

## **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:

### **Wider issues around capacity to collect data, in light of new changes and demand of CWT**

#### **Priority for CWT**

- CWT more important as financial penalties if not submitted
- More emphasis on CWT due to financial implications
- Time/ capacity issues especially with regards to Cancer Waits
- Not enough resource in teams, CWT see priority (targets)
- 2 week wait UP
- CWT seen as priority over COSD
- CWT more important as financial penalties if not submitted
- Lack of awareness at senior level- focus on performance/CWT- no target \*early stage performance
- Dataset is too big, find it impossible to complete everything, Trust focus is always on CWT May populate critical fields only; others don't get filled, capacity concerns; MDT limits Resources, Info teams, MDT Coordinators

***There was a big concern from the majority of Trusts at the roadshows, that the complexity and increased burden of data collection for CWT (inc. 28 day FDS), will have a negative impact on the ability a Trust has to collect data for COSD. This is something which we will be monitoring very closely and also share your concerns with.***

#### **Wider issues for data collection**

- Skillset to use system/understanding of dataset not there always
- Lack of resource – knee jerk reactions for resource allocation
- Cancer Funding, DQ Improvements, National Programme
- Resources – no. of different people, different jobs/roles involved to produce a complete datasets
- Lack of resource – knee jerk reactions for resource allocation
- Manpower/resource constraints
- Resource – money for data collection staff
- COSD – Data clerks :More and more info needed but no staffing increase
- Burden of data collection - Resource and cost is an issue - Needs to be linked to other clinical system
- Lack of financial implication, although both performance reassure
- Dataset is too big – we don't have the man power to accurately and fully collect the data

- No pressure(i.e. no targets) – not high priority compliant is only pressure (Excel directorate level)
- Resource not enough with increases in data required

*I am always looking at the burden of data collection and the impact this has on a Trusts ability to collect data. This will always be a priority of mine and the advice and input from everyone throughout the roadshows and the group discussions in particular, will help balance COSD for future version changes.*

*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.*