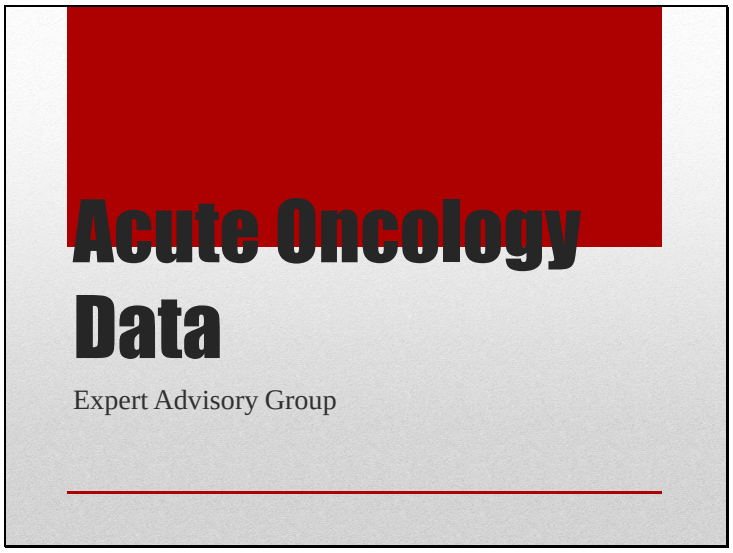
Slide 1



Presented by Catherine Donnelly, on behalf of the National Acute Oncology Expert Advisory Group.

The collection of this data, via COSD, is to ensure we can report a national picture on the good work that Acute Oncology services do across the country.

We have a lot of local and regional statistics that show AOS keep cancer patients out of hospital, or reduce the length of stay of cancer patients who are admitted to hospital after an AO episode.

We also know in our hearts that they improve the quality of care cancer patients experience and reduce the stress levels of their carers and families.

Many AOS use the data they collect locally and regionally to write successful business cases to request additional resources to grow their services.

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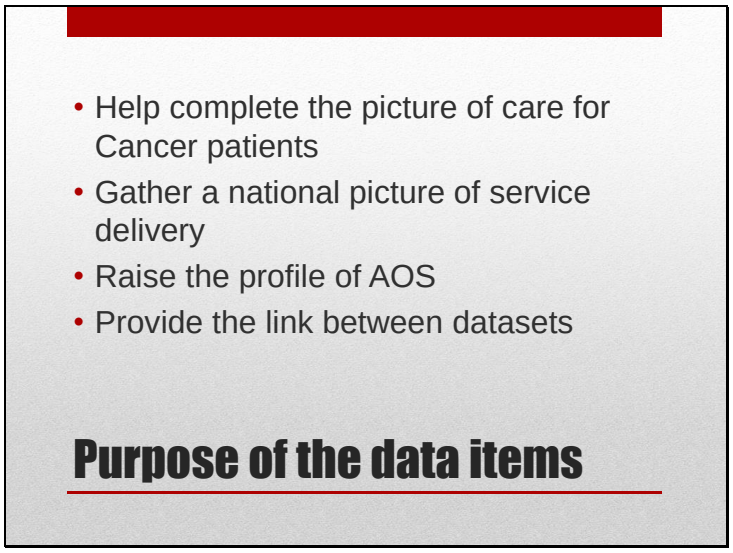
Slide 2



Current national datasets focus on the planned care for cancer patients – AOS deal with the unplanned care of these same patients and there is currently no national picture of AOS activity and outcomes, and although anyone involved in AO knows these services provide a vital, life enhancing and resource saving role, their part in the cancer patient journey is currently unknown and uncelebrated.

By including AOS data in COSD v9 we will help complete the picture, by capturing a national set of data for AO activity that can be used for research and statistical analysis, with the hope that this will improve the management of cancer patients overall and help reduce the burden on Urgent Care services.

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Slide 3

This is a list of all the National datasets managed or linked to PHE.

Type in any of these into a web search and you'll find out what each of them are.

The AO data will provide that link between COSD and these other datasets which will help provide a national picture on:

- Outcomes of patients with and without AO input
- Compare the average Length of Stay (LoS) of cancer patients with and without AO input (we already know locally that AO involvement reduces the LoS and these proven savings are used by AOS in their business cases to request funding for more resources)
- The data will also provide an opportunity for research
- And statistical analysis will (we hope) lead to a nationally commissioned service, which will also help support the care of cancer patients in the community as well as providing the urgent care they need in Secondary care.

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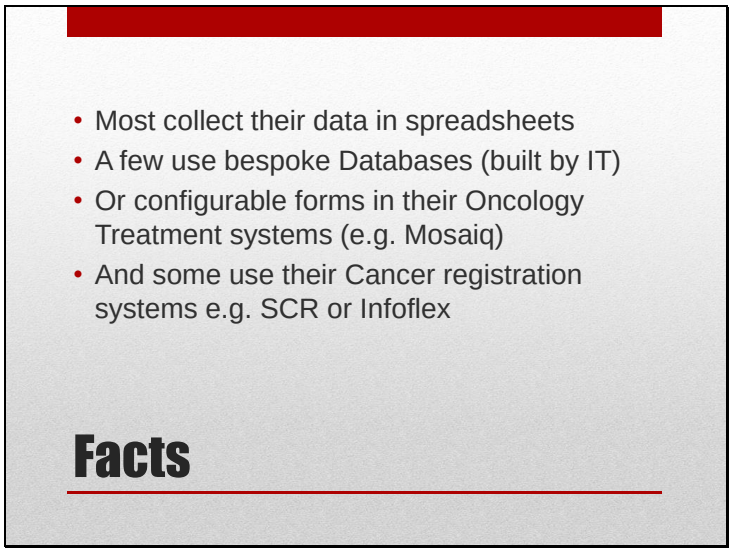
Slide 4



AOS collect their data in a variety of ways.

Some regions have an AOS dataset which all AOS in the area collect and then send to a central Organisation to collate e.g. Manchester AOS send their data to their Cancer Alliance for collation and report production and the Cheshire and Merseyside Cancer Alliance collate the AOS data for their region.

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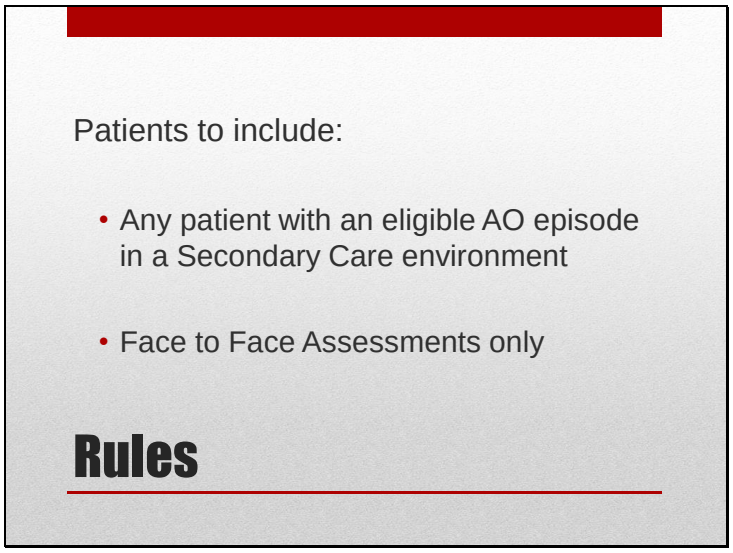
Slide 5



The AO data being collected will be for Patients with an emergency attendance or admitted patients (where the patient was in a bed for one or more nights).

Patients to include are those who were:
• assessed and then admitted
• assessed and sent to their usual place of residence
• assessed as an Admitted Patient after an emergency attendance and kept in
• assessed as an Admitted Patient after an emergency attendance and discharged to their usual place of residence

The assessment will have been 'face to face' with the patient (rather than by phone) and carried out by Nursing or Medical staff who are contracted members of the local AOS or trained by the AOS to provide appropriate levels of care and decision making on behalf of the AOS.

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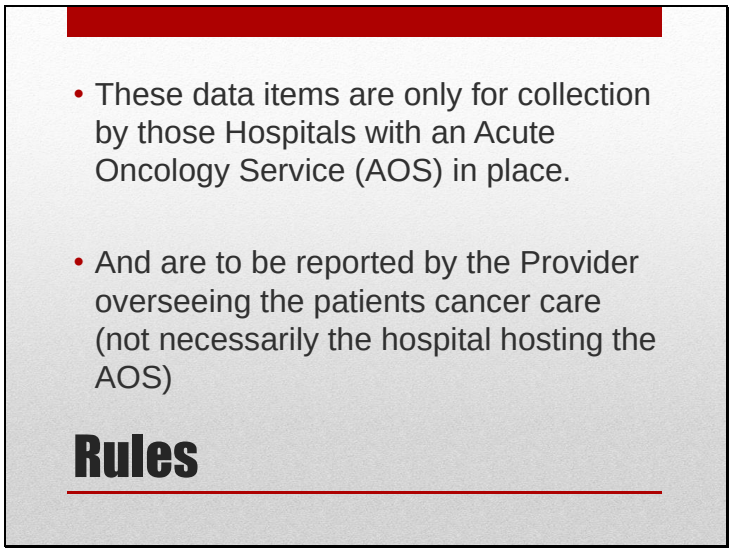
Slide 6



Only hospitals with an ED are required to have an AOS in place, although this has naturally extended to include Cancer Treatment Centres where SACT is regularly delivered even if there is no ED on site.

If the provider overseeing the patient's ongoing cancer care also hosts the AOS overseeing their AO episode, that provider will be responsible for reporting the data in their COSD submission. If they are different providers, the AOS provider needs to develop a mechanism for sending over the COSD data to the center overseeing the patient's ongoing cancer care.

Therefore the cancer service or site specific team responsible for the patient will need to have a mechanism in place for receiving this data and appending it to the patient's record for submission.

Whenever the patient has an AO episode, the data should be included in the COSD submission for that month.

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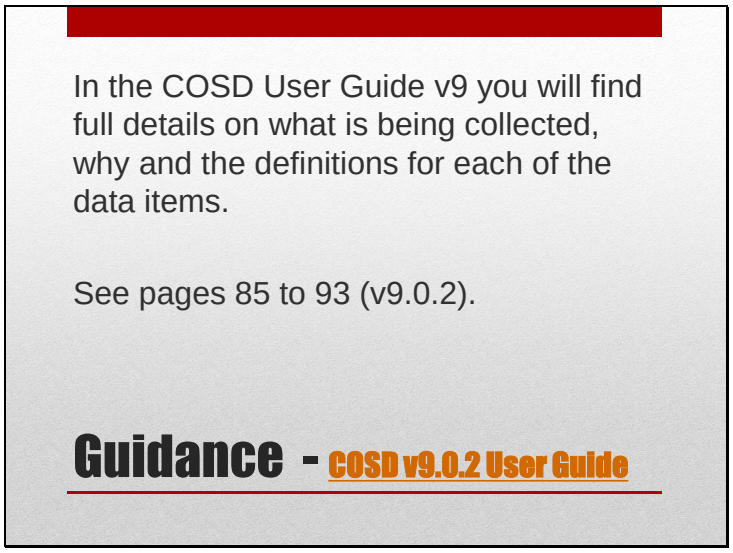
Slide 7



A great deal of information can be found in the COSD v9 User Guide. Enough information for you, your AOS and your Information or data people to understand what the data items are, what the value lists are, the context for reporting and how to interpret the data items and value lists.

If there are any questions remaining after you read the User Guide, you can email your query to the COSD help desk and they will either respond themselves or forward the query to the Expert Advisory Group to answer.

User Guide:
http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd_downloads_v9

COSD Help Desk: cosdenquiries@phe.gov.uk

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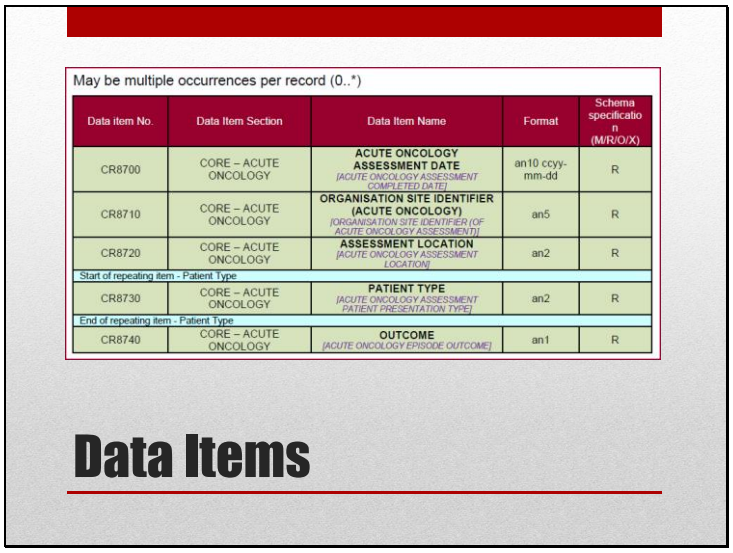
Slide 8



May be multiple occurrences per record (0..*)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR8700	CORE – ACUTE ONCOLOGY	**ACUTE ONCOLOGY ASSESSMENT DATE** *[ACUTE ONCOLOGY ASSESSMENT COMPLETED DATE]*	an10 ccyy-mm-dd	R
CR8710	CORE – ACUTE ONCOLOGY	**ORGANISATION SITE IDENTIFIER (ACUTE ONCOLOGY)** *[ORGANISATION SITE IDENTIFIER (OF ACUTE ONCOLOGY ASSESSMENT)]*	an5	R
CR8720	CORE – ACUTE ONCOLOGY	**ASSESSMENT LOCATION** *[ACUTE ONCOLOGY ASSESSMENT LOCATION]*	an2	R
Start of repeating item - Patient Type				
CR8730	CORE – ACUTE ONCOLOGY	**PATIENT TYPE** *[ACUTE ONCOLOGY ASSESSMENT PATIENT PRESENTATION TYPE]*	an2	R
End of repeating item - Patient Type				
CR8740	CORE – ACUTE ONCOLOGY	**OUTCOME** *[ACUTE ONCOLOGY EPISODE OUTCOME]*	an1	R

Data Items

These data are generally collected by the AOS as part of their day to day activity and are used in the compilation of their Quality Surveillance (peer review) returns for Acute Oncology, Neutropenic Sepsis, CUP and MSCC activity and targets.

If not all items are directly collected by your AOS, they can be derived using existing data collected for COSD, HES and by your Emergency Department.

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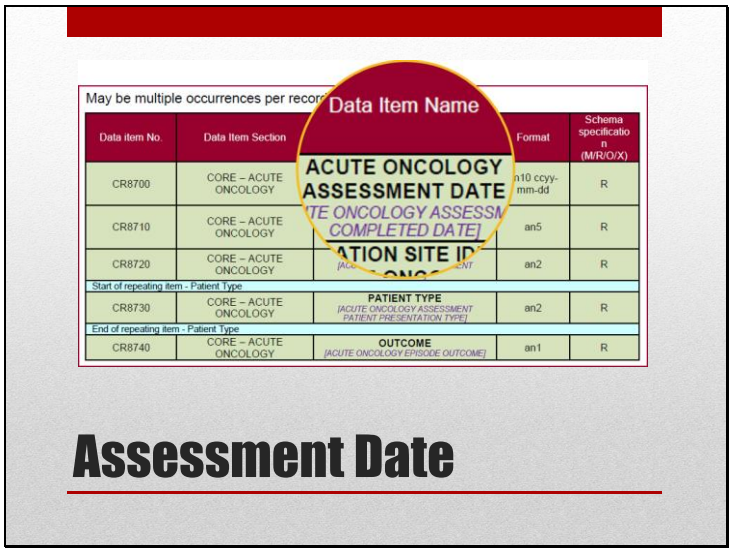
Slide 9



If more than one assessment takes place during a patient's AO episode, each assessment should be reported as an individual record, even if the assessments share the same date; it is important all data is completed for each assessment to provide the complete picture for each patient.

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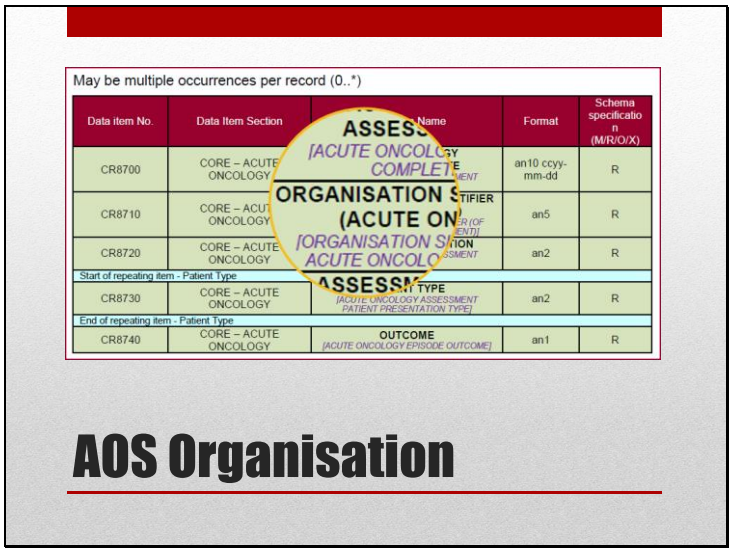
Slide 10



This data item will identify the location of the hospital or cancer treatment center in which the patient was assessed.

And it's the hospital-specific code of where the assessment took place rather than the Trust level code.

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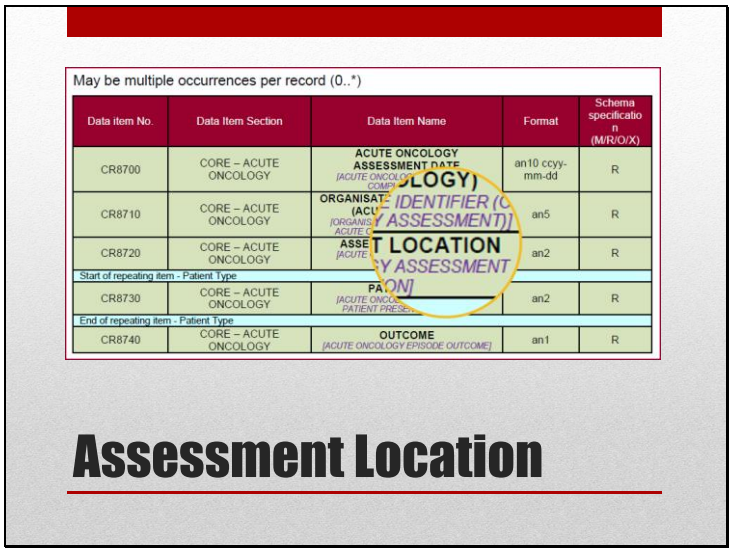
Slide 11



The location where the AO assessment was performed by the AOS e.g. Emergency Care Department, Out-Patient Clinic, Day Case Unit, etc. This is to provide a general view for where AOS activity takes place.

The value list for this data item can be found in the COSD User Guide v9.

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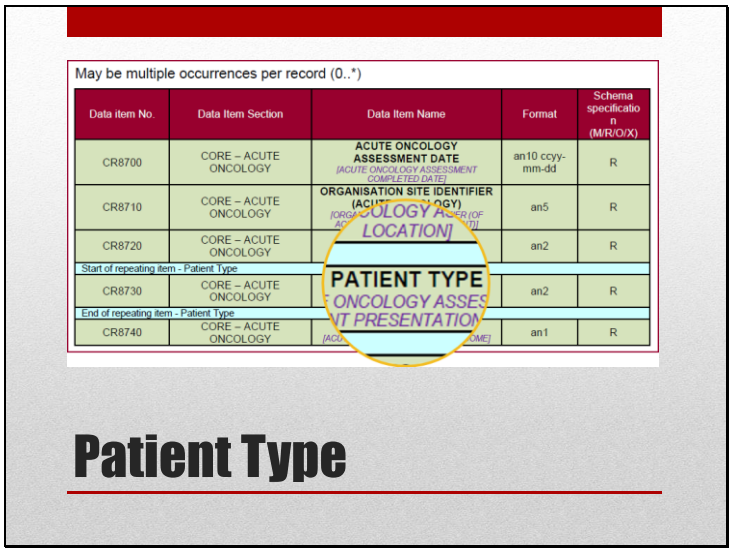
Slide 12



The Patient Type is the key data item we will use to create a picture of what types of cancer patients are presenting in an emergency setting or ending up in hospital with acute issues.

There are a few slides included in this presentation to provide an overview of what these different Patient Types are.

We acknowledge there will be some AOS activity that cannot be reported via the COSD because the patient is confirmed with a non-cancer diagnosis.

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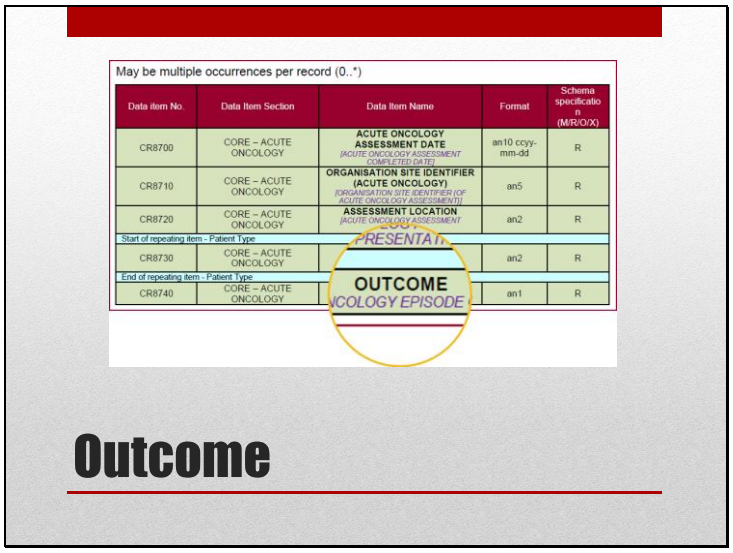
Slide 13



The Outcome is specific to each Assessment and will help us determine how AOS input can help prevent Cancer patients being admitted to hospital and help us calculate national Length of Stay for patients with AOS input vs those who do not. Values include: Not Admitted, Admitted, Remained Admitted, etc.

The value list for this data item can be found in the COSD User Guide v9.

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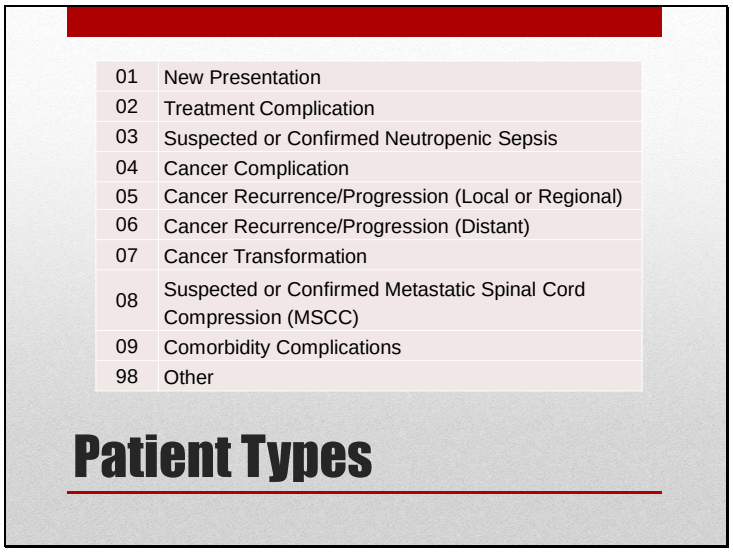
Slide 14



Patient Types are geared to help us identify those patients who present in ED with an as yet undiagnosed cancer, either site specific or CUP.

We can also identify the volume of patients on treatment who present at ED because of an adverse reaction to their treatment. This includes the group of patient who suffer from sepsis.

And there is the group of patients who present at ED because of their cancer itself. This includes patients with MSCC and with a recurrence, progression or a transformed disease, many years after their initial diagnosis and treatment.

Some patients might fit more than one option; hence multiple values can be selected for these patients.

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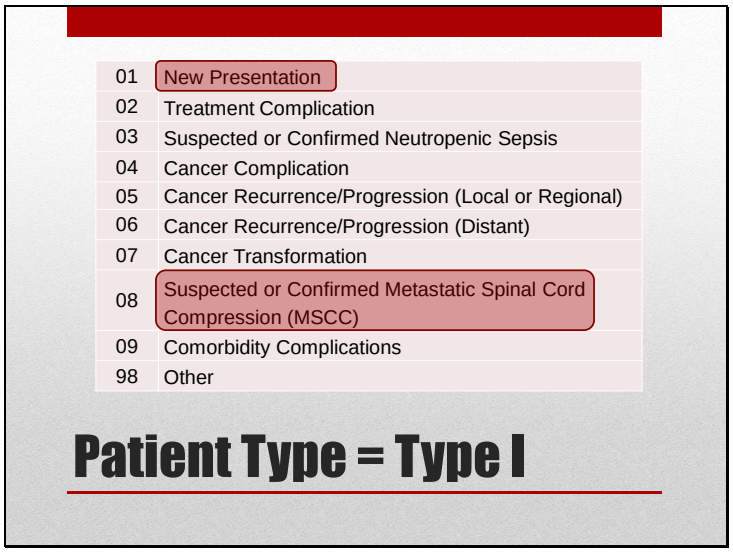
Slide 15



Type I patients

These are the cancer patients who present in an ED with an as yet undiagnosed cancer. CUP patients are generally diagnosed after an ED attendance. Some AOS are responsible for managing CUP patients and ensuring they are referred into the right MDTM and services to manage their pathway.

MSCC (metastatic spinal cord compression) patients may also be a New Presentation.

In any case, these patients benefit from having AOS oversite and signposting expertise to ensure they are diagnosed and treated as efficiently as possible within the relevant Trust.

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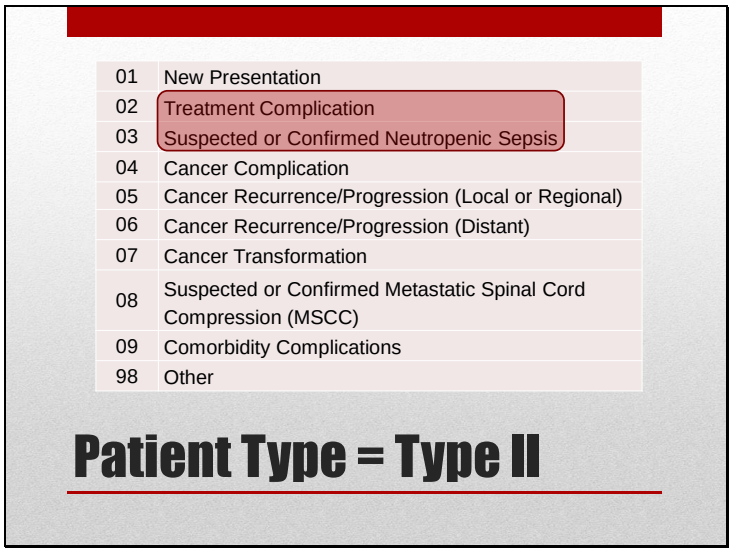
Slide 16



Type II patients

Will be those who have an adverse reaction to their SACT or Radiotherapy treatments, for example. Surgical patients generally have an open door policy for the first 30 days after surgery, so any post-surgical comps are handled directly by the site specific team. However long term effects may be picked up through the AOS if the patient presents in an ED with issues.

For sepsis patients, AOS have a door to needle target of 60 minutes, measured between the moment the patient walks through the door to the moment they receive their first lot of antibiotics.

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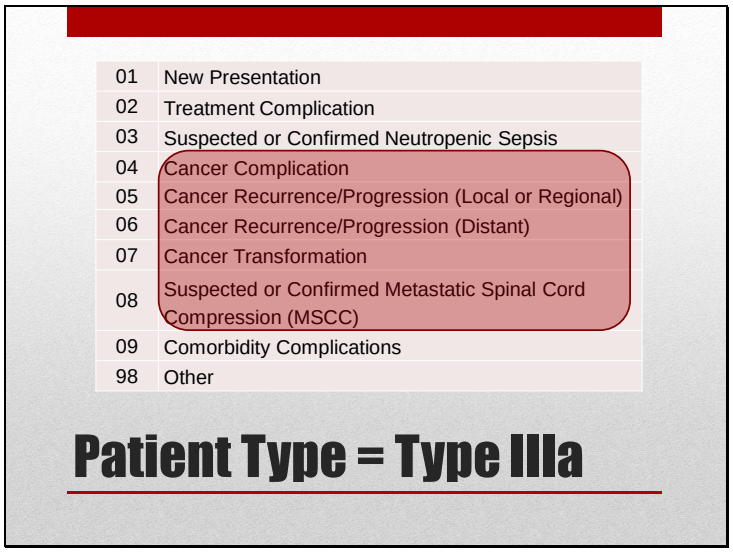
Slide 17



Type IIIa patients

Are those who have a complication caused by their cancer.

This group includes patients with recurrent cancer, progressive cancer or transformation of their cancer requiring urgent care and confirmation of the diagnosis. MSCC patients could also be patients with a cancer complication.

The Recurrence/Progression options are there to help identify those patients who present to ED with a local, regional or distance recurrence.

Patients with a recurrent cancer will need a new referral into cancer services and should follow a recurrent cancer pathway. Patients with a progression will either have their primary record updated or a new Progression referral created. Patients with a Transformation will need a new referral too so the new morphology and diagnosis can be recorded separately to their original diagnosis.

AOS CNS are best placed to identify these patients and signpost them to the appropriate services for ongoing management.

See the COSD User Guide v9 for details on the Recurrence, Progression and Transformation pathways.

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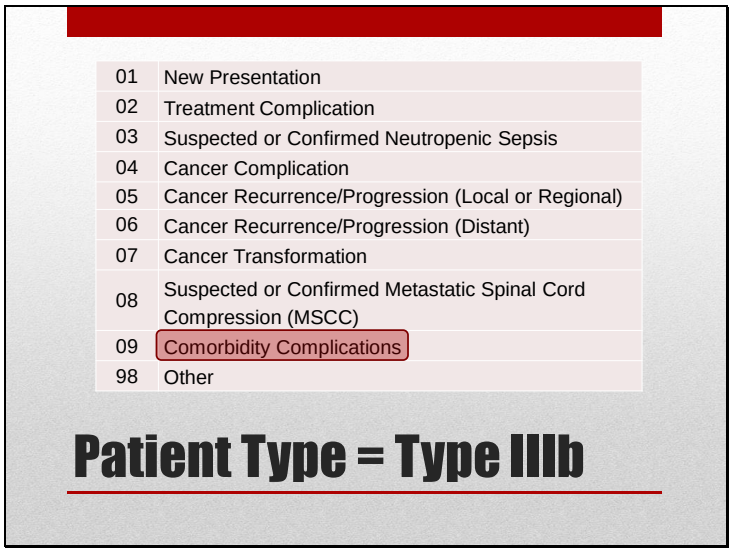
Slide 18



Type IIIb patients

Are patients who have presented to ED or be in a ward because of a Comorbidity complication, and will benefit from having AOS input to help guide their care and treatment according to their cancer status and AOS can offer their expertise in this area.

98 Other is to capture any remaining types of patients not covered by the Types I through to IIIb.

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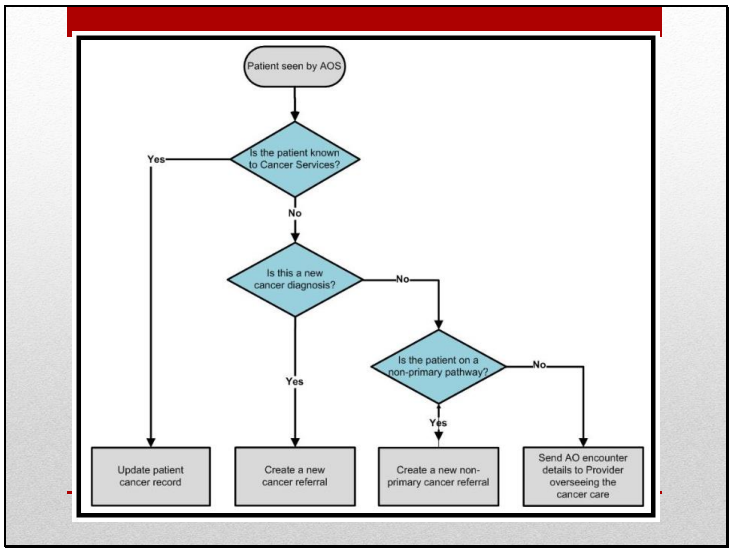
Slide 19



This flow chart helps identify whether your Trust will be responsible for submitting the AO data as part of your COSD submission or whether you will need to send the AO data to another provider for submission.

The flow assumes your Trust will provide the patient's cancer care - if the patient is referred to another provider for management, that Trust will be responsible for creating records and a COSD submission.

The final 2 steps in flow chart will help you understand if a patient should be on a non-primary patient pathway – the COSD User Guide v9 contains instructions on how to identify which Non-Primary pathway a could be on.

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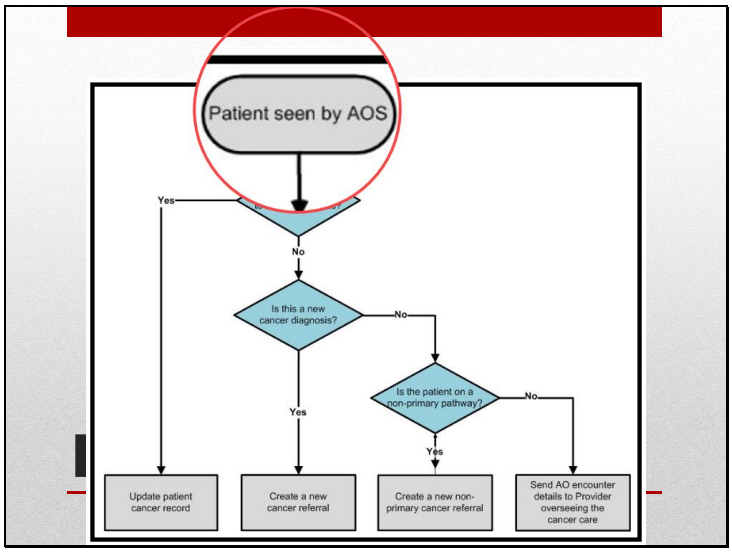
Slide 20



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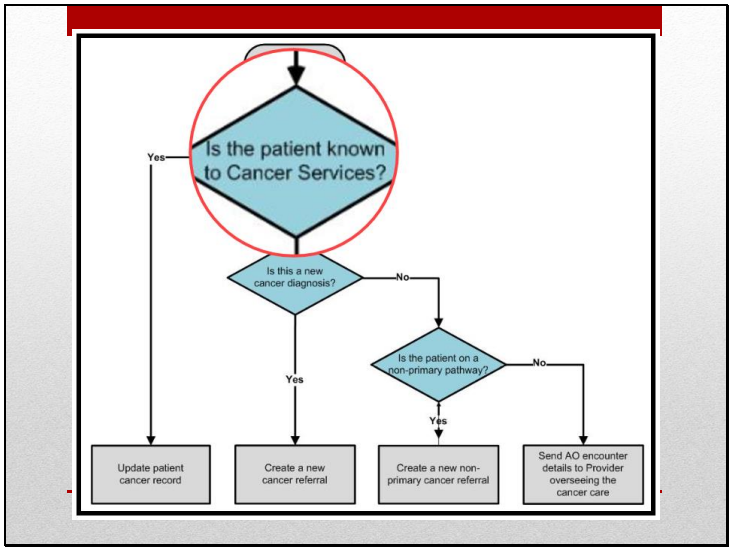

This question is to determine whether the patient is a registered cancer patient within your Trust.

This referral might be currently active or the patient may have been discharged from the service years previously and lost to follow up, for example.

Or they may not be known to your Trust at all and your AOS will need to find out about the patient from the current or last Trust who dealt with them.

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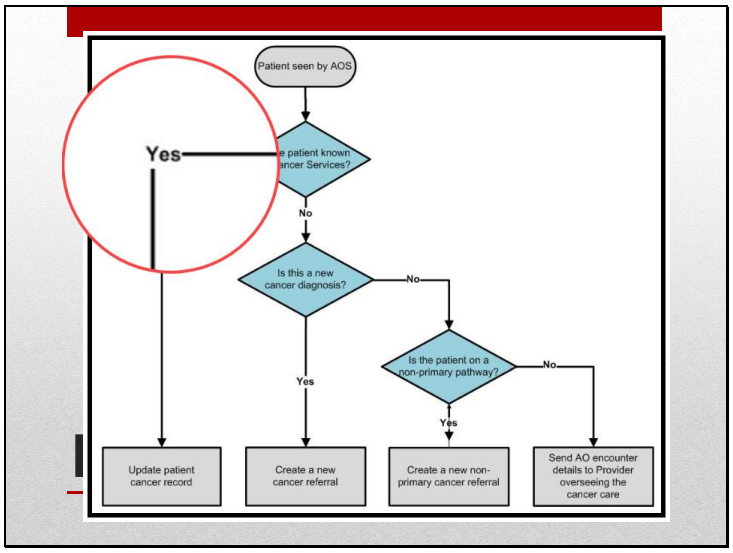
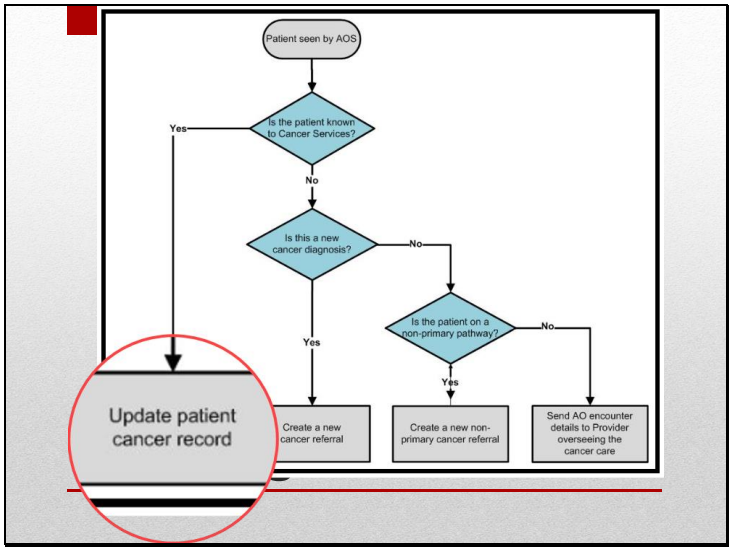
Slide 22



This pathway flow assumes the cancer patient is registered at your Trust and you have a record you can append the AO data items to.

Slide 23



The new AO data items will need to be included in the COSD v9 submission of data – how you do this will depend on how things are set up at your Trust with regard to how AO data is collected and what resources you have in place to support the AOS to make the data available electronically if it is not currently available in that format.

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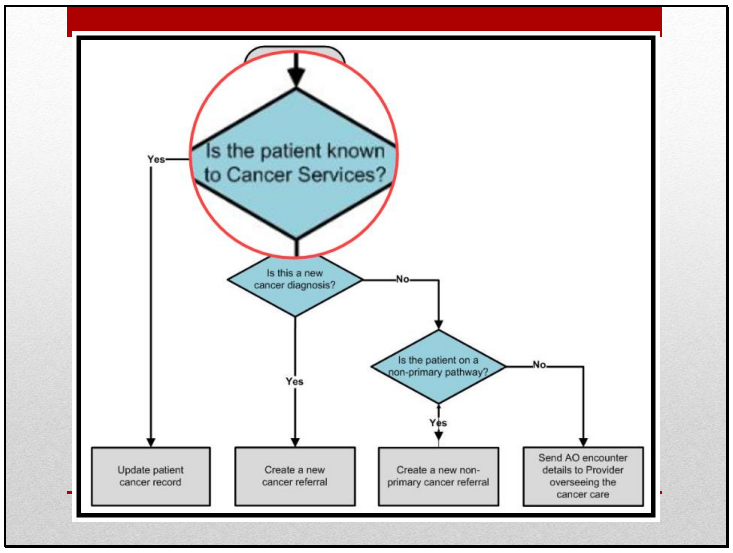
Slide 24



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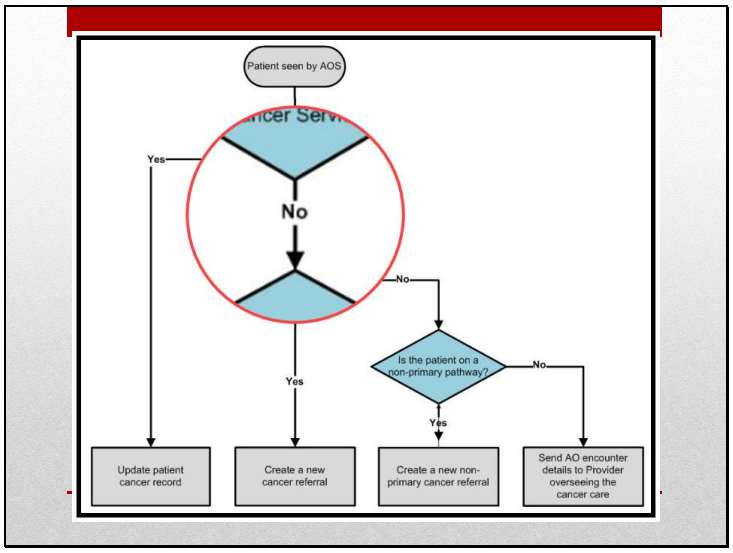

There are several reasons why the patient may not be known to your Cancer Services team:

1. They are a new presentation and do not have a cancer referral into the service yet.
    a. If you are going to oversee their cancer care, you will need to create a record on your cancer registration system
    b. If you are referring the patient on to another provider, then the AO data created for this patient will need to be sent over to the overseeing provider to include in their COSD record for the patient.
2. Or their care is already being handled by another provider and you will need to provide that provider with the AO data as per 1b.
3. They have had cancer historically and are no longer under follow up by any provider
4. They have received care abroad and do not have a record in England.

For 3 and 4 the action you follow will depend on whether you oversee the patient's care or whether you refer them to another provider.

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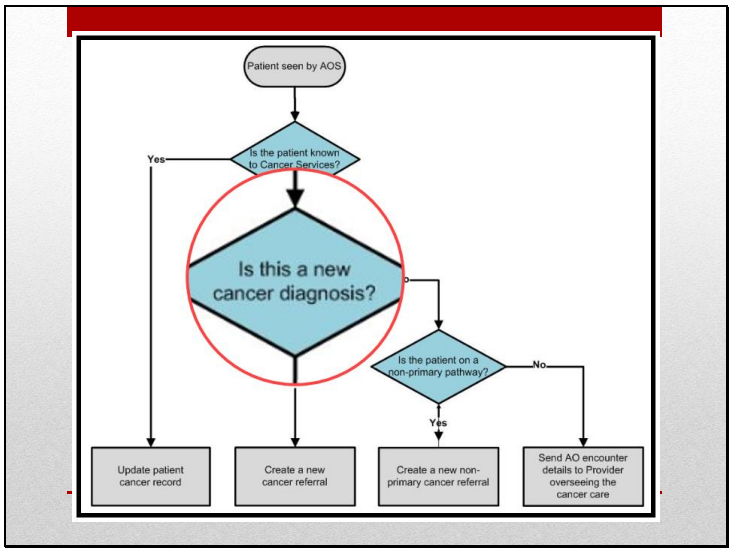
Slide 26



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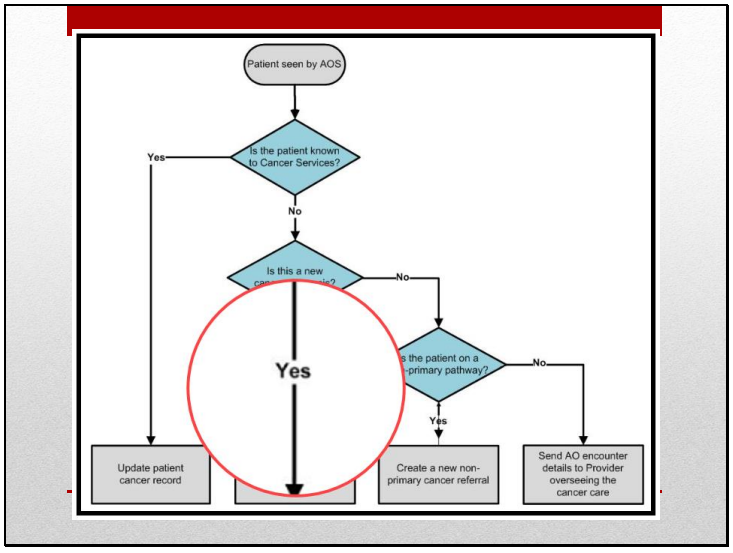

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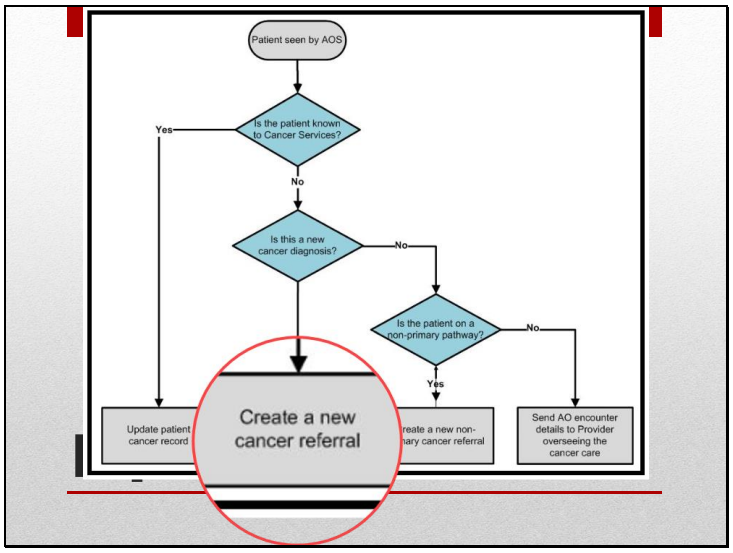
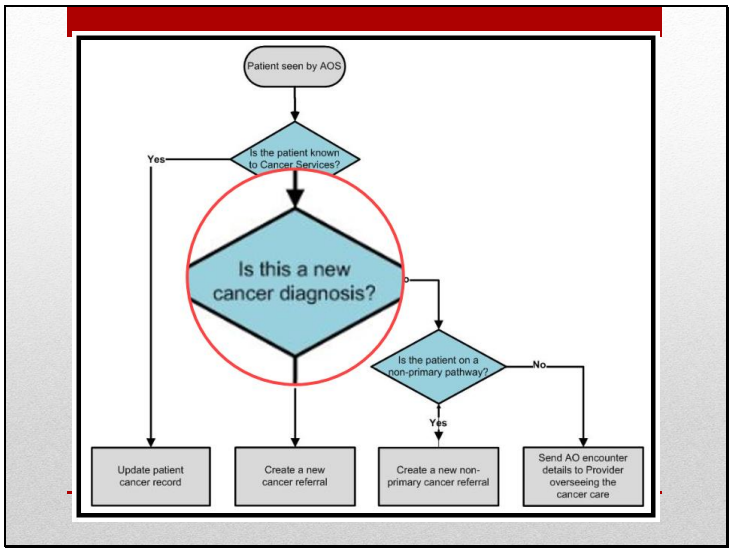
Slide 28



As previously mentioned, if the patient is presenting with a new cancer you will either need to create a new record on your cancer referral system and append the AO items to the record, or, if the patient is being referred to another provider, you will need to supply the AO items to that provider so they can report them to COSD for that patient.

Slide 29



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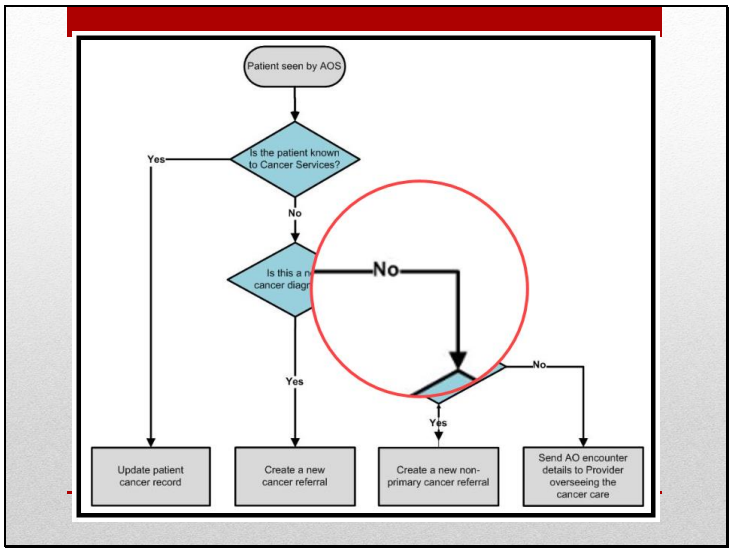

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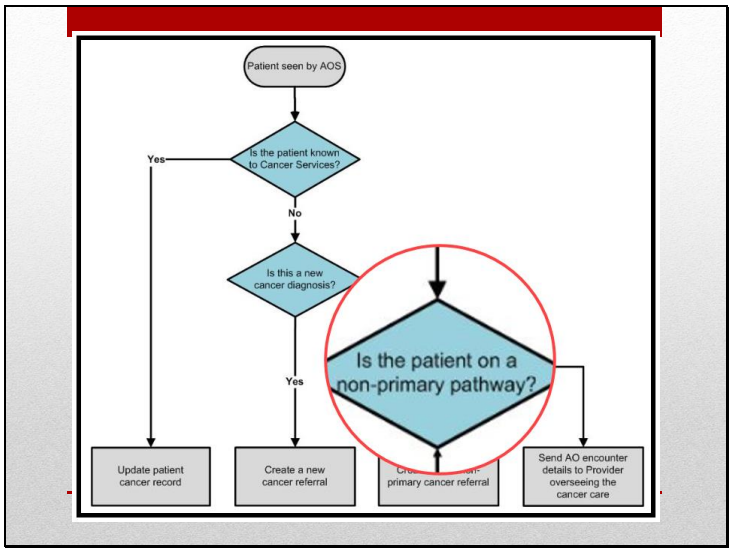
Slide 31



If the patient has a Recurrence or a Progression or their disease has transformed, the following actions will need to be taken:

- If the presentation and previous conversations with the patient indicate the disease has returned after a period where the patient was told they were disease free, they would need a new record created for them following the COSD Recurrence pathway.
    - If you were overseeing the patient care, then you would need to create the record on your cancer registration system and append the AO data items to it.
    - If you were referring the patient to another provider, you would need to supply the AO items to that provider.
- If the patent has not been told they were disease free, and the patient is known to your cancer services and you were going to oversee their care, you would need to append the AO items to their existing Primary record. If you no longer had their primary record you could create a new Progression record for them on your cancer registration system. If you were referring them on to another provider, you would need to send them the AO data for submission.
- As for No. 2, so for Transformed patients – you could append the AO data to their existing Cancer record, or, if the disease was a completely different morphology or had become a registerable disease by CWT standards you'd need to create a new record or supply the AO data to the provider overseeing the patient's care.

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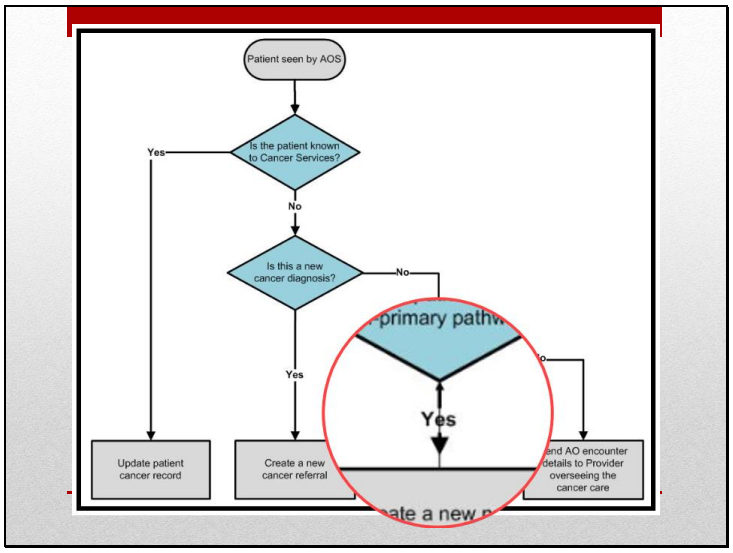
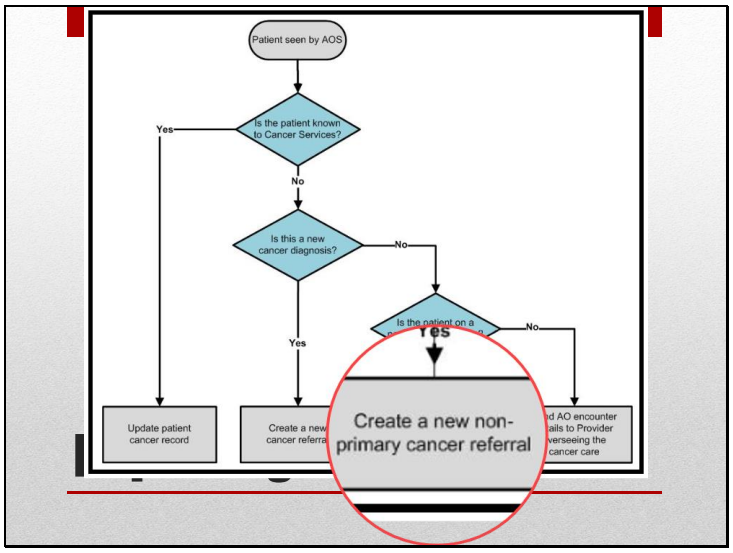


Slide 33



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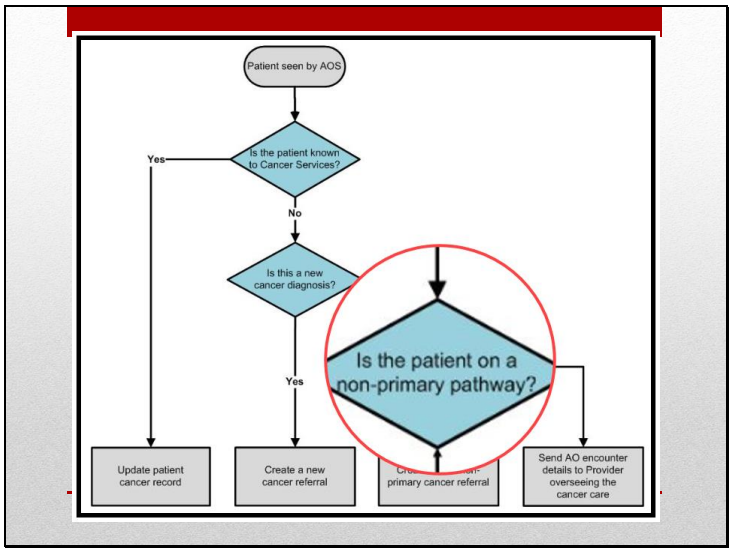
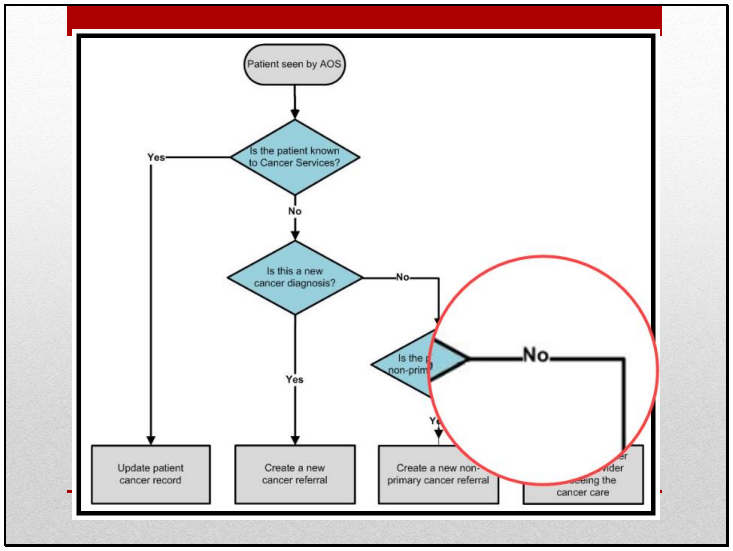


Slide 35



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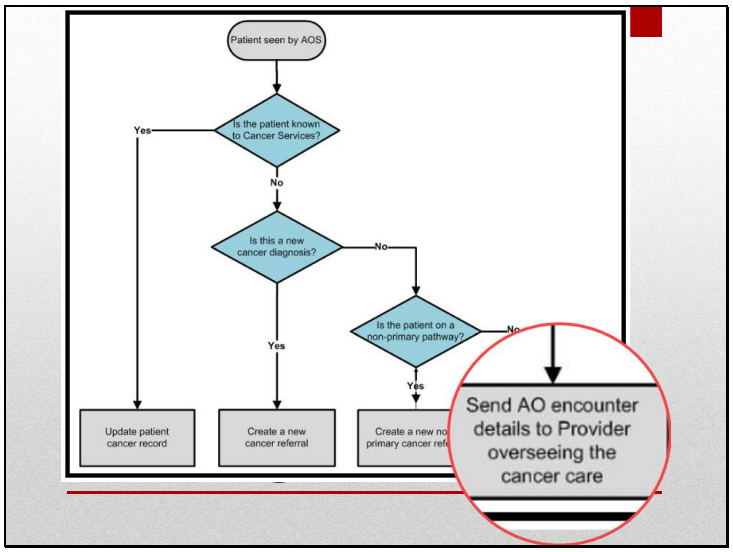
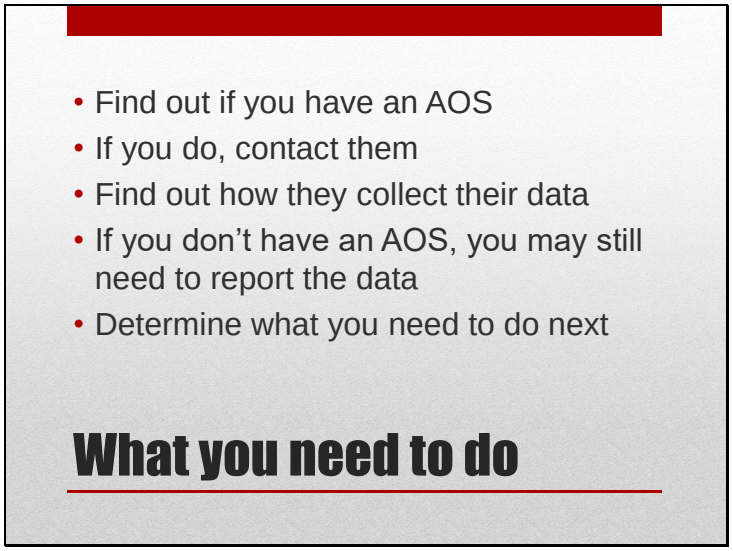
Slide 36



Slide 37



3 messages to take away with you are:

1. Find out about your AOS and the AOS in your region and determine what data they currently collect and how it is stored.
2. Establish what changes need to be made to the current AOS processes to collect the new AO data in an appropriate way and implement these changes.
3. Establish processes to allow the AO data to be sent to other Providers for submission and how you handle AO data you receive.

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