support - National Programme
	<ul style="list-style-type: none"> - Too Big? - Everything, incl. audits in COSD - Resources – no. of different people, different jobs/roles involved to produce a complete dataset - MDTc – expectations too high. Clinical responsibility - How much do clinical teams engage with MDTc/help with data - Show clinical teams the benefit of COSD. - Once Somerset implemented, all in one place, all Trusts in Network use same system - Cancer Board meeting – platform to promote COSD - Compare own Trust data with other. Also good way to pick up good practice - Gaps in COSD fed back to teams - MDTc works with CNS, live MDT, proformas
COSD	<ul style="list-style-type: none"> - Too large – GOSH fields not relevant to PAEDS - Data Collection – MDT meetings too long - Data collection – MDT meetings – Long - Clinician engagement – Accuracy - Obesity & Lifestyle – How will this be collected

	<ol style="list-style-type: none"> 1. Clinical team support – or lack of – additional information requests, clinical time constraints 2. MDT time – numbers of patients discussed 3. CNS engagement 4. Equal representation across tumour sites 5. Information in public domain engagement 6. Clinical data fields, compliance (admin staff inputting) 7. Extraction of data complexities – functionality – overview as appeared to multiple views 8. MDT collection currently best placed but long term structure to be examined 9. More emphasis on CWT due to financial implications 10. Manpower/resource constraints 11. Patients first 12. Sharing a data – <i>i.e.</i> surgical direct from consultants 13. Roll out of cancer system – one source 14. Automated systems – all dependent on manual input, “direct from source” entry 15. Link for tertiary centres – electronic access 16. “priority” of data fields – reduction of burden – duplicating fields 17. Finite resource
Data set – too big	<ul style="list-style-type: none"> • Do not record non-cancers • Pathology (Do not record – duplicate) <i>i.e.</i>, MDT pathology • Too much clinical information required • No buy – in from clinicians • Non- diagnosed - diagnostics
Clinical info – too fragmented	<p>Quality not quantity P/S , staging More clinical support</p>
New things	<p>Resource – money for data collection staff Systems more aligned Awareness + buy in from clinicians</p>
Dataset too big?	<p>Relevant but resources to complete do not match workload Difficult to go back and input missing information (time/capacity) Demonstrate relevance of datasets to clinicians (national audits) to encourage ownership</p> <p>Improvement on historic audit practices and tick box exercises Difficult to collect :-</p> <p>NLCA – Surgeon level data reporting NBOCA – Staging data is a challenging NPCA – Common experiences</p> <ul style="list-style-type: none"> - Balancing resources to obtain quality information for the highest priorities, or once, which can be reused - National message from clinical lead to encourage ownership of data input and review - Easy way to review data that has been inputted before submission