

## **Cancer Outcomes Services Dataset (COSD)**

### **Combined Group Discussion Feedback**

The following points were raised from colleagues from NHS Organisations (Primarily NHS Trusts), who currently either collect or are responsible for the collection and submission of COSD data.

These comments will help the Head of Cancer Datasets in Public Health England (PHE), and developer of the COSD, understand the issues within Trusts and guide the development of the next version change (v9.0) of COSD in 2020.

I have tried to group issues from across all the roadshows to help answer/highlight issues as follows:

### **Issues within the MDT**

#### **Information not always available**

- LAB results not discussed at MDT
- Opportunity to collect is at MDT or meeting with clinicians team (not always possible)
- Information not always available @ MDT

*I appreciate that not all data is available via the MDT itself, strong links with the clinical teams should help support admin staff collecting data on their behalf. Separate data crib sheets or data recorded clearly within patients notes have also helped many Trusts collect otherwise difficult data.*

#### **Time restrictions:**

- Time restrictions at MDT
- Data collection – MDT meetings – Long
- Time constraints within MDT already for data collection
- Most MDT's are too long (too many patients) to have the time to complete COSD staging functions
  - *This is being reviewed at a national level with NHS England, on the back of a recent CRUK report*
- Some MDTs are 3 and a half hours long
- Collecting live in MDTs – unrealistic i.e. 1min per patient no time
- Collecting live in MDT - Not enough time; Data not accurate; Not all the data is available at the time
- MDT meetings larger but no time
- Difficulties with MDT time constraints outcomes vs TMM/PS
- Timescale too tight for volume of data
- MDT time constraints; Engagement of clinical leads; Retrospective data entry

#### **Size of MDT:**

- MDT time – numbers of patients discussed
- Good if collected at \*MDT\* But not all have full discussion/treated as per protocol
- MDT discussions UP 30% (approx.), Preparation of MDT
- MDT meetings larger but no time

*These are big issues and I know that there is a move to look at this nationally, being led by NHS England following on from a CR-UK report last year.*

### **Resources:**

- Do we have enough MDTs / IPPCs to collect this information
  - ***This is a local issue, but there is a wider funding issue around all data collections which affects CWT, Audits and COSD***
- Data collection person in each cancer team
  - ***This would be the ideal but funding constraints limits this in many Trusts***
- MDTs responsibilities that sit with Band 3, Band 4 and non-clinical staff
- Trust MDT sending report (monthly) to request missing data- clinical team
- National steer in MDT/Data resource
- Burden if data collection on MDTs

***This has always been an issue since 2002 when Cancer Waits first started being collected in hospitals. If we can consolidate the information required and simplify the collection process, this should ease some of this burden. I will take this further for discussions within Public Health England.***

### **Clinical Support**

- Knowing what is cancer (for COSD) and what is considered cancer by a clinician
- Knowing what ICD codes things fall under – clinicians not always helpful. Clinicians may say ‘not cancer’ but still be recordable in COSD
  - ***There is a full list in appendix A and B of the COSD user guide. Some non-invasive cancer are still reportable tumours and need to be collected within COSD. Again refer to user guide for help***
- Lack of MDT buy in makes collecting data difficult
- Difficult in staging understanding the levels of staging
- Staging collections is difficult – MDTs need to be clear about what info they need
  - ***There are staging sheets available in the documents library in CancerStats, which will help and support MDT and the coordinators in making the right decisions***
- M Stage: Difficult to collect in MDT meeting- Radiologist not reporting on notes
- Clinicians pick and choose data items to complete live at MDT Co-ordinations still have a lot of data items to chase and collect
- Making data relevant to clinicians to drive engagement
- MDT empowered
- Performance status – MDT Struggle to collect

***It is important that the MDT/Pathway Coordinator (if they are the person collecting the data at the MDT), are seen as a valued member of the team and empowered to ask question if unsure. This works well in many MDT's and is backed by the MDT Lead Clinician.***

***In addition please use the support of the NCRAS Data Liaison Managers to help share best practice and knowledge.***

### **Software Supplier Issues:**

- System IT infrastructure – Engage MDT but IT infrastructure
- Not enough data booked to MDT's

**Use Financial Pressure as tool:**

- Best practice - Separate MDT from Data collection If Penalties – in line with CWT would put pressures on Trust to invest into MDT

*This is not always an easy task. Financial pressure can only be applied by the CCG, who manages and funds the Trusts cancer service. Many are not prepared to add additional financial pressures on services that are struggling.*

*It is recognised what a fantastic job MDT and Pathway Coordinators do in collecting the data for COSD and other cancer datasets.*

*The support of every MDT/Pathway coordinator and clinical team at all the Trusts who submit rapid and timely data through to NCRAS (via COSD), is very much appreciated. This is vital, high quality data that really does make a difference.*