Cancer Outcomes Services Dataset – 14 February 2018

Group Discussions – Workshop, Manchester

Hospital/Trust	Discussion-Notes
Round Table, COSD discussion	• Definition of recurrence • LAB results not discussed at MDT • CTYA, Lack of clinical support • Audit Data better • Moving to live Data collection • COSD – Too Big! • Poor update on analysis
COSD Round table discussion	- Is data too big?, yes some data from tertiary - Difficult to collect - If patient goes to more than a Trust - Staging problematic - Got to chase other Trusts – is this necessary - Data not moving around sufficiently between Trusts - CNS data – sometimes second Trust does this - HAEM can be complex - Consultant letters not always helpful in presentation of data - Cross Trust SCR system - Standard format for consultant letters
COSD - Issues	- Too big? – Currently yes with lots of duplication, going forward hopefully not - Collecting live in MDTs – unrealistic i.e. 1min per patient no time - Resource not enough with increases in data required - Clinician engagement/buy-in with audits but not otherwise (generally) conformance data received but not feedback on tumour groups - Reduce? Would you get the required data? New things - Improved feedback for data being sent in Audits being run in COSD/aligned to COSD reduced duplication
Bolton & Chester	- Lots of info to be recorded, lots of duplication in Somerset, Question of whether when is low completion then is it worth completing? – efforts could be focused on key data items. - All of the different audits/data feeds – merging then would be best - The more standardised the better - Performance status concerns, hard to collect – oncologists love this. They find performance status a bit too subjective – makes it wrong or inconsistent – this is probably worse than leaving it blank - CNS making a big drive to improve at Chester CWS find Somerset is not very CNS friendly – don't find it easy to record. Use their hospital administration system to record instead. Bolton find it fairly easy to use - A lot to fill in for CNS - Want nice easy reports for COSD – Matt's presentation – need something easy to give back to clinicians - Duplication due to multiple information systems - If patients are not treated within their Trust, they would like to be able to leave it blank – however currently it effects their compliance

	- We are receiving and collating it within our reg team
Works well	- N. WEST is the Best! - IT resource to help transfer data between systems - Some Trusts on lower version of COSD, i.e., V6 - Audits aligned with COSD e.g., Pathology - Haem difficult to collect data (staging)
	- Clinicians pick and choose data items to complete live at MDT Co-ordinations still have a lot of data items to chase and collect - Knowing what is cancer (for COSD) and what is considered cancer by a clinician - Making data relevant to clinicians to drive engagement - Better ways of NCRAS feeding back analysis work to Trusts to see what goes towards
Concerns	- Data set too big – No - Will SCR be ready? - Difficult data? Clarify over what is progression – not always clinical consensus but this is nothing COSD data collection can address its cons, - Lab - sometimes the measurement on the local cab system is different to SCR - Dataset too big? – No, fit for purpose at the moment - COSD in the future? – Aspirational request but all the data items required for living with and beyond - All NCASP audits to be pulled from COSD (like lung & prostate) - Align with national KPI we asked about e.g. LOS
	- NPCA submission separate to COSD file - Clinicians doubt validity of data for multi-Trust pathways - Disagreement of provided stage clinically – feedback would be welcomed if issues when registration for COSD/cancer stats - Staging from SMDT's – staging allocation performance in cancer stats - System restrictions for COSD completeness e.g., tertiary MDT's on local systems - Cancer stats 2 promising
	• Collect duplicate data for tertiary PTS when referred out • Difficult to get surgical data for PTS referred out • Removing path from MDT COSD doesn't remove for non-COSD audits • Interfacing systems would be amazing but not if you are changing one type of admin for another (i.e., instead of copying data manually, selecting reports to link manually) • Person specified Gender – unnecessary work, manual for every PT, doesn't link to ERS • Sexual orientation – GP responsibility? Part of referral, what is the benefit • Dataset too big – removing data items & replacing with others is just "rearranging the furniture". To make it smaller you need to reduce data items and not replace • Remove ability to record Data item in 3 or 4 places – not good when you spend a lot of time filling in but CS1 show completened • Cancerstats – show benchmark against other European Countries • No repercussions for poor COSD completeness • Must have CQUINS for focus, execs will pay attention then provide funding to meet • Feedback data – PHE cant mandate data & not share the results

	• Provide clinically relevant data not just “staging” at Trust level
	Dataset too Big? - CORE – all key - Welcome path updates - Need to align other audits (recluse multiple data collection) Site Specific - SSCRG’s to decide - But need to monitor actually using it Difficult Data Items - Non-mandatory fields - SCR multiple screens to complete not possible to do live at MDT - COSD overview screen - Quickly see what is missing - Like NPCA Page Haem data – complex - Difficulty in interpreting clinical information into ICD03 etc. - Which can then effect what is collected - Incorrect lympheina