Cancer Outcomes Services Dataset – 10 January 2018

Group Discussions – Workshop, London (1)

Hospital/Trust	Discussion-Notes
Round Table	- May populate critical fields only; others don't get filled, capacity concerns; MDT limits - Are there fields that few Trusts complete? – Remove Concerns/suggestions:- - CNS not well informed about COSD; concern CNS fields may not be completed – Training? - Performance status can be difficult to compete - Recurrence addition is good, but need to be clear who completes – systems not set up to capture (not all patients will be discussed at MDT) - Feedback to and engagement with clinical teams re what is being done with the data and benefits of this could improve data completion and quality - Importance of aligning datasets so stats for one Trust are the same, (e.g. COSD/HES etc.) in all reports - Need responsive and relevant dashboards - Is there scope for Royal Colleges to promote use of the datasets/demonstrate their value? - Not keen to add anything unless it has a clear purpose - Integrating cancer audits in COSD is good - Inputting staging data is difficult in multi-provider pathways – who is responsible?
COSD	- Expanding COSD to include other audits such as NBOCAP, HANA, and NLCA etc. - Is everything on COSD submission reports used? - Where is the data items presented? - Responsibility for ownership of data collection of feedback to Trust from Cancer Registry - Data input is as good as what information is given to MDTC (Co-ordinators) - Dataset too big - Clinicians input is extremely useful - Linking systems to Radiology/Pathological system
What works?	- Dataset never too big, but doesn't cover whole pathway - Staging – collected live in MDT - TX Planning – PS/Stage/CNS - Data in notes/MDT minutes - Needed to ascertain options - Multiple MDT presentations - Info collected eventually, BUT only 1st MDT sent to COSD
What doesn't work?	- **Dataset collection, responsibility falls to MDT <u>NOT</u>** other operational departments - **Usage depends on Cancer MGMT system!** - **Skillset to use system/understanding of dataset not there always**

	- **Little support from DH on systems** - **Lack of IT support in Trusts** - **Dataset changes frequently but financial cost for Trusts to implement** - **Lack of training on CMS/Dataset-what teams must vs need to record** - **CWT more important as financial penalties if not submitted** - **Lack of resource – knee jerk reactions for resource allocation**
Dataset is too big	- Good some things removed - Need automated systems to populate e.g. pathology - What impact is data on Cancerstats having - Tangible effect on patient care - Hard to gather clinical info from large MDTs - Not sure clinicians coordinators understand how best to give data - Need more education/resilience for MDT coordinators - Support from National team clinical admin - What data difficult to collect - Haematology – need to understand data requirements - Mesothelioma staging – lung - Disparities about how to record – might mean lost data - Should it be reduced? - New field – sexual orientation - Why included? Will there be more like this? - What does it mean? - New things to see in COSD:- - Vaping status - Joining all other audits, NBOCAP, NOGCA, HANA, NABCOP, Prostate
	- Resources - Cancer Funding - Info teams - MDT Coordinators - DQ Improvements - Training/Support - National Programme
	- Too Big? - Everything, incl. audits in COSD - Resources – no. of different people, different jobs/roles involved to produce a complete datasest - MDTc – expectations too high. Clinical responsibility - How much do clinical teams engage with MDTc/help with data - Show clinical teams the benefit of COSD. - Once Somerset implemented, all in one place, all Trusts in Network use same system - 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 - MDTc works with CNS, live MDT, proformas