



**Scottish Cancer Strategic Board
National Cancer Quality Improvement
Board**

**Cutaneous Melanoma
Clinical Quality Performance Indicators**

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Revision History

Version	Date	Summary of Changes
V1.0	June 2014	Initial publication
V2.0	February 2016	Baseline review changes
V3.0	August 2018	Formal review changes (1st Cycle)
V4.0	January 2022	Formal review changes (2nd Cycle)
V5.0	February 2025	Formal review changes (3rd Cycle)

Contents Update Record:

February 2025 (v5.0)

This document was updated following formal review (3rd cycle) of the Cutaneous Melanoma Quality Performance Indicators (QPIs) which took place following analysis of year 9 of the melanoma QPI data.

The following QPIs have been updated:

- QPI 3 - Multidisciplinary Team (MDT) Meeting
- QPI 7 - Time to Wide Local Excision
- QPI 8 - Molecular Testing
- QPI 9 - Imaging for Patients with Melanoma
- QPI 14 - Sentinel Lymph Node Biopsy

The following QPIs have been archived:

- QPI 5 - Sentinel Node Biopsy Pathology
- QPI 10 - Systemic Therapy
- QPI 13 - Clinical Trials and Research Study Access*
- QPI 15 - 30 Day Mortality following Systemic Anti-Cancer Therapy (SACT)*

The following new QPIs have been added:

- QPI 16 - Adjuvant Systemic Anti-Cancer Therapy (SACT)

* These important indicators will continue to be monitored via other national reporting systems rather than through the QPI process.

As a result of the changes above, the contents page and page numbering differ from earlier versions of this document. Sections 1 – 10 and the appendices have also been updated.

Please note that this version of the Cutaneous Melanoma QPI document applies to cases diagnosed from 1st July 2024. Where amended or new QPIs require new data items for measurement, this will apply for patients diagnosed from 1st July 2025.

Previous Updates:

January 2022 (v4.0)

This document was updated following formal review (2nd cycle) of the Cutaneous Melanoma Quality Performance Indicators (QPIs) which took place after analysis of year 6 of the Melanoma cancer QPI data.

The following QPIs have been updated:

- QPI 3 – Multidisciplinary Team (MDT) Meeting
- QPI 6 – Wide Local Excisions
- QPI 7 – Time to Wide Local Excision
- QPI 8 – BRAF Status
- QPI 9 – Imaging for Patients with Advanced Melanoma
- QPI 10 – Systemic Therapy

The following QPIs have been archived:

- QPI 12 – Surgical Margins

The following new QPIs have been added:

- QPI 14 – Sentinel Lymph Node Biopsy
- QPI 15 - 30-Day Mortality following Systemic Anti-Cancer Therapy (SACT)

As a result of the changes above, the contents page and page numbering differ from earlier version of this document. Sections 1 – 10 and the appendices have also been updated.

Please note that this version of the Cutaneous Melanoma QPI Document applies to cases diagnosed from 1st July 2021 onwards.

August 2018 (v3.0)

This document was updated following formal review of the Cutaneous Melanoma Quality Performance Indicators (QPIs) which took place following analysis of year 3 of the Melanoma cancer QPI data.

The following QPIs have been updated:

- QPI 1 – Diagnostic Biopsy
- QPI 6 – Wide Local Excisions
- QPI 9 – Imaging for Patients with Advanced Melanoma

The following QPIs have been archived:

- QPI 11 – Access to Lymphoedema Service

The following new QPIs have been added:

- QPI 12 – Surgical Margins

Please note the Clinical Trial and Research Study Access has now been added into each tumour specific QPI document (see QPI 13 - Clinical Trial and Research Study Access).

As a result of the changes above, the contents page and page numbering differ from earlier version of this document. Sections 1 – 10 and the appendices have also been updated.

Please note that this version of the Cutaneous Melanoma QPI Document applies to cases diagnosed from 1st July 2017 onwards. Where amended or new QPIs require new data items for measurement, this will apply for patients diagnosed from 1st July 2018.

February 2016 (v2.0)

This document was updated following baseline review of the Cutaneous Melanoma QPIs which took place following analysis of year 1 of the Melanoma data. As a result, the following QPIs have been updated:

- QPI 1 – Excision Biopsy
- QPI 6 – Wide Local Excisions
- QPI 7 – Time to Wide Local Excision
- QPI 10 – Systemic Therapy

Please note that this version of the Melanoma QPI document applies to cases diagnosed from 1st July 2015.

Contents

1. National Cancer Quality Programme	6
1.1 <i>Quality Assurance and Continuous Quality Improvement</i>	6
2. Quality Performance Indicator Development Process	6
3. QPI Formal Review Process	7
4. Format of the Quality Performance Indicators	7
5. Supporting Documentation	8
6. Quality Performance Indicators for Cutaneous Melanoma	9
<i>QPI 1: Diagnostic Biopsy</i>	9
<i>QPI 2: Pathology Reporting</i>	11
<i>QPI 3: Multi-Disciplinary Team Meeting (MDT)</i>	12
<i>QPI 4: Clinical Examination of Draining Lymph Node Basins</i>	14
<i>QPI 6: Wide Local Excisions</i>	15
<i>QPI 7: Time to Wide Local Excision</i>	16
<i>QPI 8: Molecular Testing</i>	18
<i>QPI 9: Imaging for Patients with Melanoma</i>	19
<i>QPI 14: Sentinel Lymph Node Biopsy</i>	21
<i>QPI 16: Adjuvant Systemic Anti-Cancer Therapy (SACT)</i>	22
7. Survival	23
8. Areas for Future Consideration	23
9. Governance and Scrutiny	23
9.1 <i>National</i>	23
9.2 <i>Regional – Regional Cancer Networks</i>	24
9.3 <i>Local – NHS Boards</i>	24
10. References	25
11. Appendices	27
<i>Appendix 1: QPI Development Process</i>	27
<i>Appendix 2: Cutaneous Melanoma QPI Formal Reviews</i>	30
<i>Appendix 3: 3 Yearly National Governance Process & Improvement Framework for Cancer Care</i>	33
<i>Appendix 4: Regional Annual Governance Process and Improvement Framework for Cancer Care</i>	34
<i>Appendix 5: Glossary of Terms</i>	35

1. National Cancer Quality Programme

Beating Cancer: Ambition and Action (2016)¹ details a commitment to delivering the National Cancer Quality Programme across NHSScotland, with a recognised need for national cancer QPIs to support a culture of continuous quality improvement. Addressing variation in the quality of cancer services is pivotal to delivering improvements in quality of care. This is best achieved if there is consensus and clear indicators for what good cancer care looks like.

Small sets of cancer specific outcome focussed, evidence based indicators are in place for 19 different tumour types. These QPIs ensure that activity is focused on those areas that are most important in terms of improving survival and individual care experience whilst reducing variation and supporting the most effective and efficient delivery of care for people with cancer. QPIs are kept under regular review and are responsive to changes in clinical practice and emerging evidence.

A programme to review and update the QPIs in line with evolving evidence is in place as well as a robust mechanism by which additional QPIs will be developed over the coming years.

1.1 Quality Assurance and Continuous Quality Improvement

The ultimate aim of the programme is to develop a framework, and foster a culture of continuous quality improvement, whereby real time data is reviewed regularly at an individual Multidisciplinary Team (MDT)/Unit level and findings actioned to deliver continual improvements in the quality of cancer care. This is underpinned and supported by a programme of regional and national comparative reporting and review.

NHS Boards are required to report against QPIs as part of a mandatory, publicly reported, programme at a national level. A rolling programme of reporting is in place, with approximately three national tumour specific summary reports published annually. These reports highlight the publication of performance data in the Cancer QPI Dashboard held within the Scottish Cancer Registry and Intelligence Service (SCRIS). The dashboard includes comparative reporting of performance against QPIs at MDT/Unit level across NHSScotland, trend analysis and survival. This approach helps to overcome existing issues relating to the reporting of small volumes in any one year.

In the intervening years, tumour specific QPIs are monitored on an annual basis through established Regional Cancer Network and local governance processes, with analysed data submitted to Public Health Scotland (PHS) for inclusion in the Cancer QPI Dashboard and subsequent national summary reports. This ensures that timely action is taken in response to any issues that may be identified through comparative reporting and systematic review.

2. Quality Performance Indicator Development Process

The QPI development process was designed to ensure that indicators are developed in an open, transparent and timely way. The development process can be found in appendix 1.

The Cutaneous Melanoma QPI Development Group was convened in February 2013, chaired by Mr Jim Docherty (Consultant Colorectal and General Surgeon). Membership of this group included clinical representatives drawn from the three Regional Cancer Networks, Healthcare Improvement Scotland, Information Services Division (ISD) and patient/carer representatives.

The development process and membership of the development group can be found in appendix 1.

3. QPI Formal Review Process

As part of the National Cancer Quality Programme, a systematic rolling programme of national review process has been developed. This ensures all tumour specific QPIs are subject to formal review following every 3rd year of comparative QPI data analysis.

The formal review process is clinically driven with proposals for change sought from specialty specific representatives in each of the Regional Cancer Networks. It is designed to be flexible in terms of the extent of review required with tumour specific Regional Clinical Leads undertaking a key role in this decision making. Formal review meetings to further discuss proposals are arranged where deemed necessary. The review builds on existing evidence using expert clinical opinion to identify where new evidence is available, and a full public engagement exercise will take place where significant revisions have been made or new QPIs developed.

During formal review QPIs may be archived and replaced with new QPIs. Triggers for doing so include significant change to clinical practice, targets being consistently met by all Boards, and publication of new evidence. Where QPIs have been archived, associated data items will continue to be collected where these are utilised for other indicators, or measures such as survival analysis.

Any new QPIs are developed in line with the following criteria:

- **Overall importance** – does the indicator address an area of clinical importance that would significantly impact on the quality and outcome of care delivered?
- **Evidence based** – is the indicator based on high quality clinical evidence?
- **Measurability** – is the indicator measurable i.e. are there explicit requirements for data measurement and are the required data items accessible and available for collection?

Three formal reviews of the Cutaneous Melanoma QPIs have been undertaken to date. Further information can be found in appendix 2.

4. Format of the Quality Performance Indicators

QPIs are designed to be clear and measurable, based on sound clinical evidence whilst also taking into account other recognised standards and guidelines.

- Each QPI has a **short title** which will be utilised in reports as well as a fuller **description** which explains exactly what the indicator is measuring.
- This is followed by a brief overview of the **evidence base and rationale** which explains why the development of this indicator was important.
- The measurability **specifications** are then detailed; these highlight how the indicator will actually be measured in practice to allow for comparison across NHSScotland.
- Finally a **target** is indicated, this dictates the level which each unit should be aiming to achieve against each indicator.

In order to ensure that the chosen target levels are the most appropriate and drive continuous quality improvement as intended they are kept under review and revised as necessary, if further evidence or data becomes available.

Rather than utilising multiple exclusions, a tolerance level has been built into the QPIs. It is very difficult to accurately measure patient choice, co-morbidities and patient fitness therefore target levels have been set to account for these factors. Further detail is noted within QPIs where there are other factors which influenced the target level.

Where 'less than' (<) target levels have been set the rationale has been detailed within the relevant QPI. All other target levels should be interpreted as 'greater than' (>) levels.

5. Supporting Documentation

A national minimum core dataset and a measurability specification have been developed in parallel with the indicators to support the monitoring and reporting of the Cutaneous Melanoma QPIs. The latest version of these documents can be found at:

[Public Health Scotland Cancer Audit](#)

6. Quality Performance Indicators for Cutaneous Melanoma

QPI 1: Diagnostic Biopsy

QPI Title:	Patients with cutaneous melanoma should have their initial diagnostic biopsy carried out by a skin cancer clinician*.
Description:	<p>Proportion of patients with cutaneous melanoma who have their initial diagnostic biopsy carried out by a skin cancer clinician*.</p> <p>Please note: The specifications of this QPI are separated to ensure clear measurement of both patients who undergo:</p> <ul style="list-style-type: none"> (i) Diagnostic excision biopsy as their initial procedure; and (ii) Diagnostic partial biopsy as their initial procedure.
Rationale and Evidence:	<p>The initial biopsy is important for both diagnosis and pathological staging²⁻⁴. Evidence has shown excisional biopsy to be the most appropriate procedure, because it allows accurate evaluation of tumour thickness and other prognostic factors²⁻⁵.</p> <p>If melanoma is suspected an excision biopsy should be carried out to ensure the melanoma is completely removed, except in rare circumstances where an incision or shave biopsy may be a more appropriate initial procedure, due to location or size of lesion⁶.</p> <p>Patients suspected of having melanoma should be referred to secondary care to have their excisional biopsy carried out by someone with specialist experience in melanoma^{4,6,7}.</p>
Specification (i):	<p>Numerator: Number of patients with cutaneous melanoma undergoing diagnostic excision biopsy as their initial procedure who had this carried out by a skin cancer clinician*.</p> <p>Denominator: All patients with cutaneous melanoma undergoing diagnostic excision biopsy as their initial procedure.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.

(Continued overleaf)

* A skin cancer clinician can be defined as a:

- Dermatologist,
- Plastic Surgeon,
- Oral and Maxillofacial Surgeon, or
- A locally designated clinician with a special interest in skin cancer, who is also a member (or under the supervision of a member) of the melanoma MDT.

QPI 1: Diagnostic Biopsy (continued.....)

<p>Specification (ii):</p>	<p>Numerator: Number of patients with cutaneous melanoma undergoing diagnostic partial biopsy as their initial procedure who had this carried out by a skin cancer clinician*.</p> <p>Denominator: All patients with cutaneous melanoma undergoing diagnostic partial biopsy as their initial procedure.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.
<p>Target:</p>	<p>90%</p> <p>The tolerance accounts for situations where lesion is not clinically suspicious of melanoma before excision and for factors relating to patient choice.</p>

QPI 2: Pathology Reporting

QPI Title:	Surgical pathology reports for patients with cutaneous melanoma should contain full pathology information to inform treatment decision making.
Description:	Proportion of patients with cutaneous melanoma who undergo 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).
Rationale and Evidence:	<p>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^{4,6,8}.</p> <p>The Royal College of Pathologists have agreed a minimum dataset⁸.</p> <p>The dataset is available from:</p> <p>Royal College of Pathologists - minimum dataset Cutaneous Melanoma</p>
Specifications:	<p>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).</p> <p>Denominator: All patients with cutaneous melanoma undergoing diagnostic excision biopsy.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.
Target:	<p>90%</p> <p>The tolerance level within this target is designed to account for situations where there is insufficient tissue to perform additional testing.</p>

QPI 3: Multi-Disciplinary Team Meeting (MDT)

QPI Title:	Patients with cutaneous melanoma should be discussed by a multidisciplinary team.
Description:	<p>Proportion of patients with cutaneous melanoma who are discussed at a MDT meeting.</p> <p>Please note: The specifications of this QPI are separated to ensure clear measurement of both:</p> <ul style="list-style-type: none"> (i) Patients with stage IA cutaneous melanoma who are discussed at a MDT meeting within 4 weeks of initial pathology report being issued; and (ii) Patients with stage IB and above cutaneous melanoma who are discussed at a MDT meeting before definitive treatment.
Rationale and Evidence:	<p>Evidence suggests that patients with cancer managed by a multi-disciplinary team have a better outcome. There is also evidence that the multidisciplinary management of patients increases their overall satisfaction with their care⁹.</p> <p>Discussion prior to definitive treatment decision provides reassurance that patients are being managed appropriately.</p>
Specification (i):	<p>Numerator: Number of patients with stage IA cutaneous melanoma discussed at the MDT meeting within 4 weeks of initial pathology report being issued.</p> <p>Denominator: All patients with stage IA cutaneous melanoma.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.
Specification (ii):	<p>Numerator: Number of patients with stage IB and above cutaneous melanoma who are discussed at the MDT meeting before definitive treatment (wide local excision, chemotherapy/SACT, supportive care and radiotherapy).</p> <p>Denominator: All patients with stage IB and above cutaneous melanoma.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Patients who died before first treatment. • Patients who require no wide local excision as agreed by MDT.
Target:	<p>95%</p> <p>The tolerance within this target is designed to account for situations where patients require treatment urgently, or where patients may be upstaged e.g. from IA to IB (or above) following pathology review for MDT.</p>

Please note:

The total number and percentage of patients who require no wide local excision as agreed by the MDT will also be analysed to further inform reporting of this QPI and to identify any variation between NHS Boards.

QPI 4: Clinical Examination of Draining Lymph Node Basins

QPI Title:	Patients with cutaneous melanoma should undergo clinical examination of relevant draining lymph node basins as part of clinical staging.
Description:	Proportion of patients with cutaneous melanoma undergoing clinical examination of relevant draining lymph node basins as part of clinical staging.
Rationale and Evidence:	Scottish Intercollegiate Guidelines Network ⁷ 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 ^{4,7} .
Specifications:	<p>Numerator: Number of patients with cutaneous melanoma who undergo clinical examination of relevant draining lymph node basins as part of clinical staging.</p> <p>Denominator: All patients with cutaneous melanoma.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.
Target:	<p>95%</p> <p>The tolerance within this target is designed to account for factors of patient choice.</p>

QPI 6: Wide Local Excisions

QPI Title:	Patients with cutaneous melanoma should undergo a wide local excision of the initial diagnostic biopsy site to reduce the risk of local recurrence.
Description:	Proportion of patients with cutaneous melanoma who undergo a wide local excision, following diagnostic excision or partial biopsy.
Rationale and Evidence:	<p>Surgical excision is an effective cure for primary cutaneous melanoma¹⁰. 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^{10,11}. Studies have shown the importance of removing the tumour and a margin of healthy skin¹².</p> <p>The standard treatment for primary cutaneous melanoma is wide local excision of the skin and subcutaneous tissues around the melanoma^{13,14}. Treatment for melanoma aims to achieve histologically free margins with low likelihood of local recurrence or persistent disease¹⁵.</p> <p>The appropriate surgical margin is determined by the thickness of the lesion^{4,11,12,14,15}. Various evidence exists determining the most clinically appropriate surgical margin^{4,11,12,15}. The Cutaneous Melanoma QPI Group felt ensuring a wide local excision took place was a good indicator of quality, with the decision of appropriate wide local excision surgical margin being left to MDT/Clinical judgement.</p>
Specification:	<p>Numerator: Number of patients with cutaneous melanoma undergoing diagnostic excision or partial biopsy who undergo a wide local excision.</p> <p>Denominator: All patients with cutaneous melanoma undergoing diagnostic excision or partial biopsy.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> Patients who require no wide local excision as agreed by MDT.
Target:	<p>95%</p> <p>The tolerance within this target accounts for situations where it is not clinically possible to undertake a wide local excision due to the size and location of the tumour, and for factors of patient choice. In addition, it accounts for deteriorating patient fitness including those who have died prior to further treatment.</p>

Please note:

The total number and percentage of patients who require no wide local excision as agreed by the MDT will also be analysed to further inform reporting of this QPI and to identify any variation between NHS Boards.

QPI 7: Time to Wide Local Excision

QPI Title:	Patients with cutaneous melanoma should have their wide local excision in a timely manner.
Description:	<p>Proportion of patients with cutaneous melanoma where reporting of diagnostic biopsy and wide local excision is within 84 days.</p> <p>Please note: Rather than an overall timeframe, this QPI measures three distinct elements of the pathway:</p> <ul style="list-style-type: none"> (i) Diagnostic biopsy reported within 21 days; (ii) Wide local excision carried out under local anaesthetic within 63 days of diagnostic biopsy reporting; and (iii) Wide local excision carried out under general anaesthetic within 63 days of diagnostic biopsy reporting.
Rationale and Evidence:	<p>Patients with melanoma will undergo their diagnostic 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 recurrence¹⁶.</p> <p>It is important that patients with cutaneous melanoma undergo surgical excision as soon as possible. There is no clear consensus from clinical literature on the most appropriate timeframe for wide local excision however studies have found that delays in receiving definitive treatment can have an unfavourable impact within a number of cancer types¹⁷⁻¹⁹. They have also documented that these delays could cause the patient and relatives psychological distress¹⁹.</p> <p>The Cutaneous Melanoma QPI review group has agreed that 21 days is the most appropriate timeframe in which to report diagnostic biopsy with a further 63 days to undertake wide local excision. This is based on clinical consensus and current best practice.</p> <p>The QPI has been separated by type of anaesthetic to provide further information on surgical capacity and focus improvement where required.</p>
Specification (i):	<p>Numerator: Number of patients with cutaneous melanoma undergoing diagnostic biopsy where this is reported within 21 days.</p> <p>Denominator: All patients with cutaneous melanoma undergoing diagnostic excision or partial biopsy.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.

(Continued overleaf)

QPI 7: Time to Wide Local Excision (continued....)

Specification (ii):	<p>Numerator: Number of patients with cutaneous melanoma undergoing diagnostic biopsy where wide local excision is carried out under local anaesthetic within 63 days of diagnostic biopsy reporting.</p> <p>Denominator: All patients with cutaneous melanoma undergoing diagnostic excision or partial biopsy who proceed to wide local excision carried out under local anaesthetic.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.
Specification (iii):	<p>Numerator: Number of patients with cutaneous melanoma undergoing diagnostic biopsy where wide local excision is carried out under general anaesthetic within 63 days of diagnostic biopsy reporting.</p> <p>Denominator: All patients with cutaneous melanoma undergoing diagnostic excision or partial biopsy who proceed to wide local excision carried out under general anaesthetic.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.
Target:	<p>90%</p> <p>The tolerance within this target accounts for factors of patient choice.</p>

QPI 8: Molecular Testing

QPI Title:	Patients with cutaneous melanoma should have molecular testing performed to inform treatment decision making.
Description:	Proportion of patients with stage III or IV cutaneous melanoma who undergo testing for BRAF, NRAS and c-KIT mutations.
Rationale and Evidence:	<p>The mutational status of advanced stage melanoma is an important tumour characteristic which influences treatment decision making.</p> <p>The BRAF, NRAS and c-KIT mutation status should be available to clinicians either on the pathology report or as a genetics report in order to inform the use of targeted therapies⁷.</p> <p>Patients with stage III and IV melanoma should undergo a B-RAF status check to assess suitability for BRAF inhibitors and Mek inhibitors²⁰.</p> <p>BRAF inhibitors, and Mek inhibitors, are used for the treatment of patients with BRAF V600 mutation positive unresectable or metastatic melanoma^{21,22}. Combination therapy with the BRAF inhibitor dabrafenib plus the MEK inhibitor trametinib has been shown to improve survival in patients with advanced melanoma with BRAF V600 mutations^{21,22}.</p> <p>In resected patients with stage III and IV melanoma with BRAF V600E or V600K mutations, adjuvant use of combination therapy with dabrafenib plus trametinib demonstrates a significantly lower risk of recurrence²¹.</p>
Specifications:	<p>Numerator: Number of patients with stage III or IV cutaneous melanoma who undergo testing for BRAF, NRAS and c-KIT mutations.</p> <p>Denominator: All patients with stage III or IV cutaneous melanoma.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.
Target:	<p>90%</p> <p>The tolerance level within this target is designed to account for situations where there is insufficient tissue to assess the mutation status. In addition, the tolerance accounts for situations where patients may have significant co-morbidities or may not be fit for investigation and/or treatment and for patient choice.</p>

QPI 9: Imaging for Patients with Melanoma

QPI Title:	Patients with stage IIB and above cutaneous melanoma should be evaluated with appropriate imaging to guide treatment decision making.
Description:	<p>Proportion of patients with pathologically or radiologically confirmed stage IIB and above cutaneous melanoma who undergo computed tomography (CT) or positron emission tomography (PET) CT within 35 days of pathology report being issued, and where the report is available within 14 days of the imaging procedure.</p> <p>Please note: The specifications of this QPI are separated to ensure clear measurement of the following:</p> <ul style="list-style-type: none"> (i) Patients with pathologically or radiologically confirmed stage IIB and above cutaneous melanoma who undergo CT or PET CT[†] within 35 days of pathology report being issued; and (ii) Patients undergoing CT or PET CT[†] where the report is available within 14 days of the imaging procedure.
Rationale and Evidence:	<p>Guidelines recommend that patients with stage IIB and above should be offered initial staging imaging⁷.</p> <p>Guidelines report that patients with high grade cutaneous melanoma should undergo imaging of the head, chest, abdomen and pelvis to exclude metastases⁴. It has been reported that low grade cutaneous melanoma do not benefit from imaging due to the high incident rate of false positives^{4,7}. To ensure alignment with current clinical practice stage has been utilised to stratify patients for inclusion within this QPI over grading.</p>
Specification (i):	<p>Numerator: Number of patients with pathologically or radiologically confirmed stage IIB and above cutaneous melanoma who undergo CT or PET CT[†] within 35 days of pathology report being issued.</p> <p>Denominator: All patients with pathologically or radiologically confirmed stage IIB and above cutaneous melanoma.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Patients that are deemed inappropriate for radiological staging by MDT.

(Continued overleaf)

[†] CT or PET/CT of the chest, abdomen, pelvis and head

QPI 9: Imaging for Patients with Melanoma (continued....)

Specification (ii):	<p>Numerator: Number of patients with pathologically or radiologically confirmed stage IIB and above cutaneous melanoma who undergo CT or PET CT imaging where the report is available within 14 days of the imaging procedure.</p> <p>Denominator: All patients with pathologically or radiologically confirmed stage IIB and above cutaneous melanoma who undergo CT or PET CT⁺ imaging.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • No exclusions.
Target:	<p>95%</p> <p>The tolerance within this target accounts for factors of patient choice.</p>

Please note:

The total number and percentage of patients that are deemed inappropriate for radiological staging by the MDT will also be analysed to further inform reporting of this QPI and to identify any variation between NHS Boards.

QPI 14: Sentinel Lymph Node Biopsy

QPI Title:	Patients with cutaneous melanoma should undergo a sentinel lymph node biopsy (SLNB) where eligible.
Description:	Proportion of patients with stage pT1b (with either a mitotic rate of $\geq 2/\text{mm}^2$ or lymphovascular invasion) and stage pT2 and above cutaneous melanoma that undergo SLNB.
Rationale and Evidence:	<p>Undergoing SLNB may provide more accurate staging and a better indication of survival and the potential of recurrent disease⁷.</p> <p>The sentinel lymph node is the node at greatest risk for the development of metastases therefore biopsy of this node can assist in staging patients at risk of metastatic disease. It can determine whether metastasis are present within the regional lymph node basin and is a useful for staging in melanomas which are AJCC stage IB or above^{7,23}. Patients with a pT1b melanoma should be considered if they display lymphovascular invasion or a mitotic rate of $\geq 2/\text{mm}^2$²⁴.</p> <p>In addition to a prognostic indicator, sentinel node biopsy influences treatment decision making in terms of access to adjuvant therapy²⁴.</p>
Specifications:	<p>Numerator: Number of patients with stage pT1b (with either a mitotic rate of $\geq 2/\text{mm}^2$ or lymphovascular invasion) and stage pT2 and above cutaneous melanoma who undergo SLNB.</p> <p>Denominator: All patients with stage pT1b (with either a mitotic rate of $\geq 2/\text{mm}^2$ or lymphovascular invasion) and stage pT2 and above cutaneous melanoma.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Patients who proceed to adjuvant therapy with no requirement for SLNB • Patients who are clinically unfit for surgery • Patients who decline SLNB
Target:	<p>90%</p> <p>The tolerance accounts for those patients in whom the sentinel lymph node biopsy procedure fails (e.g. sentinel node cannot be located) or where other clinical reasons preclude surgery.</p>

Please note:

The total number and percentage of patients within each exclusion category will also be analysed to identify any variation between NHS Boards.

QPI 16: Adjuvant Systemic Anti-Cancer Therapy (SACT)

QPI Title:	Adjuvant Systemic Anti-Cancer Therapy (SACT) in patients with resected stage IIB or IIC cutaneous melanoma.
Description:	Proportion of patients with resected stage IIB or IIC cutaneous melanoma who undergo adjuvant SACT.
Rationale and Evidence:	<p>Studies have found that patients with resected stage IIB–IIC melanoma who undergo treatment with adjuvant pembrolizumab showed a significant improvement in disease free survival⁷.</p> <p>Patients with completely resected stage IIB or IIC melanoma (with or without BRAF mutation) should be considered for adjuvant treatment with Pembrolizumab. Pembrolizumab is accepted for use by the SMC for patients with stage IIB or IIC melanoma who have undergone complete resection⁷.</p>
Specifications:	<p>Numerator: Number of patients with resected stage IIB or IIC cutaneous melanoma who undergo adjuvant SACT.</p> <p>Denominator: All patients with resected stage IIB or IIC cutaneous melanoma.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Patients who died before SACT treatment.
Target:	<p>25%</p> <p>The tolerance accounts for situations where patients may not be suitable for SACT due to co-morbidities and fitness, as well as factors of patient choice.</p>

7. Survival

Improving survival forms an integral part of the national cancer quality improvement programme. Cutaneous Melanoma survival analysis will be reported and analysed on a 3 yearly basis by Public Health Scotland (PHS). The specific issues which will be identified by an expert group ahead of any analysis being undertaken, as per the agreed national cancer quality governance and improvement framework.

The Cutaneous Melanoma QPI Group has identified; during the QPI development process, the following issues for survival analysis.

- 1, 2 and 5 year overall survival

To ensure consistent application of survival analysis, it has been agreed that a single PHS analyst on behalf of all three regional cancer networks undertakes this work. Survival analysis will be scheduled as per the national survival analysis and reporting timetable, agreed with the National Cancer Quality Improvement Board and Scottish Cancer Strategic Board. This reflects the requirement for record linkage and the more technical requirements of survival analyses which would make it difficult for individual Boards to undertake routinely and in a nationally consistent manner.

8. Areas for Future Consideration

The Cutaneous Melanoma QPI Groups have not able to identify sufficient evidence, or determine appropriate measurability specifications to address all areas felt to be of key importance in the treatment of Cutaneous Melanoma, and therefore in improving the quality of care for patients affected by Cutaneous Melanoma.

The following area for future consideration has been raised across the lifetime of the Cutaneous Melanoma QPIs.

- Genotyping of a patient's melanoma.
- Neoadjuvant immunotherapy treatment for melanoma.

9. Governance and Scrutiny

A national and regional governance framework to assure the quality of cancer services in NHSScotland has been developed; key roles and responsibilities within this are set out below. Appendices 5 and 6 provide an overview of these governance arrangements diagrammatically. The importance of ensuring robust local governance processes are in place is recognised and it is essential that NHS Boards ensure that cancer clinical audit is fully embedded within established processes.

9.1 *National*

- Scottish Cancer Strategic Board
 - Accountable for overall national cancer quality programme and overseeing the quality of cancer care across NHSScotland.
- Healthcare Improvement Scotland
 - Proportionate scrutiny of performance.
 - Support performance improvement.

- Quality assurance: ensure robust action plans are in place and being progressed via regions/Boards to address any issues identified.
- Public Health Scotland
 - Publish national comparative report on tumour specific QPIs and survival for 3 tumour types per annum and specified generic QPIs as part of the rolling programme of reporting.

9.2 Regional – Regional Cancer Networks

- Annual regional comparative analysis and reporting against tumour specific QPIs.
- Support national comparative reporting of specified generic QPIs.
- Identification of regional and local actions required and development of an action plan to address regional issues identified.
- Performance review and monitoring of progress against agreed actions.
- Provide assurance to NHS Board Chief Executive Officers and Scottish Cancer Taskforce that any issues identified have been adequately and timeously progressed.

9.3 Local – NHS Boards

- Collect and submit data for regional comparative analysis and reporting in line with agreed measurability and reporting schedule (generic and tumour specific QPIs).
- Utilise local governance structures to review performance, develop local action plans and monitor delivery.
- Demonstrate continual improvements in quality of care through on-going review, analysis and feedback of clinical audit data at an individual multidisciplinary team (MDT) or unit level.

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11. Appendices

Appendix 1: QPI Development Process

Preparatory Work and Scoping

The preparatory work involved the development of a structured briefing paper by Healthcare Improvement Scotland. This paper took account of existing, high quality, clinical guidance and provided a basis for the development of QPIs.

The scope for development of Cutaneous Melanoma QPIs and a search narrative were defined and agreed by the Cutaneous Melanoma QPI Development Group. The table below shows the final search criteria used in the literature search.

Inclusion	Exclusion
<p><i>Melanoma types:</i></p> <ul style="list-style-type: none"> Primary cutaneous melanoma: <p><i>Interventions:</i></p> <ul style="list-style-type: none"> Diagnosis Staging and prognostic indicators Surgical management Non-surgical management <p><i>Age range:</i> Adults only</p> <p><i>Date:</i> 2005 to present day</p> <p><i>Language:</i> English only</p> <p><i>Document type:</i> Clinical guidelines</p>	<p><i>Related melanoma types:</i></p> <ul style="list-style-type: none"> Secondary malignant melanoma Cutaneous squamous cell carcinoma Basal cell carcinoma Primary cutaneous lymphoma Non-cutaneous melanoma (including ocular) <p><i>Interventions:</i></p> <ul style="list-style-type: none"> Clinical trials recruitment and protocols Communication, information sharing and support Follow-up Palliative/end-of-life care (pain management, end-of-life counselling, hospice management) Pre-cancerous conditions including: in situ and lentigo maligna Prevention Primary care/referral Recurrent disease/relapsed disease management Screening Symptom management (e.g. nausea and vomiting, neutropenic sepsis)

Table 1 – Cutaneous Melanoma Search Criteria

A systematic search was carried out by Healthcare Improvement Scotland using selected websites and two primary medical databases to identify national and international guidelines.

Twenty one guidelines were appraised for quality using the AGREE II instrument²⁵. This instrument assesses the methodological rigour used when developing a guideline. Seven of the guidelines were not recommended for use. The remaining 14 were recommended for use with consideration of their applicability or currency.

Indicator Development

The Cutaneous Melanoma QPI Development group defined evidence based, measurable indicators with a clear focus on improving the quality and outcome of care provided.

The group developed QPIs using the clinical recommendations set out in the briefing paper as a base, ensuring all indicators met the following criteria:

- Overall importance** – does the indicator address an area of clinical importance that would significantly impact on the quality and outcome of care delivered?

- **Evidence based** – is the indicator based on high quality clinical evidence?
- **Measurability** – is the indicator measurable i.e. are there explicit requirements for data measurement and are the required data items accessible and available for collection?

Engagement Process

A wide clinical and public engagement exercise was undertaken as part of development in February 2014 where the Cutaneous Melanoma QPIs, along with accompanying draft minimum core dataset and measurability specifications, were made available on the Scottish Government website. During the engagement period clinical and management colleagues from across NHSScotland, patients affected by Cutaneous Melanoma and the wider public were given the opportunity to influence the development of Cutaneous Melanoma QPIs.

Draft documentation was circulated widely to professional groups, health service staff, voluntary organisations and individuals for comment and feedback.

Following the engagement period all comments and responses received were reviewed by the Cutaneous Melanoma QPI Development Group and used to produce and refine the final indicators.

Cutaneous Melanoma QPI Development Group Membership (2013)

Name	Designation	Cancer Network/Base
Jim Docherty (Chair)	Consultant Surgeon	NOSCAN / NHS Highland
Asok Biswas	Consultant Dermatopathologist	SCAN / NHS Lothian
Lorna Bruce	SCAN Audit Manager	SCAN
Sandy Burnham	Patient Representative	
Hazel Carnegie	Patient Representative	
Tim Crooks	Medical Oncologist	NOSCAN / NHS Tayside
Michaela Davies	Consultant Plastic Surgeon	NOSCAN / NHS Grampian
Amanda Degabrielle	Macmillan Skin Cancer Clinical Nurse Specialist	NOSCAN / NHS Tayside
Sheena Dryden	Clinical Nurse Specialist	SCAN / NHS Lothian
Alan Evans	Consultant Pathologist	NOSCAN / NHS Tayside
Colin Fleming	Consultant Dermatologist	NOSCAN / NHS Tayside
Girish Gupta	Consultant Dermatologist	WoSCAN / NHS Lanarkshire
Michelle Hilton Boon	Programme Manager	Healthcare Improvement Scotland
Alex Holme	Consultant Dermatologist	SCAN / NHS Lothian
Matt Hough	Consultant Plastic Surgeon	NOSCAN / NHS Tayside

Name	Designation	Cancer Network/Base
Ehab Husain	Consultant Pathologist	NOSCAN / NHS Grampian
Daniel Kemmett	Consultant Dermatologist	WoSCAN / NHS Greater Glasgow and Clyde
Kelly Macdonald	Project Manager	National Cancer QPI Development Programme
Melanie McColgan	General Manager, Emergency Care & Medical Services	WoSCAN / NHS Greater Glasgow and Clyde
Claire McKenzie	Clinical Quality Service Coordinator	WoSCAN / NHS Lanarkshire
Neil McLachlan	MCN Manager	NOSCAN / NHS Grampian
Frank Muller	Consultant Dermatologist	NOSCAN / NHS Grampian
Brian Murray	Principle Information Development Manager	Information Services Division
Taimur Shoaib	Consultant Plastic Surgeon	WoSCAN / NHS Greater Glasgow and Clyde
Leigh Smith	Patient Representative	
Amir Tadros	Consultant Plastic Surgeon	NOSCAN / NHS Grampian
Evelyn Thomson	Regional Manager (Cancer)	WoSCAN
James Vestey	Consultant Dermatologist and Melanoma coordinator	NOSCAN / NHS Highland
Ashita Waterston	Consultant Oncologist	WoSCAN / NHS Greater Glasgow and Clyde

NOSCAN - North of Scotland Cancer Network
SCAN - South East Scotland Cancer Network
WoSCAN - West of Scotland Cancer Network

Appendix 2: Cutaneous Melanoma QPI Formal Reviews

Formal review of the Cutaneous Melanoma QPIs was undertaken for the first time in January 2018 following reporting of 3 years of national QPI data. A Formal Review Group was convened, chaired by Dr Carrie Featherstone, Consultant Clinical Oncologist, WoSCAN. Membership of this group is outlined below.

Cutaneous Melanoma QPI formal Review Group Membership (2018)

Name	Designation	Cancer Network/Base
Carrie Featherstone (Chair)	Consultant Clinical Oncologist	WoSCAN / NHS Greater Glasgow and Clyde
Andrew Affleck	Consultant Dermatologist / MCN Clinical Lead	NOSCAN / NHS Tayside
Lorna Bruce	Audit Manager	SCAN
Roger Currie	Consultant Maxillofacial Surgeon / MCN Clinical Lead	WoSCAN / NHS Ayrshire and Arran
Jen Doherty	Project Co-ordinator	National Cancer Quality Programme
Megan Mowbray	Consultant Dermatologist / MCN Clinical Lead	SCAN / NHS Lothian
Lorraine Stirling	Project Officer	National Cancer Quality Programme

Formal review of the Cutaneous Melanoma QPIs has been undertaken in consultation with various other clinical specialties.

NOSCAN - North of Scotland Cancer Network

SCAN - South East Scotland Cancer Network

WoSCAN - West of Scotland Cancer Network

The 2nd Cycle of Formal Review commenced in March 2021 following reporting of 6 years of QPI data. This cycle of review is more selective and focussed on ensuring the ongoing clinical relevance of the QPIs. A Formal Review Group was convened with Dr Carrie Featherstone, Consultant Clinical Oncologist, WoSCAN appointed as Clinical Advisor/Chair of the group. Membership of this group is outlined below.

Cutaneous Melanoma QPI Formal Review Group Membership (2021)

Name	Designation	Cancer Network/Base
Carrie Featherstone (Chair)	Consultant Clinical Oncologist	WoSCAN
Ewan Brown	Consultant Medical Oncologist / MCN Clinical Lead	SCAN
Lorna Bruce	Audit Manager	SCAN
Roger Currie	Consultant Oral and Maxillofacial Surgeon	WoSCAN
Sarah Digby	Consultant Pathologist	WoSCAN

Name	Designation	Cancer Network/Base
Jen Doherty	Project Co-ordinator	National Cancer Quality Programme
Andy Malyon	Consultant Plastic Surgeon / MCN Clinical Lead	WoSCAN
Fiona Macdonald	Consultant Dermatologist	WoSCAN
Bryan McKellar	Programme Co-ordinator	NCA
Megan Mowbray	Consultant Dermatologist	SCAN
Kaz Rahman	Consultant Plastic Surgeon / MCN Clinical Lead	NCA
Shantini Rice	Consultant Dermatologist	SCAN
Lorraine Stirling	Project Officer	National Cancer Quality Programme
Christine Urquhart	Information Analyst	WoSCAN
Heather Wotherspoon	MCN Manager	WoSCAN

Formal review of the Cutaneous Melanoma QPIs has been undertaken in consultation with all relevant clinical specialties.

NCA - North Cancer Alliance
SCAN - South East Scotland Cancer Network
WoSCAN - West of Scotland Cancer Network

3rd Cycle Formal Review

The 3rd cycle of Formal Review commenced in January 2024. This coincided with reporting and review of Year 9 national QPI data. Membership of this group is outlined below:

Cutaneous Melanoma QPI Formal Review Group Membership (2024)

Name	Designation	Cancer Network/Base
Jen Doherty (Deputy Chair)	Programme Co-ordinator	National Cancer Quality Programme
Lorna Bruce	Audit Manager	SCAN
Fiona Macdonald	Clinical Lead	WoSCAN
Kaz Rahman	Clinical Lead	NCA
Shantini Rice	Clinical Lead	SCAN
Mark Stares	Consultant Medical Oncologist	SCAN
Lorraine Stirling	Project Officer, National Cancer Quality Programme	National
Christine Urquhart	Information Analyst	WoSCAN

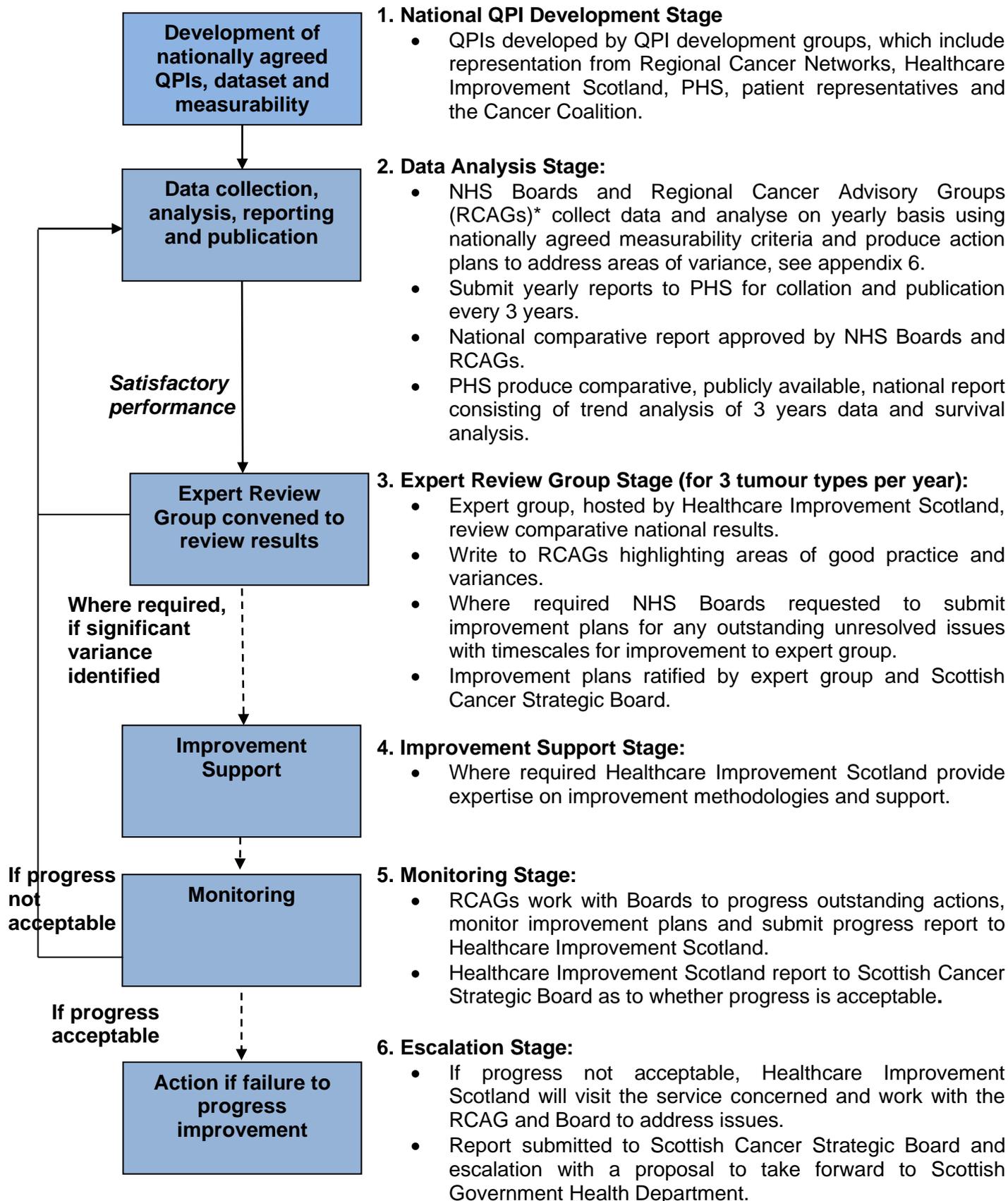
Name	Designation	Cancer Network/Base
Ashita Waterston	Consultant Medical Oncologist	WoSCAN
Heather Wotherspoon	MCN & Improvement Manager	WoSCAN

Formal review of the Cutaneous Melanoma QPIs has been undertaken in consultation with various other clinical specialties.

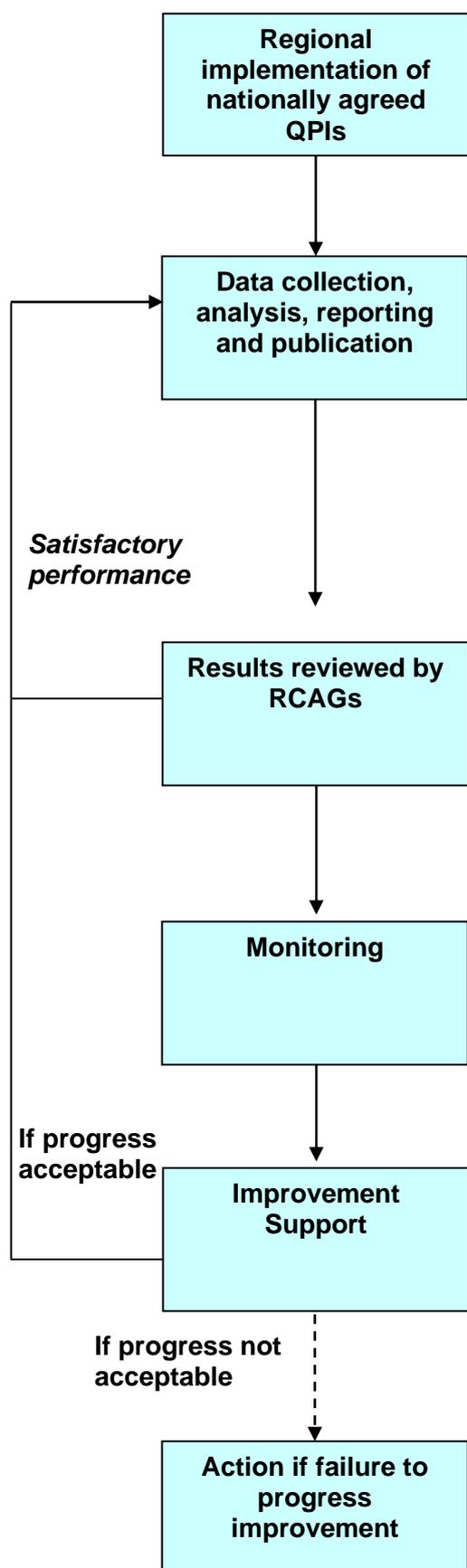
NCA - North Cancer Alliance
 SCAN – South East Scotland Cancer Network
 WoSCAN – West of Scotland Cancer Network

Appendix 3: 3 Yearly National Governance Process & Improvement Framework for Cancer Care

This process is underpinned by the annual regional reporting and governance framework (see appendix 4).



Appendix 4: Regional Annual Governance Process and Improvement Framework for Cancer Care



1. Regional QPI Implementation Stage:

- National cancer QPIs and associated national minimum core dataset and measurability specifications, developed by QPI development groups.
- Regional implementation of nationally agreed dataset to enable reporting of QPIs.

2. Data Analysis Stage:

- NHS Boards collect data and data is analysed on a yearly basis using nationally agreed measurability criteria at local/ regional level.
- Data/results validated by Boards and annual regional comparative report produced by Regional Networks.
- Areas of best practice and variance across the region highlighted.
- Yearly regional reports submitted to PHS for collation and presentation in national report every 3 years.

3. Regional Performance Review Stage:

- RCAGs* review regional comparative report.
- Regional or local NHS Board action plans to address areas of variance developed.
- Appropriate leads identified to progress each action.
- Action plans ratified by RCAGs.

4. Monitoring Stage:

- Where required, NHS Boards monitor progress with action plans and submit progress reports to RCAGs.
- RCAGs review and monitor regional improvement.

5. Improvement Support Stage:

- Where required Healthcare Improvement Scotland maybe requested to provide expertise to NHS Boards/RCAGs on improvement methodologies and support.

6. Escalation Stage:

- If progress not acceptable, RCAGs will escalate any issues to relevant Board Chief Executives. If progress remains unacceptable RCAGs will escalate any relevant issues to Healthcare Improvement Scotland.

**The Regional Cancer Planning Group (South and East of Scotland) and the North Cancer Clinical Leadership Group (North Cancer Alliance) are equivalent to the Regional Cancer Advisory Group (RCAG) in the West of Scotland.*

Appendix 5: Glossary of Terms

Adjuvant Treatment	Treatment such as chemotherapy, or radiotherapy that is given after a surgical procedure to reduce the risk of the cancer coming back.
Biopsy	Removal of a sample of tissue from the body to assist in diagnosis of a disease.
BRAF	Specific genetic marker that when mutated allows tumour cells to be killed off with a specific class of anticancer drugs
Chemotherapy	The use of drugs used to kill cancer cells, to prevent or slow their growth.
Clinical staging	Process of describing to what degree cancer has spread from its original site to another part of the body. Staging involves clinical, surgical and pathology assessments. <i>See TNM Classification</i>
Co-morbidity/ Comorbidities	Other conditions and symptoms prevalent other than the primary diagnosis.
Computed Tomography (CT)	An x-ray imaging technique, which allows detailed investigation of the internal organs of the body.
Curative Treatment	Treatment given to cure the illness.
Definitive Treatment	Treatment designed to potentially cure cancer using one or a combination of interventions.
Dermatologist	A clinician who works within a branch of medicine concerned with the study and treatment of disorders of the skin.
Diagnosis	The process of identifying a disease, such as cancer, from its signs and symptoms.
Grade	The degree of malignancy of a tumour, i.e. how closely the cancer cells look like normal cells.
Histological / Histopathological	The study of the structure, composition and function of tissues under the microscope, and their abnormalities.
Immunotherapy	A treatment that uses the body's own immune system to help fight cancer.
Lymphoedema	A swelling that develops as a result of an impaired lymphatic system.
Metastatic	Spread of cancer away from the primary site to somewhere else via the bloodstream or the lymphatic system. Metastatic disease can be local (close to the area where the cancer is) or distant (in another area of the body).
Morbidity	How much ill health a particular condition causes.
Mortality	Either (1) the condition of being subject to death; or (2) the death rate, which reflects the number of deaths per unit of population in a specific region, age group, disease or other classification, usually expressed as deaths per 1,000, 10,000 or 100,000.
Multidisciplinary Team	Team which consists of various specialities and may be different depending on disease. For example, pathologist, surgeon, etc.
Multidisciplinary Team Meeting (MDT)	A meeting which is held on a regular basis, which is made up of participants from various disciplines appropriate to the disease area, where diagnosis, management and appropriate treatment of patients is discussed and agreed.
Lymph nodes	Small bean shaped organs located along the lymphatic system. Nodes filter bacteria or cancer cells that might travel through the lymphatic system.
Pathological/Pathology	The study of disease processes with the aim of understanding their nature and causes. This is achieved by observing samples of fluid and tissues obtained from the living patient by various methods, or at a post mortem.

Positron emission tomography / Computed Tomography (PET CT)	A specialised imaging technique which demonstrates uptake of tracer in areas of high cell metabolism and can help differentiate between benign and malignant masses.
Postoperative Complication	Postoperative complications are unexpected problems that arise following surgery; these can range from minor to major complications.
Prognosis	An assessment of the expected future course and outcome of a person's disease.
Radiotherapy	The use of radiation (such as x-rays) to diagnose or treat disease.
Sentinel Node Biopsy	The lymph node near a body organ or part of an organ which is thought to be the first reached by tissue fluid draining from that organ. This lymph node may be the one most likely to contain cancer cells if the cancer has begun to spread.
Surgery/ Surgical Resection	Surgical removal of the tumour/lesion.
Subcutaneous	Beneath the skin.
Survival	The percentage of people in a study or treatment group who are alive for a certain period of time after they were diagnosed with or treated for a disease, such as cancer.
Systematic Anti Cancer Therapy (SACT)	Treatment of cancer using drugs which prevent the replication or growth of cancer cells. This encompasses biological therapies and cytotoxic chemotherapy.
Toxicity	The extent to which something is poisonous or harmful.
Tumour Node Metastases (TNM)	'TNM' stands for Tumour, Node, Metastasis. This system can describe the size of a primary tumour, whether the cancer has spread to the lymph nodes and whether the cancer has spread to a different part of the body (metastasised). The system uses numbers to describe the cancer.
Wide Local Excision	The removal of the lump together with some surrounding normal tissue.