Melanoma Quality Performance Indicators
Patients diagnosed during July 2014 to June 2015
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Introduction

The Better Cancer Care plan, published in 2008, included a commitment to 'develop a work programme which will define how we will take forward quality indicators for cancer services'.

To achieve this, the Scottish Cancer Taskforce established the National Cancer Quality Steering Group (NCQSG), which includes responsibility for:

- The development of small sets (approximately 10-15 indicators) of tumour specific national quality performance indicators (QPIs) as a proxy measure of quality care.
- Overseeing the implementation of the national governance framework that underpins the reporting of performance against these national QPIs.

The QPIs have been developed collaboratively with the three Regional Cancer Networks: North of Scotland Cancer Network (NOSCAN), South East Scotland Cancer Network (SCAN), West of Scotland Cancer Network (WoSCAN), Information Services Division (ISD), and Healthcare Improvement Scotland. The QPIs are published on the Healthcare Improvement Scotland website.

These indicators, used to drive quality improvement in cancer care across NHSScotland are kept under regular review; NHS Boards will be required to report against QPIs as part of a mandatory national cancer quality programme.

ISD support NHS Boards in improving the quality of local data collection and reporting through the production of data validation specifications, and measurability criteria for QPIs. The current data sets are outlined on the Cancer Audit website.

A rolling programme of reporting is planned across many tumour sites. National reports will include comparative reporting of performance against QPIs at NHS Board level across NHS Scotland, trend analysis and survival analysis (where applicable). This approach will help overcome existing issues relating to the reporting of small volumes in any one year.

This report assesses performance against 11 Melanoma QPIs using clinical audit data relating to patients diagnosed with Melanoma for the period from July 2014 to June 2015. This was the first year of QPI data collection; therefore, this report provides the first opportunity to review performance against these new measures and to review the effectiveness of the measures themselves. Therefore, this report contains only one year, rather than three years of data, as will be the norm in future publications. As a result of this, the information in this report may be impacted by the effect of small numbers. Future reporting of Melanoma QPIs may include changes or refinements to indicator definitions and measurability criteria based on a review of this first publication.
**Data collection and analysis**

Melanoma QPI data for patients diagnosed between July 2014 and June 2015 were collected by NHS Boards, supported by the regional cancer networks, and then analysed against the [Melanoma measurability document](#). Aggregated analysed data were then submitted to ISD via a data collection template for collation to allow comparisons at NHS Board level.

To support the national reporting of QPIs and to provide context in their interpretation, an analysis of Melanoma survival was undertaken. A cohort of patients diagnosed with Melanoma during 2009 to 2011, and registered on the Scottish Cancer Registry, was used and linked to deaths data (up to December 2014) to provide 3 years of follow up for all patients (and up to 5 years of follow up for some).

**Data quality and completeness**

*Small numbers:*

Where the number of cases meeting the denominator criteria for any indicator is between one and four, the percentage calculation has not been shown on any associated charts or tables. This is to avoid any unwarranted variation associated with small numbers and to minimise the risk of disclosure. Any charts or tables impacted by this are denoted with a dash (-). However, any commentary provided by NHS Boards relating to the impacted indicators will be included as a record of continuous improvement.

*Baseline Review:*

Following analysis and reporting of year 1 QPI results, the data were reviewed with the aim of identifying any potential refinements to the QPIs which are required to ensure the QPIs are fit for purpose. Any refinements will be based clearly on the criteria set out below:

- QPIs may be revised only and cannot be added or removed.
- Any revisions to the QPI target level can only be made where it makes the QPI more challenging.
- New data items cannot be added to the tumour specific minimum core dataset and existing data items, and the associated data validations, cannot be amended.
- Measurability can be changed in order to ensure that the QPIs are reliable, valid and non-counterproductive, within the confines of the existing dataset.

Consequently, the information presented in this report has been subject to review and may be impacted by various issues raised consistent with the criteria above, which may affect the accuracy and comparability of these measures. Subsequent changes to the QPIs will be reflected in future reporting of these QPIs where accuracy and comparability is expected to improve.
Private Patients:

There may be differences across the regions in the inclusion or exclusion of private patients within this dataset. In WoSCAN, patients diagnosed privately but treated within the NHS are included in any figures reported by hospital of surgery/treatment but excluded when reported by hospital of diagnosis. This differs in the approach adopted by the other regions where private patients are included in QPIs reported by NHS Board of diagnosis. These differences, though, will account for very small numbers across the regions.
Foreword from Melanoma Clinical Leads

Background
Data collection with regards to melanoma skin cancer disease and management was commenced by the Scottish Melanoma Group in 1979. Rigorous data collection has enabled observations with regards epidemiology and pathogenesis of melanoma skin cancer. Since 2005 National data collection has been co-ordinated through Information Services Division (ISD). Data collection for the melanoma national Quality Performance Indicators (QPIs) began in July 2014.

The QPIs have been developed by clinical staff across the three Regional Cancer Networks (South East Scotland Cancer Network, West of Scotland Cancer Network and North of Scotland Cancer Network), in collaboration with Information Services Division, Healthcare improvement Scotland, Scottish Cancer Coalition and the Scottish Government. The QPIs have been developed with focus on quality of patient care. Targets have been set for each QPI to allow us to identify where QPIs have not been achieved, identify areas of high quality care that should continue and be shared across NHS Boards, and to reflect on whether the QPIs are robust and achieving what they set out to achieve.

The first year of melanoma QPI data collection is presented in this document. There have been some ‘teething problems’ with QPI data collection, these were discussed at a national baseline review on 11th December 2015. The next review of the QPIs will be following a further 2 years of data collection. We welcome the introduction of a robust national, regional and local governance and scrutiny framework.

Key recommendations/key points to note:
There are 11 melanoma QPIs. Not every network or health board has been able to meet each QPI target. The targets remain unchanged so as to encourage us to strive to improve cancer care and performance. Some QPIs have been adjusted to ensure the data being collected is meaningful to clinical practice.

QPI 1 requires that a patient with cutaneous melanoma should have their diagnostic excision biopsy carried out by a skin cancer clinician. A skin cancer clinician is a dermatologist, plastic surgeon, or a locally designated clinician who attends the MDT. Target compliance 90%, Scotland 92%. All regions have included surgeons who are ‘under the supervision’ of a member of the melanoma MDT as meeting the QPI criteria. Such surgeons may include dermatology nurses or hospital practitioners who are surgically trained. Following baseline review it was agreed that the wording of the QPI document will be changed to include ‘a clinician who is under the supervision’ of a member of the MDT. It was agreed that the clinical lead for each area should forward a list of relevant clinicians for their area to their audit staff. This list should be updated annually.

QPI 2 requires that surgical pathology reports for melanomas undergoing diagnostic excision biopsy contain a full set of data items, as defined by the current Royal College of Pathologists (RCP) dataset. Target compliance 90%, Scotland 54%. The main reason for low performance for this QPI is that it requires inclusion of a SNOMED code on the pathology report. Pathologists believe that all specimens that have been reported will have been issued with a SNOMED code but it is not good practice to include this code within the printed report.
At baseline review it was agreed that the requirement of a SNOMED code will be removed from the report.

Even if the requirement for a SNOMED code is overlooked the majority of regions fail this QPI. Most clinicians and pathologists believe that the list of data items is too long and not relevant from a clinical, management or prognostic point of view. It was suggested that the requirement of approximately 5 key data items would be sufficient and more practical for data collection. A decision was made to review these discussions in 2 years time.

QPI 5 details that SLNB reports for melanoma patients undergoing sentinel lymph node biopsy (SLNB) should contain a full set of data items, as defined by the current RCP dataset. Target compliance 90%, Scotland 23%. Similarly to QPI 2, the reason for low performance is the absence of a SNOMED code on the pathology report. As with QPI 2, the requirement for this will be removed. If the requirement for SNOMED code is overlooked the compliance improves but does not reach the 90% target. Other items which are not relevant and will be removed include: TNM stage, localisation and localising marker.

QPI 3 details that patients with cutaneous melanoma should be discussed by a multidisciplinary team prior to definitive treatment. Target compliance 95%, Scotland 87%. The Highlands have only recently commenced MDM discussion for all melanomas, it is hoped that this will improve future compliance. The QPI states specifically that the date of MDM discussion should be after diagnostic excision and before definitive treatment (wide local excision WLE, SLNB). In some regions the MDM discussion was had after the definitive treatment, this was for sound clinical reasons. At baseline review discussions were had suggesting QPI criteria could be changed to make allowances for such cases. It was agreed to keep the QPI as it is so as we can highlight those having definitive treatment before MDM discussion and therefore ensure management is appropriate.

QPI 4 requires that patients with primary cutaneous melanoma undergo clinical examination of their draining lymph node basins. The date of this examination must be documented in the notes or at MDM. Target compliance 95%, Scotland 60%. In most cases this examination is being performed, however there is an absence of good documentation in notes and in particular clinic letters. Much discussion was had at the baseline review as to whether the examination date could be substituted by ‘yes/no’. The group agreed that the date was an important factor therefore the QPI/measurability document should remain unchanged.

QPI 6 states that a patient with primary cutaneous melanoma should undergo a wide local excision (WLE). Target compliance 90%, Scotland 92%. Currently this QPI only includes data for those melanomas diagnosed by excisional biopsy. If diagnosed by sample biopsy (incision, punch, curette) the data is not included.

QPI 7 details that a patient with primary cutaneous melanoma should have their WLE within 84 days of their diagnostic surgical biopsy. Target compliance 95%, Scotland 65%. There were problems with the calculation of this QPI, for example, in NHS Dumfries & Galloway, 41% of patients had their diagnosis made by sample biopsy and therefore were not included in the numerator. This is of particular relevance as diagnosis by sample biopsy often introduces an increased risk of delay into the patient management pathway. It was agreed at baseline review that in future, data for those diagnosed by ‘sample biopsy’ will also be included in calculating QPIs 6 & 7.
QPI 8 requires that BRAF status is performed in all patients with unresectable stage III or IV disease. QPI 9 requires that patients with stage III and IV disease should be evaluated with appropriate imaging. QPI 10 states that these patients should receive systemic anti cancer therapy.

QPI 8 target compliance 75%, Scotland 89%.
QPI 9 target compliance 95%, Scotland 92%.
QPI 10 target compliance 60%, Scotland 61%.

It is important to note that the QPIs only provide information for patients who present with a primary melanoma within the reporting time period. The QPIs do not include data for patients presenting with metastatic disease or recurrence. The number of patients eligible for inclusion in QPI8 – 10 is therefore very small.

QPI 11 requires that patients with primary cutaneous melanoma, who undergo groin block dissection, should be assessed for lymphoedema and have access to a lymphoedema service. QPI 11 target compliance 40%, Scotland 29%. Few patients will present with primary melanoma, have a groin clearance, and develop lymphoedema within the reporting time period. At QPI baseline review it was agreed that the appropriate patients are not being captured. As the intent of the QPIs is only to provide information for those presenting with primary melanoma, it is difficult to make improvements to this QPI. It was agreed to leave this QPI unchanged until formal review when more results will be available.

Conclusions
Having completed the first year of QPI data collection we have been able to look with a critical eye as to whether they are providing us with the information that was intended. Some changes have been made at baseline review to improve on this.

We welcome the opportunity to compare the quality of melanoma care across Scotland. It is important that we use this data to develop targeted audit, regional review and inter-network national discussions to continue the process of quality improvement and to maintain equity of care across Scotland. Most importantly, where NHS Boards have not met QPIs it is important to have feedback as to the reasons behind this, and the actions that are being taken to make improvements.

We would like to thank all staff involved in compiling data for the national melanoma QPI report, in particular the Network audit facilitators.

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Case Ascertainment

Case ascertainment is a measure of data quality and is calculated by comparing the number of new patients captured by the cancer audit with a five year average of the numbers recorded on the cancer registry. A five year average is used for registry data as the information is not available until sometime after the year under examination. This is due to data collection and verification processes. As the number of cases will vary each year, it is possible for case ascertainment to be over or under 100%. Therefore, the figures presented should be seen as an indication only.

In July 2014 – June 2015, the overall Scotland case ascertainment was 110.8%:
Overall Performance Summary

The tables below summarise the overall performance across the country for each QPI.

QPI Summary table – Melanoma by Health Board

<table>
<thead>
<tr>
<th>QPI</th>
<th>Target Score</th>
<th>Grampian</th>
<th>Highland</th>
<th>Islands</th>
<th>Stirling</th>
<th>Tayside</th>
<th>Western Isles</th>
<th>NHS Forth</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Lanarkshire</th>
<th>Strathclyde</th>
<th>Tayside &amp; Kinross</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>QPI 1 - Excision Biopsy</td>
<td>1.90</td>
<td>79.0%</td>
<td>71.0%</td>
<td>-</td>
<td>100.0%</td>
<td>95.1%</td>
<td>-</td>
<td>76.0%</td>
<td>100.0%</td>
<td>92.9%</td>
<td>92.7%</td>
<td>95.2%</td>
<td>95.7%</td>
<td>93.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>QPI 2 - Pathology Reporting</td>
<td>2.90</td>
<td>63.2%</td>
<td>65.2%</td>
<td>-</td>
<td>100.0%</td>
<td>95.0%</td>
<td>-</td>
<td>86.5%</td>
<td>91.4%</td>
<td>23.0%</td>
<td>68.3%</td>
<td>6.0%</td>
<td>14.1%</td>
<td>0.0%</td>
<td>43.0%</td>
</tr>
<tr>
<td>QPI 3 - Multi-Disciplinary Team Meeting (MDM)</td>
<td>2.85</td>
<td>57.4%</td>
<td>65.6%</td>
<td>-</td>
<td>100.0%</td>
<td>94.8%</td>
<td>-</td>
<td>70.5%</td>
<td>100.0%</td>
<td>99.0%</td>
<td>95.4%</td>
<td>100.0%</td>
<td>94.0%</td>
<td>95.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>QPI 4 - Clinical Examination of Draining Lymph Node Basins</td>
<td>2.95</td>
<td>58.0%</td>
<td>65.7%</td>
<td>-</td>
<td>74.1%</td>
<td>74.3%</td>
<td>-</td>
<td>90.4%</td>
<td>91.4%</td>
<td>39.8%</td>
<td>71.9%</td>
<td>49.0%</td>
<td>45.3%</td>
<td>96.8%</td>
<td>86.2%</td>
</tr>
<tr>
<td>QPI 5 - Sentinel Node Biopsy (Pathology)</td>
<td>2.90</td>
<td>60.0%</td>
<td>-</td>
<td>-</td>
<td>6.0%</td>
<td>6.0%</td>
<td>-</td>
<td>42.0%</td>
<td>-</td>
<td>-</td>
<td>6.0%</td>
<td>6.0%</td>
<td>3.5%</td>
<td>0.0%</td>
<td>-</td>
</tr>
<tr>
<td>QPI 6 - Wide Local Excisions</td>
<td>2.85</td>
<td>50.0%</td>
<td>92.0%</td>
<td>-</td>
<td>100.0%</td>
<td>52.3%</td>
<td>-</td>
<td>67.1%</td>
<td>96.7%</td>
<td>95.7%</td>
<td>97.0%</td>
<td>90.6%</td>
<td>91.3%</td>
<td>97.4%</td>
<td>97.4%</td>
</tr>
<tr>
<td>QPI 7 - Time to Wide Local Excisions</td>
<td>3.85</td>
<td>47.7%</td>
<td>70.0%</td>
<td>-</td>
<td>55.6%</td>
<td>75.4%</td>
<td>-</td>
<td>65.5%</td>
<td>94.7%</td>
<td>46.3%</td>
<td>58.3%</td>
<td>87.4%</td>
<td>82.5%</td>
<td>95.4%</td>
<td>50.5%</td>
</tr>
</tbody>
</table>

Clinical Trials Summary Table – by Scottish Cancer Research Network (SCRN)

<table>
<thead>
<tr>
<th>Clinical Trials Access to Clinical Trials Translational</th>
<th>SCRN - North &amp; East</th>
<th>SCRN - South East</th>
<th>SCRN - West</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 7.5% Interventional</td>
<td>0.0%</td>
<td>2.6%</td>
<td>1.1%</td>
</tr>
<tr>
<td>&gt; 15%</td>
<td>6.7%</td>
<td>2.3%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

- Data not shown due to small numbers
* No data matching QPI criteria

Target not met
Met or exceeded target
Quality Performance Indicators

The following section includes a detailed summary of each of the eleven Melanoma QPIs outlining the variation at NHS Board level. Charts are colour coded by network. Where performance is shown to fall below the target, commentary from the relevant NHS Board is included to provide context to the variation. Unless otherwise stated, information in this report is shown by the Health Board of diagnosis.

**QPI 1: Excision Biopsy – Patients with cutaneous melanoma should have their diagnostic excision biopsy carried out by a skin cancer clinician***.

The initial biopsy is important for both diagnosis and pathological staging. Evidence has shown excisional biopsy to be the most appropriate procedure because it allows accurate evaluation of tumour thickness and other prognostic factors.

Numerator: Number of patients with cutaneous melanoma undergoing diagnostic excision biopsy who had this carried out by a skin cancer clinician ***.

Denominator: All patients with cutaneous melanoma undergoing diagnostic excision biopsy.

Exclusions: No Exclusions.

Target: 90%

*Note: A skin cancer clinician can be defined as a: Dermatologist, Plastic Surgeon or a locally designated clinician with a special interest in skin cancer, who is also a member of the melanoma MDT.

In Scotland, there were 982 patients diagnosed with melanoma during the reporting period who underwent diagnostic excision biopsy. Out of these patients, 902 (91.9%) patients had this carried out by a skin cancer clinician and therefore the QPI target of 90% was met.

The majority of NHS Boards within Scotland met this QPI target excluding NHS Grampian and NHS Highland where the majority of patients have excision biopsies carried out by GPs.
Several NHS Boards (NHS Grampian, NHS Highland, NHS Tayside and NHS Ayrshire & Arran) have commented that a number of excision biopsies were performed by GPs meaning these cases did not meet the QPI target.

It was noted that in NHS Grampian there is limited surgery provided by Skin Cancer clinicians and that excision biopsies in peripheral hospitals are carried out by GP surgeons. This applies to a third of the NHS Grampian patients who did not meet the target for this QPI. A small number of excision biopsies were carried out by ENT surgeons.

NHS Ayrshire and Arran have commented that the QPIs have now been sent to all GPs/Practice Managers in NHS Ayrshire & Arran to ensure GPs are aware of this standard.
QPI 2: Pathology Reporting - Surgical pathology reports for patients with cutaneous melanoma should contain full pathology information to inform treatment decision making.

To allow treatment planning to take place for patients diagnosed with cutaneous melanoma, prognostic information from the primary excision biopsy is needed. The use of datasets ‘improves the ‘completeness’ of data’ in pathology reports.

Numerator: Number of patients with cutaneous melanoma undergoing diagnostic excision biopsy where the surgical pathology report contains a full set of data items (as defined by the current Royal College of Pathologists dataset).

Denominator: All patients with cutaneous melanoma undergoing diagnostic excision biopsy.

Exclusions: No Exclusions.

Target: 90%

Only 53.6% of patients in Scotland undergoing diagnostic excision biopsy for melanoma had a surgical pathology report containing a full set of data items. This was significantly below the QPI target of 90%. NHS Highland, NHS Shetland, NHS Lanarkshire and NHS Orkney (small numbers) were the only NHS Boards who managed to achieve this target.
Many NHS Boards (NHS Tayside, NHS Lothian, NHS Borders, NHS Ayrshire & Arran and NHS Forth Valley) noted that one of the data items (SNOMED code) was missing from the final pathology report which meant the patient failed this QPI. It has since been agreed at the Baseline Review that this data item should be removed from the list of information required for pathology reports to be considered complete.

NHS Lothian and NHS Borders noted that after excluding the cases failing due to lack of SNOMED code, the QPI target would still not have been met due to missing primary tumour staging data.

NHS Grampian commented that the majority of patients who failed this QPI target were reported before tumour staging was routinely being included in the pathology dataset. The remaining cases had histology reported by an external private company due to lack of internal capacity. The external company used a different format for reporting and therefore these cases failed the QPI target.

NHS Lanarkshire noted that all cases not meeting this QPI target have been reviewed and that the pathology dataset has been circulated to the local skin cancer pathologists.

NHS Greater Glasgow & Clyde noted that a proforma for melanomas was introduced to ensure that all data items would be in the summary of a melanoma report. The new proforma has made a significant difference in providing complete reports however it was introduced after the initial launch of the QPIs and has not yet been adopted by all pathologists across NHS Greater Glasgow & Clyde. To obtain better and more consistent results the NHS Board will recommend that the proforma is used by all Pathologists reporting melanoma.
QPI 3: Multi-Disciplinary Team Meeting (MDT) - Patients with cutaneous melanoma should be discussed by a multidisciplinary team prior to definitive treatment.

Evidence suggests that patients with cancer managed by a multidisciplinary team have a better outcome. There is also evidence that the multidisciplinary management of patients increases their overall satisfaction with their care.

Numerator: Number of patients with cutaneous melanoma discussed at the MDT before definitive treatment (wide local excision, chemotherapy/SACT, supportive care and radiotherapy).

Denominator: All patients with cutaneous melanoma.

Exclusions: Patients who died before first treatment.

Target: 95%

Of the 1,254 patients in Scotland with melanoma, 1,085 patients were discussed at an MDT before definitive treatment. This meant the overall Scotland performance was 86.5% and the QPI target of 95% was not met. The following NHS Boards met the QPI target: NHS Orkney (small numbers), NHS Shetland, NHS Borders, NHS Fife, NHS Lothian and NHS Ayrshire & Arran.
Some NHS Boards (NHS Grampian, NHS Tayside and NHS Forth Valley) noted that several cases failed this QPI due to having treatment carried out before MDT. A few NHS Boards (NHS Grampian, NHS Forth Valley and NHS Greater Glasgow & Clyde) also commented about the frequency of their MDT meetings and how this influenced patients being treated before MDT discussion.

NHS Greater Glasgow & Clyde noted that some patients had a definitive treatment date that was recorded as the same as the diagnosis date, usually because they did not go on to have further surgery/chemotherapy etc (or that no further surgery was required for example, adequate margins or the patient was palliative). Therefore it was not possible to discuss these patients at MDT prior to the ‘definitive treatment date’. In the cases where MDT has been delayed in NHS Greater Glasgow & Clyde, they will audit these to establish the reasons for delay.

NHS Tayside commented that all of the patients who failed this QPI target either had adequate excision at biopsy prior to MDT or diagnostic excision biopsy prior to MDT with no further treatment.

NHS Highland noted they were only in a position to offer MDT meetings from the beginning of January 2015. This meant all the patients from 2014 were not included in an MDT discussion and will have failed the QPI target. This in turn would have affected any NHS Western Isles patients treated in NHS Highland during 2014.

In NHS Ayrshire & Arran, some of the cases which were not discussed at MDT prior to wide local excision (WLE) had missed the MDT cut off. NHS Ayrshire & Arran have subsequently agreed that cases would be added to MDT as late additions to ensure they are discussed before WLE.

NHS Lanarkshire commented that in some of the cases failing to meet this QPI target, excision biopsy was the first and definitive treatment. This is because patients had either refused WLE, died before WLE or because metastases were diagnosed prior to WLE and therefore the WLE was cancelled. The majority of these cases were discussed at MDT post excision. Some cases
who were awaiting WLE at the time of compiling NHS Lanarkshire figures have since had surgery. These patients were all discussed at MDT prior to definitive treatment. Some of the remaining cases were discussed at MDT after WLE and the others, have no record of ever being discussed. NHS Lanarkshire will undertake a review of the current process for adding patients to the MDT and appropriate action will be taken if necessary.
**QPI 4: Clinical Examination of Draining Lymph Node Basins - Patients with cutaneous melanoma should undergo clinical examination of relevant draining lymph node basins as part of clinical staging.**

Scottish Intercollegiate Guidelines Network reports the examination of the regional lymph node basin as an important aspect of the clinical evaluation of patients with cutaneous melanoma as the presence of nodal metastasis is an important predictor of outcome and prognosis.

Numerator: Number of patients with cutaneous melanoma who undergo clinical examination of relevant draining lymph node basins as part of clinical staging.

Denominator: All patients with cutaneous melanoma.

Exclusions: No Exclusions.

Target: 95%

Overall in Scotland, 764 (60.3%) of 1,266 patients with melanoma underwent clinical examination of relevant draining lymph node basins as part of clinical staging. Only NHS Ayrshire & Arran met the 95% target for this QPI.
For this QPI, there has been a high number of ‘Not Recorded for Numerator’ cases (194 cases) recorded across Scotland. It was noted that this high number of Not Recorded cases was a consequence of the lack of documentation in patient records of this examination being carried out. Most NHS Boards have commented that they are working to ensure this information is recorded going forward.
QPI 5: Sentinel Node Biopsy Pathology - Sentinel node biopsy (SNB) reports for patients with cutaneous melanoma should contain full pathology information to inform treatment decision making.

Evidence suggests SNB reports should be carried out in a standardised way so that findings between centres are comparable.

Numerator: Number of patients with cutaneous melanoma who undergo SNB where the SNB report contains a full set of data items (as defined by the current Royal College of Pathologists dataset).

Denominator: All patients with cutaneous melanoma undergoing SNB.

Exclusions: No Exclusions.

Target: 90%

There were 168 melanoma patients in Scotland who underwent sentinel node biopsy (SNB). Only 39 (23.2%) of these patients had an SNB report which contained a full set of data items recorded.
As with QPI 2, it has been commented about the lack of SNOMED code affecting these figures. It has since been agreed at Baseline Review to remove any items that do not need to be included for the pathology report to be marked complete.
**QPI 6: Wide Local Excisions - Patients with cutaneous melanoma should undergo a wide local excision of the initial excision biopsy site to reduce the risk of local recurrence.**

Surgical excision is an effective cure for primary cutaneous melanoma. The lesion is initially removed for histological diagnosis and assessment of tumour depth. A further excision is carried out to minimise the risk of local recurrence. Studies have shown the importance of removing the tumour and a margin of healthy skin.

Numerator: Number of patients with cutaneous melanoma undergoing diagnostic excision biopsy who undergo a wide local excision.

Denominator: All patients with cutaneous melanoma undergoing diagnostic excision biopsy.

Exclusions: Patients who died before treatment.

Target: 95%

In Scotland, 92.3% of melanoma patients undergoing diagnostic excision biopsy underwent a wide local excision. This fell short of the 95% QPI target. The following NHS Boards were unable to achieve the target for this QPI: NHS Grampian, NHS Highland, NHS Tayside, NHS Dumfries & Galloway, NHS Lothian, and NHS Lanarkshire.
Across Scotland, some of the reasons given for patients failing to meet the QPI target included: patients refusing treatment, patients having cancer adequately excised at biopsy, patients being found to have metastases prior to WLE, or patients dying before WLE.

One issue discussed at Baseline Review was whether this QPI should include patients undergoing diagnostic partial biopsy. It has been agreed going forward to add a second part to this QPI to measure patients undergoing diagnostic partial biopsy and then WLE separately.

Many of the NHS Grampian cases which did not meet the QPI target had documented MDT decisions with reasons why WLE was not felt necessary or appropriate.

Of the patients not meeting this QPI target in NHS Tayside, nearly half were because cancer was adequately excised at biopsy. Other reasons noted included patients receiving amputation or having chemotherapy straight after excision biopsy.

NHS Dumfries & Galloway also gave reasons for patients failing to meet this QPI target including patients declining further treatment and patients receiving WLE only.

NHS Ayrshire & Arran commented that the patients failing this QPI target were deemed to have adequate excision margins and the MDT felt WLE was not required.

NHS Lanarkshire reviewed the cases not meeting this QPI target and reasons for failing included: patients refusing treatment, patients having metastases and patients dying prior to WLE. Several other patients were awaiting WLE when the figures were being compiled however surgery has since been performed on all these patients. If these patients were included, the results for NHS Lanarkshire would increase to meet the QPI target.
QPI 7: Time to Wide Local Excision - Patients with cutaneous melanoma should have their wide local excision within 84 days of their diagnostic excision biopsy.

Patients with melanoma will undergo their diagnostic excision biopsy and may continue to have a wide local excision. A wide local excision is undertaken to achieve histologically negative margins and decrease the risk of local recurrence.

Numerator: Number of patients with cutaneous melanoma undergoing wide local excision within 84 days of their diagnostic excision biopsy.

Denominator: All patients with cutaneous melanoma undergoing wide local excision.

Exclusions: No Exclusions.

Targets: 95%

Overall in Scotland, only 64.7% of melanoma patients undergoing wide local excision had this within 84 days of their diagnostic excision biopsy. Other than NHS Orkney and NHS Western Isles who both had a small number of cases, no NHS Board managed to meet the 95% QPI target.
Across Scotland there were a multitude of reasons for delays in WLEs being performed.

As for QPI 6, it was agreed at Baseline Review that QPI 7 should additionally measure patients undergoing diagnostic partial biopsy separately from those patients undergoing excision biopsy. This would have had an effect on NHS Tayside figures who commented that some of their patients who did not meet this target only had a partial biopsy rather than an excision biopsy.

NHS Grampian noted that delays in WLEs were probably multifactorial due to delays in pathology reporting, delays in MDT discussion and delays in scheduling of WLE procedure. NHS Shetland also commented how these delays would affect their patients who were treated in NHS Grampian.

Several NHS Highland patients who failed to meet this QPI target underwent WLEs more than 84 days after their diagnostic surgery. Reasons for these delays included: patients being visited by specialist registrar, patients being referred to ENT department for WLE due to location of melanoma and patient induced delays.

NHS Ayrshire & Arran felt that the longest delay to WLE was the wait for plastic clinic appointments. It has been agreed that at MDT discussion, those cases suitable for WLE to be carried out by a Nurse Practitioner could be appointed for straight to surgery without an outpatient appointment with a plastic surgeon. A cancer pathway co-ordinator carried out an audit to focus on pathway and length of time for; pathology reports, referral to plastics, wait for plastic clinic and time to WLE. This has helped identify bottlenecks in the pathway and the Cancer pathway co-ordinator will aim to escalate patients to ensure they meet the 84 day target.

At NHS Forth Valley, the reason for targets being missed was because of delays in patients who were referred to NHS Greater Glasgow & Clyde who decline Sentinel Node Biopsy and then are referred back to NHS Forth Valley. NHS Forth Valley also had a resource issue which put pressure on the service. They are having provisional talks about the service starting sentinel node biopsies at NHS Forth Valley which would remove the delays affecting this QPI.
NHS Lanarkshire stated that there have been detailed discussions within NHS Lanarkshire and NHS Greater Glasgow & Clyde about how best to improve access to plastics. This is under review by both management teams together with options to improve the service to patients. Often a delay occurs due to co-morbidities or patient wishes. NHS Lanarkshire commented that the 5% tolerance level for this QPI does not seem sufficient to accommodate such cases.

NHS Greater Glasgow & Clyde commented that the majority of those not meeting the target were related to the effect of patients undergoing partial biopsy prior to wide local excision being recorded as having not met the target on the basis of not having had an initial diagnostic biopsy. This has now been addressed in the QPI review process. Other additional cases of patients falling outwith the 84 days had legitimate reasons for delay such as “Did Not Attends”, complexity of surgery (including multiple surgical interventions) and patient choice. NHS Greater Glasgow & Clyde will continue to monitor this.
**QPI 8: BRAF Status - Patients with unresectable stage III or IV cutaneous melanoma should have their BRAF status checked.**

BRAF inhibitors, such as vemurafenib, significantly increase overall survival and progression-free survival compared with current standard chemotherapy for patients with previously untreated unresectable stage III or stage IV melanoma with V600 BRAF mutation.

Numerator: Number of patients with unresectable stage III or IV cutaneous melanoma who have their BRAF status checked.

Denominator: All patients with unresectable stage III or IV cutaneous melanoma.

Exclusions: No Exclusions.

Target: 75%

There were 18 patients in Scotland with unresectable stage III or IV cutaneous melanoma. Of these patients, 16 had their BRAF status checked. Although there were a small number of cases, overall Scotland managed to achieve the 75% target for this QPI.
It was noted at Baseline Review that many stage III or IV patients cannot be captured within the current audit process, for example those patients whose cancer progressed outwith the reporting period or those patients who had disease recurrence.

In NHS Dumfries & Galloway there were 18 patients with no staging recorded therefore these patients were included in the ‘Not recorded for denominator’ category.
QPI 9: Imaging for Patients with Advanced Melanoma - Patients with stage III and IV cutaneous melanoma should be evaluated with appropriate imaging to guide treatment decision making.

Evidence found that patients should be imaged by CT prior to surgery, with specialist skin cancer multidisciplinary team review.

Numerator: Number of patients with stage III and stage IV cutaneous melanoma undergoing completion lymphadenectomy who undergo CT or PET CT prior to completion lymphadenectomy.

Denominator: All patients with stage III and stage IV cutaneous melanoma undergoing completion lymphadenectomy.

Exclusions: No Exclusions.

Target: 95%

Of the 25 patients in Scotland with stage III or stage IV cutaneous melanoma undergoing completion lymphadenectomy, 23 patients underwent CT or PET CT prior to completion lymphadenectomy. This means the Scotland performance was 92% and fell just short of the 95% target.
As in QPI 8, it was again noted at the Baseline Review that many patients could not be captured within the current QPI process due to cancer progressing outwith the reporting period or patients having disease recurrence.

NHS Greater Glasgow & Clyde commented that they plan to feedback to all surgeons involved that CT should be performed prior to completion lymphadenectomy.

In NHS Dumfries & Galloway there were 18 patients with no staging recorded therefore these patients were included in the ‘Not recorded for denominator’ category.
QPI 10: Systemic Therapy - Patients with unresectable stage III and IV cutaneous melanoma should receive Systemic Anti Cancer Therapy (SACT).

As the majority of metastatic melanomas are not amenable to surgery, it is often found that systemic therapy is the best option. SACT should be available for the management of patients with cutaneous melanoma where appropriate.

Numerator: Number of patients with unresectable stage III and IV cutaneous melanoma who undergo SACT.

Denominator: All patients with unresectable stage III and IV cutaneous melanoma.

Exclusions: No Exclusions.

Target: 60%

Overall in Scotland, 11 (61.1%) out of 18 patients with unresectable stage III or stage IV cutaneous melanoma underwent SACT.
NHS Greater Glasgow & Clyde have commented that a number of patients will not be fit for SACT and will require palliative care instead.

In NHS Dumfries & Galloway there were 18 patients with no staging recorded therefore these patients were included in the 'Not recorded for denominator' category.

It has been agreed at Baseline Review that patients who died before treatment should be excluded from this QPI in future reporting.
**QPI 11: Access to Lymphoedema Service - Patients with cutaneous melanoma who undergo groin block dissection should be assessed for lymphoedema and have access to a lymphoedema service where clinically required.**

Secondary lymphoedema is a common condition acquired from surgery. 10-45% patients with melanoma develop secondary lymphoedema due to inguinal lymph nodes dissection.

Numerator: Number of patients with cutaneous melanoma undergoing groin block dissection who have been referred to a lymphoedema service.

Denominator: All patients with cutaneous melanoma undergoing groin block dissection.

Exclusions: No Exclusions.

Target: 40%

Out of the 21 patients with cutaneous melanoma who underwent groin block dissection in Scotland, 6 had been referred to a lymphoedema service. This equates to an overall Scotland performance of 28.6% which fails to meet the QPI target of 40%.
NHS Greater Glasgow & Clyde commented that lymphoedema usually occurs after a period of time and therefore patients do not require referral to a lymphoedema service in the immediate post operative period. A lymphoedema assessment pathway has been incorporated into local guidelines which was written to help comply with this QPI but no patients have met the criteria for referral.
Clinical Trials

Access to Clinical Trials is a common issue for all cancer types; therefore, a generic QPI was developed to measure performance across the country. Further details on the development and definition of this QPI can be found here. Specifically, for Melanoma, the QPI is defined as follows and Appendix A3 contains a list of Melanoma trials into which patients have been recruited in Scotland during January – December 2014. Information is shown by each Scottish Cancer Research Network (SCRN).

**Clinical Trials Access: Proportion of patients with melanoma who are enrolled in an interventional clinical trial or translational research.**

All patients should be considered for participation in available clinical trials, wherever eligible.

Numerator: Number of patients with melanoma enrolled in an interventional clinical trial or translational research.

Denominator: Number of melanoma registration cases (5 year average 2009/10 – 2013/14)

Exclusions: No exclusions.

Target: Interventional clinical trials – 7.5%

Translational research – 15%

The aspiration is to enrol a minimum of 7.5% of patients into Interventional Clinical Trials and 15% into Translational research.

The QPI targets for clinical trials are 7.5% for interventional trials and for translational trials are 15%. It should be noted that these targets are ambitious, particularly with the move towards more targeted trials. No interventional trials were open to recruitment for melanoma patients during this reporting period in NOSCAN, but patients have been referred to other centres.
where interventional trials are open such as the Royal Marsden, London and The Beatson Institute, Glasgow. This was due to a lack of suitable trials that could be opened in NOSCAN.

Many melanoma trials that are open have very select eligibility criteria and will only be available to a small percentage of people diagnosed with melanoma within a region. This is due to the demise of larger general trials and the advent of genetically selective trials that only target small populations of patients. NOSCAN had 2 translational trials open to recruitment during 2014. NOSCAN has screened 20 (6.7%) patients for translational trials during the reporting period. All patient recruitments were obtained from NHS Grampian as NHS Highland and NHS Tayside did not have any trials open for melanoma patients in this period.

All melanoma patients that pass through the cancer centres in NOSCAN are considered for the open trials in melanoma. It is not currently possible to open a greater number of trials, to have a greater scope of available trials, due to a lack of clinical and research support to run further trials especially due to the increasing complexity of trials and time burden needed to run them effectively. Constraints imposed by the commercial trial sponsors also limit the number of trials it is possible to open in smaller cancer centres such as those in the NOSCAN region. All feasibility requests for trials are reviewed by all consultants and if an expression of interest is submitted the chances are high that the site will be selected for running the trial.
Survival Analysis

To support the national reporting of QPIs and to provide context in their interpretation, an analysis of melanoma survival was undertaken. A cohort of patients diagnosed with melanoma during 2009 to 2011, and registered on the Scottish Cancer Registry, was used and linked to deaths data (up to December 2014) to provide 3 years of follow up for all patients (and up to 5 years of follow up for some). The analysis was based on Melanoma specific deaths rather than all causes of deaths.

There follows a series of survival curves showing the variation in survival rates for this cohort of patients by the following key criteria:

- Age and gender
- Site of origin
- Breslow thickness (mm)
- Clark’s Level
- Deprivation category (SIMD)
- Regional cancer network
- Charlson co-morbidity index

Further details on this analysis, including patient characteristics, analysis criteria and additional survival curves are available in the data tables.

1a) Survival Rates by Age Group – Males
### 1b) Survival Rates by Age Group – Females

#### Skin melanoma (melanoma specific deaths), Scotland, by age group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Patients</th>
<th>%</th>
<th>Deaths</th>
<th>1-year survival (%)</th>
<th>3-year survival (%)</th>
<th>5-year survival (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-44</td>
<td>222</td>
<td>14.4%</td>
<td>15</td>
<td>98.6%</td>
<td>95.5%</td>
<td>92.6%</td>
</tr>
<tr>
<td>45-54</td>
<td>218</td>
<td>14.1%</td>
<td>24</td>
<td>97.2%</td>
<td>91.2%</td>
<td>88.3%</td>
</tr>
<tr>
<td>55-64</td>
<td>306</td>
<td>19.8%</td>
<td>37</td>
<td>96.1%</td>
<td>91.1%</td>
<td>86.1%</td>
</tr>
<tr>
<td>65-74</td>
<td>353</td>
<td>22.9%</td>
<td>48</td>
<td>97.1%</td>
<td>89.2%</td>
<td>83.8%</td>
</tr>
<tr>
<td>75-84</td>
<td>330</td>
<td>21.4%</td>
<td>49</td>
<td>95.9%</td>
<td>86.4%</td>
<td>81.1%</td>
</tr>
<tr>
<td>85-99</td>
<td>114</td>
<td>7.4%</td>
<td>19</td>
<td>91.6%</td>
<td>81.7%</td>
<td>72.6%</td>
</tr>
</tbody>
</table>

p-value < 0.000

Age Group at Diagnosis:
- 15-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85-99

Years since diagnosis
Figures 1a and 1b show the survival rates at 1, 3 and 5 year intervals for males and females across all age groups. In general, survival rates for females are slightly better than for males across most age groups. These figures also show that survival rates are generally lower in the older population.

2) Survival Rates by Site of Origin

![Graph showing survival rates by cancer site](image)
Figure 2 shows the 1, 3 and 5 year survival rates by cancer site of origin. Five year survival rates for the four main sites of origin were all over 88%. Survival rates were generally highest for melanomas originating on the Arm.

3) Survival Rates by Breslow thickness (mm)
The survival rates by Breslow thickness (mm) are shown in Figure 3. The Chart and Table show that those patients with a higher Breslow thickness have a lower survival rate. The 5 year survival rate for patients with Breslow thickness 4.00mm+ is nearly half the survival rate of patients with Breslow thickness 0.01-0.99mm.

<table>
<thead>
<tr>
<th></th>
<th>Total Patients</th>
<th>%</th>
<th>Deaths</th>
<th>1-year survival (%)</th>
<th>3-year survival (%)</th>
<th>5-year survival (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.01-0.99</td>
<td>1,762</td>
<td>52.2%</td>
<td>26</td>
<td>99.8%</td>
<td>99.1%</td>
<td>98.1%</td>
</tr>
<tr>
<td>1.00-1.99</td>
<td>646</td>
<td>19.2%</td>
<td>32</td>
<td>98.8%</td>
<td>96.8%</td>
<td>93.9%</td>
</tr>
<tr>
<td>2.00-3.99</td>
<td>414</td>
<td>12.3%</td>
<td>68</td>
<td>98.3%</td>
<td>87.5%</td>
<td>80.6%</td>
</tr>
<tr>
<td>4.00+</td>
<td>365</td>
<td>10.9%</td>
<td>143</td>
<td>88.7%</td>
<td>65.8%</td>
<td>51.1%</td>
</tr>
<tr>
<td>Not Recorded</td>
<td>185</td>
<td>5.5%</td>
<td>50</td>
<td>82.1%</td>
<td>72.1%</td>
<td>71.1%</td>
</tr>
</tbody>
</table>

4). Survival Rates by Clarks Level

**Skin melanoma (melanoma specific deaths), Scotland, by Clarks Level**

![Graph showing survival rates by Clarks Level](image_url)

p-value < 0.000

---

**Observed (KM) survival (%)**

**Years since diagnosis**
Figure 4 shows the survival rates by Clarks Level. As expected, 5 year survival rates decrease significantly from level II to level V.

5). Survival Rates by Deprivation Category (SIMD)
Figure 5 shows the effect of deprivation on survival rates. It shows that survival rates are generally lower in the most deprived population.

6). Survival Rates by Regional Cancer Network of Diagnosis

Skin melanoma (melanoma specific deaths), Scotland, by network of diagnosis

![Graph showing survival rates by network of diagnosis](image)

- Total Patients: 459, %: 13.6%, Deaths: 57, 1-year survival (%): 96.1%, 3-year survival (%): 90.5%, 5-year survival (%): 86.2%
- Total Patients: 551, %: 16.3%, Deaths: 65, 1-year survival (%): 96.7%, 3-year survival (%): 90.3%, 5-year survival (%): 86.4%
- Total Patients: 700, %: 20.8%, Deaths: 71, 1-year survival (%): 97.2%, 3-year survival (%): 91.1%, 5-year survival (%): 88.5%
- Total Patients: 760, %: 22.5%, Deaths: 59, 1-year survival (%): 97.1%, 3-year survival (%): 93.8%, 5-year survival (%): 91.3%
- Total Patients: 903, %: 26.8%, Deaths: 67, 1-year survival (%): 98.5%, 3-year survival (%): 94.6%, 5-year survival (%): 90.5%
Figure 6 shows the survival rates by Regional Cancer Network. The chart and table show there are minimal differences in survival rates between the three Cancer Networks.

7). Survival Rates by Charlson co-morbidity index

[Table]

<table>
<thead>
<tr>
<th>Network</th>
<th>Total Patients</th>
<th>%</th>
<th>Deaths</th>
<th>1-year survival (%)</th>
<th>3-year survival (%)</th>
<th>5-year survival (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOSCAN</td>
<td>874</td>
<td>26.9</td>
<td>71</td>
<td>98.2%</td>
<td>93.1%</td>
<td>90.6%</td>
</tr>
<tr>
<td>SCAN</td>
<td>875</td>
<td>26.9</td>
<td>74</td>
<td>97.8%</td>
<td>93.5%</td>
<td>90.4%</td>
</tr>
<tr>
<td>WOSCAN</td>
<td>1,524</td>
<td>48.1</td>
<td>174</td>
<td>95.6%</td>
<td>91.5%</td>
<td>87.7%</td>
</tr>
</tbody>
</table>

Skin melanoma (melanoma specific deaths), Scotland, by Charlson co-morbidity index

[p-value < 0.000]

- None [score=0]
- Mild [score=1]
- Moderate [score=2]
- Severe [score=3]
Figure 7 shows survival rates by Charlson co-morbidity index. Those with a severe index in general have the lowest survival rates at 1, 3 and 5 years.

<table>
<thead>
<tr>
<th></th>
<th>Total Patients</th>
<th>%</th>
<th>Deaths</th>
<th>1-year survival (%)</th>
<th>3-year survival (%)</th>
<th>5-year survival (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None (score=0)</td>
<td>2,947</td>
<td>87.4%</td>
<td>255</td>
<td>97.6%</td>
<td>93.4%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Mild (score=1)</td>
<td>130</td>
<td>3.9%</td>
<td>21</td>
<td>96.1%</td>
<td>87.8%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Moderate (score=2)</td>
<td>209</td>
<td>6.2%</td>
<td>24</td>
<td>96.4%</td>
<td>88.3%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Severe (score&gt;3)</td>
<td>87</td>
<td>2.6%</td>
<td>19</td>
<td>90.0%</td>
<td>73.6%</td>
<td>73.6%</td>
</tr>
</tbody>
</table>
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>Computed Tomography scan</td>
</tr>
<tr>
<td>ISD</td>
<td>Information Services Division</td>
</tr>
<tr>
<td>QPI</td>
<td>Quality Performance Indicator</td>
</tr>
<tr>
<td>MDT</td>
<td>Multidisciplinary team</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging scan</td>
</tr>
<tr>
<td>NOSCAN</td>
<td>North of Scotland cancer network</td>
</tr>
<tr>
<td>SACT</td>
<td>Systemic Anti Cancer Therapy</td>
</tr>
<tr>
<td>SCAN</td>
<td>South East Scotland cancer network</td>
</tr>
<tr>
<td>SCRN</td>
<td>Scottish Cancer Research Network</td>
</tr>
<tr>
<td>SIMD</td>
<td>Scottish Index of Multiple Deprivation</td>
</tr>
<tr>
<td>SMR01</td>
<td>Scottish Morbidity Record (Inpatient and Daycase Activity)</td>
</tr>
<tr>
<td>SNB</td>
<td>Sentinel Node Biopsy</td>
</tr>
<tr>
<td>SNOMED</td>
<td>Systematised Nomenclature of Medicine</td>
</tr>
<tr>
<td>WLE</td>
<td>Wide Local Excision</td>
</tr>
<tr>
<td>WoSCAN</td>
<td>West of Scotland cancer network</td>
</tr>
<tr>
<td>Table No.</td>
<td>Name</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Data Tables</td>
<td>Melanoma QPI Data Tables</td>
</tr>
<tr>
<td>Survival Analysis</td>
<td>Melanoma Survival Analysis</td>
</tr>
</tbody>
</table>
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Further Information
Further information on Cancer Quality Performance Indicators can be found on the Cancer QPI section of the ISD website.

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Please provide feedback on this publication to help us improve our services.
Appendix

A1 – Background Information

The purpose of the cancer quality work programme and the roles and responsibilities of each organisation are outlined in Chief Executives Letter (CEL 06). This document also provides details of the data collection, quality assurance and governance processes that are critical to the reporting of QPIs.

A2 – Melanoma QPIs

The table below shows the list of Melanoma QPIs applicable to this publication. Please note that revisions to these QPIs may have been made since the initial data collection – refer to the Healthcare Improvement Scotland website for the latest version of these QPIs.

<table>
<thead>
<tr>
<th>QPI</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>QPI 1: Excision Biopsy</td>
<td>Number of patients with cutaneous melanoma undergoing diagnostic excision biopsy who had this carried out by a skin cancer clinician *.</td>
<td>All patients with cutaneous melanoma undergoing diagnostic excision biopsy.</td>
<td>No Exclusions</td>
<td>90%</td>
</tr>
<tr>
<td>QPI 2: Pathology Reporting</td>
<td>Number of patients with cutaneous melanoma undergoing diagnostic excision biopsy where the surgical pathology report contains a full set of data items (as defined by the current Royal College of Pathologists dataset).</td>
<td>All patients with cutaneous melanoma undergoing diagnostic excision biopsy.</td>
<td>No Exclusions</td>
<td>90%</td>
</tr>
<tr>
<td>QPI 3: Multi-Disciplinary Team Meeting (MDT)</td>
<td>Number of patients with cutaneous melanoma discussed at the MDT before definitive treatment. (wide local excision, chemotherapy/SACT, supportive care and radiotherapy).</td>
<td>All patients with cutaneous melanoma.</td>
<td>Patients who died before first treatment</td>
<td>95%</td>
</tr>
<tr>
<td>QPI 4: Clinical Examination of Draining Lymph Node Basins</td>
<td>Number of patients with cutaneous melanoma who undergo clinical examination of relevant draining lymph node basins as part of clinical staging.</td>
<td>All patients with cutaneous melanoma.</td>
<td>No Exclusions</td>
<td>95%</td>
</tr>
<tr>
<td>QPI 5: Sentinel Node Biopsy Pathology</td>
<td>Number of patients with cutaneous melanoma who undergo SNB where the SNB report contains a full set of data items (as defined by the current Royal College of Pathologists dataset).</td>
<td>All patients with cutaneous melanoma undergoing SNB.</td>
<td>No Exclusions</td>
<td>90%</td>
</tr>
<tr>
<td>QPI 6: Wide Local Excisions</td>
<td>Number of patients with cutaneous melanoma undergoing diagnostic excision biopsy who undergo a wide local excision.</td>
<td>All patients with cutaneous melanoma undergoing diagnostic excision</td>
<td>Patients who died before treatment</td>
<td>95%</td>
</tr>
<tr>
<td>QPI 7: Time to Wide Local Excision</td>
<td>Number of patients with cutaneous melanoma undergoing wide local excision within 84 days of their diagnostic excision biopsy.</td>
<td>All patients with cutaneous melanoma undergoing wide local excision.</td>
<td>No Exclusions.</td>
<td>95%</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>----------------</td>
<td>-----</td>
</tr>
<tr>
<td>QPI 8: BRAF Status</td>
<td>Number of patients with unresectable stage III or IV cutaneous melanoma who have their BRAF status checked.</td>
<td>All patients with unresectable stage III or IV cutaneous melanoma.</td>
<td>No Exclusions.</td>
<td>75%</td>
</tr>
<tr>
<td>QPI 9: Imaging for Patients with Advanced</td>
<td>Number of patients with stage III and stage IV cutaneous melanoma undergoing completion lymphadenectomy who undergo CT or PET CT prior to completion lymphadenectomy.</td>
<td>All patients with stage III and stage IV cutaneous melanoma undergoing completion lymphadenectomy.</td>
<td>No Exclusions.</td>
<td>95%</td>
</tr>
<tr>
<td>QPI 10: Systemic Therapy</td>
<td>Number of patients with unresectable stage III and IV cutaneous melanoma who undergo SACT.</td>
<td>All patients with unresectable stage III and IV cutaneous melanoma.</td>
<td>No Exclusions.</td>
<td>60%</td>
</tr>
<tr>
<td>QPI 11: Access to Lymphoedema Service</td>
<td>Number of patients with cutaneous melanoma undergoing groin block dissection who have been referred to a lymphoedema service.</td>
<td>All patients with cutaneous melanoma undergoing groin block dissection.</td>
<td>No Exclusions.</td>
<td>40%</td>
</tr>
</tbody>
</table>

*Note: A skin cancer clinician can be defined as a: Dermatologist, Plastic Surgeon or a locally designated clinician with a special interest in skin cancer, who is also a member of the melanoma MDT.*
A3 – Melanoma Clinical Trials

The list of clinical trials in use for Melanoma patients in Scotland across the Scottish Cancer Research Networks is shown below. Further details on these clinical trials are available from the relevant SCRN.

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Study Title</th>
<th>SCRN - West</th>
<th>SCRN - South East</th>
<th>SCRN - North &amp; East</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional</td>
<td>DESCRIBE</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BRF115532</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G028399</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paclitaxel +/- GSK1120212 or Pazopanib in Melanoma - PACMEL</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Melanoma Lifestyle Study</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Translational</td>
<td>ASICA Project Pilot Study</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Role of soluble CTLA-4 in controlling immune responses in melanoma</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>MK-3475-006</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>NCRN442 BRIM8: Vemurafenib in adjuvant melanoma</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Paclitaxel +/- GSK1120212 or Pazopanib in Melanoma - PACMEL</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
A2 – Publication Metadata (including revisions details)

<table>
<thead>
<tr>
<th>Metadata Indicator</th>
<th>Description</th>
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<tbody>
<tr>
<td>Publication title</td>
<td>Melanoma Quality Performance Indicators</td>
</tr>
<tr>
<td>Description</td>
<td>This report shows the performance of NHS Boards against eleven Melanoma QPIs for the period July 2014 to June 2015. Relevant commentary from NHS Boards is also included to provide local context to the data.</td>
</tr>
<tr>
<td>Theme</td>
<td>Health and Social Care</td>
</tr>
<tr>
<td>Topic</td>
<td>Cancer services</td>
</tr>
<tr>
<td>Format</td>
<td>PDF Document</td>
</tr>
<tr>
<td>Data source(s)</td>
<td>Cancer audit, Cancer registry</td>
</tr>
<tr>
<td>Date that data are acquired</td>
<td>November 2015</td>
</tr>
<tr>
<td>Release date</td>
<td>17th May 2016</td>
</tr>
<tr>
<td>Frequency</td>
<td>Every 3 years</td>
</tr>
<tr>
<td>Timeframe of data and timeliness</td>
<td>Data covering patients diagnosed between July 2014 and June 2015.</td>
</tr>
<tr>
<td>Continuity of data</td>
<td>First release of QPI data</td>
</tr>
<tr>
<td>Revisions statement</td>
<td>This is the first release of Melanoma QPI data. It is expected that QPI definitions and measurability documents will evolve and therefore future publications may contain revisions to previously published information.</td>
</tr>
<tr>
<td>Revisions relevant to this publication</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Concepts and definitions</td>
<td>QPI definitions and measurability criteria are available from the Cancer Audit section of the ISD website.</td>
</tr>
<tr>
<td>Relevance and key uses of the statistics</td>
<td>The reporting of performance against these national QPIs is underpinned by a national governance framework that aims to use these data to improve cancer services in Scotland.</td>
</tr>
<tr>
<td>Accuracy</td>
<td>Information on the accuracy of some of the national datasets used within this publication is available on the ISD website.</td>
</tr>
<tr>
<td></td>
<td>ISD only receives aggregate data from each NHS Board to populate these indicators (with the exception of case ascertainment). Derivations of the figures and data accuracy are matters for individual NHS Boards.</td>
</tr>
<tr>
<td>Completeness</td>
<td>100% of QPI aggregate data was returned.</td>
</tr>
<tr>
<td>Comparability</td>
<td>The national dataset and data definitions in conjunction with the final quality performance indicators and the accompanying measurability document were agreed in</td>
</tr>
</tbody>
</table>
public engagement to ensure data collection is comparable across the country.

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>It is the policy of ISD Scotland to make its web sites and products accessible according to published guidelines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coherence and clarity</td>
<td>Statistics for each QPI are presented consistently in chart and table format at NHS Board level, with national figures and performance targets included for comparison and clarity.</td>
</tr>
<tr>
<td>Value type and unit of measurement</td>
<td>The units of measure include numbers and percentages.</td>
</tr>
<tr>
<td>Disclosure</td>
<td>The ISD protocol on Statistical Disclosure Protocol is followed.</td>
</tr>
<tr>
<td>Official Statistics designation</td>
<td>Official Statistics</td>
</tr>
<tr>
<td>UK Statistics Authority Assessment</td>
<td>Not currently put forward for assessment</td>
</tr>
<tr>
<td>Last published</td>
<td>First release</td>
</tr>
<tr>
<td>Next published</td>
<td>May 2019</td>
</tr>
<tr>
<td>Date of first publication</td>
<td>n/a</td>
</tr>
<tr>
<td>Help email</td>
<td><a href="mailto:johnconnor@nhs.net">johnconnor@nhs.net</a></td>
</tr>
<tr>
<td>Date form completed</td>
<td>22nd February 2016</td>
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</tbody>
</table>
A3 – Early Access details (including Pre-Release Access)

Pre-Release Access
Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ISD are obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access.

Standard Pre-Release Access:
  Scottish Government Health Department
  NHS Board Chief Executives
  NHS Board Communication leads

Early Access for Management Information
These statistics will also have been made available to those who needed access to 'management information', i.e. as part of the delivery of health and care:

Members of the National Cancer Quality Operational Group
Members of the National Cancer Quality Steering Group

Early Access for Quality Assurance
These statistics will also have been made available to those who needed access to help quality assure the publication:

Members of the National Cancer Quality Operational Group
Members of the National Cancer Quality Steering Group
Regional and NHS Board Melanoma Clinical Leads
Network Lead Clinicians
A4 – ISD and Official Statistics

About ISD

Scotland has some of the best health service data in the world combining high quality, consistency, national coverage and the ability to link data to allow patient based analysis and follow up.

Information Services Division (ISD) is a business operating unit of NHS National Services Scotland and has been in existence for over 40 years. We are an essential support service to NHSScotland and the Scottish Government and others, responsive to the needs of NHSScotland as the delivery of health and social care evolves.

Purpose: To deliver effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.

Mission: Better Information, Better Decisions, Better Health

Vision: To be a valued partner in improving health and wellbeing in Scotland by providing a world class intelligence service.

Official Statistics

Information Services Division (ISD) is the principal and authoritative source of statistics on health and care services in Scotland. ISD is designated by legislation as a producer of ‘Official Statistics’. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within ISD.