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**Cancer Outcomes Services Dataset (COSD)**
**Combined Group Discussion Feedback**

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**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:**

## What Works?

### MDTs

- Data in notes/MDT minutes
- Multiple MDT presentations
- MDTs works with CNS, live MDT, proformas
- Live collection of data @ MDT – Lung, Breast, Skin
- Ensuring data collection/MDT impact expected
- Lung Team have a template to collect at MDT
- Live MDT data collection driven by greater clinical engagement
- Lead clinician/MDT co-ordinator, relationship is key
- Having a really well trained MDT. Co-CRD
- Some MDTs are 3 and a half hours long
- Collecting data outside MDT – but there is time consuming
- Where you have clinical engagement live data entry @MDT meetings are not always possible

*Live collection of data @ MDT's (where implemented), have been shown to reduce the time in collecting data and improves the accuracy of the data submitted.  It is recognised that due to size, and time restraints this is not possible within every MDT or at every Trust.*

### Staging

- Staging – collected live in MDT
- TX Planning – PS/Stage/CNS
- Needed to ascertain options
- Trust focus on data items i.e., stages PS

*It is important to focus on certain important items like stage and PS, but we will start to widen our conformance reporting to include new items, that we believe need improvement and are comparable between Trusts.*

### One system reporting

- Once Somerset implemented, all in one place, all Trusts in Network use same system
- Some systems "idiot proof" with boxes to indicate what is mandated

**Other General Comments**

- 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
- All audit in COSD - Good clinical and admin leadership, Data on a sheet, Training the clinical team – understand the dataset and where to get in
- Linking systems to Radiology/Pathological system
- Need automated systems to populate e.g. pathology
    - *As Trusts update local systems to COSD compliant LIMS solutions, this should be possible.  Pathology should not be collected independently anymore for COSD*
- External "competition"
- Mandatory items are well recognised and reasonably easy to collect

*There are some really good ideas here that could be adopted by many Trusts to improve the quality, ascertainment and reporting of data, as well as engaging clinicians within the MDT. Clinical champions have proven really successful where implemented too.*

*I have to mention again that it is recognised what a fantastic job MDT and Pathway Coordinators do in collecting the data for COSD and other cancer datasets.  This work is hugely appreciated by me, the cancer registration community and the analysts who use these data.*

*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.*