

SOUTH EAST SCOTLAND CANCER NETWORK (SCAN) PROSPECTIVE CANCER AUDIT

Bladder Cancer 2021-22 Comparative Audit Report

Patients diagnosed 1st April 2021 to 31st March 2022

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Document History

Version	Circulation	Date	Comments
1	SCAN leads sign off meeting	23/02/2023	Agree actions and comments
2	SCAN Sign off group	14/04/2023	For confirmation of actions and comments. For insertion of clinical Lead's commentary
3	SCAN Urology Group	14/04/2023	For final approval / comments
4	SCAN Clinical Governance Framework, Action Plan Leads and SCAN Urology Group	12/05/2023	Checked for disclosive data January 2024
4w	Report assessed for disclosive data, completed action plans to be added and report to be added to SCAN Website	January 2024	

Lead clinician summary

This is year 8 of the Scottish national Bladder Cancer QPIs and I am pleased to note the audit findings from SCAN – we have now completed 4 years since incorporating changes to QPIs and measurability criteria following the 1st national formal review meeting in 2018. In addition, SCAN data and clinicians have been vital to the *Scot BC Quality OPS* clinical project [<https://pubmed.ncbi.nlm.nih.gov/34419380/>], where upon completion of analyses of outcomes from the cohort of patients diagnosed between April 2014 - Mar2017, the first paper describing the overview is ready for publication. These results have helped inform discussions at the 2nd national formal review meeting in June 2022. Moreover, we are proud that recommendations made by SCAN at this review have influenced changes to the QPIs, including the introduction of a more nuanced approach to the use of single post TURBT chemotherapy instillation (QPI 3) and re-TURBT (QPI 4) as well as introducing a new QPI evaluating early recurrence rates and under-staging (new QPI 14). Evaluation of long term clinical outcomes from the second 3-year cycle (patients diagnosed April 2017 to March 2020) is already underway and will assess the benefits of the changes to the QPIs enacted following the 1st formal review in 2018. These findings are anticipated to further inform wider clinical practice. I am very grateful for SCAN's contribution to this ongoing novel piece of work.

The case attainment for the Bladder Cancer QPIs has been extremely good and I continue to be impressed by the high quality and diligence practiced by the audit personnel within the region. Regular, necessary dialogue between audit and clinical staff ensures data accuracy; particularly where (accepted) discrepancy exists between pathology and staging scans (QPI 4, for example). I am confident that the audit data reflects real world clinical experience across the SCAN region.

The targets set nationally following the 2nd formal review are also very high this time, reflecting the overall desire to improve cancer outcomes and reduce variability across Scotland.

The action points and recommendations following the 2020-21 audit and comparative report have also been explored in my comments.

QPI 1– SCAN has done very well with this QPI - almost every new cancer patient has gone through a multi-disciplinary team meeting.

QPI 2(i) – Documentation of tumour characteristics are essential in the management of NMIBC. The target has now increased to 95%. SCAN had a shortfall of only 3% (an absolute

improvement of 14% compared with the previous year). The emphasis continues to be the utilisation of the standard operation proforma - the electronic TRAKcare version (developed by and currently being used in Lothian) is expected to facilitate improved compliance with this QPI. The technical programming elements of this electronic operation note / audit tool has been passed to Intersystems and we await the rollout across Scotland. We have noted that D&G do not use TRAKcare, therefore will continue to use the paper proforma.

QPI 2(ii) – The target has now increased to 95%. SCAN had a shortfall of 1% for the third time in as many years. Once again the electronic proforma / operation note is anticipated to help compliance with this QPI too. We welcome the future inclusion of ‘unsure’ as a data item for the ‘completion of resection’ data field, especially as ‘unsure’ is currently recorded as a “not met” for this QPI.

QPI 2(iii) – Following the 2nd formal review, this QPI now measures sampling detrusor muscle in patients with high grade cancer with a target of 90%. SCAN missed the target by 11.4%. As it is critical to achieve this benchmark, training in performing TURBT effectively and to a high standard is vital to ensuring excellent outcomes as well as reducing the requirement for re-TURBT. Lothian have now emphasised the need to protect capacity in dedicated bladder cancer surgeons’ lists to carry out TURBTs. I will share presented and published data with colleagues to highlight the importance of achieving this QPI.

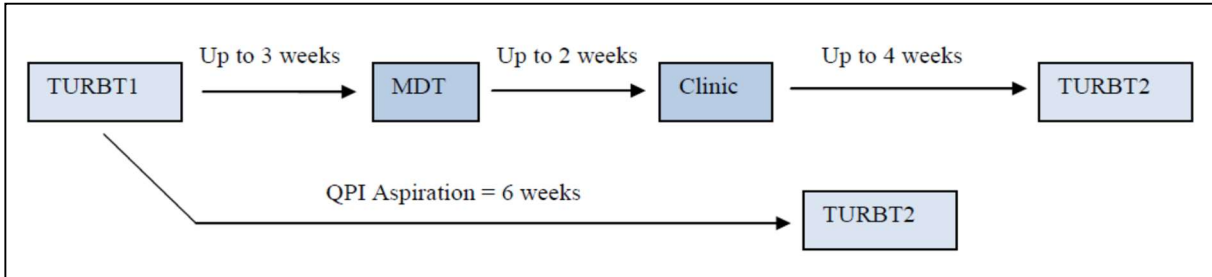
QPI 3 – This QPI is not being reported in this round as changes have been made at the second formal review.

QPI 4 (i), (ii), (iii) – SCAN and each constituent health board have failed to meet the target of carrying out re-TURBT (in selected patients) within 42 days of the initial TURBT. It must be noted that the significant shortfall is mainly the result of not meeting the timing, as opposed to actually performing the re-TURBT when indicated.

Despite best intention and attempting to ring-fence spaces on theatre lists (as in NHS Lothian) for the early re-TURBT (or GA cystoscopy) within 42 days of the initial TURBT, there has been a significant shortfall in being able to meet this target in the SCAN region for a variety of reasons (some have been described in my summaries from the previous 2 years):

- (a) Capacity - There was a shortfall in capacity, despite taking up extra lists to accommodate patients with bladder cancer. In NHS Lothian, the main reason for the capacity shortfall is the specific loss of lists to support bladder cancer capacity. Appointment of a second consultant and a process to secure the ring-fenced lists in Lothian are expected to help. Some health boards in SCAN, BGH for example, do not have regular lists and therefore cannot ring-fence.
- (b) Some of the patients with high grade cancer were deemed un-fit to undergo re-TURBT.
- (c) MDM recommendation for BCG instead of re-TURBT in these patients. This also reflects the overall need to be more nuanced in performing re-TURBT.
- (d) Apparent delays in pathology reporting and MDM, especially for D&G and BGH, have resulted in delays in the pathway to re-TURBT.
- (e) Timing - based on the timeline below, it is close to impossible to achieve this QPI in SCAN, given the current capacity and processes to ring-fence theatre capacity (Lothian have now planned for a specific monthly dedicated list for re-TURBT) and innovative approaches to efficiently secure this capacity are much needed and should help:

2021/22 Re-TURBT (QPI 4) practice in Lothian v QPI aspiration:



However, reassuringly, from our clinical study in 92% of Scotland’s patients (where SCAN centres and clinicians have contributed data), the risk of under-staging with the initial TURBT (the main reason for performing re-TURBT) in high risk NMIBC is very low (2.9%)

[<https://pubmed.ncbi.nlm.nih.gov/32690321/>]. Clinicians are therefore reassured that consequent to a better quality TURBT at the outset, the need for repeat TURBT within 42 days has reduced and that we can be even more selective. However, the first TURBT has to be performed to a high standard and therefore meeting QPI 2(iii) has a direct consequence to the requirement for QPI 4. Selection of patients for re-TURBT must therefore be more nuanced and the yet to be published data supports this. Additionally, we have demonstrated (presented at BAUS 2022 and EAU 2023) that within the QPI 'environment' there doesn't seem to be a disadvantage if the re-TURBT is performed beyond 42 days – perhaps once this data is published, it might help us modify QPI 4 at the 3rd formal review. In the future we will also explore including only patients who the MDM recommend for this QPIs denominator.

QPI 5(i) and 5(ii) – Consequent to the high compliance across Scotland, the 2nd formal review has recommended that this QPI be archived.

QPI 6 – SCAN has had a shortfall of 28.3% with Lothian and Fife not meeting the 95% target. (77.8% & 33.3% respectively). It is still being recommended that Fife surgeon(s) consider using the same standardised operative template from NHS Lothian, where description of the lymphadenectomy template is specified. The 2nd formal review had recommended that the lymphadenectomy template, as well as lymph node count are now used as the metrics for this QPI. The challenge seems to be meeting the target for the lymph node count. Some patients who were included in the denominator were not surgically suitable to undergo extended pelvic lymphadenectomy (for example scarring and fibrosis in the pelvis from previous surgery). Whilst the much needed survival outcomes in the MIBC patients from *Scot BC Quality OPS* are awaited (and we would have the necessary granularity to determine if the LN count determines rates of cure), we recommend splitting this QPI into 2 sections: template and lymph node count (with a smaller target). This will be raised for discussion at the 3rd formal review in 2024.

QPI 7(i) and (ii) – not reported in this QPI round as there has been a change to the timing between TURBT and radical treatment from 3 months to 6 weeks at the 2nd formal review. I look forward to reviewing the outcomes next year.

QPI 8 – This is the 4th year of reporting using the new target for the hospital being 20 cystectomies. Radical surgery for SCAN is only carried out in Lothian and Fife and the case ascertainment has been accurate. SCAN met the target for hospital volume and surgeon volume. However, Fife had a shortfall of 9 cystectomies for the hospital volume target. It has been recommended that this is reviewed at the Fife health board level. Of course, the hospital volume versus outcomes analysis from our QPI dataset is something we are looking at as well in *Scot BC Quality OPS*.

QPI 9 – As in the previous 7 years, this continues to be a difficult QPI to meet for SCAN, albeit with a significantly smaller shortfall of 1.7% this time. Lothian missed the target by 4.4%. This trend has been noted previously in the other two Scottish cancer networks as well. The vast majority of patients with MIBC not meeting this QPI are noted to have a specific surgical option recommended at the MDM, i.e. there is no oncology option. Oncologists for SCAN were satisfied that patients in this cohort received appropriate treatment without the potential delays that comes with an additional (oncology) clinic appointment. SCAN oncologists agreed that this QPI should be considered for revision at the next (3rd) formal review in 2024. The suggested option is: "changing the denominator to include only patients suitable for all radical treatment options".

QPI 10 – not reported in this QPI round as there has been a change to the inclusion criteria for this QPI as well as the target for the use of concurrent chemotherapy.

QPI 11 – Of 55 patients who underwent radical treatment for muscle invasive bladder cancer in SCAN, there was one death within 30 days of radical surgery (had a stroke) and one further death within 90 days of radical surgery and radical radiotherapy, respectively (from disease progression). All 3 occurred in Lothian. One of the surgical patients suffered a stroke, and discussion at the Urology morbidity and mortality (M&M) meeting deemed that this mortality, whilst unfortunate, was within the accepted risk in patients with higher risk

undergoing major surgery and did not necessitate any practice change. The other patients had advanced cancer that progressed rapidly after surgery and radiotherapy, respectively. It was felt during the previous formal review, as the denominators are small, that performance against this QPI will be analysed / reviewed in 5-year cycles to allow for more accurate interpretation of trends. In addition, as QPIs need to reflect and measure quality of care as opposed to cancer biology, perhaps the definitions and measurability criteria should be altered to only measure 30 and 90 day mortality consequent to causes un-related to the Bladder Cancer – something for discussion at the 3rd formal review in 2024.

QPI 12 – This is not being reported as it is understood that QPI 12, which measures recruitment to clinical trials, will be evaluated as part of a process separated from the QPIs.

Professor Param Mariappan
March 2023

Clinical Recommendation Summary from 2021-22

QPI	Action required	Lead	Date for update
2i	Audit staff is monitoring the use of the Bladder proforma in theatres throughout the year.	Martin Keith / Campbell Wallis.	June 2023
2ii	With the new data option of adding “unsure” field to future analysis, improvement should be achieved.	SCAN / Formal Review.	June 2023
2iii	Clinically deemed high grade or high risk procedures should be booked in for dedicated Bladder cancer surgeons only to perform. Initial clinical triage will be required.	Mr Thomas / Martin Keith / Mr Mitchell / Prof Mariappan.	June 2023
4i – 4iii	Borders will attempt more timely repeat procedures as soon as capacity returns to normal. D&G are triaging and booking procedures post MDM. Lothian has ring-fenced theatre slots to try and accommodate repeat resections. QPI steering group – Consider QPI revision to base re-resection decisions on MDM recommendations post TURBT1.	Mr Thomas / Martin Keith / Mr Mitchell / Prof Mariappan / Formal Review.	June 2023
6	Fife service need to update or be more clear in operation notes on what procedure has been performed. QPI steering group – Need to consider revision of QPI to either, include exclusion criteria or increase tolerance to ensure this QPI truly reflect service quality.	Mr Mitchell / Formal Review.	June 2023
9	QPI Steering Group – To amend the measurement of this QPI. Only include cases where, on MDM review, it would be of benefit for both surgeons and oncologists to offer treatment options.	Formal Review.	June 2023

Clinical Recommendation Summary from 2020-21

QPI	Action required	Progress
2	TRAK proforma roll out across Scotland planned with Intersystem.	Well established in Lothian. Work to improve proforma use in other boards is ongoing.
2ii	Need a “not sure” drop down option for this data item.	Added post formal review. Complete.
3	NHS Fife need to review the 10 Fife patients to ascertain why they had no MMC.	10 cases reviewed and the TURBT operation note has been amended to improve the recording of clinical reasons why MMC was not given post-op. Complete.
4	QPI to be discussed at the formal review and no other actions were identified.	Updated QPIs post formal review. Complete.

Bladder Cancer QPI Attainment Summary 2021-22		Target%	Borders			D&G			Fife			Lothian			SCAN		
QPI 1: MDT Discussion	Before definitive treatment (MIBC)	95	N 9 D 9	100%	N 7 D 7	100%	N 27 D 28	96.4%	N 60 D 63	95.2%	N 103 D 107	96.3%					
	NMIBC discussed at the MDT after histological confirmation of NMIBC	95	N 22 D 22	100%	N 34 D 34	100%	N 68 D 69	98.6%	N 124 D 124	100%	N 248 D 249	99.6%					
QPI 2: Quality of TURBT at initial resection	Detailed description with tumour location, size, number, appearance	95	N 31 D 31	100%	N 26 D 40	65.0%	N 68 D 74	91.9%	N 163 D 169	96.4%	N 288 D 314	91.7%					
	Where the resection is documented as complete or not	95	N 28 D 28	100%	N 35 D 39	89.7%	N 63 D 67	94.0%	N 154 D 164	93.9%	N 280 D 298	94.0%					
	HG NMIBC with detrusor muscle in the specimen at initial TURBT.	90	N 10 D 10	100%	N 13 D 15	86.7%	N 17 D 24	70.8%	N 41 D 54	75.9%	N 81 D 103	78.6%					
QPI 4: Early TURBT	All Grades T1 or HG Ta (>1 or >3cm) NMIBC to have re-resection within 42 days from TURBT1	80	N 0 D 8	0%	N 0 D 9	0%	N 0 D 25	0%	N 0 D 50	0%	N 0 D 92	0%					
	HG NMIBC with no Detrusor muscle at TURBT1 to have re-resection in 42 days	80	N 0 D 0	N/A	N 0 D 1	0%	N 0 D 9	0%	N 0 D 14	0%	N 0 D 24	0%					
	NMIBC where resection was incomplete at TURBT1 to have re-resection in 42 days	80	N 0 D 1	0%	N 0 D 1	0%	N 0 D 3	0%	N 0 D 4	0%	N 0 D 9	0%					
QPI 6: Lymph Node Yield. Pelvic lymph node dissection (>10 lymph nodes) and level 2 undertaken at radical cystectomy		95	Presented by Board of surgery				N 3 D 9	33.3%	N 21 D 27	77.8%	N 24 D 36	66.7%					
QPI 8: Volume of Cases / Surgeon: radical cystectomies 20 per centre, 10 procedures by a surgeon over a 1 year.		>20	2 Surgeons met the QPI criteria. 1 Health Board met the QPI criteria.														
QPI 9: Oncological Discussion: MIBC patients who had radical surgery who met with an oncologist prior to radical cystectomy		60	N 0 D 0	N/A	N 0 D 1	0%	N 4 D 5	80.0%	N 10 D 18	55.6%	N 14 D 24	58.3%					
QPI 11: 30 Day Mortality Patients who die within 30 days of treatment with curative intent for bladder cancer.	Radical Surgery	<3	Presented by Board of surgery				N 0 D 9	0%	N 1 D 26	3.8%	N 1 D 35	2.9%					
	Radiotherapy	<3	N 0 D 4	0%	N 0 D 2	0%	N 0 D 3	0%	N 0 D 11	0%	N 0 D 20	0%					
QPI 11: 90 Day Mortality Patients who die within 90 days of treatment with curative intent for bladder cancer.	Radical Surgery	<5	Presented by Board of surgery				N 0 D 9	0%	N 2 D 27	7.4%	N 2 D 36	5.6%					
	Radiotherapy	<5	N 0 D 4	0%	N 0 D 2	0%	N 0 D 3	0%	N 1 D 11	9.1%	N 1 D 20	5.0%					

Introduction and Methods

Cohort

This report covers patients newly diagnosed with bladder cancer in SCAN between 01/04/2021 and 31/03/2022. The results contained within this report have been presented by NHS board of diagnosis. Where the QPI relates to surgical outcomes the results are presented by hospital of surgery.

Dataset and Definitions

The QPIs have been developed collaboratively with the three Regional Cancer Networks, Public Health Scotland (PHS), and Healthcare Improvement Scotland. It is intended that QPIs will be kept under regular review and be responsive to changes in clinical practice and emerging evidence.

The overarching aim of the cancer quality work programme is to ensure that activity at NHS board level is focused on areas most important in terms of improving survival and patient experience, whilst reducing variance and ensuring safe, effective and person-centred cancer care.

Following a period of development, public engagement and finalisation, each set of QPIs is published by Healthcare Improvement Scotland.

Accompanying datasets and measurability criteria for QPIs are published on the PHS website link. NHS boards are required to report against QPIs as part of a mandatory, publicly reported, programme at a national level.

The QPI dataset for bladder cancer was implemented from 01/04/2014, and this is the eighth publication of QPI results for bladder cancer within SCAN.

The Bladder QPIs were subject to a second formal review and revised documents for data collection were published in June 2022. The table below encompasses most of the changes made at formal review.

The following QPIs were updated:

QPI	Change	Year for reporting
2	<ul style="list-style-type: none">• Specification (i): Removed exclusion of patients with very small tumours (≤ 5mm).• Specification (iii): Denominator changed from all bladder cancer to high grade NMIBC. This group of patients would benefit the most from resecting detrusor muscle and will allow for the avoidance of over resection in lower grade tumours.• Target increased from 80% to 90%	8 (2021-22)
2 Additional	Total number of patients with complete / incomplete resection for QPI 2i to QPI 2iii.	9 (2022-23)
3	<ul style="list-style-type: none">• QPI updated to include 'other alternative chemotherapy agents' as well as Mitomycin C.• Denominator changed from 'all NMIBC' to low grade Ta NMIBC who benefit most from a single dose of Mitomycin C.• Increase in target from 60% to 80% to accommodate this more focussed group of patients.	9 (2022-23)
4	<ul style="list-style-type: none">• Specification (ii) – Low grade G2 tumours removed for NMIBC patients who have undergone TURBT where detrusor muscle is absent from specimen.• Specification (iii) – An additional code has been added to 'Complete resection at TURBT' for 'unsure' (previously recorded as No).	8 (2021-22)

6	<ul style="list-style-type: none"> QPI has been updated to include number of nodes (≥ 10) as well as the extent of dissection. Target increased from 90% to 95% 	8 (2021-22)
7	<ul style="list-style-type: none"> Specification (i) – Timeframe changed from 3 months to 6 weeks from the time between diagnosis to radical cystectomy. Specification (ii) – Wording changed from ‘chemoradiation’ to ‘radiotherapy’ to account for change in terminology from chemoradiotherapy to radiotherapy in combination with a radiosensitiser 	9 (2022-23)
10	<ul style="list-style-type: none"> QPI changed from radiotherapy with chemotherapy to radiotherapy with a concomitant radiosensitiser. 	9 (2022-23)
11	<ul style="list-style-type: none"> Chemotherapy been removed as a treatment option from the measurement of this QPI. This will now be measured via the national SACT Data Group using Chemocare data to include all patients receiving SACT rather than just newly diagnosed patients as per audit. 	8 (2021-22)
13	<ul style="list-style-type: none"> New QPI – looking at residual disease at 3 month follow up cystoscopy and at 2nd re-resection during initial treatment pathway. 	9 (2022-23)

QPI 5 has been archived – All regions have met and exceeded the 90% target over a number of years and consistent pathology reporting according to guidelines is now considered standard practice.

QPI 11 has been removed - Chemotherapy been removed as a treatment option from the measurement of this QPI. This will now be measured via the national SACT Data Group using Chemocare data to include all patients receiving SACT rather than just newly diagnosed patients as per audit.

QPI 12 Not being reported.

The standard QPI format is shown below:

QPI Title:	Short title of Quality Performance Indicator (for use in reports etc.)	
Description:	Full and clear description of the Quality Performance Indicator.	
Rationale and Evidence:	Description of the evidence base and rationale which underpins this indicator.	
Specifications:	Numerator:	Of all the patients included in the denominator those who meet the criteria set out in the indicator.
	Denominator:	All patients to be included in the measurement of this indicator.
	Exclusions:	Patients who should be excluded from measurement of this indicator.
	Not recorded for numerator	Include in the denominator for measurement against the target. Present as <i>not recorded</i> only if the patient cannot otherwise be identified as having met/not met the target
	Not recorded for exclusion	Include in the denominator for measurement against the target unless there is other definitive evidence that the record should be excluded. Present as <i>not recorded</i> only where the record cannot otherwise be definitively identified as an inclusion/exclusion for this standard.
	Not recorded for denominator	Exclude from the denominator for measurement against the target. Present as <i>not recorded</i> only where the patient cannot otherwise be definitively identified as an inclusion/exclusion for this standard
Target:	Statement of the level of performance to be achieved.	

¹ QPI documents are available at www.healthcareimprovementscotland.org

² Datasets and measurability documents are available at www.isdscotland.org

Audit Processes

Data was analysed by the audit facilitators in each NHS board according to the measurability document provided by PHS. SCAN data was collated by Adam Steenkamp, SCAN Audit Facilitator for Urological cancer.

Data capture focuses around the process for the weekly multidisciplinary meetings (MDM), ensuring that information is collected through routine processes. Data is recorded in eCase for Borders, Dumfries & Galloway, Fife and Lothian.

Clinical Sign-Off: This report compares analysed data from Borders, D&G, Fife and Lothian and was signed off as accurate following review by the lead clinicians from each board. The collated SCAN results were reviewed jointly by the lead clinicians, including oncologists, to assess variances and provide comments on results.

Lead Clinicians and Audit Personnel

SCAN Region	Hospital	Lead Clinician	Audit Support
NHS Borders	Borders General Hospital	Mr Ben Thomas	Suzanne Tunmore
NHS Dumfries & Galloway	Dumfries & Galloway Royal Infirmary	Miss Maria Bews-Hair	Campbell Wallis
NHS Fife	Queen Margaret Hospital	Mr I Mitchell	Julie Whyte
SCAN & NHS Lothian	Western General Hospital and St John's Hospital	Prof P Mariappan Dr D Noble	Adam Steenkamp

Data Quality

Estimate of Case Ascertainment

An estimate of case ascertainment (the percentage of the population with bladder cancer recorded in the audit) is made through comparison with the Scottish Cancer Registry five year average data from 2016 to 2020. High levels of case ascertainment provide confidence in the completeness of the audit recording and contribute to the reliability of results presented. Levels greater than 100% may be attributable to an increase in incidence. Allowance should be made when reviewing results where numbers are small and variation may be due to chance.

Number of cases recorded in audit: Patients diagnosed between 01/04/2021 and 31/03/2022

	Borders	D&G	Fife	Lothian	SCAN
Bladder Cancer	35	42	106	225	408

Estimate of Case Ascertainment: Calculated using the average of the most recent available five years of Cancer Registry Data 2016 – 2020.

	Borders	D&G	Fife	Lothian	SCAN
Cases from Audit	35	42	106	225	408
Cancer Registry 5 Year Average	15	23	47	134	219
Case Ascertainment %	233	183	226	168	186

Note: Extract of data taken from PHS Cancer Registry data mart ACaDMe on 12/01/2023

Quality Assurance

All hospitals in the region participate in a Quality Assurance (QA) programme provided by Public Health Scotland (PHS). QA of the bladder cancer data has been carried out on year 1 QPI data. Performance was above 90% in each SCAN Health Board but numerous dataset changes and different interpretation by ISD mean that the performance is not a true reflection of audit practice in SCAN and around the country.

Clinical Sign-Off

This report compares data from reports prepared for individual hospitals and was signed off as accurate following review by the lead clinicians from each service. The collated SCAN results are reviewed jointly by the lead clinicians, to assess variances and provide comments on results:

- Individual health board results were reviewed and signed-off locally.
- Regional sign off meeting achieved remotely on 23/02/2023.
- Final report circulated to SCAN Urology Group and Clinical Governance Groups on 14/04/2023

Actions for Improvement

After final sign off, the process is for the report to be sent to the Clinical Governance groups with action plans for completion at Health Board level which are returned to SCAN Audit and subsequently reported to the Regional Cancer Planning Group.

The final report is placed on the SCAN website, with completed action plans, once it has been fully signed-off and checked for any disclosive information.

QPI 1i - Multi-Disciplinary Team Meeting Discussion – Target = 95%

Title: Patients with bladder cancer should be discussed by a multidisciplinary team (MDT) prior to definitive treatment.

Numerator = Patients with muscle invasive bladder cancer (MIBC) discussed at the MDT before definitive treatment (this includes: neo-adjuvant SACT, radical cystectomy, radiotherapy and supportive care only).

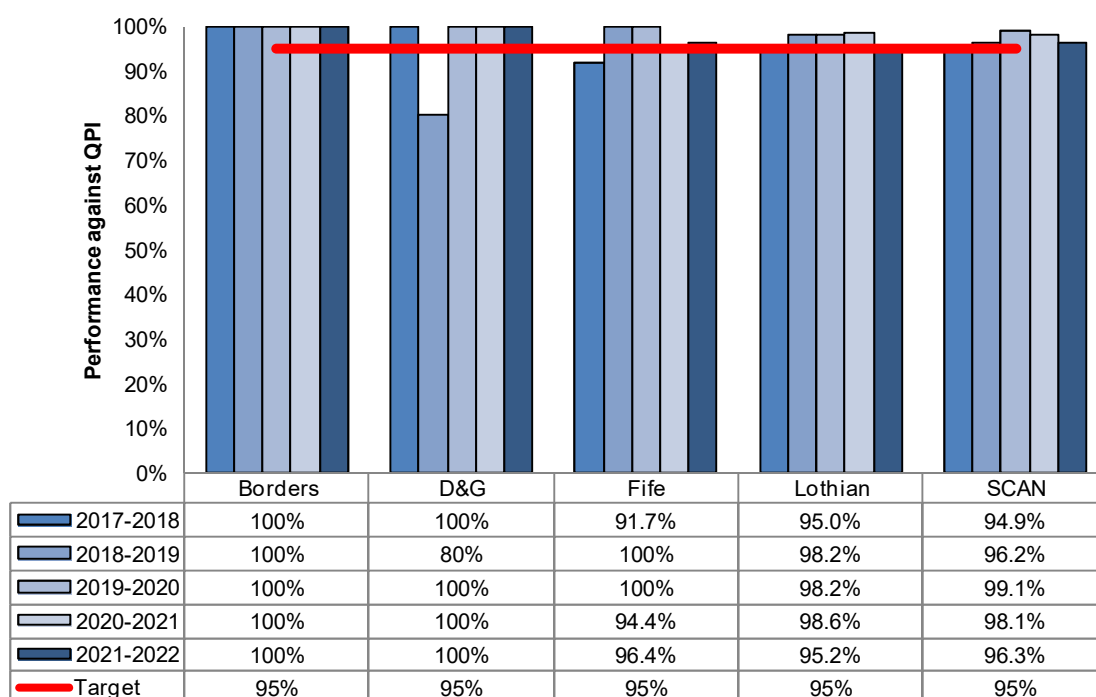
Denominator = All patients with MIBC, excluding patients who died before first treatment.

The tolerance within this target is designed to account for situations where patients require treatment urgently.

Presented by Board of Diagnosis

Target 95%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	26	35	78	161	300
Excluded from analysis	0	0	0	1	1
Numerator	9	7	27	60	103
Not recorded for numerator	0	0	0	0	0
Denominator	9	7	28	63	107
Not recorded for exclusion	0	0	0	0	0
Not recorded for denominator	1	0	0	0	1
% Performance	100	100	96.4	95.2	96.3

QPI 1i - MDM discussion 2015/16 to 2021/22



QPI 1ii - Multi-Disciplinary Team Meeting Discussion – Target = 95%

Title: Patients with bladder cancer should be discussed by a multidisciplinary team (MDT) prior to definitive treatment.

Numerator = Patients with NMIBC discussed at the MDT following histological confirmation of bladder cancer.

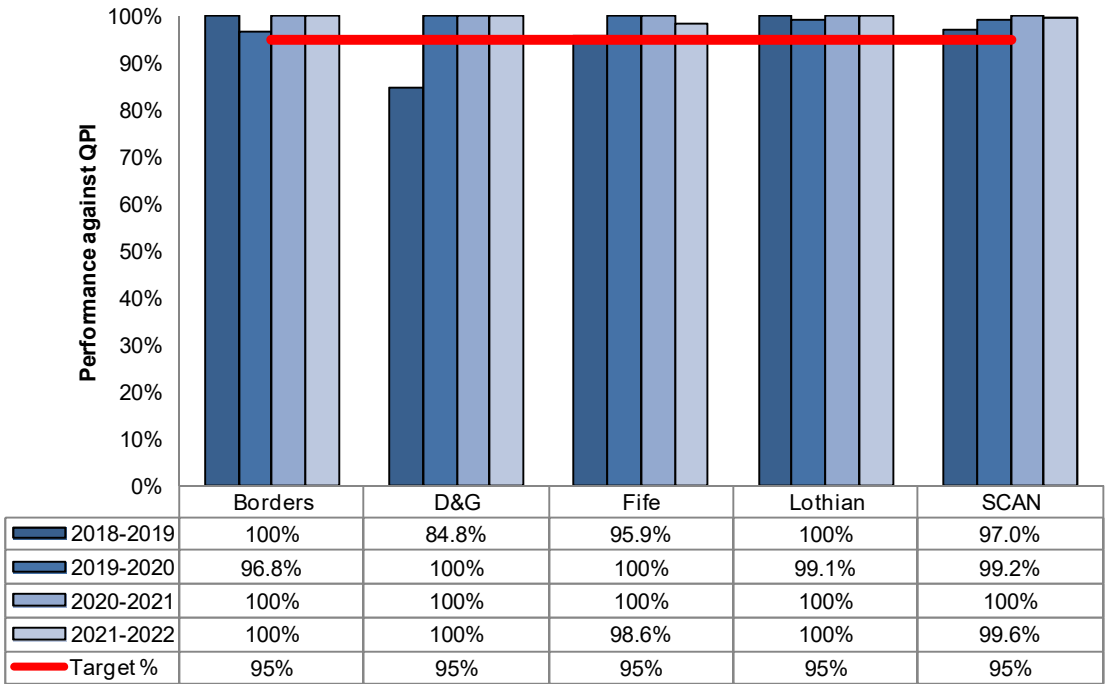
Denominator = All patients with NMIBC.

The tolerance within this target is designed to account for situations where patients require treatment urgently.

Presented by Board of Diagnosis

Target 95%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	13	8	37	101	159
Excluded from analysis	0	0	0	0	0
Numerator	22	34	68	124	248
Not recorded for numerator	0	0	0	0	0
Denominator	22	34	69	124	249
Not recorded for exclusion	0	0	0	0	0
Not recorded for denominator	0	0	0	1	1
% Performance	100	100	98.6	100	99.6

QPI 1ii - MDM Discussion 2018/2019 to 2021/22



QPI 2i - Quality of Transurethral Resection of Bladder Tumour – Target = 95%

Title: Transurethral resection of bladder tumour (TURBT) procedures undertaken should be of good quality.

Numerator = Patients with bladder cancer who undergo TURBT where a bladder diagram / detailed description with documentation of tumour location, size, number and appearance has been used at initial resection.

Denominator = All patients with bladder cancer who undergo TURBT.

Exclusions = Patients undergoing palliative resection or very small tumours ($\leq 5\text{mm}$).

The tolerance within this target level accounts for the fact that it is not always possible to include detrusor muscle within the specimen.

Target 95%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	4	1	16	51	72
Excluded from analysis	0	1	16	5	22
Numerator	31	26	68	163	288
Not recorded for numerator	0	0	3	0	3
Denominator	31	40	74	169	314
Not recorded for exclusion	0	0	1	0	1
Not recorded for denominator	0	0	0	0	0
% Performance	100	65.0	91.9	96.4	91.7

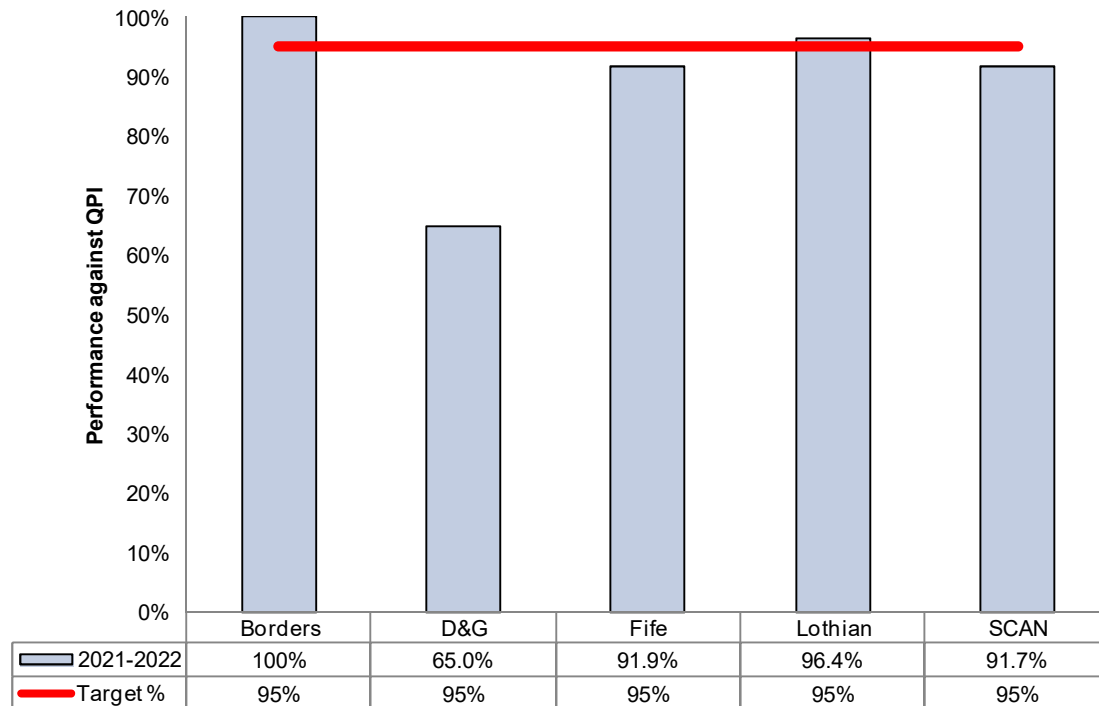
Comment:

D&G: The QPI target was not met showing a shortfall of 30% (14 cases) not all items were fully documented. 7 number of tumours were not recorded. In 7 the appearance of tumours were not recorded, 6 size of tumours were not recorded. This will have been impacted by locums and disruption of theatre staff in urology theatre during the year.

Fife: The QPI target was not met showing a shortfall of 3.1% (6 cases) TURBT pro-forma were not used in each case. In the 3 cases 'not recorded for numerator', the op note was missing from the casenotes. Similarly, the 'not recorded for exclusion' op note was missing from the casenotes and the TURBT intention was not indicated. NOTE: there has been a significant increase in the use of a TURBT pro-forma from the previous year. 4 did not have a pro-forma for initial TURBT (previously 27) with 3 op notes missing from the casenotes (same as previously).

Action: Audit staff in D&G are monitoring the use of the Bladder proforma in theatres throughout the year.

QPI 2i - TURBT Quality 2021/22



QPI 2ii - Quality of Transurethral Resection of Bladder Tumour – Target = 95%

Title: Transurethral resection of bladder tumour (TURBT) procedures undertaken should be of good quality.

Numerator = Patients with bladder cancer who undergo TURBT where it is documented whether the resection was complete or not at initial resection.

Denominator = All patients with bladder cancer who undergo TURBT.

Exclusions = Patients undergoing palliative resection or with very small tumours ($\leq 5\text{mm}$).

The tolerance within this target level accounts for the fact that it is not always possible to include detrusor muscle within the specimen.

Target 95%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	4	1	16	51	72
Excluded from analysis	3	2	23	10	38
Numerator	28	35	63	154	280
Not recorded for numerator	0	0	0	0	0
Denominator	28	39	67	164	298
Not recorded for exclusion	0	6	6	5	17
Not recorded for denominator	0	0	0	0	0
% Performance	100	89.7	94.0	93.9	94.0

Comment:

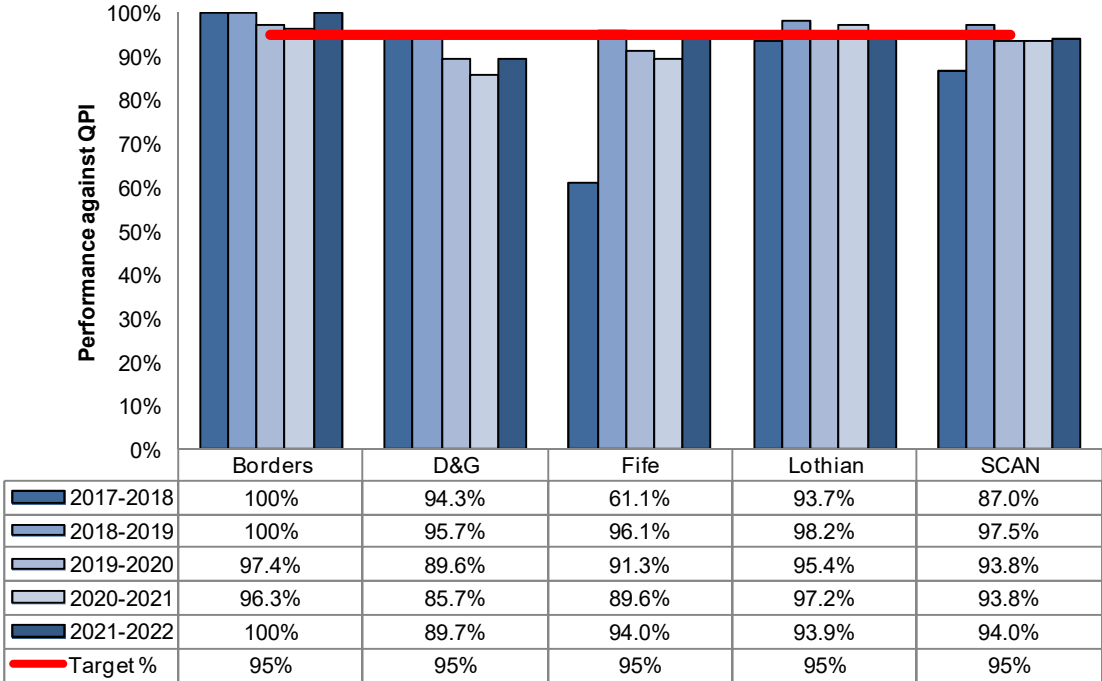
D&G: The QPI target was not met showing a shortfall of 5.3% (4 cases) 3 had not specified in the operation notes if resection was complete or incomplete. 1 incidental finding - TURBT polypoidal mass and confirmed concurrent cancer.

Fife: The QPI target was not met showing a shortfall of 1% (4 cases) TURBT operation note was missing from the casenotes for 3 out of 4 cases. The pro-forma was not used for 1 so there was no record of whether the resection was complete or not. The 6 'not recorded for exclusion' did not have any reference to the size of the tumour.

Lothian: The QPI target was not met showing a shortfall of 1.1% (10 cases) 5 had resections where the status was "Unsure". 5 had no paper or electronic proforma completed and information wasn't available on operation notes. Mr Mariappan has had a teaching session with clinical staff in Lothian and emphasised the importance of completing all mandatory fields of the proforma.

Action: With the new data option of adding "unsure" field to future analysis, improvement should be achieved.

QPI 2ii - TURBT Quality 2015/16 to 2021/22



QPI 2iii - Quality of Transurethral Resection of Bladder Tumour – Target = 90%

Title: Transurethral resection of bladder tumour (TURBT) procedures undertaken should be of good quality.

Numerator = Patients with high grade NMIBC who undergo TURBT where detrusor muscle is included in the specimen at initial resection.

Denominator = All patients with bladder cancer who undergo TURBT.

Exclusions = Patients undergoing palliative resection, with very small tumours (≤ 5 mm) or patients with bladder diverticular tumours.

The tolerance within this target level accounts for the fact that it is not always possible to include detrusor muscle within the specimen.

Target 90%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	21	26	68	158	273
Excluded from analysis	4	1	13	13	31
Numerator	10	13	17	41	81
Not recorded for numerator	0	0	0	0	0
Denominator	10	15	24	54	103
Not recorded for exclusion	0	1	2	2	5
Not recorded for denominator	0	1	1	0	2
% Performance	100	86.7	70.8	75.9	78.6

Comment:

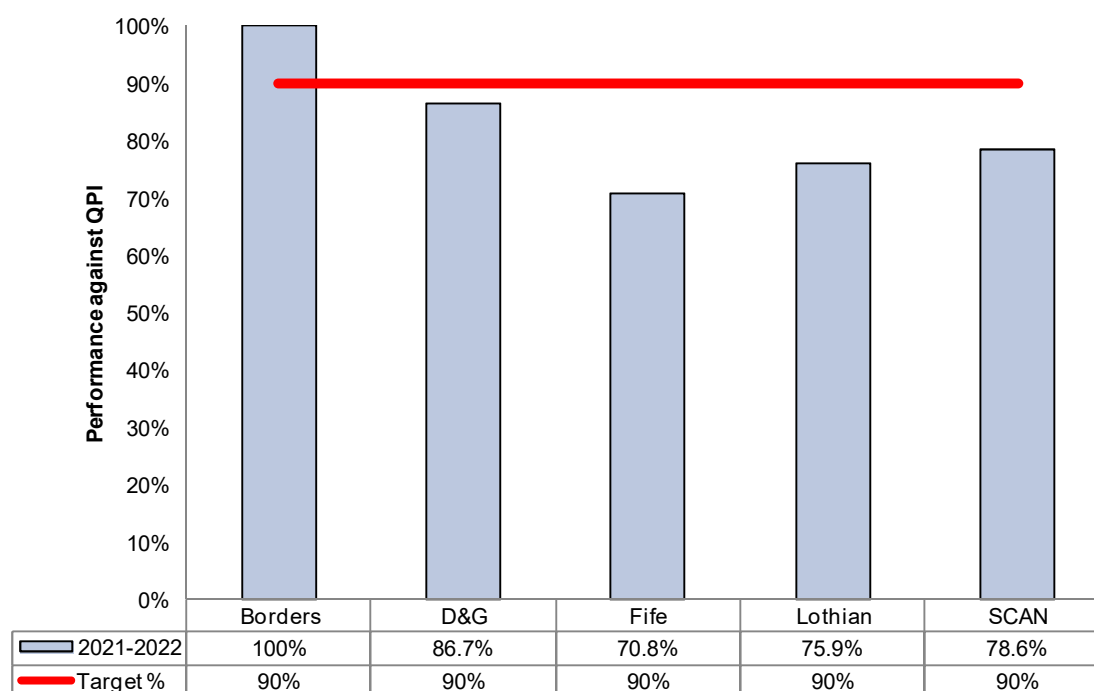
DGRI: The QPI target was not met showing a shortfall of 3.3% (2 cases) 1 resected to muscle - no muscle in pathology. 1 large necrotic tumour, difficult resection. Unable to secure detrusor muscle.

Fife: The QPI target was not met showing a shortfall of 19.2% (7 cases) 1 resection had to be abandoned due to high risk of perforation. 1 deep resection was not attempted due to age and medical related concerns. 5 did not have detrusor muscle within the pathology specimen. The 'not recorded exclude from denominator' had no TGRADE2004 recorded and the 2 'not recorded for exclusion' did not have any reference to size of tumour (both operation notes missing).

Lothian: The QPI target was not met showing a shortfall of 14.1% (13 cases) Detrusor Muscle was absent at first endoscopic resection. Many resections had to be done on non-regular bladder cancer surgeons and plans have been put in place to increase available capacity in dedicated bladder cancer lists.

Action: Clinically deemed high grade or high risk procedures should be booked in for dedicated Bladder cancer surgeons to perform. Initial clinical triage will be required.

QPI 2iii - TURBT Quality 2021/22



QPI 4i - Early TURBT – Target = 80%

Title: Patients who have undergone TURBT with high grade Ta (multifocal - more than 2 or large >3cm) and/ or T1 NMIBC, where detrusor muscle is absent from specimen or initial resection is incomplete, who have a second resection or early cystoscopy (\pm biopsy) within 6 weeks of initial TURBT.

Numerator = Patients with T1 (all grades) or select high grade Ta (multifocal - more than 2 or large >3cm) NMIBC who have undergone TURBT who have a second TURBT or early cystoscopy (\pm biopsy) within 6 weeks (42 days) of initial resection.

Denominator = All patients with T1 (all grades) or select high grade Ta NMIBC who have undergone TURBT.

Exclusion = Where TURBT has been carried out for palliation, undergone early cystectomy or where metastatic disease is confirmed.

The tolerance within this target is designed to account for situations where patients are not fit enough for a further operation, where patients are frail and a thin bladder wall is suspected and where there is imaging which suggests re-TURBT is not required or where PDD (photodynamic diagnosis) TURBT has been carried out. It also accounts for those patients where there has been intra or extraperitoneal perforation.

Target 80%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	25	32	69	165	291
Excluded from analysis	2	1	10	10	23
Numerator	0	0	0	0	0
Not recorded for numerator	0	0	0	0	0
Denominator	8	9	25	50	92
Not recorded for exclusion	0	0	1	0	1
Not recorded for denominator	0	2	2	3	7
% Performance	0	0	0	0	0

Comment:

Borders: The QPI target was not met showing a shortfall of 80% (8 cases) 5 had MDM decision not to attempt re-resection. 2 had scheduling delays which led to TURBT2 taking place outwith 6 weeks. 1 didn't proceed with a second TURBT as the patient had a diagnosis of a concurrent cancer.

D&G: The QPI target was not met showing a shortfall of 80% (9 cases) 3 repeat TURBTs were carried out outside of 6 week timeframe (51-70 days). 1 declined repeat TURBT. 1 performance status deteriorated before resection. 1 was unfit for repeat TURBT. 3 were recommended intravesical BCG by MDM.

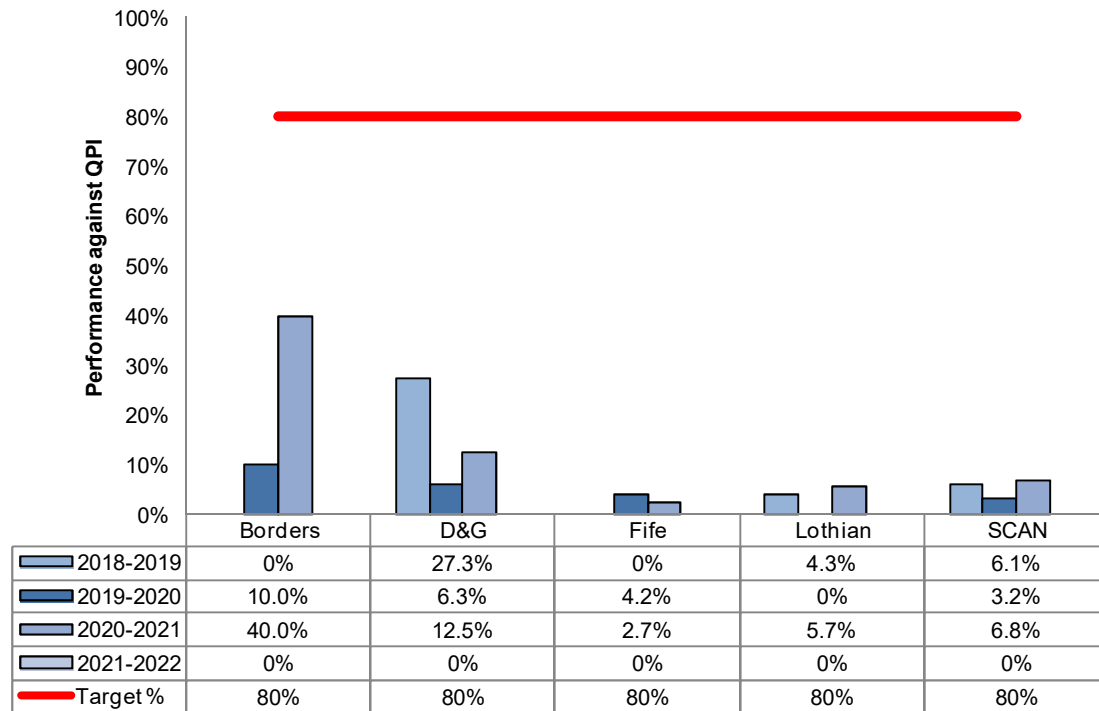
Fife: The QPI target was not met showing a shortfall of 80% (25 cases) 6 had 3 month Cystoscopic follow up as recommended at MDM. 3 had BCG/Mitomycin instillations following TURBT. 1 had pT1 on pathology (so included in measurability) but suspected muscle invasive disease, so went on to have Radiotherapy. 1 had a stroke post TURBT1 so their further investigations were deferred. 3 did not have a second procedure due to patient deterioration/death. The remaining 11 cases waited more than 42 days for their second procedure. It should be noted that the failure of QPIs 4(i), 4(ii) + 4(iii) is mostly due to capacity issues in theatre. However, two cases had a delay to MDM which appears to have been a contributing factor.

Lothian: The QPI target was not met showing a shortfall of 80% (50 cases) the median time from TURBT1 to TURBT2 or Cystoscopy + biopsy was 158 days. 21 had BCG as initial follow up. 5 had other medical issues that took priority over Bladder cancer follow up. 1 opted for surveillance only. 23 didn't have repeat resections within the prescribed 42 days.

Action: Borders will attempt more timely repeat procedures as soon as capacity returns to normal. D&G are triaging and booking procedures post MDM. Lothian has ring-fenced theatre slots to try and accommodate repeat resections.

QPI steering group – Consider QPI revision to base re-resection decisions on MDM recommendations post TURBT1.

QPI 4i - Re-TURBT - High Grade 2018/19 to 2021/22



QPI 4ii - Early TURBT (detrusor muscle) – Target = 80%

Title: Patients who have undergone TURBT with high grade Ta* (multifocal - more than 2 or large >3cm) and/ or T1 NMIBC, where detrusor muscle is absent from specimen or initial resection is incomplete, who have a second resection or early cystoscopy (± biopsy) within 6 weeks of initial TURBT.

Numerator = Patients with high grade or low grade G2 NMIBC who have undergone TURBT where detrusor muscle absent from specimen who have a second TURBT or early cystoscopy (± biopsy) within 6 weeks (42 days) of initial resection.

Denominator = All patients with high grade NMIBC who have undergone TURBT where detrusor muscle is absent from specimen.

Exclusion = Where TURBT has been carried out for palliation, undergone early cystectomy or where metastatic disease is confirmed.

The tolerance within this target is designed to account for situations where patients are not fit enough for a further operation, where patients are frail and a thin bladder wall is suspected and where there is imaging which suggests re-TURBT is not required or where PDD (photodynamic diagnosis) TURBT has been carried out. It also accounts for those patients where there has been intra or extraperitoneal perforation.

Target 80%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	33	40	93	205	371
Excluded from analysis	2	1	4	6	13
Numerator	0	0	0	0	0
Not recorded for numerator	0	0	0	0	0
Denominator	0	1	9	14	24
Not recorded for exclusion	0	0	1	0	1
Not recorded for denominator	0	0	0	0	0
% Performance	N/A	0	0	0	0

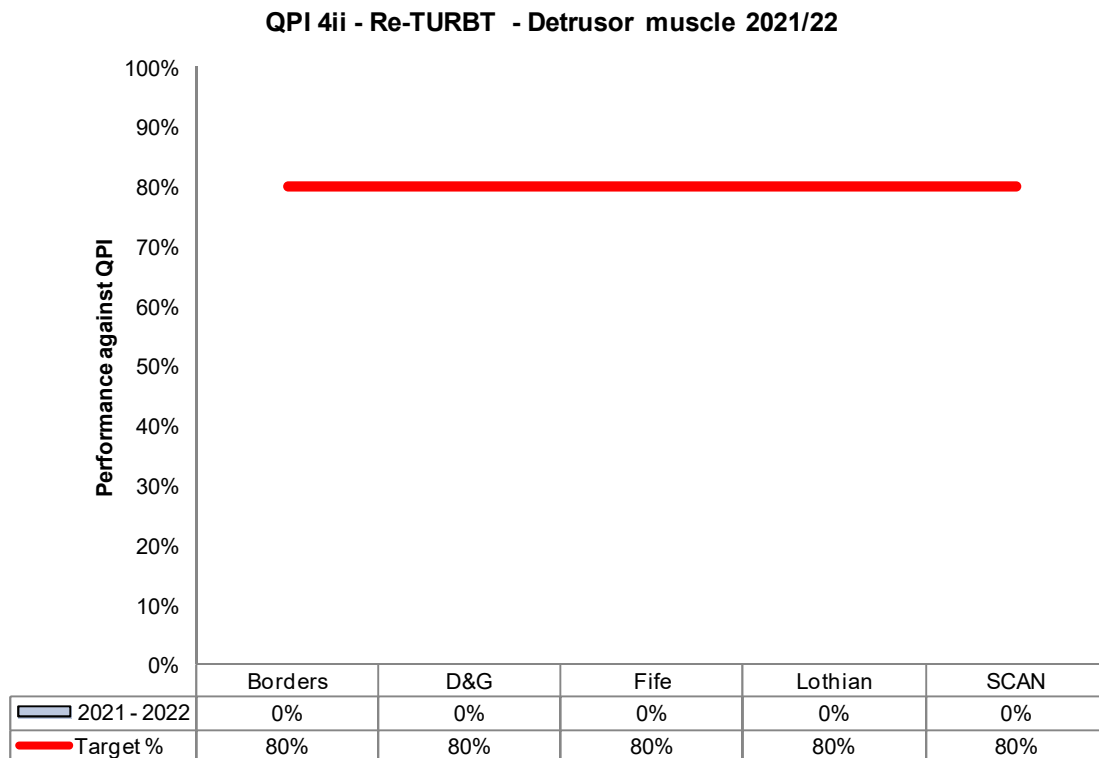
Comment:

D&G: The QPI target was not met showing a shortfall of 80% (1 case) MDT recommended intravesical BCG.

Fife: The QPI target was not met showing a shortfall of 80% (9 cases) 1 had three month Cystoscopic follow up as recommended at MDM. 1 had BCG instillations following TURBT1. 1 was pT1 on pathology (so included in measurability) but suspected MIBC so went on to have Radiotherapy. 1 had a stroke post TURBT1 so further investigations were deferred. Deep resection was not attempted in 1 case due to age. 4 waited more than 42 days for their second procedure. It should be noted that the failure of QPIs 4(i), 4(ii) + 4(iii) is mostly due to capacity issues in theatre. However, one case had a delay to MDM which appears to have been a contributing factor.

Lothian: The QPI target was not met showing a shortfall of 80% (14 cases) 6 had BCG post TURBT1. 3 had other medical conditions that took priority to follow up TURBT. 5 had follow up TURBT or Cystoscopy + biopsy outwith the prescribed 42 days.

Action: D&G are triaging and booking procedures post MDM. Lothian has ring-fenced theatre slots to try and accommodate repeat resections. QPI steering group – Consider QPI revision to base re-resection decisions on MDM recommendations post TURBT1.



QPI 4iii - Early TURBT (incomplete resection) – Target = 80%

Title: Patients who have undergone TURBT with high grade Ta* (multifocal - more than 2 or large >3cm) and/ or T1 NMIBC, where detrusor muscle is absent from specimen or initial resection is incomplete, who have a second resection or early cystoscopy (± biopsy) within 6 weeks of initial TURBT.

Numerator = Patients with NMIBC who have undergone TURBT where initial resection is incomplete who have a second TURBT or early cystoscopy (± biopsy) within 6 weeks (42 days) of initial resection.

Denominator = All patients with NMIBC who have undergone TURBT where initial resection is incomplete.

Exclusion = Where TURBT has been carried out for palliation, undergone early cystectomy or where metastatic disease is confirmed.

The tolerance within this target is designed to account for situations where patients are not fit enough for a further operation, where patients are frail and a thin bladder wall is suspected and where there is imaging which suggests re-TURBT is not required or where PDD (photodynamic diagnosis) TURBT has been carried out. It also accounts for those patients where there has been intra or extraperitoneal perforation.

Target 80%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	32	41	95	216	384
Excluded from analysis	2	0	4	5	11
Numerator	0	0	0	0	0
Not recorded for numerator	0	0	0	0	0
Denominator	1	1	3	4	9
Not recorded for exclusion	0	0	0	0	0
Not recorded for denominator	0	4	4	7	15
% Performance	0	0	0	0	0

Comment:

Borders: The QPI target was not met showing a shortfall of 80% (1 case) re- resection was not attempted due to patient co-morbidities.

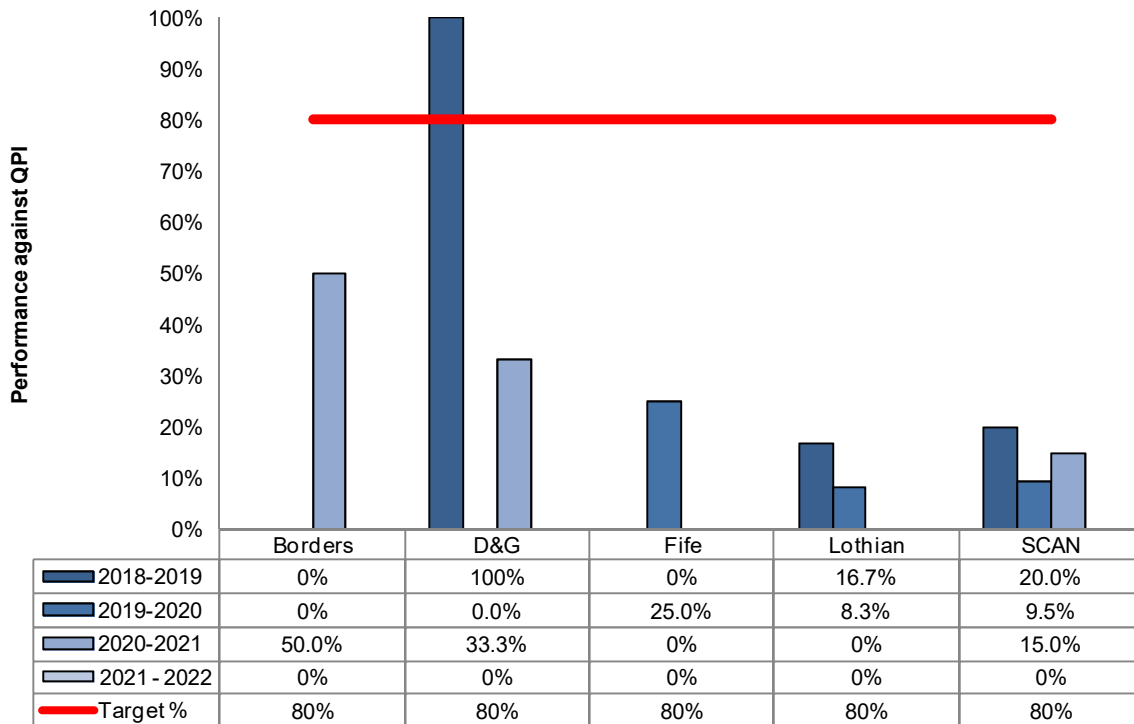
D&G: The QPI target was not met showing a shortfall of 80% (1 case) MDT recommended not to attempt repeat resection, also had concurrent metastatic lung cancer.

Fife: The QPI target was not met showing a shortfall of 80% (3 cases) 3 waited more than 42 days for their second procedure. Resection status could not be determined for 4 Not Recorded Denominator cases. It should be noted that the failure of QPIs 4(i), 4(ii) + 4(iii) is mostly due to capacity issues in theatre. However, one case experienced a delay to MDM which appears to have been a contributing factor.

Lothian: The QPI target was not met showing a shortfall of 80% (4 cases) 3 had follow up TURBT or Cystoscopy + biopsy outwith the prescribed 42 days. 1 had BCG post TURBT1. 7 not recorded for Denominator is where resection status is unsure.

Action: Borders will attempt more timely repeat procedures as soon as capacity returns to normal. D&G are triaging and booking procedures post MDM. Lothian has ring-fenced theatre slots to try and accommodate repeat resections. QPI steering group – Consider QPI revision to base re-resection decisions on MDM recommendations post TURBT1.

QPI 4iii - Re-TURBT - Incomplete resection 2018/19 to 2021/22



QPI 6 – Lymph Node Yield – Target = 95%

Title: Patients with bladder cancer that undergo primary radical cystectomy where ≥ 10 lymph nodes are resected and pathologically examined and at least level 2 pelvic lymph node dissection (to the middle of the common iliac artery or level of the crossing of the ureter) has been undertaken.

Numerator = Patients with bladder cancer who undergo primary radical cystectomy where ≥ 10 lymph nodes are resected and pathologically examined, and at least level 2 pelvic lymph node dissection (i.e. to the middle of the common iliac artery or level of the crossing of the ureter) has been undertaken.

Denominator = All patients with bladder cancer who undergo primary radical cystectomy.

Exclusions = Patients undergoing salvage cystectomy.

The tolerance within this target accounts for situations where patients are not fit enough to undergo extensive lymphadenectomy.

Target 95%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	35	38	97	202	372
Excluded from analysis	0	0	0	0	0
Numerator	-	-	3	21	24
Not recorded for numerator	-	-	3	0	3
Denominator	-	-	9	27	36
Not recorded for exclusion	-	-	0	0	0
Not recorded for denominator	-	-	0	0	0
% Performance	N/A	N/A	33.3	77.8	66.7

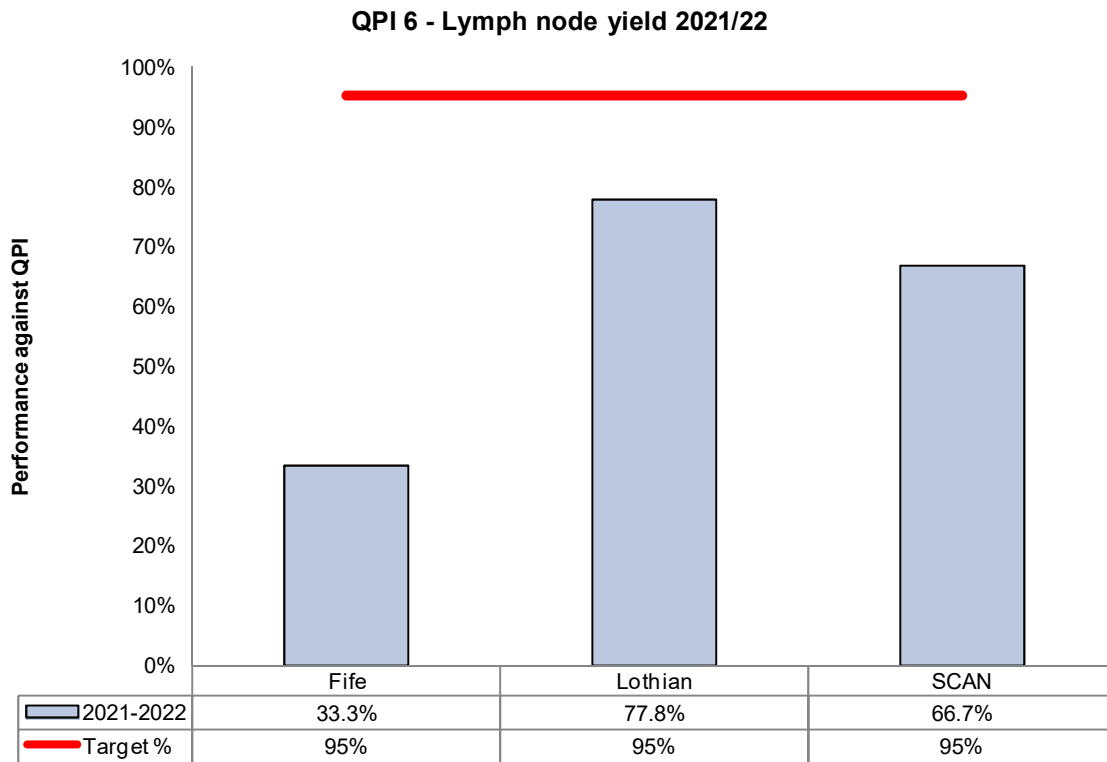
Comment:

Fife: The QPI target was not met showing a shortfall of 61.7% (6 cases) 3 didn't have bilateral lymph node dissection for valid clinical reasons. 3 'not recorded for numerator' did not have the level of lymph node dissection recorded within the op note (as per 2019-20 Comparative Report, cystectomy op note should be used to evaluate compliance of this QPI) although it should be noted the clinician has verbally indicated at local sign-off that level 2 lymph node dissections were undertaken in these cases (nodal count = 14, 11 & 5).

Lothian: The QPI target was not met showing a shortfall of 17.2% (6 cases) 3 didn't have extended lymph node dissection due to other medical factors. 3 had less than 10 lymph nodes taken during extended pelvic node dissection.

Action: Fife service need to be clear in operation notes on what procedure has been performed.

QPI steering group – Need to consider revision of QPI to either, include exclusion criteria or increase tolerance to ensure this QPI truly reflects service quality.



QPI 8 – Volume of Cases per Centre/Surgeon – Target = ≥ 20 cases per year.

Title: Radical cystectomy should be performed by surgeons who perform the procedure routinely.

The criteria for this QPI are defined by a minimum of 10 operations per surgeon and overall 20 operations per centre.

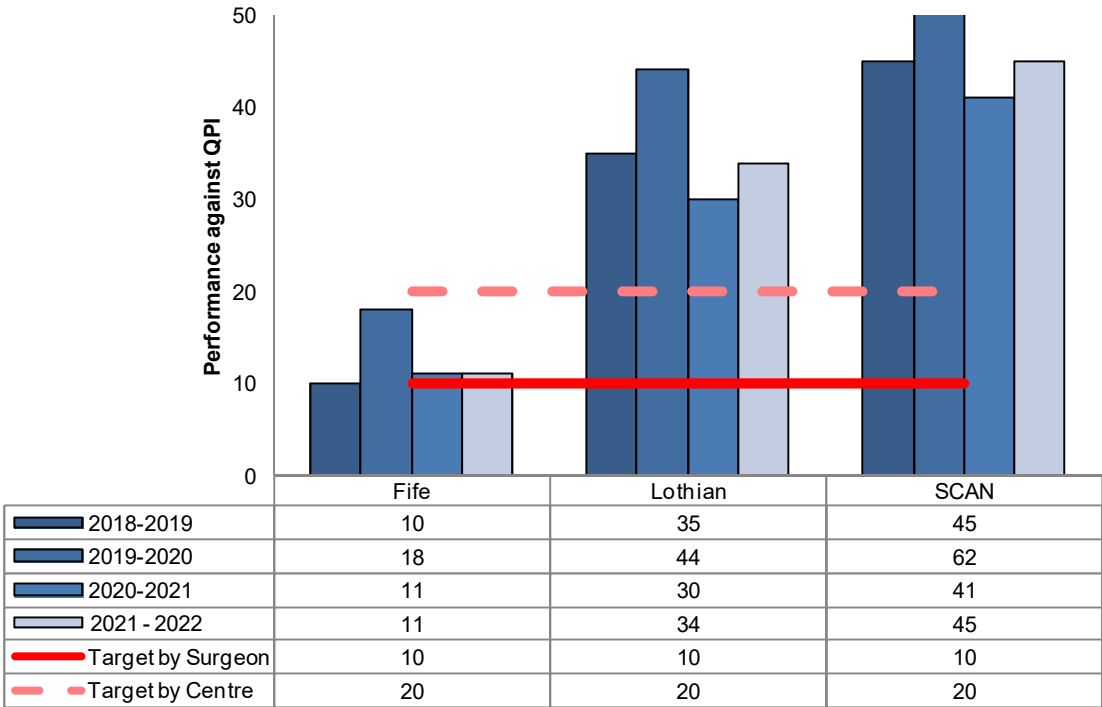
Numerator = Number of radical cystectomy procedures performed by each surgeon in a given year (no exclusions).

All cystectomies are carried out in Fife and Lothian.

Board of Surgery*	Surgeon	Number of radical cystectomies
NHS Fife	A	11
NHS Lothian	B	29
NHS Lothian	C	5

*Data supplied by PHS SMR01 returns.

QPI 8: Volume of cases 2018/19 to 2021/22



QPI 9 – Oncological Discussion – Target = 60%

Title: Patients with muscle invasive bladder cancer should have all treatment options discussed with them prior to radical cystectomy.

Numerator = Number of patients with muscle invasive bladder cancer who undergo cystectomy who met with an oncologist prior to radical cystectomy.

Denominator = All patients with muscle invasive bladder cancer who undergo radical cystectomy (no exclusions)

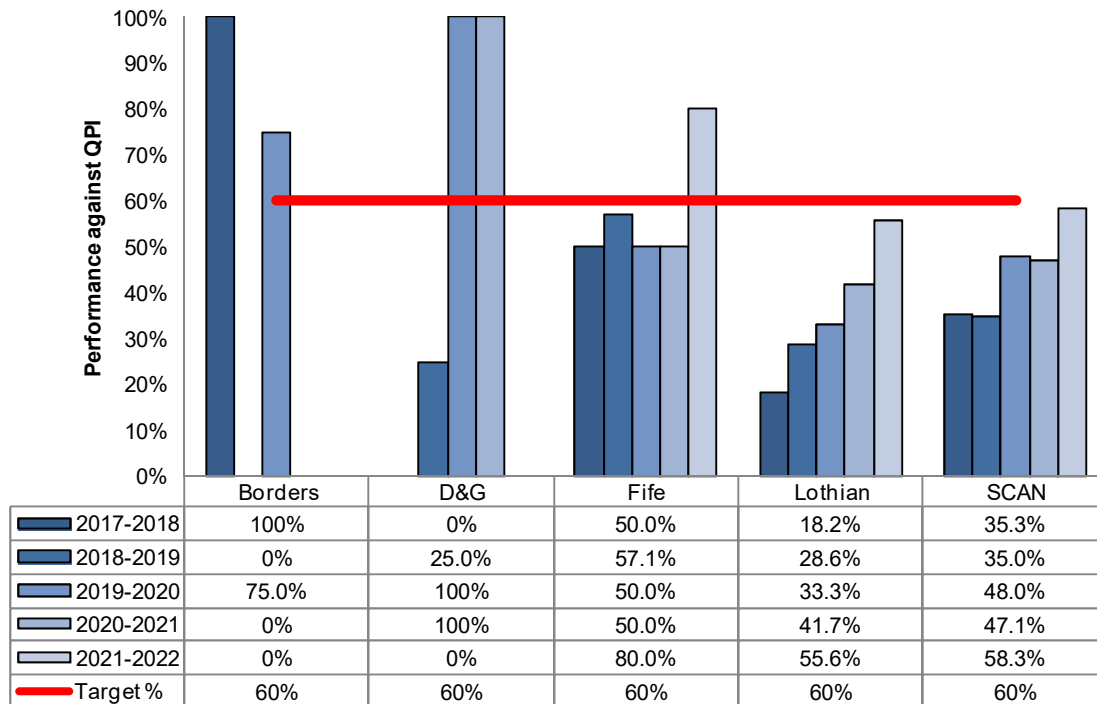
The tolerance accounts for the fact that patients might decline to see an oncologist, are deemed at multi-disciplinary team meeting to not be suitable for radical radiotherapy or neo-adjuvant chemotherapy, due to co-morbidities and for patients who undergo emergency cystectomy.

Target 60%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	35	41	101	207	384
Excluded from analysis	0	0	0	0	0
Numerator	0	0	4	10	14
Not recorded for numerator	0	0	0	0	0
Denominator	0	1	5	18	24
Not recorded for exclusion	0	0	0	0	0
Not recorded for denominator	0	0	0	0	0
% Performance	N/A	0	80.0	55.6	58.3

SCAN Oncology Comment: These patients always get discussed in MDM and for various reasons (multifocal disease, extensive CIS, symptoms and presence of hydronephrosis) would have surgery recommended as the better treatment option. There are no concerns about these cases. Given the trends over the past 6 years, this target might be too ambitious.

Action: QPI Steering Group – To amend the measurement of this QPI. Only include cases where, on MDM review, it would be of benefit for both surgeons and oncologists to offer treatment options.

QPI 9 - Oncology discussion 2017/18 to 2021/22



QPI 11 – 30 day Mortality after radical treatment for Bladder cancer –Target= <3%

Title: 30 day mortality following treatment with curative intent for bladder cancer.

Numerator: Number of patients with bladder cancer who receive treatment with curative intent (radical cystectomy or radiotherapy) that die within 30 days of treatment.

Denominator: All patients with bladder cancer who receive treatment with curative intent (radical cystectomy, radiotherapy).

Exclusion: No exclusions.

Surgery – Presented by Board of surgery

Target <3%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	35	38	97	202	372
Excluded from analysis	0	0	0	0	0
Numerator – Surgery	-	-	0	1	1
Denominator – Surgery	-	-	9	26	35
% Performance	N/A	N/A	0	3.8	2.9

Comment:

Lothian: The QPI target was not met showing a shortfall of 0.8% (1 case) Patient died from a stroke and M&M meeting consensus was this was not a modifiable risk.

Radiotherapy – Presented by Board of diagnosis

Target <3%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	31	40	103	214	388
Excluded from analysis	0	0	0	0	0
Numerator	0	0	0	0	0
Denominator	4	2	3	11	20
% Performance	0	0	0	0	0

QPI 11 – 90 day Mortality after radical treatment for Bladder cancer –Target= <5%

Title: 90 day mortality following treatment with curative intent for bladder cancer.

Numerator: Number of patients with bladder cancer who receive treatment with curative intent (radical cystectomy or radiotherapy) that die within 90 days of treatment.

Denominator: All patients with bladder cancer who receive treatment with curative intent (radical cystectomy or radiotherapy).

Exclusion: No exclusions.

Surgery – Presented by Board of surgery

Target <5%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	35	38	97	202	372
Excluded from analysis	0	0	0	0	0
Numerator – Surgery	-	-	0	2	2
Denominator – Surgery	-	-	9	27	36
% Performance	N/A	N/A	0	7.4	5.6

Comment:

Lothian: The QPI target was not met showing a shortfall of 2.4% (2 cases) 1 died from a stroke and M&M meeting consensus was this was not a modifiable risk. 1 had rapidly progressing disease post surgery.

Radiotherapy – Presented by Board of diagnosis

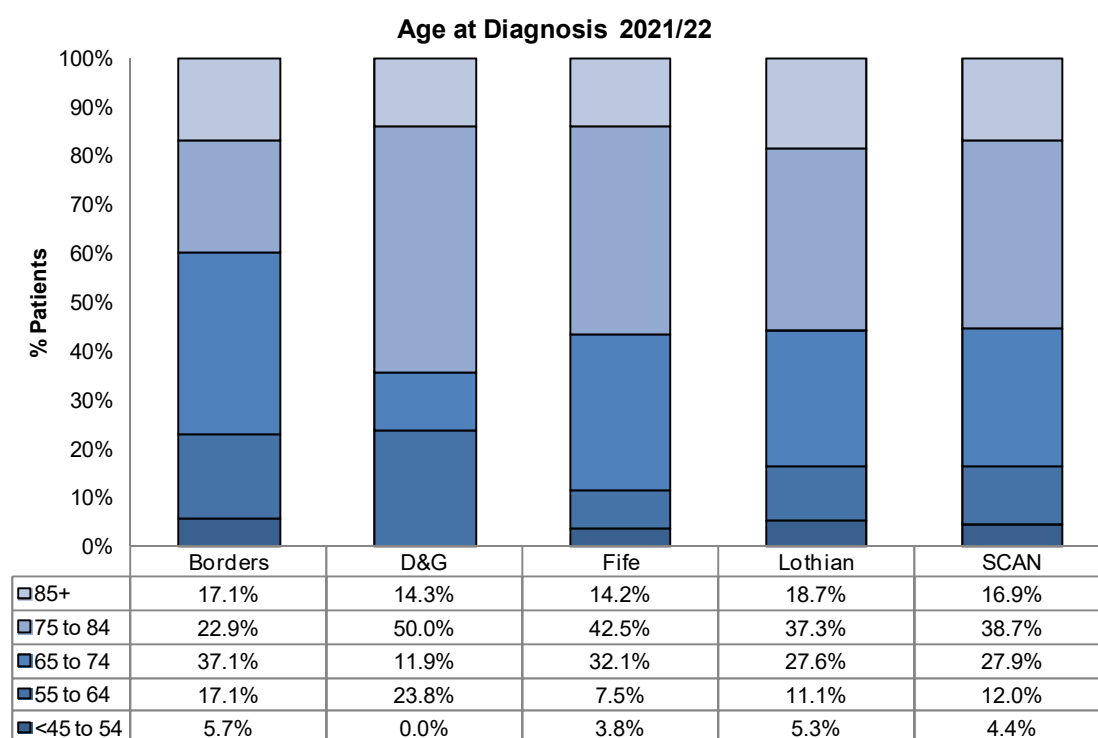
Target <5%	Borders	D&G	Fife	Lothian	SCAN
2021-22 cohort	35	42	106	225	408
Ineligible for analysis	31	40	103	214	388
Excluded from analysis	0	0	0	0	0
Numerator	0	0	0	1	1
Denominator	4	2	3	11	20
% Performance	0	0	0	9.1	5.0

Comment:

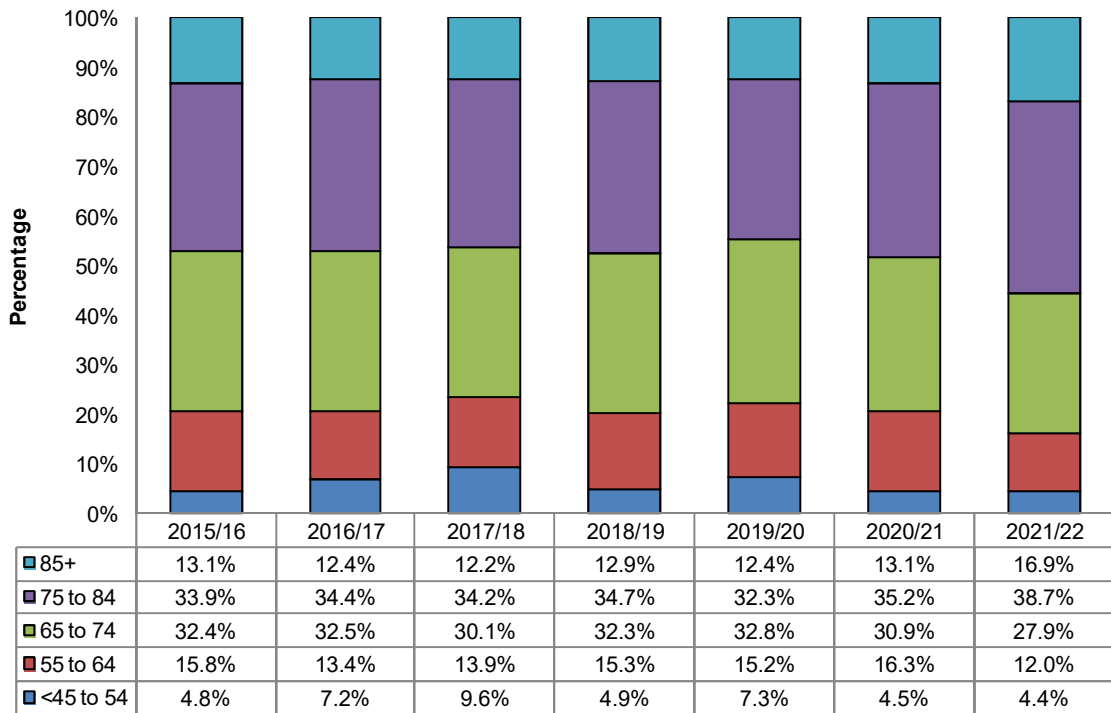
Lothian: The QPI target was not met showing a shortfall of 4.1% (1 case) The Oncology teams review any and all deaths at M&M meetings, and no specific concerns were identified.

Age and Gender Analysis

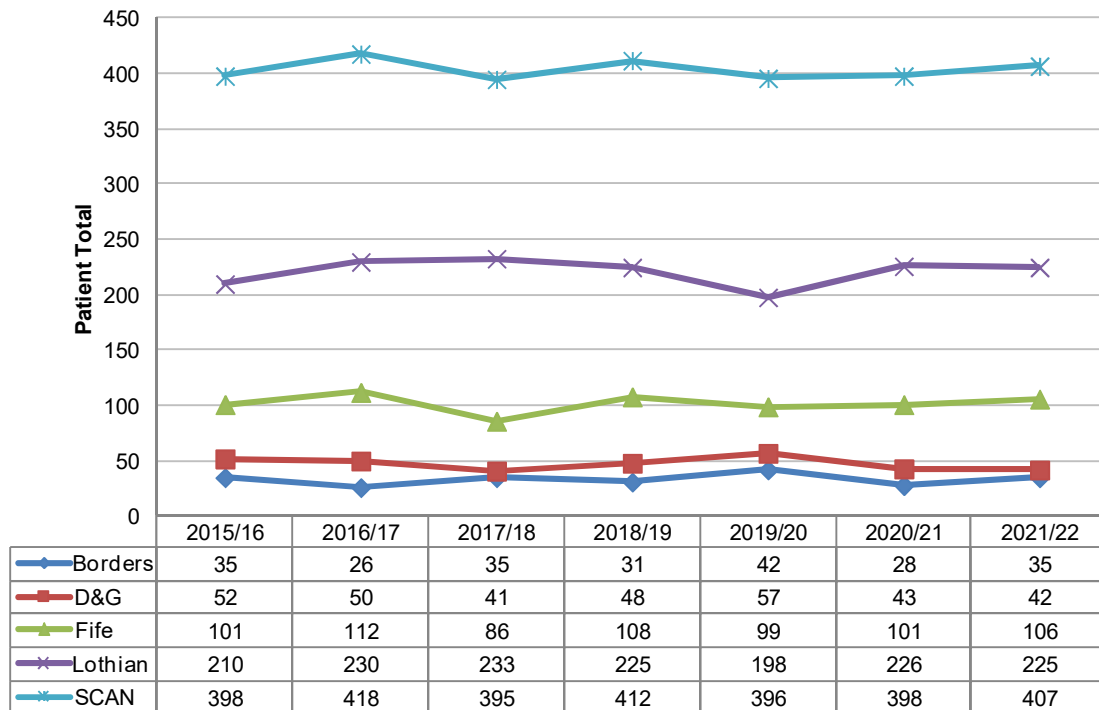
Age and Gender Analysis		Borders	D&G	Fife	Lothian	SCAN
Under 45	M	0	0	0	4	4
	F	0	0	0	2	2
45 - 49	M	0	0	1	0	1
	F	0	0	0	0	0
50 - 54	M	1	0	2	4	7
	F	1	0	1	2	4
55 - 59	M	3	4	2	5	14
	F	1	0	0	2	3
60 - 64	M	1	2	5	10	18
	F	1	4	1	8	14
65 - 69	M	2	1	12	18	33
	F	4	3	4	9	20
70 - 74	M	5	1	12	25	43
	F	2	0	6	10	18
75 - 79	M	3	9	29	34	75
	F	0	4	4	11	19
80 - 84	M	3	8	11	24	46
	F	2	0	1	15	18
85+	M	3	4	13	27	47
	F	3	2	2	15	22
Total	M	21	29	87	151	288
	F	14	13	19	74	120



Age at Diagnosis - SCAN Total over 7 years



New Bladder Cancer totals by Year of Diagnosis



Bladder Cancer QPI Attainment Summary 2020-21		Target%	Borders		D&G		Fife		Lothian		SCAN	
QPI 1: MDT Discussion	Before definitive treatment (MIBC)	95	N 7 D 7	100%	N 12 D 12	100%	N 17 D 18	94.4%	N 70 D 71	98.6%	N 106 D 108	98.1%
	NMIBC discussed at the MDT after histological confirmation of NMIBC	95	N 21 D 21	100%	N 30 D 30	100%	N 72 D 72	100%	N 128 D 128	100%	N 251 D 251	100%
QPI 2: Quality of TURBT at initial resection	Detailed description with tumour location, size, number, appearance	95	N 26 D 27	96.3%	N 4 D 42	9.5%	N 58 D 77	75.3%	N 164 D 176	93.2%	N 252 D 322	78.3%
	Where the resection is documented as complete or not	95	N 26 D 27	96.3%	N 36 D 42	85.7%	N 69 D 77	89.6%	N 171 D 176	97.2%	N 302 D 322	93.8%
	Where detrusor muscle is included in the specimen at initial TURBT.	80	N 25 D 25	100%	N 36 D 39	92.3%	N 64 D 74	86.5%	N 126 D 168	75.0%	N 251 D 306	82.0%
QPI 3: Mitomycin C following TURBT		60	N 14 D 21	66.7%	N 5 D 30	16.7%	N 39 D 75	52.0%	N 96 D 139	69.1%	N 154 D 265	58.1%
QPI 4: Early TURBT	All T1 or Ta where multifocal or >3cm NMIBC to have re TURBT within 42 days from TURBT1	80	N 2 D 5	40.0%	N 1 D 8	12.5%	N 1 D 37	2.7%	N 3 D 53	5.7%	N 7 D 103	6.8%
	HG or LG G2 NMIBC with no Detrusor muscle at TURBT1 to have re TURBT in 42 days	80	N 0 D 0	N/A	N 0 D 2	0%	N 0 D 10	0%	N 2 D 40	5.0%	N 2 D 52	3.8%
	NMIBC where resection was incomplete at TURBT1 to have re TURBT in 42 days.	80	N 1 D 2	50.0%	N 2 D 6	33.3%	N 0 D 5	0%	N 0 D 7	0%	N 3 D 20	15.0%
QPI 5: Pathology Reporting: reported according to the guidelines by the RCPATH	TURBT	90	N 27 D 28	96.4%	N 41 D 42	97.6%	N 88 D 89	98.9%	N 177 D 187	94.7%	N 333 D 346	96.2%
	Cystectomy	90	Presented by Board of surgery		N 6 D 6	100%	N 19 D 19	100%	N 25 D 25	100%		
QPI 6: Lymph Node Yield. Pelvic lymph node dissection to at least level 2 undertaken at radical cystectomy		90	Presented by Board of surgery		N 3 D 6	50%	N 18 D 19	94.7%	N 21 D 25	84.0%		
QPI 7: Time to Treatment (MIBC)	Radical treatment within 3 months of diagnosis of MIBC	90	N 1 D 1	100%	N 3 D 3	100%	N 2 D 2	100%	N 24 D 24	100%	N 30 D 30	100%
	Cystectomy or chemoradiotherapy within 8 weeks of neoadjuvant chemotherapy	90	N 0 D 0	N/A	N 3 D 3	100%	N 1 D 1	100%	N 2 D 4	50.0%	N 6 D 8	75.0%
QPI 8: Volume of Cases / Surgeon: number of radical cystectomy procedures performed by a surgeon over a 1 year.		≥20	2 Surgeons met the QPI Target in SCAN.									

Bladder Cancer QPI Attainment Summary 2020-21		Target%	Borders			D&G			Fife			Lothian			SCAN		
QPI 9: Oncological Discussion: MIBC patients who had radical surgery who met with an oncologist prior to radical cystectomy.		60	N	0	0%	N	2	100%	N	1	50.0%	N	5	41.7%	N	8	47.1%
			D	1		D	2		D	2		D	12		D	17	
QPI 10 Patients with TCC of the bladder (stage T2-T4) undergoing radical radiotherapy who receive concomitant chemotherapy.		50	N	0	N/A	N	2	50.0%	N	0	N/A	N	2	12.5%	N	4	20.0%
			D	0		D	4		D	0		D	16		D	20	
QPI 11: 30 Day Mortality.	Radical Surgery	<3	Presented by Board of surgery			N	0	0%	N	0	0%	N	0	0%	N	0	0%
			D	6		D	6		D	19		D	25		D	25	
Patients with bladder cancer who die within 30 days of treatment with curative intent for bladder cancer.	Radiotherapy	<3	N	0	N/A	N	0	0%	N	0	0%	N	0	0%	N	0	0%
			D	0		D	4		D	1		D	16		D	21	
	Chemotherapy	<3	N	0	N/A	N	0	0%	N	0	0%	N	0	0%	N	0	0%
			D	0		D	3		D	1		D	6		D	10	
QPI 11: 90 Day Mortality	Radical Surgery	<5	Presented by Board of surgery			N	0	0%	N	2	10.5%	N	2	8.0%	N	2	8.0%
			D	6		D	6		D	19		D	25		D	25	
Patients with bladder cancer who die within 90 days of treatment with curative intent for bladder cancer.	Radiotherapy	<5	N	0	N/A	N	0	0%	N	0	0%	N	1	6.7%	N	1	5.0%
			D	0		D	4		D	1		D	15		D	20	
	Chemotherapy	<5	N	0	N/A	N	0	0%	N	0	0%	N	0	0%	N	0	0%
			D	0		D	3		D	1		D	5		D	9	
Clinical Trial Access. N = Consented to trials or research (SCRN database) D = 5 year average Cancer Registry incidence		15	N	1	5.3%	N	2	6.7%	N	0	0%	N	10	8.5%	N	13	5.7%
			D	19		D	30		D	61		D	118		D	228	