Cancer Outcomes Services Dataset – 7 February 2018

Group Discussions – Workshop, Leeds

Hospital/Trust	Discussion-Notes
Table 1	**COSD** • Dataset is to big – we don't have the man power to accurately and fully collect the data • Lack of MDT buyin makes collecting data difficult • Should be clinicians lead collection • How does COSD influence actual clinicians practice? • Difficult in staging understanding the levels of staging. • Why does COSD not feed all national audits, and the national audit be shut down? • Could submission be quality so that validation and MDT buyin could be managed, better?
Table 2 (Hull/NLAG/Virgin Care	**Summerset check reports** • Would these do more validation? - Better for audit • Review local processes for checking completion Live MDT data collection driven by greater clinical engagement. Lead clinician/MDT co-ordinator Relationship is key. Staging collections is difficult – MDTs need to be clear about what info they need. Improve data sharing for patients with shared pathways.
Table 3	**Difficulty** • Clinicians not supported with data collection • Data not readily available • Not enough resource in teams • CWT see priority (targets) **New** • Making readable referral forms to understand symptoms at diagnosis **Difficult Data to collect** • Performance status good but different • Lack of info from team Use case studies of good practice.
Table 4	Haem Difficult to collect – Range of sites US, CT before staging. Lengthy process. Need clinical lead buy in Not all at MDT Changes increasing burden on staff with both COSD/ CWT – Same staff, no extra resource. Cancer stats Helps as a central reference point – needs to user-friendly Reliant on system providers to implement in timely manner. Someone has to

	be last so it is hard to train staff Improvement integration of systems –within Trust and also between IPT – inter provider transfers Would like dataset to be as small as possible i.e. really meaningful and critical data items Realise if not collected in COSD well be in danger of spawning more audits
Table 5	**Funding** - Collection – Skill and Knowledge (person) - Clinicians time to forward information (staging) - Audits through COSD (validations) - Haematology difficult to collect (knowledge) - Reduction in size of COSD
Table 6	**COSD –** **Data Collection** - Difficult to collect in external - Not always recorded so have to dig for information - Cross Trust pathways difficult to get information. - Good if collected at *MDT* <u>But</u> not all have full discussion/treated as per protocol **Dataset** - DOWN - No relevant information - UP - Awareness of why and what used for and relevance of data/info Future developments? - Audit through COSD only combined data collection. - DOWN – Duplication - Manpower/grades of staff clinical buy in essential
Table 7	**Too Big?** - Need resource – as data get bigger (resource doesn't follow – no finance) - Feels like it's added on- not a dedicated team. I Trust – Very separate – I person responsible for pulling COSD data (information) - Different computer systems - 2 week wait UP - MDT discussions UP 30% (approx.). - Preparation of MDT - No pressure(i.e. no targets) – not high priority compliant is only pressure (Excel directorate level) - *Clearly see benefit of collection and importance – don't always see direct correlation. - (System IT infrastructure – Engage MDT but IT infrastructure) - 1 System (government mandate!) as an NHS organisation **OUTPUT**

	• Key information • Recurrences • Cancer Stats 2 • Cancer Stats 1 • Report for cancer board • Validation report • Clinicians not engaged • Same coding and numbering for audits and COSD and CWT e.g. HANA (non data item matched) • All audits should come through COSD • Cons to look @ progression – recurrences • Urology – not same validation • NOGCA (upper GI) • HANA (H+N)
Table 8 Newcastle, Sunderland	**Too Much Data?** • What is the value? • Benefits for patients/pathways? • Is the cost worth the effort? **What Work Well?** • Having a really well trained MDT. Co-CRD • Some MDTs are 3 half hours long • Collecting data outside MDT – but there is time consuming **Audits** • Collect once many sources • Clinical team are more engaged if there is an audit. **How Do We Know Where the Gaps Are** • Give patients level data back to Trust **Have Key Data Items Per Tumour** • Make data relevant