National Cancer Quality Steering Group
Action Note of Meeting: 25th June 2019 10:00am – 1:00pm
Conference Room, Breast Screening, Nelson Mandela Place, Glasgow

Present:

Hilary Dobson, Deputy Director, Innovative Healthcare Delivery Programme (Chair)	HD
Matthew Barber, Consultant Breast Surgeon, NHS Lothian	MB
Hugh Brown, National Primary Care Group, NHS Ayrshire and Arran	HB
Jen Doherty, Project Co-ordinator, National Cancer Quality Programme	JD
David Morrison, Director, Scottish Cancer Registry	DM
Kate MacDonald, Regional Manager (Cancer), SCAN	KM
Elizabeth Mallon, Lead Clinician, Scottish Pathology Network	EM
Lorraine Stirling, Project Officer, National Cancer Quality Programme	LS
Iain Tait, Regional Lead Cancer Clinician, NCA (VC)	IT
Evelyn Thomson, Regional Manager (Cancer), WoSCAN	ET

Apologies:

Roger Black, Head of Service, Information Services Division Scotland	RB
Lorraine Cowie, Regional Manager, Interim (Cancer), NCA (VC)	LC
Asa Dahle-Smith, Medical Oncologist, NCA	ADS
David Dodds, Chief of Medicine for Regional Services, NHSGGC	DD
Alan Finlayson, Service Manager, Information Services Division Scotland	AF
Kevin Freeman-Ferguson, Head of Service Review, Healthcare Improvement Scotland	KFF
Belinda Henshaw, Senior Programme Manager, Healthcare Improvement Scotland	BH
Rob Jones, Consultant Medical Oncologist, NHSGGC	RJ
James Mander, Regional Lead Cancer Clinician, SCAN	JM
Gerard McMahon, Cancer Coalition, Prostate Cancer UK	GMcM
Hamish McRitchie, Clinical Lead Scottish Clinical Imaging Network	HMcR
Gren Oades, Consultant Urological Surgeon, NHSGGC	GO
Peter Sandiford, Deputy National Clinical Lead, Cancer QPI Review Group, Healthcare Improvement Scotland	PS
Nadeem Siddiqui, National Clinical Lead, Cancer QPI Review Group, Healthcare Improvement Scotland	NS
Seamus Teahan, Regional Lead Cancer Clinician, WoSCAN	ST
Hamish Wallace, Consultant Paediatric Oncologist, NHS Lothian	HW

In attendance:

Kiana Collins, Knowledge Officer (Research and Evidence), Cancer Coalition, Prostate Cancer UK (TC)	KC
Roger Currie, Melanoma Clinical Lead, WoSCAN	RC
Rafael Moleron, Head and Neck Cancer Clinical Lead, NCA (VC)	RM
James Morrison, Head and Neck Cancer Clinical Lead, SCAN (VC)	JM
Megan Mowbray, Melanoma Clinical Lead, SCAN	MM

1. Welcome, apologies and declarations of interest

(a) HD welcomed the group and introduced those in attendance. HD also welcomed Iain Tait (IT) to his first NCQSG meeting as Clinical Lead for North Cancer Alliance (NCA) and Kiana Collins from Prostate Cancer UK representing Gerard McMahon on behalf of the Cancer Coalition.

Apologies for the meeting are listed above. No declarations of interest were noted.

2. Action Notes and Minutes From the Previous Meeting – *Paper 1*

a) The group considered the previous minute held on Tuesday 12th March 2019 *(Paper 1)* and approved as an accurate record.

3. Matters Arising

(a) Recurrence Data

This was discussed under item 4(b).

4. Governance

(a) National QPI Reports

- *ISD National Melanoma QPI Report (2015-2018) – Paper 2*

MM and RC presented to the group on behalf of the 3 regions an overview of the ISD National Melanoma QPI report that was published today on 25th June 2019. HD noted that Andy Affleck, Melanoma Regional Clinical Lead in NCA had provided a written response to the report ahead of this meeting.

Areas of improvement noted around pathology reporting (QPIs 2 and 5) which has improved year on year with the introduction of a proforma. It was highlighted that outsourcing can be an issue in terms of fully complete information, particularly in the North and this is being communicated.

Compliance has improved against a number of QPIs e.g. MDT (QPI 3), Wide Local Excisions (QPI 6) and B-RAF Status (QPI 8). The main reason for Boards not meeting the target for MDT discussion is due to Stage I patients undergoing definitive treatment prior to MDT date. It was noted that all regions now have MDTs which are on average held every 2 weeks and RC advised that Glasgow are moving to a weekly MDT by September. ET added that there is a wider issue of inclusion of standard MDT QPI in all tumour types going forward when there may be an opportunity to protocolise some standard pathway cases.

MM noted variation in QPI 1 (i) Excision Biopsy due to diagnostic biopsies being undertaken by general surgeons, GPs and Locums therefore not meeting the definition of a 'skin cancer clinician'. RC stated that there needs to be communication with a representative who attends the MDT and this will be looked into within local services.

There is significant regional variation in relation to QPI 4 Clinical Examination of Draining Lymph Node Basins. It was agreed that this is around documentation and not a reflection that lymph node examination has not been carried out. This variation is being actioned through better communication with colleagues to allow information to be documented on

MDT or pathology forms.

Time to wide local excision within 84 days (QPI 7) has been difficult to achieve due to varying challenges at different points in the patient pathway. Cases that do not meet are being reviewed to determine where improvements are required. HD stated that this is a good example of cases outwith the 62 day waiting times target and breaking down each element to audit will show an improvement in the future. This is a similar issue with QPI 9 - Imaging for Patients with Advanced Melanoma which requires timeline data to be looked at to better understand the delays.

Finally it was highlighted that there has been a new QPI developed on Surgical Margins which has yet to be reported.

HD thanked the Clinical Leads for their contribution and ongoing clinical engagement.

- *ISD National Head and Neck QPI Report (2015-2018) – Paper 3*

RM and JM presented to the group on behalf of the 3 regions an overview of the ISD National Head and Neck Cancer QPI report that was published on 14th May 2019. Compliance is high across a number of QPIs e.g. pathological diagnosis, MDT, surgical margins and intensity modulated radiotherapy (IMRT). The main areas focussed for discussion were around imaging, nutritional screening, access to specialist speech and language therapy and post operative chemoradiotherapy.

RM advised that there was significant variation between Boards with regard to nutritional screening (QPI 6) with only NHS Ayrshire and Arran meeting the target. This is due to the shortage of dietetic resource in some Boards and issues with data collection particularly in NHS Tayside (NHS Highland surgical patients also go to Tayside). HD acknowledged the challenges associated with electronic systems capturing this data and the need to improve recording in order to provide evidence of the true issues. Data collection may improve if this was recorded at time of MDT. RM suggested that alternatively this could be collected by nurses at the first clinical appointment and noted in electronic patient records.

There are similar recording issues with access to specialist speech and language therapist (QPI 7). None of the Boards met the 90% target which was mainly due to staffing and service demand issues where intervention is not always possible prior to treatment. Steps have been taking to address these issues by implementing a proactive tracking system in NHS Grampian. NHS Lanarkshire have changed the structure of clinics and this has been shared with all Boards which will ultimately improve access for patients.

The target for Post Operative Chemoradiotherapy (QPI 10) has not been

met in all Boards for 2017/18. This variation is mainly due to small numbers included in this clinical cohort highlighting the limited value of this QPI. There are also a percentage of head and neck cancer patients over 70 who are not suitable for this treatment, although the target was reduced at formal review to reflect this. Reducing the cohort further will cause further variation. Aggregated data (3 years) will be beneficial to review and consensus is to amend this QPI at the next Formal Review.

It was highlighted that clinical trials will improve within the North in the next year and more allocated time would be welcomed. Smoking Cessation and Oral Assessment were noted as areas of importance which were changed at formal review therefore not reported as yet.

RM concluded that good progress has been made and a proactive approach is ongoing to increase performance and positive change. HD thanked the Clinical Leads for their contribution and ongoing clinical engagement.

(b) Survival Analysis

- *Head and Neck Cancer – update*

HD updated that the first draft of the Head and Neck Cancer survival analysis had been sent to the clinicians for review. An update will be available for discussion at the next NCQSG meeting.

- *Recurrence Data*

DM presented to the group the ongoing work evaluating the use of a new 5th digit on ICD-10 diagnostic codes in SMR01 records as well as the existing C77-79 codes for regional and distant metastasis. Literature informs that valid recurrence is not available from routine data capture but will require to be more reliable and clinically driven. This will need consensus from clinicians about consistency of information on recurrence and further agreement on definitions.

DM outlined examples of SMR01 data collected for 6-12 months following diagnosis throughout Scotland. DM advised that the new 5th digit began to be collected in late 2015.

An example in Breast Cancer highlighted that there were 359 out of 3,455 cases that appeared to have a recurrence (incident between 2014 and 2017). To assess sensitivity would require looking through case-notes, split by consultant, to validate the 3,455 cases. This is a lengthy process and unlikely to be a worthwhile exercise in itself due to missing figures, data not accurate or incomplete. Random sampling was discussed for larger tumour groups but this could reduce the apparent number of recurrences. However, the process of getting clinical consensus on how recurrence should be coded and recorded may be the more valuable side-effect of the validation work.

IT highlighted that outpatient attendances are not incorporated in SMR01 reports. It was also noted that collecting recurrence data is an important issue and will help with the impact on services.

DM is preparing a paper to send to the Regional Network Leads to inform them of the process to date. HD highlighted that it should be noted on the email communication that there needs to be a consensus on the clinical definitions required for this valid exercise.

- *Proposed national approach for survival analysis (including publication of further analysis – Paper 4*

HD discussed the different strands of survival analysis that is currently being undertaken and the need to co-ordinate this work. As well as various teams within ISD, there is also a programme of work on cancer pathways being delivered through Macmillan Cancer Support and ISD as outlined in paper 4. DM advised that within ISD there are currently 3 teams working with survival analysis 1) consultancy team working with Macmillan; 2) population team generated survival analyses and 3) ISD team that is working with QPIs. DM advised that he has had various meetings with the management of each of these teams to discuss the internal coordination of this work. These discussions have had the aim of improving efficiency of available resources, avoiding duplication of work and achieving a more joined up approach,

ET highlighted that currently the QPIs have a schedule in place for 3 tumour groups in one year undergoing survival analysis. ET stated that a collaborative programme would allow more tumour types to be analysed in a shorter timeframe. ET added that this is a priority area within the QPIs that clinicians are currently looking for.

DM stated that the main aspiration of SCRIS is to work on innovating modern technologies. DM is conscious that if SCRIS took on this analytical work with QPI survival analysis it would result in less time spend on other work with data linkages.

HD agreed to formally write on behalf of the NCQSG to DM to take forward a timetable of survival analysis recognising this is a basic requirement for clinicians.

Action: Hilary Dobson

5. QPI Reporting

(a) Revised QPI Dashboard

HD provided an update on the revised dashboard on behalf of ISD. AF advised that the team have been liaising with their website colleagues and have a number of new ideas/versions of the dashboard for future development and review. This will be shared in the first instance with the National Cancer Quality Operational Group.

(b) Systemic Anti Cancer Therapy (SACT) 30-day Mortality

At the previous meeting the NCQSG supported SACT 30 day mortality reporting using the methodology for CEL 30 (2012) through Chemocare data that is more inclusive and robust. JD updated that feedback is still to be received from David Cameron, Chair of the SACT National Reporting Group regarding agreement on a consistent methodology and alignment across the regions.

6. Assurance of National Performance

(a) Update on progress using revised methodology

HD updated that Healthcare Improvement Scotland (HIS) has completed the analysis of the QPI data in NCA and review visit. A report has been sent out for factual accuracy.

WoSCAN review visits to discuss QPI data and governance arrangements have taken place on 6th and 7th June. WoSCAN are currently waiting on the draft report for factual accuracy.

SCAN review visits are due to commence in August 2019.

7. QPI Formal Review Process

(a) Formal Review Process – 2nd cycle update

JD provided an update on progress with the 2nd cycle of Formal Reviews and noted that Breast and Renal Cancers QPIs are in the final stages of revision prior to publication. The reviews are tailored as required. This has resulted in extensive changes to the Breast Cancer QPIs, while only minor revisions were necessary to the Renal QPIs.

Submission templates are due to be returned by the regions for Prostate Cancer by 12th July following QPI discussion at the BAUS meeting on 25th June. The next set of formal reviews due to commence are Upper GI, Lung and HPB cancers.

JD noted that more clinical advisors will require to be sought from the membership of the NCQSG for future reviews. HD stated the importance of reinstating the engagement and the significance of input from tumour specific and clinical leads to drive this process locally and regionally.

ET added that it was noted by HIS at the WoSCAN review visit that the process for this cycle of reviews has been downgraded. There was a perception by colleagues that this is less meaningful compared to the previous cycle of Formal Reviews. ET re-iterated that the QPIs are still subject to the same robust process and is dependent on the level of change required for each tumour group.

(b) Mesothelioma QPIs - development

JD provided an update on the development and implementation of the

national Mesothelioma QPIs. The QPIs have now been approved by the NCQSG for publication. Measurability and dataset supporting documents have been sent to the audit staff within the regions for comment prior to being published.

8. Scottish participation in UK cancer audits - NLCA

(a) HD advised that work is ongoing pursuing a meaningful contribution to the National Lung Cancer Audit (NLCA). Currently, HD is liaising with Dr Kevin Blyth, Consultant Respiratory Physician in NHSGGC to discuss the national audit and what can be achieved with a Scottish contribution to the NLCA.

9. NCQSG Workplan 2019 – 2021 – *Paper 5*

(a) JD advised that a draft workplan has been developed for 2019-21. The workplan contains priority areas including survival analysis and the dashboard, governance, QPI formal reviews (2nd cycle), and data linkage through the Innovative Healthcare Deliver Programme (IHDP).

DM advised that Roger Black, Head of Service, ISD is due to retire. HD advised that she will write to thank RB for his contribution to the NCQSG and seek a replacement for the group.

Action: Hilary Dobson

10. Innovative Healthcare Delivery Programme (IHDP)

(a) Information Governance – Paper has been compiled detailing the experience of 15 cases seeking to obtain PBPP approval for data access. Recommendations on the PBPP process will be presented to Penni Rocks, Head of eHealth (Digital Health and Care) for discussion on how to deliver need.

(b) SCRIS – now moving towards delivering most of its outcomes and the benefits of data realisation have been showcased to stakeholders. The NCQSG is a key contributor as an overarching group looking at cancer quality.

(c) PROMS/PREMS – Presentations from two products as follows:

- 'My Clinical Outcomes' (MCO) which is a web-platform used to collect and analyse variation in patient reported outcomes in clinical care; and
- oWISE – mobile app which offers breast cancer patients personalised medical information throughout treatment.

Evaluation has been completed on Boards that have piloted these two products and end report will be available in September/October this year. A further project on 'automated response to treatment as monitored by chest imaging' is currently undergoing a 6 month evaluation.

(d) Treatment Summaries – HD and Professor Aileen Keel met with Geoff Huggins, Director, NES Digital Service to discuss a digital platform for Treatment Summaries. Now on the IHDP workplan and in the process of finding an early adopter to take forward this work.

(e) IHDP – HD updated that funding for IHDP continues until the middle of 2020. An external review has taken place and a paper has been submitted to the Joint Strategy Board to continue business as usual beyond this date.

11. Healthcare Foundation Applications

(a) DM provided a brief update on the Health Foundation grants which are directed at work on national clinical audits and patient registries to improve health care quality. Each project team will receive up to £400,000 for projects with a maximum duration of four years.

There have been 3 submissions submitted to the Health Foundation in relation to the following topics: 1) Bladder Cancer; 2) Cancer in ICU care; And 3) Radiotherapy – variation on access. DM noted that these submissions have made reference to QPIs and Scottish Cancer Registry.

DM has been advised that he will be informed by the end of the month if the initial outlines have been accepted. HD requested that the group be kept updated with this work.

12. Risk and Issues Log – *Paper 6*

(a) The updated risk and issues log was circulated. ET made reference to the Patient Experience Survey results *(link below)* that have been published in May 2019 and results have been submitted to regions/Boards.

ET/KM added that the survey results have been taken to their Regional Cancer Advisory Groups and IT advised that he will flag with Lorraine Cowie in the north.

The Patient Experience QPIs have been extant for a number of years and are not being widely used as an improvement tool within the units. A paper will be available to inform discussion at the next meeting on the future position of these QPIs.

https://www.gov.scot/publications/scottish-cancer-patient-experience-survey-2018-national-report/

Jen Doherty / Regional Managers

13. AOCB

(a) **Ovarian Cancer Survival Analysis**
KM advised that the clinicians are keen to look at the further Ovarian Cancer Survival analysis that has been carried out with a view to publication. A meeting will be arranged to look at the data collectively across the regions.

(b) **Prostate Cancer UK**
Kiana Collins informed that Prostate Cancer UK had submitted proposals for the Prostate Cancer QPIs through the formal review process that is currently being undertaken. The Scottish Cancer Coalition will continue to

submit recommendations in the future for each tumour group undertaking formal review.

14. Date of Next Meeting

(a) **Friday 6th September 2018, 10:00am – 1:00pm**
Cramond Room
Scottish Health Service Centre
Crewe Road South
Edinburgh EH4 2LF