Cancer Outcomes Services Dataset – 31st January 2018

Group Discussions – Workshop, Sheffield

Hospital/Trust	Discussion-Notes
Table A	Haem Data • Too Complex • Requires lab data • Needs clinical analyse impact • Question – Why do we not get this? source Clinical Fields • Already being collected - can this be linked up? Burden of data collection • Resource and cost is an issue • Needs to be linked to other clinical system All audit in COSD WORKS WELL • Good clinical and admin leadership. • Data on a sheet • Training the clinical team – understand the dataset and where to get in.
Table B	• Some systems "idiot proof" with boxes to indicate what is mandated. • Time/ capacity issues especially with regards to Cancer Waits • Responsibilities of data + sharing this out *being mandatory* • Data champions / leads + CNS buy in – encourage this both management + colleagues maintaining interest in spite of daily challenges. • External "competition" • Lack of financial implication, although both performance reassure • Better attainment why site specific audit? These aligned with COSD more so • Ensuring data collection/MDT impact expected • What happens to the data? Reducing multiple systems for data collection – Are all results the same? • Usefulness of data items locally? • Investment of time/hard work effort against length of time in use • IG risk around certain demographics? Expectation/realisation of where it goes.
Table C	CMS could be improved to push co-orss?? Through pathways (i.e. key data items) Link Systems COSD will improve dramatically with inescapability. Trust are not just cancer focussed - Needs to benefit the whole Trust or at least elsewhere (i.e.? up time in pathway).

	Automated submission of data to NCRAS <u>BUT</u> must be confident data is QA'd before sending. Improving validation processes - email reports for clinical sign off etc. Make data easier to extract from CMS. Data in the "wrong" field or not conditional on a hidden tick box, etc.… Quite Big / complex. As a whole. - Difficult to ascertain what <u>Needs</u> to be completed - Responsibility to collect data 1. Clinicians 2. CNS 3. MDT Prioritisation of what to collect. Knowledge – Specialist Areas?? - Tracks cover multiple sites. So can be difficult is their skills are lost or overburdened. Training of new staff - Takes a long time to understand a site/ clinical info. - Understand pathway – Expecting tests etc. what is mandatory us "nice to have" Understanding of where dataset come from and why being collected Bring ALL the audits into COSD - No extra work - Lucada – MLCA was the best thing to happen.
Table D	Ovarian Cancer would like to collect more data – mortality data Buy in at different MDTs - By lead affects ability to collect live at MDT Info flex over developed – too many fields not used. Duplicate fields Project to overhaul info flex Clinicians not prepared to commit to P.S Because not seen patients - Lung Team have a template to collect at MDT - If not diagnosing Trust make a part of transfer from to new Trust. - Knowing what ICD codes things fall under – clinicians not always helpful. Clinicians may say 'not cancer' but still be recordable in COSD. - Giving option of unknown gives away out of completing data items.
Table E	Derby/Doncaster/East midland CA /NCRAS/ NHS England Info Flex – Extra Burden on the Trusts to map all the amendments to the datasets Clinical commitment - This is really difficult to achieve - More likely id her is a national audit. - Send out validation reports to MDT leads but don't always respond.

	- Don't always see any clinical value of COSD- Just receive performance based info on CWT. * Cancer Stats could help. - Would be more helpful if other data source were more structured, e.g. pathology, clinical letters – so that data is easier to find. - Headset things to collect - Haematology – especially diagnosis (concerns re: transformation/progressions - Gynaecology