

# **Audit Report**

## **Renal Cancer Quality Performance Indicators**

**Clinical Audit Data: 1st January - 31st December 2020**

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# Renal Cancer QPI Overview

Patients diagnosed between 1st January - 31st December 2020

Number of cases diagnosed:

**442**

Gender split:

Males: 62.4%  
Females: 37.6%

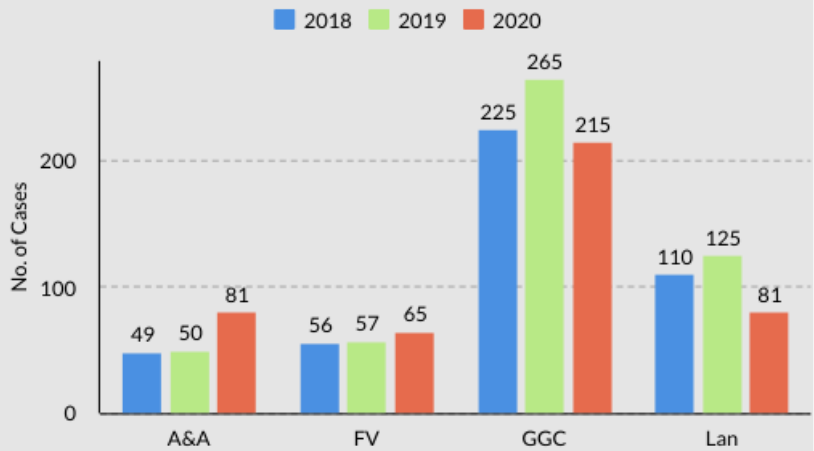
Mode age group

Males: 70-74  
Females: 60-64

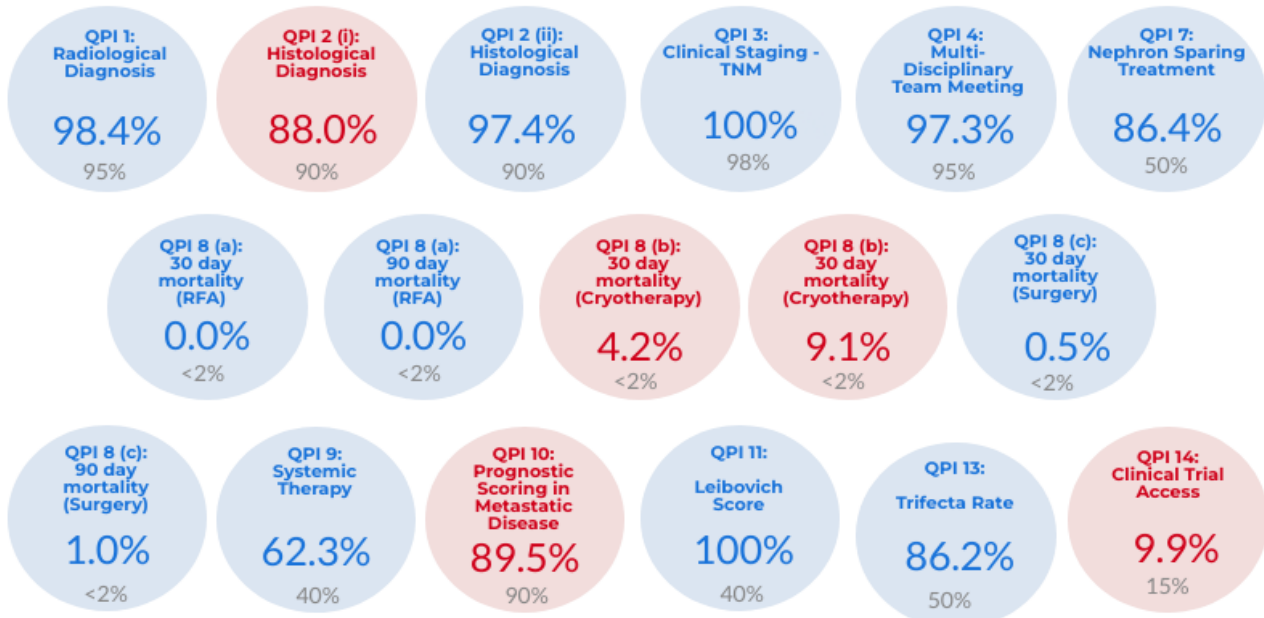
Case ascertainment:

**89.1%**

## Number of patients by Board



## Quality Performance Indicators



## Achievements

Performance across the Boards is variable for a number of QPIs however it is encouraging that targets were met regionally for the following indicators



- . Radiological Diagnosis . Histological Diagnosis (SACT) .Clinical Staging-TNM .MDT Meeting
- . Nephron Sparing Treatment . 30 and 90 mortality (Surgery and RFA) . Systemic therapy
- . Leibovich Score . Trifecta Rate

# Executive Summary

## Introduction

This report contains an assessment of the performance of West of Scotland (WoS) urological cancer services using clinical audit data relating to patients diagnosed with renal cancer in 2020. Data analysed and included within this report relates to cancer of the kidney and results are measured against the Renal Cancer Quality Performance Indicators (QPIs) <sup>1</sup>. Twelve months of data were measured against the Renal Cancer QPIs for the ninth consecutive year.

In order to ensure the success of the Cancer QPIs in driving quality improvement in cancer care, QPIs will continue to be assessed for clinical effectiveness and relevance. The 2<sup>nd</sup> review of the Renal QPIs was completed at the beginning of 2019. QPIs are reviewed every 3 years with the next renal review is currently underway and due to be completed in 2022. This clinically led review aims to identify potential refinements to the current QPIs and involves key clinicians from each of the three Regional Cancer Networks.

## Methodology

Further detail on the audit and analysis methodology and data quality is available in the meta data within [Appendix 1](#).

## Results

A summary of the Renal Cancer QPIs (QPI 1 to 13) 2020 clinical audit data is presented below, with a more detailed analysis of the results set out in the main report. Data are analysed in the most part by location of diagnosis or treatment (Hospital of Surgery), and illustrate NHS Board performance against each target and overall regional (WoS) performance for each performance indicator. Results are presented graphically and the accompanying tabular format also highlights any missing data and possible effects on any of the measured outcomes.

Where the number of cases meeting the denominator criteria for any indicator is between one and four, the percentage calculation has not been shown on any associated charts or tables. This is to avoid any unwarranted variation associated with small numbers and to minimise the risk of disclosure. Any charts or tables impacted by this restricted data are denoted with a dash (-). An asterisk (\*) is used to specify a denominator of zero and to distinguish between this and a 0% performance. Any commentary provided by NHS Boards relating to the impacted indicators will however be included as a record of continuous improvement.

In accordance with the regional governance process, specific NHS Board actions are identified to address issues highlighted through data analysis.

Please note actions have been categorised into groupings (for example surgery, oncology, pathology or data capture) for internal management purposes to allow regional trends to be identified and co-ordinated regional action across multiple tumour groups where appropriate.

## Summary of QPI Results

Colour Key		Symbol Key	
	Above QPI target	†	Analysed by Board/hospital of surgery
	Below QPI target	^	Small numbers in some Boards - percentage comparisons over a single year should be viewed with caution

Summary of the QPI results for clinical audit data. A dash (-) denotes restricted data where the denominator is less than 5. An asterisk (\*) denotes data where the denominator is zero.

Renal MCN					
	AA	FV	GGC	LAN	WoSCAN
<b>2020</b>	81	65	215	81	<b>442</b>
<b>2019</b>	50	57	265	125	<b>497</b>
<b>2018</b>	49	56	225	110	<b>440</b>

Quality Performance Indicator (QPI)	Performance by NHS Board of diagnosis						
	QPI target	Year	AA	FV	GGC	LAN	WoSCAN
<b>QPI 1:</b> Proportion of patients with RCC receiving active treatments who undergo pre-treatments cross-sectional imaging of the chest, abdomen +/- pelvis.	<b>95%</b>	2020	97.7%	97.5%	100.0%	96.3%	98.4%
		2019	100.0%	100.0%	97.4%	100.0%	98.6%
		2018	100.0%	100.0%	99.3%	98.5%	99.3%
<b>QPI 2(i):</b> Proportion of patients with RCC where surgery is not the primary treatments who have a histological diagnosis before treatments, via biopsy. <b>Cryotherapy / Radiofrequency ablation</b>	<b>90%</b>	2020	75.0%	81.8%	100.0%	100.0%	88.0%
		2019	80.0%	91.7%	100.0%	90.0%	93.5%
		2018	100.0%	100.0%	94.7%	100.0%	97.1%
<b>QPI 2(ii):</b> Proportion of patients with RCC where surgery is not the primary treatments who have a histological diagnosis before treatments, via biopsy. <b>Systemic Anti-Cancer Therapy (SACT)</b>	<b>90%</b>	2020	100.0%	100.0%	94.1%	100.0%	97.4%
		2019	100.0%	100.0%	100.0%	90.0%	97.1%
		2018	100.0%	100.0%	100.0%	90.0%	97.3%

Quality Performance Indicator (QPI)	Performance by NHS Board of diagnosis						
	QPI target	Year	AA	FV	GGC	LAN	WoSCAN
<b>QPI 3:</b> Proportion of patients whose RCC is staged pre-treatments using the TNM staging system	<b>98%</b>	2020	100.0%	100.0%	100.0%	100.0%	100.0%
		2019	100.0%	100.0%	100.0%	100.0%	100.0%
		2018	100.0%	100.0%	99.1%	100.0%	99.5%
<b>QPI 4:</b> Proportion of patients with RCC who are discussed at the MDT before definitive treatments.	<b>95%</b>	2020	97.5%	98.4%	96.3%	98.8%	97.3%
		2019	97.9%	100.0%	95.2%	99.2%	97.1%
		2018	85.7%	98.2%	92.0%	98.2%	93.6%
<b>QPI 7:</b> Proportion of patients with T1aN0M0 RCC who undergo NSS (laparoscopic partial nephrectomy or open partial nephrectomy).	<b>50%</b>	2020	88.9%	100.0%	83.3%	75.0%	86.4%
		2019	100.0%	92.9%	90.9%	94.7%	93.3%
		2018	100.0%	85.7%	85.0%	78.6%	85.5%
<b>QPI 8(i):</b> Proportion of patients who die within 30 days of treatments for RCC. <b>(a) Cryotherapy</b>	<b>&lt;2%</b>	2020	25.0%	0.0%	0.0%	0.0%	4.2%
		2019	0.0%	0.0%	5.3%	0.0%	2.2%
		2018	0.0%	0.0%	0.0%	0.0%	0.0%
<b>QPI 8(i):</b> Proportion of patients who die within 30 days of treatments for RCC. <b>b) RFA</b>	<b>&lt;2%</b>	2020	0.0%	0.0%	0.0%	0.0%	0.0%
		2019	0.0%	0.0%	0.0%	0.0%	0.0%
		2018	0.0%	0.0%	0.0%	0.0%	0.0%
<b>* † QPI 8(i):</b> Proportion of patients who die within 30 days of treatments for RCC. <b>Analysed by HOSPSURG</b> <b>(c) Surgery</b>	<b>&lt;2%</b>	2020	0.0%	0.0%	0.8%	0.0%	0.5%
		2019	0.0%	0.0%	0.0%	0.0%	0.0%
		2018	0.0%	0.0%	0.7%	0.0%	0.5%
<b>QPI 8(ii):</b> Proportion of patients who die within 90 days of treatments for RCC. <b>(a) Cryotherapy</b>	<b>&lt;2%</b>	2020	25.0%	10.0%	0.0%	0.0%	9.1%
		2019	0.0%	0.0%	5.6%	0.0%	2.3%
		2018	0.0%	0.0%	0.0%	0.0%	0.0%

Quality Performance Indicator (QPI)	Performance by NHS Board of diagnosis						
	QPI target	Year	AA	FV	GGC	LAN	WoSCAN
<b>QPI 8(ii):</b> Proportion of patients who die within 90 days of treatments for RCC. <b>b) RFA</b>	<2%	2020	0.0%	0.0%	0.0%	0.0%	0.0%
		2019	0.0%	0.0%	0.0%	0.0%	0.0%
		2018	0.0%	0.0%	0.0%	0.0%	0.0%
<b>* † QPI 8(ii):</b> Proportion of patients who die within 90 days of treatments for RCC. <b>Analysed by HOSPSURG</b> <b>(c) Surgery</b>	<2%	2020	0.0%	0.0%	0.8%	3.3%	1.0%
		2019	0.0%	0.0%	0.6%	0.0%	0.5%
		2018	0.0%	0.0%	0.7%	2.3%	0.9%
<b>QPI 9:</b> Proportion of patients presenting with advanced and/or metastatic RCC who receive initial SACT within 12 months of diagnosis.  <b>Patients diagnosed 1st January 2019 - 31st December 2019.</b>	40%	2020	33.3%	75.0%	73.9%	50.0%	62.3%
		2019	66.7%	57.1%	56.0%	77.8%	61.7%
		2018	66.7%	50.0%	56.3%	35.7%	48.6%
<b>QPI 10:</b> Prognostic Scoring in Metastatic Disease - Patients with metastatic Renal Cell Carcinoma (RCC) should be assigned a valid prognostic score following diagnosis.	90%	2020	83.3%	100.0%	87.9%	100.0%	89.5%
		2019	72.7%	90.0%	76.6%	77.8%	77.9%
		2018	-	-	-	-	-
<b>QPI 11:</b> Proportion of patients with clear cell RCC who are assigned a Leibovich score following radical nephrectomy. <b>Analysed by HOSPSURG</b>	100%	2020	100.0%	100.0%	100.0%	100.0%	100.0%
		2019	100.0%	100.0%	100.0%	88.9%	97.7%
		2018	100.0%	100.0%	98.5%	100.0%	99.2%
<b>QPI 12: Volume of Cases per Surgeon</b> - Number of renal surgical resections performed by each surgeon in a given year (SMR01 data).	Minimum of 15	2020	0 MET 2 NOT MET	1 MET	4 MET 2 NOT MET	2 MET 1 NOT MET	7 MET 5 NOT MET
		2019	2 MET	1 MET	5 MET 2 NOT MET	2 MET 1 NOT MET	10 MET 3 NOT MET
		2018	-	-	-	-	-
<b>QPI 13:</b> Proportion of patients with T1a RCC undergoing partial nephrectomy who achieve trifecta (ischaemia time less than 25 minutes, negative surgical margins and no complication). <b>Analysed by HOSPSURG</b>	50%	2020	NA	NA	86.2%	NA	86.2%
		2019	NA	NA	79.5%	NA	79.5%
		2018	NA	NA	85.3%	NA	85.3%

Quality Performance Indicator (QPI)	Performance by NHS Board of diagnosis						
	QPI target	Year	AA	FV	GGC	LAN	WoSCAN
QPI 14: Clinical trials - Proportion of patients diagnosed with renal cancer who consented for a clinical trial / research study.	15%	2020	18.8%	5.5%	8.3%	8.5%	9.9%
		2019	19.6%	11.3%	12.9%	17.8%	14.7%
		2018	11.4%	6.0%	4.0%	10.2%	6.8%



## Conclusions and Actions Required

Overall WoS results from the 9th year of Renal Cancer QPI analysis demonstrates that NHS Boards have performed well in achieving the QPI targets in this reporting period. Some variance in performance does exist across the region and, as per the agreed Regional governance process, each NHS Board was asked to complete a Performance Summary Report, providing a documented response where performance was below the QPI target.

Notwithstanding the exemplar overall regional performance, in line with local governance arrangements, boards have welcomed the opportunity to review their clinical practice on a case by case basis where the QPI target was not achieved and consider whether improvement actions are required.

Resulting actions are summarised below and outlined in the main report under the relevant section.

The MCN will actively take forward regional actions identified and NHS Boards are asked to develop local Action/Improvements Plans in response to the findings presented in the report. A summary of actions for each NHS Board has been included within the Action Plan templates in [Appendix 3](#).

### Actions required:

#### QPI 10: Prognostic Scoring in Metastatic Disease

- NHS GGC and NHS Ayrshire & Arran to flag with the regional MDT the importance of recording prognostic score particularly in patients where there is no plan for specialist review.

#### QPI 7: Nephron Sparing Surgery

- MCN to propose that the QPI target is increased to 70% at the next Formal Review.

**Completed Action Plans should be returned to WoSCAN within two months of publication of this report.**

Progress against these plans will be monitored by the MCN Advisory Board and any service or clinical issue which the Advisory Board considers not to have been adequately addressed will be escalated to the NHS Board Territorial Lead Cancer Clinician and Regional Lead Cancer Clinician.

Additionally, progress will be reported annually to the Regional Cancer Advisory Group (RCAG) by NHS Board Territorial Lead Cancer Clinicians and MCN Clinical Leads, and nationally on a three-yearly basis to Healthcare Improvements Scotland as part of the governance processes set out in CEL 06 (2012).

## 1. Introduction

This report contains an assessment of the performance of West of Scotland (WoS) urological cancer services using clinical audit data relating to patients diagnosed with renal cancer in 2020. Data analysed and included within this report relates to cancer of the kidney and results are measured against the Renal Cancer Quality Performance Indicators<sup>1</sup>. Twelve months of data were measured against the Renal Cancer QPIs for the ninth consecutive year.

In order to ensure the success of the Cancer QPIs in driving quality improvement in cancer care, QPIs will continue to be assessed for clinical effectiveness and relevance. The 2<sup>nd</sup> review of the Renal QPIs was completed at the beginning of 2019. QPIs are reviewed every 3 years with the next Renal review currently underway. This clinically led review aims to identify potential refinements to the current QPIs and involves key clinicians from each of the Regional Cancer Networks.

## 2. Background

Four NHS Boards across the WoS serve the 2.5 million population<sup>7</sup>. From this population, on average 454 people were diagnosed with Renal cancer annually between 2016 and 2020 in WoS.

As of February 2019, all renal cancers are referred to the Regional Renal MDT which includes representation from all four boards across a range of clinical specialties with a particular interest in renal cancer

### 2.1 National Context

Renal cancer is the seventh most common cancer in Scotland with 1,082 cases diagnosed in Scotland in 2019<sup>3</sup>. These account for 3.2% of cancer diagnoses in Scotland in 2019<sup>3</sup>. It is the sixth most common cancer in Scotland for males and the ninth most common cancer for females.

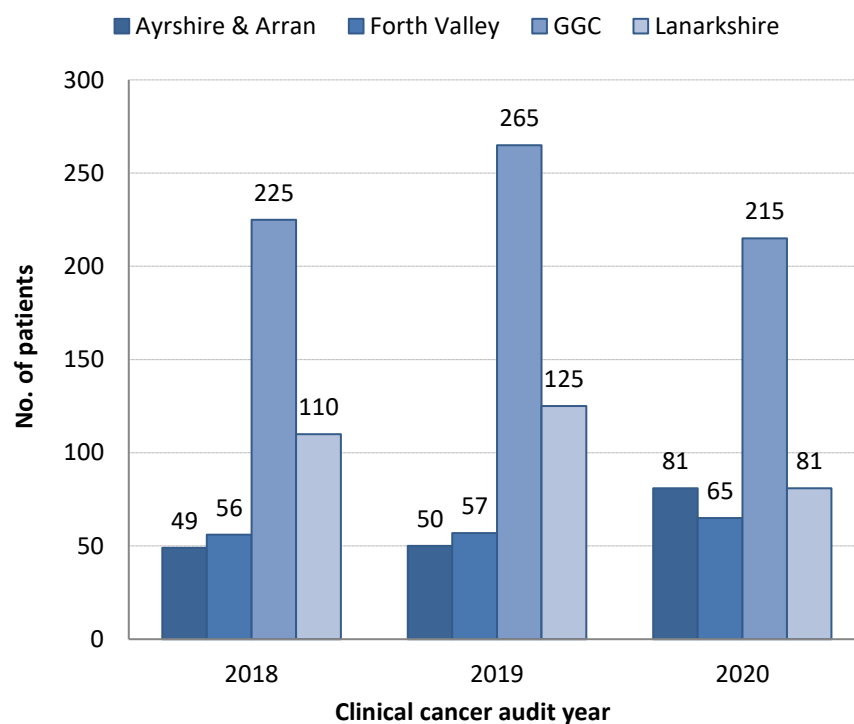
Data shows that for renal cancer patients diagnosed between 2013-2017<sup>4,6</sup>, 1 year relative survival was 78.7% for males and 76.7% for females. 5 year relative survival is marginally higher in males than females at 60.7% and 59.4% respectively.

Survival rates are age-standardised to allow fair comparison over time. Major advances in surgical, chemotherapy and radiotherapy treatments for cancer have contributed to the high survival rates observed<sup>4,6</sup>.

## 2.2 West of Scotland Context

442 cases of renal cancer were recorded through audit as diagnosed in the WoS in 2020. As the largest health board<sup>7</sup> in WoS, 48.6% (215) of all new cases of renal cancers were diagnosed in NHS GGC. There has been an 11.5% decrease in 2020 audit cases in WoSCAN from the previous year.

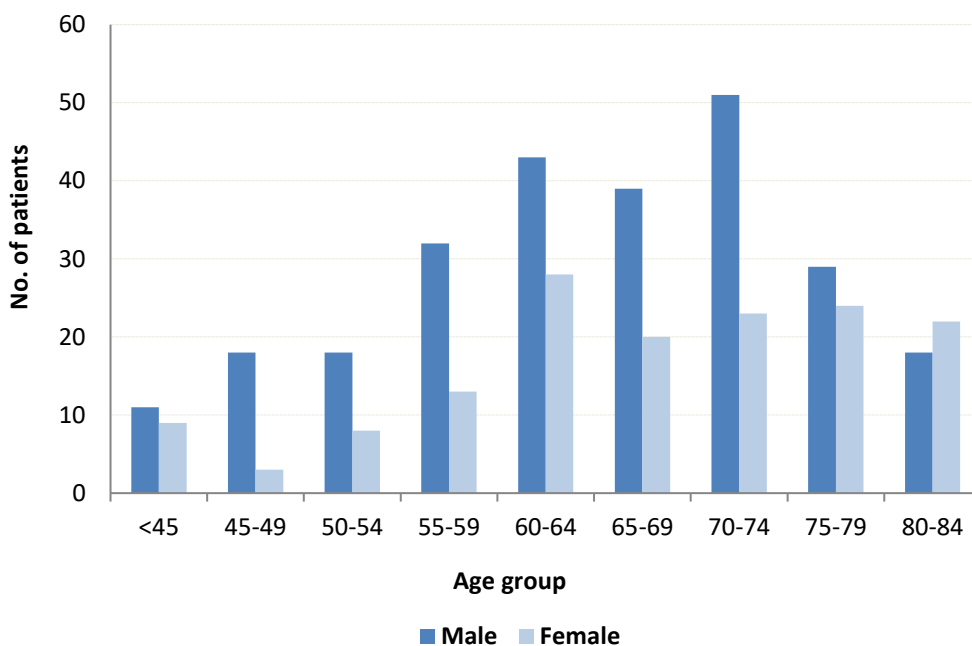
**Fig 1: Number of patients diagnosed with Renal cancer within each WoS NHS Board, 2018 – 2020.**



Year	AA	FV	GGC	LAN	WoSCAN
2018	49	56	225	110	440
2019	50	57	265	125	497
2020	81	65	215	81	442

The distribution of new cases of renal cancer is illustrated in Figure 2 by age group and sex. There were more male cases (62.4%) of renal cancer diagnosed in 2020 compared to female cases (37.6%) in the WoS. More cases were diagnosed in 70-74 age group (18.5%) in males and 60-64 age group (16.9%) in females.

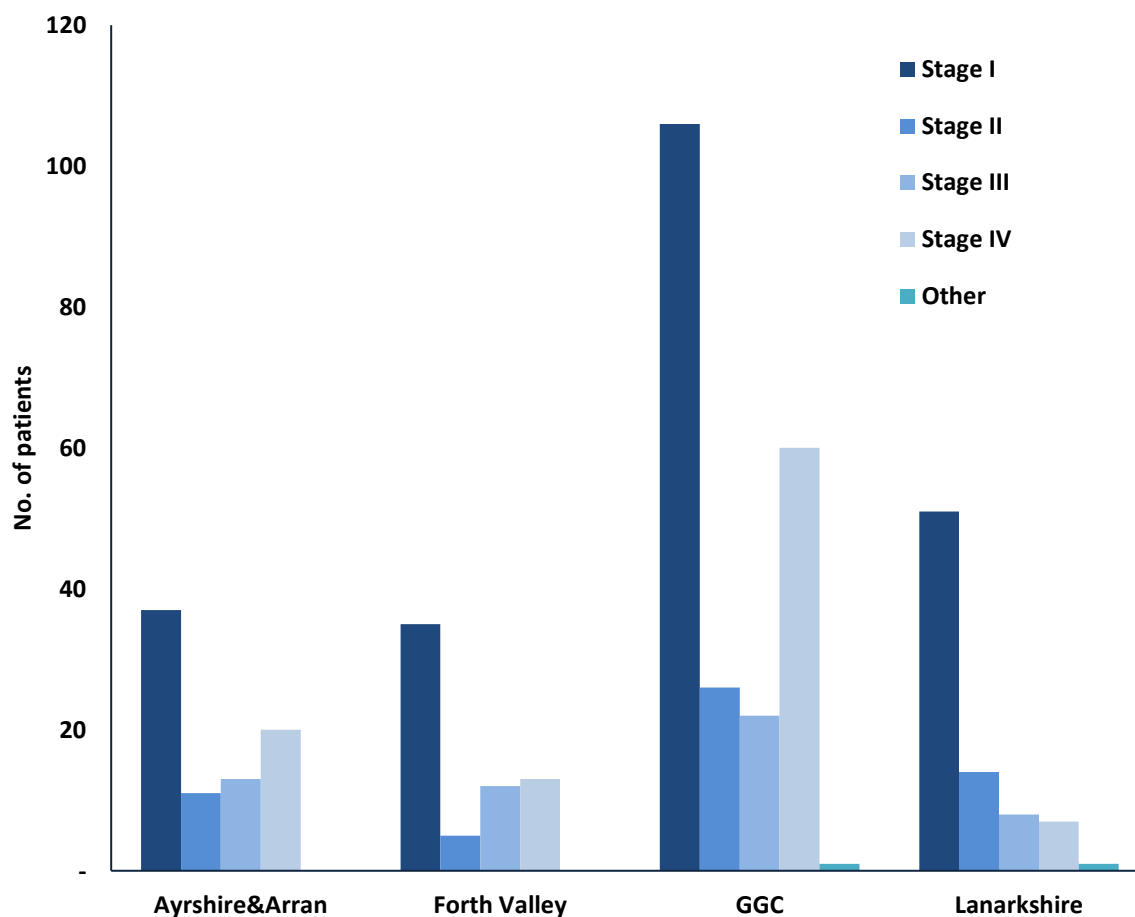
**Fig 2: Number of patients diagnosed with Renal cancer in WoS within each 5-year age group. 2020.**



Age		<45	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	>85	Total
Male	N	11	18	18	32	43	39	51	29	18	17	<b>276</b>
	%	4.0%	6.5%	6.5%	11.6%	15.6%	14.1%	18.5%	10.5%	6.5%	6.2%	
Female	N	9	3	8	13	28	20	23	24	22	16	<b>166</b>
	%	5.4%	1.8%	4.8%	7.8%	16.9%	12.0%	13.9%	14.5%	13.3%	9.6%	

Figure 3 shows the distribution of Renal cancers by clinical stage, indicating the predominance of early stage disease with 51.8% of Renal tumours presenting at Stage I followed by Stage IV (22.6%).

**Fig 3: Number of patients diagnosed with Renal cancer in WoS by Stage. 2020.**



*\*Other includes Not Assessable*

	Hospital of Diagnosis									
	A&A		FV		GGC		Lan		Total	
Stage	n	%	n	%	n	%	n	%	n	%
Not Assessable	*	0.0%	*	0.0%	1	0.5%	1	1.2%	2	0.5%
Stage 1	37	45.7%	35	53.8%	106	49.3%	51	63.0%	229	51.8%
Stage II	11	13.6%	5	7.7%	26	12.1%	14	17.3%	56	12.7%
Stage III	13	16.0%	12	18.5%	22	10.2%	8	9.9%	55	12.4%
Stage IV	20	24.7%	13	20.0%	60	27.9%	7	8.6%	100	22.6%
<b>Total</b>	<b>81</b>		<b>65</b>		<b>215</b>		<b>81</b>		<b>442</b>	

(\*) denotes a zero.

### **3. Methodology**

Further detail on the audit and analysis methodology and data quality is available in the meta data within [Appendix 1](#).

### **4. Results and Actions Required**

Results of the analysis of Renal Cancer QPIs (QPIs 1 - 13) are set out in the following sections. Data are presented by location of diagnosis or treatment and illustrate NHS Board performance against each target and overall regional performance for each performance indicator.

Results are presented graphically and the accompanying tables also highlight any missing data and its possible effect on any of the measured outcomes for the current year of analysis. Where the number of cases meeting the denominator criteria for any indicator is between one and four, the percentage calculation has not been shown on any associated charts or tables. This is to avoid any unwarranted variation associated with small numbers and to minimise the risk of disclosure. Any charts or tables impacted by this restricted data are denoted with a dash (-). An asterisk (\*) is used to specify a denominator of zero and to distinguish between this and a 0% performance. Any commentary provided by NHS Boards relating to the impacted indicators will however be included as a record of continuous improvement.

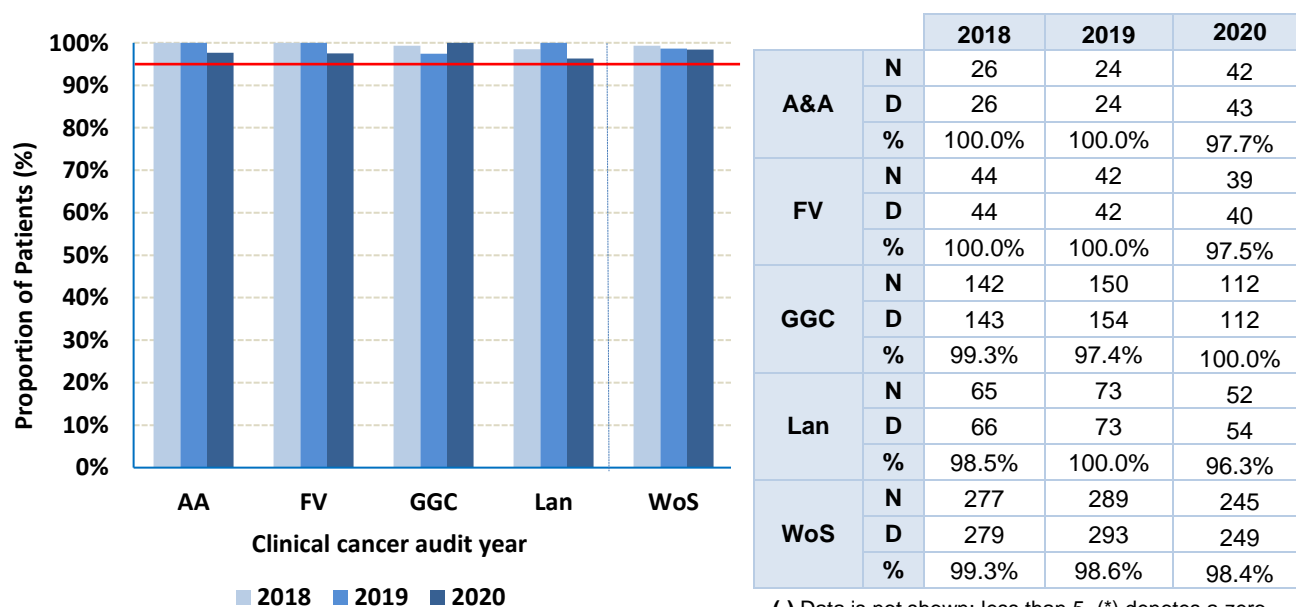
Where required, specific regional and NHS Board actions have been identified to address issues highlighted through the data analysis.

## QPI 1: Radiological diagnosis prior to first treatment

Although pathological assessment is required for definitive diagnosis of renal cell carcinoma, radiology is an accurate diagnostic tool in almost all cases of renal cancer and is the first line of investigation<sup>1</sup>. Patients with renal cell carcinoma should undergo computerised tomography (CT) with contrast to assess the extent of local and distant metastatic disease<sup>1</sup>. Magnetic resonance imaging (MRI) is also an alternative option for patients who require further imaging or have allergies to intravenous (IV) contrast media.

QPI 1	Patients with renal cancer should have cross sectional imaging for staging of Renal Cell Carcinoma (RCC).
Description:	Proportion of patients with RCC receiving active treatment who undergo pre-treatment cross-sectional imaging of the chest, abdomen +/- pelvis.
Numerator:	Number of patients receiving active treatment with a diagnosis of RCC who undergo cross-sectional imaging (CT or MRI) of the chest, abdomen +/- pelvis (with contrast) before first treatment.
Denominator:	All patients receiving active treatment with a diagnosis of RCC.
Exclusions:	No exclusions
Target:	<b>95%</b>

Fig 4: Proportion of patients with RCC diagnosed that underwent pre-treatment cross-sectional imaging of the chest, abdomen +/- pelvis before first treatment, 2018 – 20.



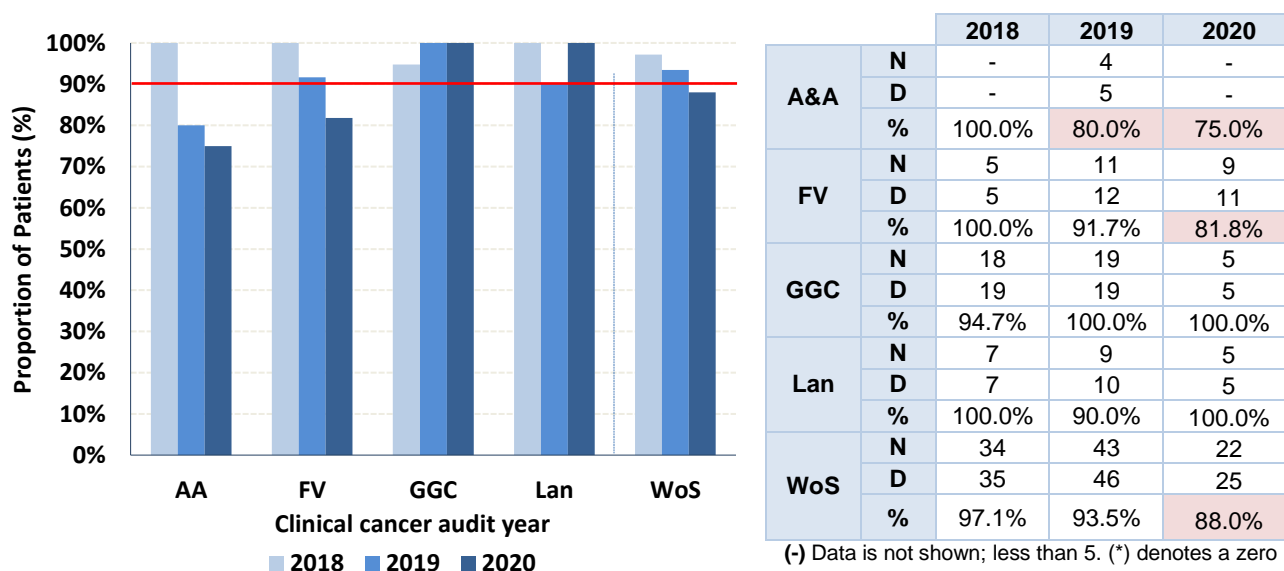
Overall 98.4% of patients with a diagnosis of RCC undergoing active treatment underwent pre-treatment cross-sectional imaging of the chest, abdomen +/- pelvis before first treatment, which exceeds the 95% QPI target. All Boards met the target with NHSGGC achieving 100%.

## QPI 2: Histological diagnosis prior to treatment

It is important to confirm a diagnosis of RCC prior to any minimally invasive therapies such as radiofrequency ablation (RFA), cryotherapy or systemic anti-cancer therapy (SACT) to avoid treatment of non-malignant lesions<sup>1</sup>. Additionally if SACT is being considered it must be known that there is a definitive diagnosis of RCC as other types of renal cancer may not respond to these treatments<sup>1</sup>.

QPI 2	Patients with renal cancer not undergoing surgery should have a histological diagnosis prior to commencing treatment.
Description:	Proportion of patients with RCC where surgery is not the primary treatment who have a histological diagnosis before treatment, via biopsy.
Numerator:	Number of patients with RCC who have a histological diagnosis (confirmed by biopsy) before first treatment with; (i) Cryotherapy or radiofrequency ablation (RFA) (ii) Systemic Anti-Cancer Treatment (SACT)
Denominator:	All patients with RCC undergoing first treatment with; (i) Cryotherapy or RFA (ii) SACT
Exclusions:	Patients with inherited genetic renal cancer
Target:	<b>90%</b>

**Fig 5: Proportion of patients with RCC who have a histological diagnosis (confirmed by biopsy) before first treatment with cryotherapy or RFA, 2018 – 20**

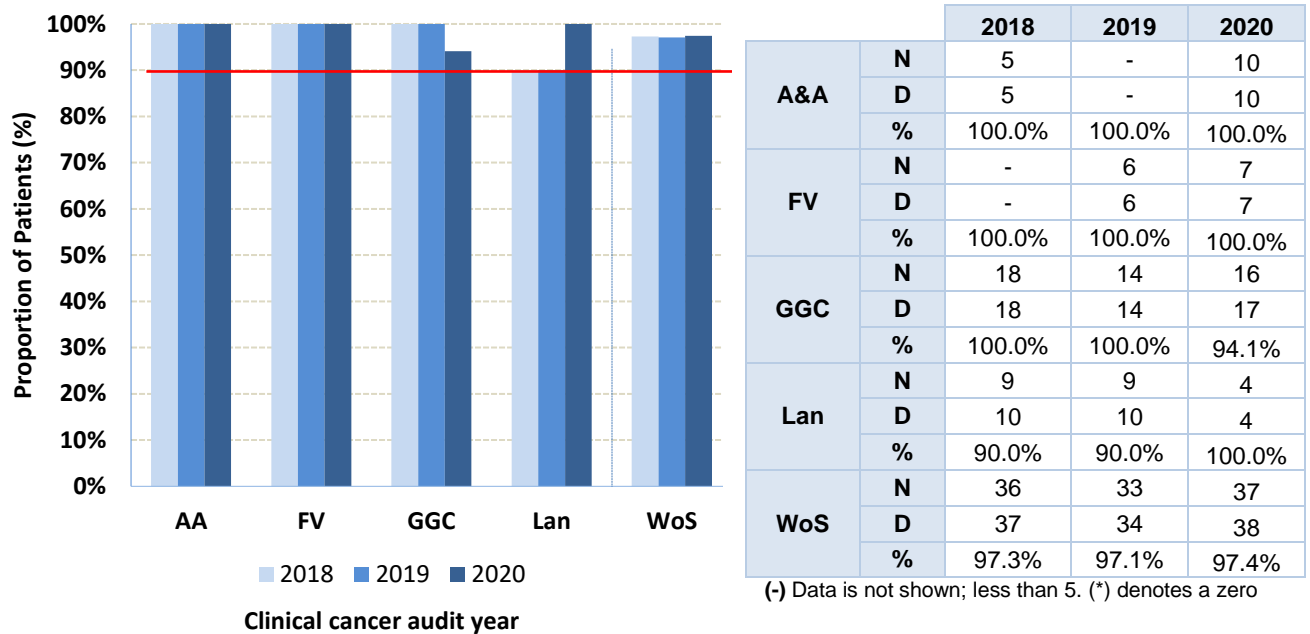


Overall performance in the WoS was 88% against the 90% target with 22 of 25 patients having a histological diagnosis prior to starting treatment with cryotherapy or RFA. NHS GGC and NHS Lanarkshire achieved the target with 100%. NHS Ayrshire & Arran and NHS Forth Valley missed the target. However, failure to meet this target was a result of the small numbers in the denominator.

NHS Ayrshire & Arran and NHS Forth Valley reviewed cases and noted that biopsy was not performed either due to the largely cystic nature of the tumour or due to the high likelihood of malignancy.



**Fig 6: Proportion of patients with RCC diagnosed who have a histological diagnosis (confirmed by biopsy) before first treatment with SACT, 2018 – 20.**



All Boards met the 90% target with NHS Ayrshire & Arran, NHS Forth Valley and NHS Lanarkshire achieving 100%. The overall WoS performance was 97.4%, achieving the target of 90% on three consecutive years.

### QPI 3: Clinical Staging by TNM

Patients with RCC should be staged using the Tumour, Nodes and Metastases (TNM) staging system. The TNM stage of disease will aid in determining prognosis, choice of therapy and follow up<sup>1</sup>. It is vital that data is recorded for the cT, cN and cM stage as all three data fields are required to enable stage of disease at presentation to be determined. This will also facilitate analysis of additional performance indicators which are based on disease stage.

QPI 3:	The TNM staging system should be used to stage patients with RCC.
Description:	Proportion of patients whose RCC is staged pre-treatment using the TNM staging system.
Numerator:	Number of patients diagnosed with RCC who were clinically staged using TNM staging system before first treatment.
Denominator:	All patients diagnosed with RCC
Exclusions:	No exclusions
Target:	<b>98%</b>

Fig 7: Proportion of patients whose RCC is staged prior to treatment using the TNM staging system, 2018 – 20.

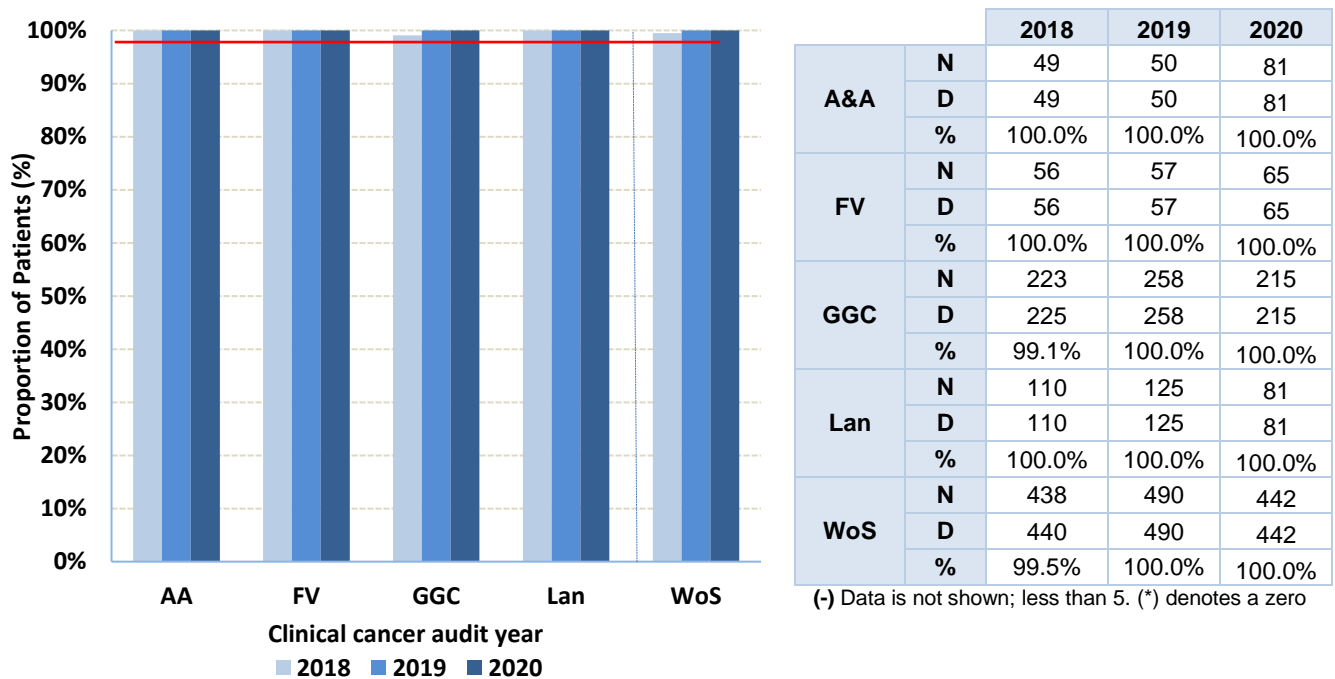


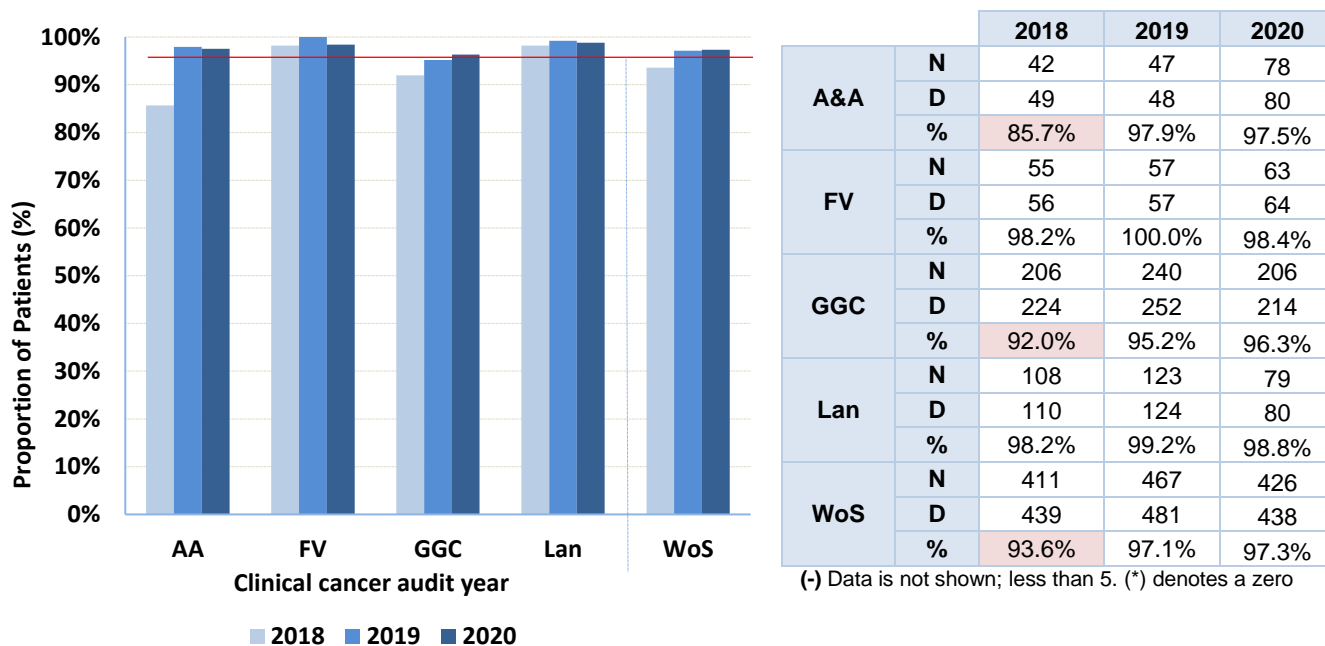
Figure 7 demonstrates excellent results across all Boards with all units consistently achieving the QPI target year on year; overall regional performance in the WoS in 2020 was noted as 100.0%.

## QPI 4: Multi-Disciplinary Team (MDT) Meeting

Evidence suggests that patients with cancer managed by a multidisciplinary team have a better outcome. There is also evidence that the multidisciplinary management of patients increases their overall satisfaction with their care<sup>1</sup>. Discussion prior to definitive treatment decisions being made provides reassurance that patients are being managed appropriately<sup>1</sup>.

QPI 4:	Patients with Renal Cell Carcinoma (RCC) should be discussed by a multidisciplinary team (MDT) prior to definitive treatment.
Description:	Proportion of patients with RCC who are discussed by an MDT prior to definitive treatment.
Numerator:	Number of patients with RCC who are discussed by an MDT prior to definitive treatment.
Denominator:	All patients with RCC.
Exclusions:	Patients who died before first treatment
Target:	<b>95%</b>

Fig 8: Proportion of patients with RCC who are discussed at MDT prior to definitive treatment, 2018 – 20.



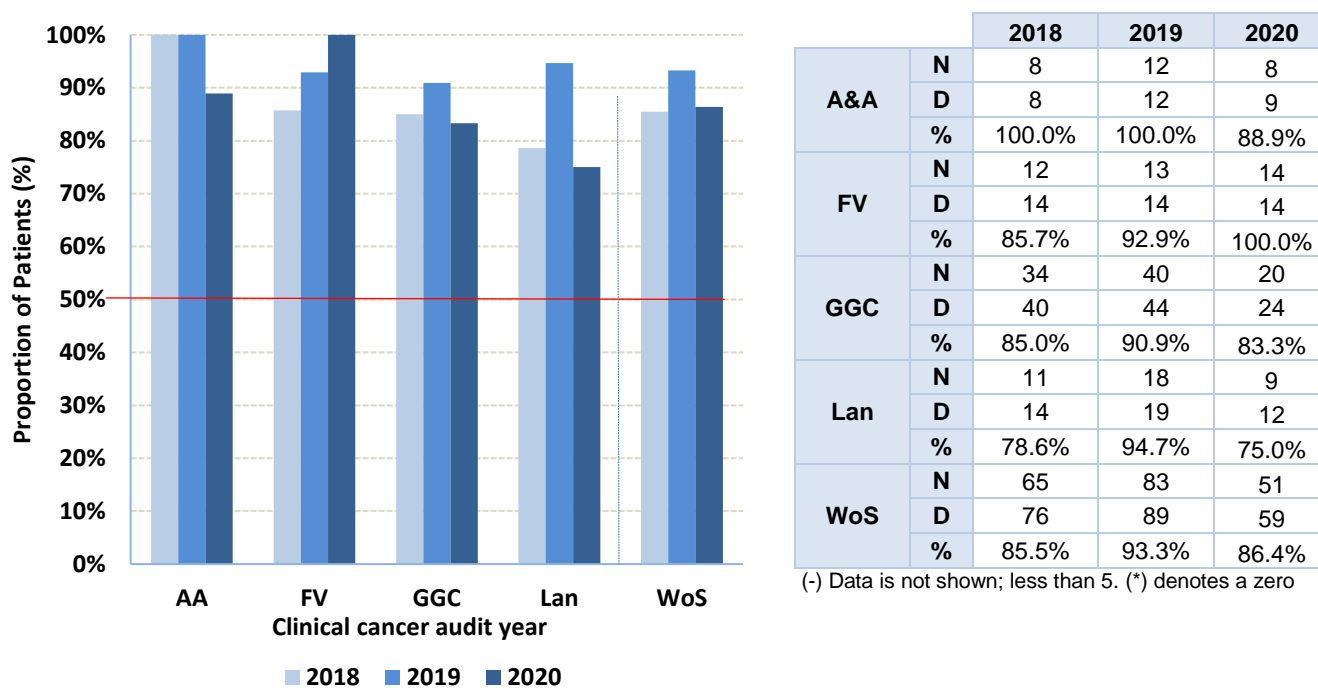
The 95% target for QPI 4 was achieved for patients diagnosed with RCC in 2020 in WoS. Of the 438 patients diagnosed, 426 were discussed at MDT prior to starting treatment. All the Boards achieved the target for two consecutive years, of all patients being diagnosed with RCC in 2020 being discussed at MDT. As of February 2019, all renal cancers are referred to the Regional Renal MDT which includes representation from all four Boards across a range of clinical specialties with a particular interest in renal cancer.

## QPI 7: Nephron sparing treatment

Nephron sparing surgery (NSS) is appropriate surgical treatment for patients with early stage disease (T1aNoMo) and clinical trials have indicated comparable long-term survival with radical treatment<sup>1</sup>. The advantages of NSS are improved renal function and lesser chance of post-operative cardiovascular complications<sup>1</sup>. It is however recognised that some patients may opt to have laparoscopic radical nephrectomy, rather than open nephron sparing surgery, due to the shorter recovery time and the decreased risk of post-operative complications.

QPI 7:	Patients with T1a renal cancer should receive Nephron Sparing Treatment.
Description:	Proportion of patients with T1aNoMo RCC who undergo nephron sparing treatment (cryotherapy, RFA or robotic/laparoscopic/open partial nephrectomy).
Numerator:	Number of patients with a T1aNoMo RCC undergoing nephron sparing treatment (cryotherapy, RFA or robotic/laparoscopic/open partial nephrectomy).
Denominator:	All patients with T1aNoMo RCC
Exclusions:	<ul style="list-style-type: none"> <li>• Patients who refuse treatment</li> <li>• Patients receiving supporting care only (not for active treatment)</li> <li>• Patients receiving active surveillance (no active treatment)</li> <li>• Patients who died before treatment</li> </ul>
Target:	<b>50%</b>

Fig 9: Proportion of patients with T1a RCC who received nephron sparing treatment, 2018 – 20



Of the 59 patients with T1a RCC, 51 received nephron sparing treatment. This equates to 86.4% and successfully achieves the 50% QPI target. As demonstrated in Figure 9 all Boards met the target with NHS Ayrshire & Arran and NHS Forth Valley achieving 100%.

### Action required:

- MCN to propose that the QPI target is increased to 70% at the next Formal Review.

## QPI 8: 30/90 Day Mortality

Treatment related mortality is a marker of the quality and safety of the whole service provided by the Multi-Disciplinary Team (MDT) <sup>1</sup>. However, all causes of death have been used in this indicator as the recording of cause of death by the certifying medical practitioner is not always as specific as the recording of a cancer diagnosis<sup>1</sup>. Treatment types included in analysis are cryotherapy, radiofrequency ablation (RFA) and surgery. .

QPI 8:	(i) 30-day and (ii) 90-day mortality for RCC - a) Cryotherapy, b) RFA, c) Surgery
Description:	Proportion of patients who die within 30 or 90 days of treatment for RCC.
Numerator:	Number of patients with RCC who undergo minimally invasive (Cryotherapy or RFA) or operative treatment who die within 30 or 90 days of treatment.
Denominator:	All patients who undergo minimally invasive (Cryotherapy or RFA) or operative treatment.
Exclusions:	Patients who undergo emergency surgery (nephrectomy).
Target:	< 2% for patients receiving cryotherapy, RFA or surgery.

**Table 2: Proportion of patients who died within 30 days of Cryotherapy or Surgery by NHS Board, 2018 - 20**

		Cryotherapy						Surgery					
		30 Day mortality			90 Day mortality			30 Day mortality			90 Day mortality		
		2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020
AA	N	-	*	-	-	*	-	*	*	*	*	*	*
	D	-	5	-	-	5	-	12	8	18	12	8	18
	%	0.0%	0.0%	25%	0.0%	0.0%	25%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
FV	N	*	*	*	*	*	1	*	*	*	*	*	*
	D	5	12	11	5	12	10	25	18	14	25	18	14
	%	0.0%	0.0%	0.0%	0.0%	0.0%	10%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
GGC	N	*	1	*	*	1	-	1	*	1	1	1	2
	D	19	19	5	19	18	-	141	158	132	139	154	130
	%	0.0%	5.3%	0.0%	0.0%	5.6%	0.0%	0.7%	0.0%	0.8%	0.7%	0.6%	1.5%
Lan	N	*	*	-	*	*	-	*	*	*	1	*	1
	D	7	9	-	6	9	-	44	36	30	44	35	30
	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.3%	0.0%	3.3%
WoS	N	*	1	1	*	1	2	1	*	1	2	1	3
	D	35	45	24	34	44	22	222	220	194	220	215	192
	%	0.0%	2.2%	4.2%	0.0%	2.3%	9.1%	0.5%	0.0%	0.5%	0.9%	0.5%	1.6%

(-) Data is not shown; less than 5. (\*) denotes a zero

Across the WoS, there was 1 death within 30 days and 2 deaths within 90 days of cryotherapy in patients diagnosed with RCC in 2020. This represents 4.2% and 9.1% of patients receiving cryotherapy across the WoS and is out with the QPI target of less than 2%. It should be noted that cryotherapy for renal cancer is provided in NHS GGC for all WoS Boards, however data for this QPI is reported by Board of diagnosis. As with previous QPIs, the number of patients included within the denominator is low and this has a considerable effect on overall proportions; therefore percentages should be viewed in context.

Across the WoS, one death was reported within 30 days of surgery in patients diagnosed with RCC in 2020. Three deaths occurred in WoS within 90 days which represents 1.6% of surgical mortality across the WoS and is within the QPI target of less than 2%. All deaths were reviewed and feedback provided by Boards indicating that treatment for renal cancer was unlikely to have been a factor in these deaths.

There were no patients treated with RFA in WoS in 2020.

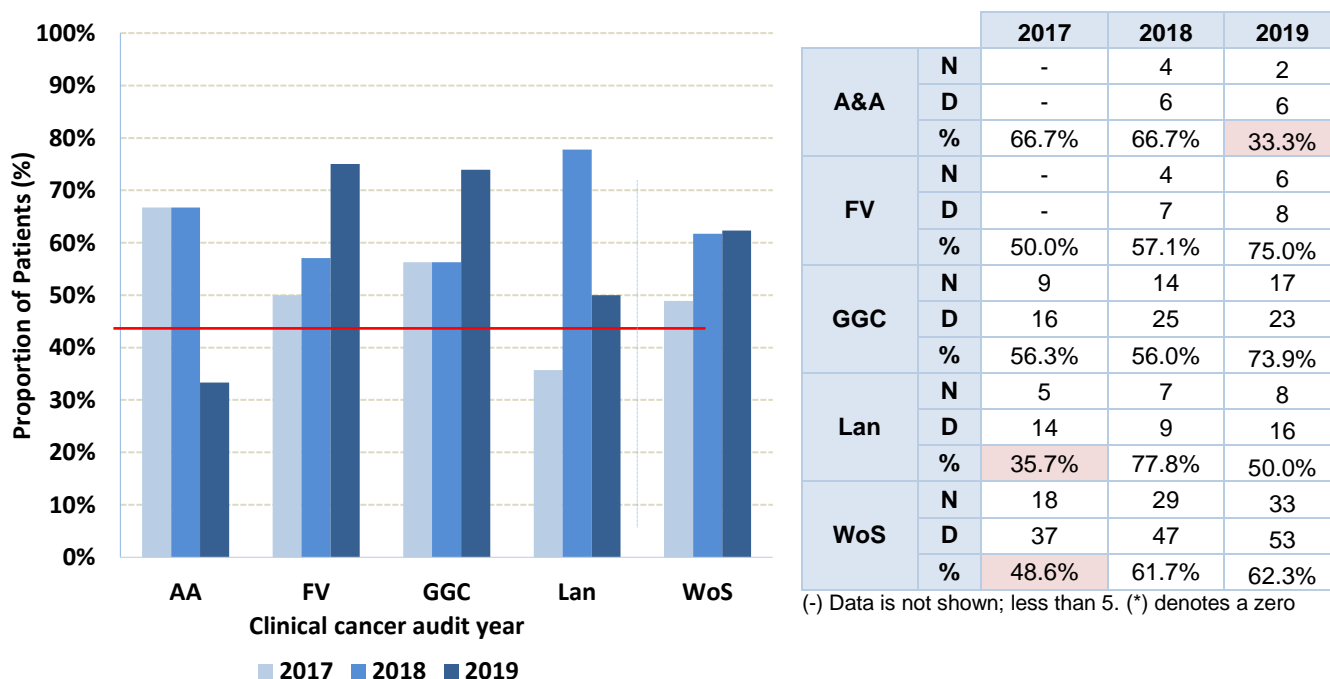
## QPI 9: Systemic Therapy

Patients with advanced and/or metastatic renal cell carcinoma (RCC) should receive systemic therapy between diagnosis and death<sup>1</sup>. To ensure accurate reporting of this QPI, i.e. that all patients are included where a year has elapsed since their diagnosis, the data below relates to patients diagnosed in the twelve months from 1st January 2019 to 31st December 2019.

Following the previous formal review, the target QPI target changed from 70% to 40%. This particular clinical cohort is often not clinically suitable to receive SACT for the reasons outlined in the QPI. Results are reviewed and compared across Scotland, every 3 years by Public Health Scotland, to ensure there is no sub-optimal care being delivered.

QPI 9:	Patients with advanced and/or metastatic renal cell carcinoma (RCC) should receive systemic therapy between diagnosis and death.
Description:	Proportion of patients presenting with advanced and/or metastatic RCC who receive systemic anti-cancer therapy (SACT) for RCC within 12 months of diagnosis.
Numerator:	Number of patients with RCC which is advanced and / or metastatic at time of diagnosis where at least 12 months have elapsed since diagnosis, irrespective of whether or not they have died, who receive first treatment with SACT, within 12 months of diagnosis.
Denominator:	All patients with RCC which is advanced and / or metastatic at time of diagnosis where at least 12 months have elapsed since diagnosis irrespective of whether or not they have died.
Exclusions:	<ul style="list-style-type: none"> <li>• Patients with a performance status of 2, 3 or 4 at time of diagnosis</li> <li>• Patients who refused systemic treatment</li> <li>• Patients enrolled in a clinical trial</li> </ul>
Target:	<b>40%</b>

Fig 10: Proportion of patients diagnosed with metastatic RCC who receive first treatment with SACT within 12 months of diagnosis, by NHS Board, 2017 - 19



Overall WoS performance was 62.3% against the 40% QPI target. All health boards except NHS Ayrshire & Arran met the 40% target. Small numbers are noted for this QPI and comparison of results should be made with caution.

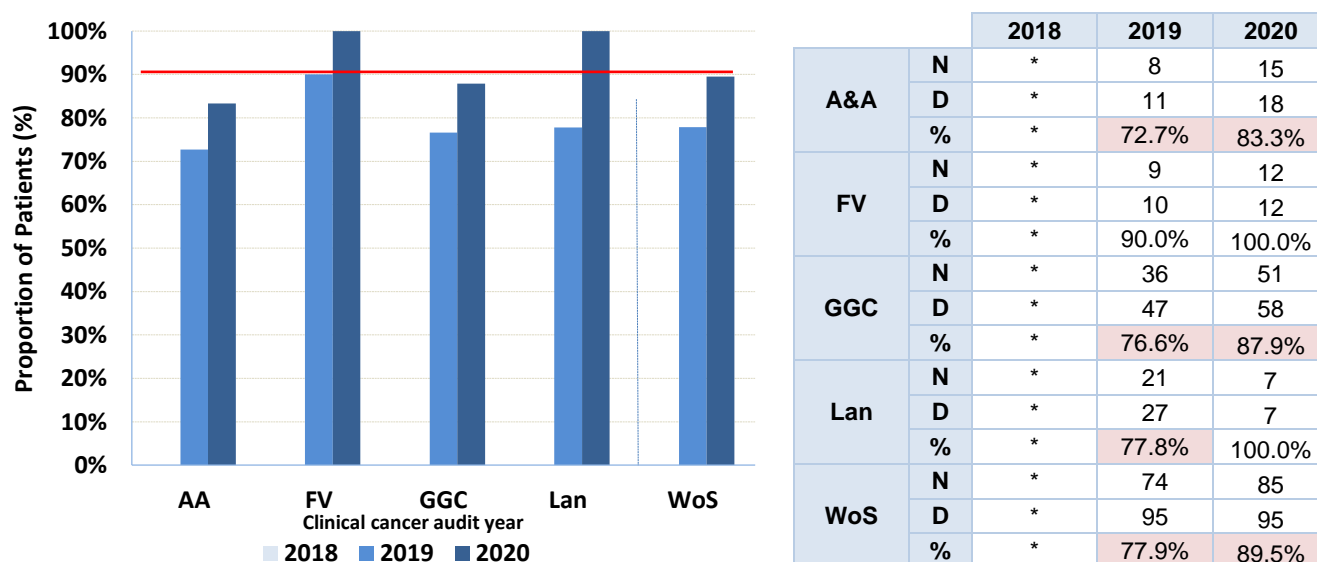
NHS Ayrshire & Arran commented of the four patients failed the target, two died before the treatment and two were deemed not fit for SACT.

## QPI 10: Prognostic Scoring in Metastatic Disease

Various models exist to predict the survival and prognosis for patients with metastatic RCC. These are key in making decisions about the most appropriate treatment plan for patients, particularly with the use of targeted therapies<sup>1</sup>.

QPI 10:	Patients with metastatic Renal Cell Carcinoma (RCC) should be assigned a valid prognostic score following diagnosis.
Description:	Proportion of patients with metastatic RCC who are assigned a valid prognostic score following diagnosis.
Numerator:	Number of patients with metastatic RCC who are assigned a valid prognostic score following diagnosis.
Denominator:	All patients diagnosed with metastatic RCC.
Exclusions:	No exclusions
Target:	<b>90%</b>

Fig 10: Proportion of patients diagnosed with metastatic RCC who receive first treatment with SACT within 12 months of diagnosis, by NHS Board, 2018 - 2020



(-) Data is not shown; less than 5. (\*) denotes a zero

Overall WoS performance was 89.5% against the 90% QPI target. While NHS Ayrshire & Arran and NHS GGC failed the 90% target, NHS Forth Valley and NHS Lanarkshire achieved 100%. However, results for this QPI should be interpreted with caution due to small numbers.

NHS Ayrshire & Arran commented that three patients failed to meet the target because the prognostic score was not documented.



NHS GGC provided detailed clinical reasons for the seven patients who failed to meet the target. The main issue appears to be with those patients who receive supportive care or have a plan for watchful waiting, and are therefore not seen by oncology or any specialist clinic. Going forward NHS GGC will flag with the MDT the need of recording prognostic score, particularly in patients where there is no plan for specialist review.

**Action required:**

- NHS GGC and NHS Ayrshire and Arran to flag with the regional MDT the importance of recording prognostic score particularly in patients where there is no plan for specialist review.

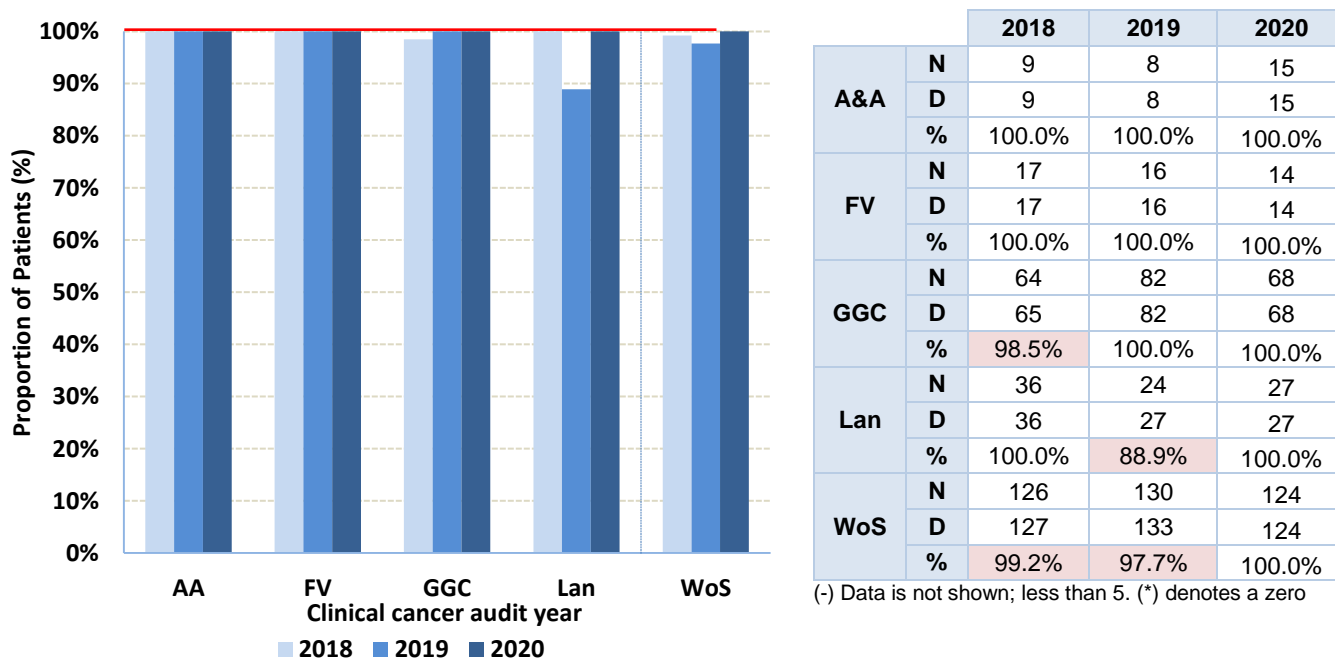
## QPI 11: Leibovich Score

Various prognostic scores exist to predict the likelihood of developing metastatic disease following surgery. The Leibovich score was specifically developed for patients following radical nephrectomy for clear cell RCC.

Evidence shows that the Leibovich score is an accurate model of prediction and assists clinicians and patients in making decisions regarding treatment plans, follow up and selection for clinical trials<sup>1</sup>.

QPI 11:	Patients with clear cell Renal Cell Carcinoma (RCC) should be assigned a Leibovich score following radical nephrectomy.
Description:	Proportion of patients with clear cell RCC who are assigned a Leibovich score following radical nephrectomy.
Numerator:	Number of patients with clear cell RCC who undergo radical nephrectomy and are assigned a Leibovich score following surgery.
Denominator:	All patients with clear cell RCC who undergo radical nephrectomy.
Exclusions:	Patients with metastatic disease (TanyNanyM1)
Target:	<b>100%</b>

Fig 11: Proportion of patients with clear cell RCC who were assigned a Leibovich score following radical nephrectomy by NHS Board, 2018 – 20



In 2020, all the 124 patients with clear cell Renal Cell Carcinoma (RCC) were assigned a Leibovich score following radical nephrectomy.

## QPI 12: Volume of cases per surgeon

Renal surgical resection should be performed by surgeons who perform the procedure routinely. The literature demonstrates that there is a relationship between increasing surgical volume and lower complication rates for surgeons undertaking partial nephrectomy for renal cell carcinoma<sup>1</sup>.

At formal review the target for the number of renal surgical resections performed by each surgeon in a given year was increased from a minimum of 12 to 15 procedures.

Description:	Number of renal surgical resections performed by each surgeon in a given year.
Exclusions:	No exclusions
Target:	Minimum 15 procedures per surgeon in a 1-year period.

**Table 1: The number of renal surgical resections performed in each NHS Board in 2020, the total number of surgeons recorded as having carried out procedures and the number of surgeons meeting QPI target**

	No. of Operating Surgeons	No. of Procedures	No. of Surgeons Meeting Target
AA	2	25	0
FV	1	20	1
GGC*	6	181	4
Lan	3	14	2
WoS	14	241	7

\*Board adjusted figures

SMR01 data is used to measure performance for this QPI (rather than QPI audit data) and although the data indicates that a number of surgeons did not meet the minimum target of 15 procedures, further scrutiny of the data has identified a small number of SMR01 data recording issues. This data also includes renal surgical resections for non-cancer diagnoses.

In NHS Ayrshire & Arran one surgeon performed 14 procedures and the other 11 procedures with both just short of the target. NHS Forth Valley commented that the main consultant carried out 20 procedures in total. NHS GGC commented that given the pandemic impacting the surgical services one surgeon failed to meet the target and the other surgeon left the service. NHS Lanarkshire provided detailed feedback and noted that one consultant did not meet this target and was unable to perform further renal surgeries in view of COVID restrictions.

### QPI 13: Trifecta Rate

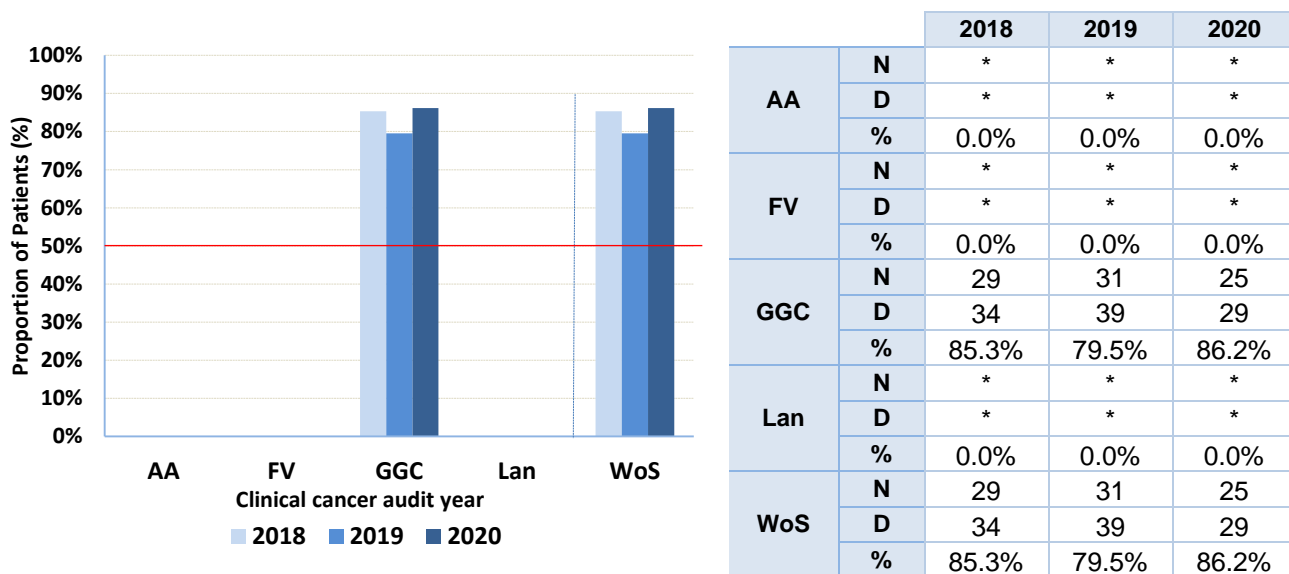
Trifecta is regarded as a surrogate measure of surgical quality. The combination of achieving negative margins, minimal surgical complications and warm ischaemia time (associated with improved renal function) is associated with better outcomes for patients undergoing partial nephrectomy.

Length of stay is being used as a surrogate measure for the quality of surgery and post-operative care including post-operative complications.

Following formal review QPI 13 was updated. Warm ischaemic time has been removed from the QPI and replaced with 'ischaemic time' to account for both warm and cold ischaemic time.

<b>QPI 13:</b>	Trifecta Rate in Partial Nephrectomy T1a Renal Cell Carcinoma (RCC) patients.
<b>Description:</b>	Proportion of patients with T1a RCC undergoing partial nephrectomy who achieve trifecta (ischaemia time less than 25 minutes, negative surgical margins and no complications).
<b>Numerator:</b>	Number of patients with T1a RCC undergoing partial nephrectomy who have ischaemia time less than 25 minutes, negative surgical margins and no complications (length of stay ≤7days).
<b>Denominator:</b>	All patients with T1a RCC undergoing partial nephrectomy.
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>No exclusions</li> </ul>
<b>Target:</b>	50%

Figure 13: Proportion of patients with T1a RCC undergoing partial nephrectomy who achieve trifecta by NHS Board of Surgery.



(-) Dash denotes restricted data where the denominator is less than 5. (\*) Asterisk denotes a denominator of zero.

This is a centralised regional service within NHS Greater Glasgow and Clyde for robotic partial nephrectomy where robotics was introduced during 2019. The 50% target was achieved regionally with a performance of 86.2%.

## QPI 14: Clinical Trials Access

Clinical trials are necessary to demonstrate the efficacy of new therapies and other interventions. Evidence suggests improved patient outcomes when hospitals are actively recruiting patients into clinical trials<sup>1</sup>.

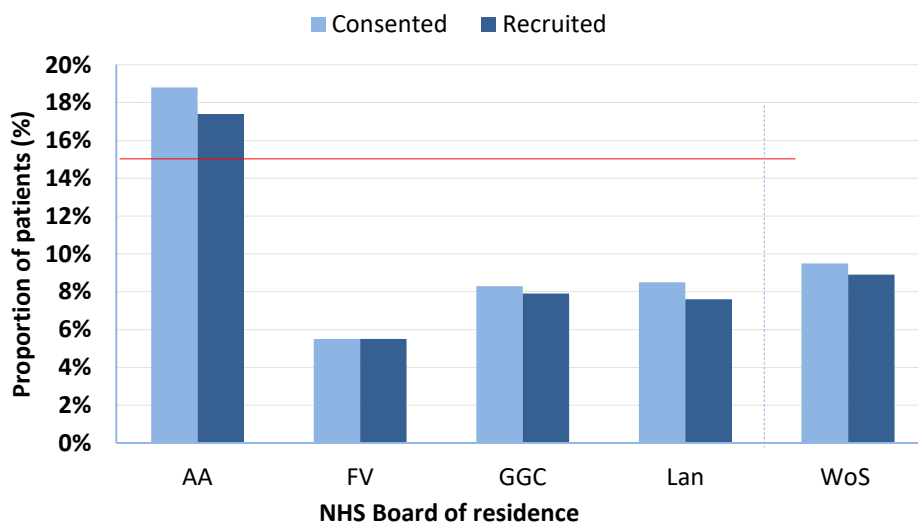
Clinicians are therefore encouraged to enter patients into well designed trials and to collect longer term follow up data. High accrual activity into clinical trials is used as a goal of an exemplary clinical research site.

The measurement of this QPI focuses on those patients who have consented in order to reflect the intent to join a clinical trial and demonstrate the commitments to recruit patients. Often patients can be prevented from enrolling within a trial due to stratification of studies and precise inclusion criteria identified during the screening process.

The clinical trials QPI is measured utilising Scottish Cancer Research Network (SCRN) data and Public Health Scotland incidence data, as is the methodology currently utilised by the Chief Scientist Office (CSO) and the National Cancer Research Institute (NCRI). The principal benefit of this approach is that this data is already collected utilising a robust mechanism<sup>1</sup>.

QPI 13:	All patients should be considered for participation in available clinical trials/research studies, wherever eligible.
Description:	Proportion of patients diagnosed with Renal cancer who are consented for a clinical trial/research study.
Numerator:	Number of patients diagnosed with Renal cancer consented for a clinical/research study.
Denominator:	All patients with Renal cancer.
Exclusions:	No exclusions
Target:	<b>15%</b>

Fig 11: Proportion of patients consented for and recruited into clinical trials for Renal cancer by NHS Board of residence, 2020.



**Table 2: Number of patients with renal cancer who were consented for inclusion in a clinical trial/research study, 2018 - 20.**

Board of Residence	Consented – QPI Target 15%								
	2018			2019			2020		
	N	D	%	N	D	%	N	D	%
<b>AA</b>	8	70	11.4%	14	72	19.6%	13	69	18.8%
<b>FV</b>	3	50	6.0%	6	53	11.3%	3	55	5.5%
<b>GGC</b>	10	250	4.0%	33	257	12.9%	22	266	8.3%
<b>Lan</b>	10	98	10.2%	18	101	17.8%	9	106	8.5%
<b>WoS Total</b>	31	468	6.6%	71	482	14.7%	47	496	9.5%

N: Number of patients enrolled in trials

D: Cancer registry data (5-year average)

?: Percentage of patients enrolled in clinical trials.

Overall WoS performance was 9.5% against the 15% QPI target. NHS Ayrshire & Arran met the target achieving 18.8%. NHS Forth Valley, NHSGGC and NHS Lanarkshire achieved 5.5%, 8.3% and 8.5%, respectively and therefore did not meet the target of 15%.

The clinical trial access QPI for renal cancer was not met in 2020. This was anticipated as the COVID-19 pandemic forced most clinical trials in the UK to stop recruiting patients for several months in 2020. Pandemic related factors impacting on trials recruitment included:

- Researchers needed to minimise the number of patients visiting hospitals, as these visits risked infecting their patients with COVID-19.
- Patients were reluctant to attend hospitals and participate in trials due to concerns around COVID infection.
- Some clinical staff usually dedicated to cancer research needed to support frontline services as part of the NHS's response to COVID-19 or to support research into COVID-19 vaccination and treatments.
- Sponsor trial personnel were unable to visit sites to perform data safety checks during monitoring visits.
- Formal risk assessments had to be carried out for every trial before it re-opened. This was mandated by sponsors and R&D Director in NHS GGC and the process for this didn't start until the beginning of June.

**Table 3: Number of patients consented and recruited into Renal clinical trials, 2020.**

Project Title	2020	
	Consented	Recruited
Renal Adjuvant MultiPle Arm Randomised Trial (RAMPART)	5	4
COSMIC-313	2	1
MK6482-005	1	0
ENDOTOX	39	39
<b>Grand Total</b>	<b>47</b>	<b>44</b>

Source: SCR data

## 5. Next Steps

The MCN will actively take forward regional actions identified and NHS Boards are asked to develop local Action/Improvements Plans in response to the findings presented in the report. A summary of actions for each NHS Board has been included within the Action Plan templates in [Appendix 3](#).

## **6. Acknowledgments**

This report has been prepared using clinical audit data provided by the following NHS Boards in the WoSCAN area:

NHS Ayrshire & Arran  
NHS Forth Valley  
NHS Greater Glasgow and Clyde  
NHS Lanarkshire

We would like to thank all members and active participants in the cancer network for their continued support of the MCN, and the many hospitals that are committed to making the audit succeed. We also acknowledge the efforts of the clinical effectiveness staff, nurses, and other service users for their work in ensuring the data are available to enable analysis to take place each year. Without their considerable efforts this level of progress would not be possible.



## 7. Glossary

<b>NHS AA</b>	NHS Ayrshire & Arran
<b>CNS</b>	Clinical Nurse Specialist
<b>CT</b>	Computed tomography
<b>eCASE</b>	Electronic Cancer Audit Support Environment
<b>NHS FV</b>	NHS Forth Valley
<b>NHS LAN</b>	NHS Lanarkshire
<b>MCN</b>	Managed Clinical Network - Linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and NHS Board boundaries, to ensure equitable provision of high quality clinically effective services.*
<b>MDT(s)</b>	Multidisciplinary Team(s) - A Multidisciplinary Team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatments of individual patients.**
<b>NHSGGC</b>	NHS Greater Glasgow and Clyde
<b>QPI(s)</b>	Quality Performance Indicator(s)
<b>RCAG</b>	Regional Cancer Advisory Group
<b>SMR01</b>	General / Acute Inpatient and Day Case
<b>TNM</b>	Tumour, Nodes, Metastases (staging system)
<b>WoS</b>	West of Scotland
<b>WoSCAN</b>	West of Scotland Cancer Network

Sources:

\* [www.woscan.scot.nhs.uk](http://www.woscan.scot.nhs.uk)

\*\* [www.datadictionary.nhs.uk](http://www.datadictionary.nhs.uk)

## 8. References

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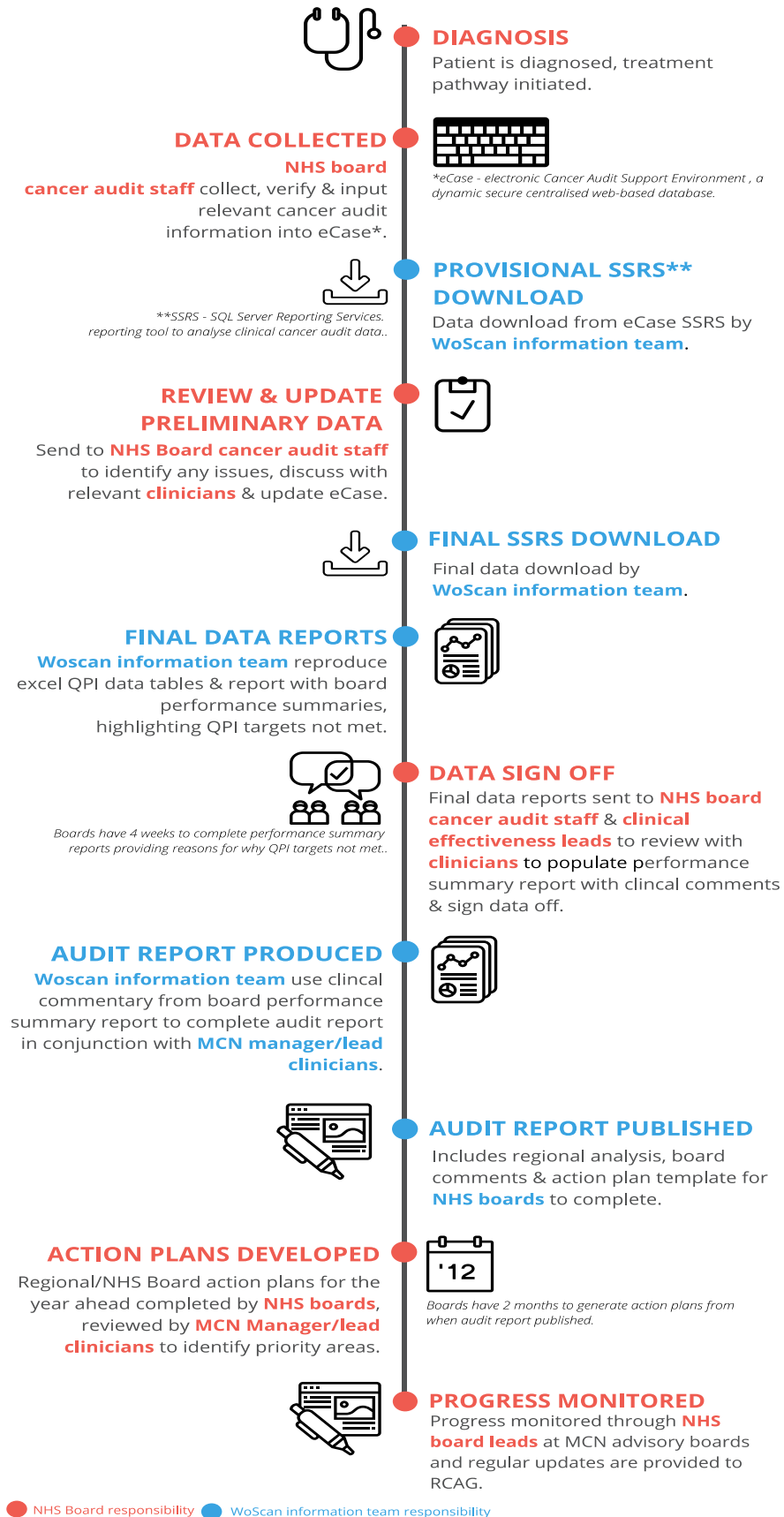
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## Appendix 1: Meta Data

Report Title	Cancer Audit Report: Renal Cancer Quality Performance Indicators																												
Time Period	Patients diagnosed between 1st January - 31st December 2020																												
Data Source	Cancer Audit Support Environment (eCASE). A secure centralised web-based database which holds cancer audit information in Scotland.																												
Data extraction date	2200 hrs on 08 December 2021.																												
Methodology	<p>Analysis was performed centrally for the region by the WoSCAN Information Team. The timescales agreed took into account the patient pathway to ensure that a complete treatments record was available for the majority of patients.</p> <p>Initial results were provided to Boards to check for inaccuracies, inconsistencies or obvious gaps and a subsequent download taken upon which final analysis was carried out.</p> <p>The final data analysis was disseminated for NHS Board verification in line with the regional audit governance process to ensure that the data was an accurate representation of service in each area. Please see info graphic in appendix 2 for a more detailed look at the reporting process.</p>																												
Data Quality	<p>Audit data completeness can be assessed by estimating the proportion of expected patients that have been identified through audit compared to the number reported by the National Cancer registry (provided by ISD, National Services Division); this is known as case ascertainment. Figures should only be used as a guide as it is not possible to compare the same exact cohort from each data source. Note that a 5 year average is taken for cancer registry cases to take account of annual fluctuations in incidence within NHS Boards.</p> <table border="1" data-bbox="386 1123 1351 1413"> <thead> <tr> <th></th> <th>Ayrshire &amp; Arran</th> <th>Forth Valley</th> <th>GGC</th> <th>Lanarkshire</th> <th>WoS</th> </tr> </thead> <tbody> <tr> <td>Cases from audit</td> <td>81</td> <td>65</td> <td>215</td> <td>81</td> <td>442</td> </tr> <tr> <td>Cases from ISD (2015-19)</td> <td>69</td> <td>55</td> <td>266</td> <td>106</td> <td>496</td> </tr> <tr> <td>Case ascertainment</td> <td>117.4%</td> <td>118.2%</td> <td>80.8%</td> <td>76.4%</td> <td>89.1%</td> </tr> </tbody> </table>						Ayrshire & Arran	Forth Valley	GGC	Lanarkshire	WoS	Cases from audit	81	65	215	81	442	Cases from ISD (2015-19)	69	55	266	106	496	Case ascertainment	117.4%	118.2%	80.8%	76.4%	89.1%
	Ayrshire & Arran	Forth Valley	GGC	Lanarkshire	WoS																								
Cases from audit	81	65	215	81	442																								
Cases from ISD (2015-19)	69	55	266	106	496																								
Case ascertainment	117.4%	118.2%	80.8%	76.4%	89.1%																								

## Appendix 2: Cancer Audit Timeline



### Appendix 3: NHS Board Action Plans

A summary of actions for each NHS Board has been included within the following Action Plan templates. Completed Action Plans should be returned to WoSCAN within two months of publication of this report.

#### Renal Cancer QPI Action / Improvements Plan

<b>Area:</b>	NHS Ayrshire & Arran
<b>Action Plan Lead:</b>	
<b>Date:</b>	

KEY (Status)	
<b>1</b>	<b>Action fully implemented</b>
<b>2</b>	<b>Action agreed but not yet implemented</b>
<b>3</b>	<b>No action taken (please state reason)</b>

QPI No.	Action Required	Health Board Action Taken	Timescales		Lead	Progress/Action Status	Status (see Key)
			Start	End			
	<i>Ensure actions mirror those detailed in Audit Report.</i>	<i>Detail specific actions that will be taken by the NHS Board.</i>	<i>Insert date</i>	<i>Insert date</i>	<i>Insert name of responsible lead for each specific action.</i>	<i>Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.</i>	<i>Insert No. from key above.</i>
<b>QPI 10: Prognostic Scoring in Metastatic Disease</b>	NHS Ayrshire and Arran to flag with the regional MDT the importance of recording prognostic score particularly in patients where there is no plan for specialist review.						

## Renal Cancer QPI Action / Improvements Plan

<b>Area:</b>	NHS Forth Valley
<b>Action Plan Lead:</b>	
<b>Date:</b>	

<b>KEY (Status)</b>	
<b>1</b>	<b>Action fully implemented</b>
<b>2</b>	<b>Action agreed but not yet implemented</b>
<b>3</b>	<b>No action taken (please state reason)</b>

QPI No.	Action Required	Health Board Action Taken	Timescales		Lead	Progress/Action Status	Status (see Key)
			Start	End			
	<i>Ensure actions mirror those detailed in Audit Report.</i>	<i>Detail specific actions that will be taken by the NHS Board.</i>	<i>Insert date</i>	<i>Insert date</i>	<i>Insert name of responsible lead for each specific action.</i>	<i>Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.</i>	<i>Insert No. from key above.</i>

## Renal Cancer QPI Action / Improvements Plan

<b>Area:</b>	NHS Lanarkshire
<b>Action Plan Lead:</b>	
<b>Date:</b>	

<b>KEY (Status)</b>	
<b>1</b>	<b>Action fully implemented</b>
<b>2</b>	<b>Action agreed but not yet implemented</b>
<b>3</b>	<b>No action taken (please state reason)</b>

QPI No.	Action Required	Health Board Action Taken	Timescales		Lead	Progress/Action Status	Status (see Key)
			Start	End			
	<i>Ensure actions mirror those detailed in Audit Report.</i>	<i>Detail specific actions that will be taken by the NHS Board.</i>	<i>Insert date</i>	<i>Insert date</i>	<i>Insert name of responsible lead for each specific action.</i>	<i>Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.</i>	<i>Insert No. from key above.</i>



## Renal Cancer QPI Action / Improvements Plan

<b>Area:</b>	NHS Greater Glasgow & Clyde
<b>Action Plan Lead:</b>	
<b>Date:</b>	

KEY (Status)	
<b>1</b>	Action fully implemented
<b>2</b>	Action agreed but not yet implemented
<b>3</b>	No action taken (please state reason)

QPI No.	Action Required	Health Board Action Taken	Timescales		Lead	Progress/Action Status	Status (see Key)
			Start	End			
	<i>Ensure actions mirror those detailed in Audit Report.</i>	<i>Detail specific actions that will be taken by the NHS Board.</i>	<i>Insert date</i>	<i>Insert date</i>	<i>Insert name of responsible lead for each specific action.</i>	<i>Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.</i>	<i>Insert No. from key above.</i>
<b>QPI 10: Prognostic Scoring in Metastatic Disease</b>	NHS GGC to flag with the regional MDT the importance of recording prognostic score particularly in patients where there is no plan for specialist review						