Scottish Cancer Strategic Board
National Cancer Quality Improvement Board

Cervical Cancer
Clinical Quality Performance Indicators

Published: October 2014
Updated: April 2025

Published by:
Healthcare Improvement Scotland

Revision History

Version	Date	Summary of Changes
V1.0	October 2014	Initial publication
V1.1	June 2015	Updated document to ensure accurate measurement of QPI 1: Radiological Staging
V2.0	August 2016	Baseline review changes
V3.0	December 2018	Formal review changes (1st Cycle)
V4.0	April 2022	Formal review changes (2nd Cycle)
V5.0	April 2025	Formal review changes (3rd Cycle)

Contents Update Record

April 2025 (v5.0)
This document was updated following formal review (3rd cycle) of the Cervical Cancer Quality Performance Indicators (QPIs) which took place following analysis of year 9 of the cervical cancer QPI data.

The following QPIs have been updated:

- QPI 4: Radical Hysterectomy
- QPI 7: Chemoradiation

The following QPIs have been archived:

- QPI 1: Radiological Staging
- QPI 6: 56 Day Treatment Time for Radical Radiotherapy
- QPI 8: Clinical Trial and Research Study Access*

***** This important indicator 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 Cervical Cancer QPI document applies to cases diagnosed from 1st October 2024 onwards.

Previous updates:

April 2022 (v4.0)

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

The following QPI has been updated:

- QPI 4 – Radical Hysterectomy

The following QPIs have been archived:

- QPI 2 – Positron Emission Tomography / Computed Tomography (PET/CT)
- QPI 3 – Multidisciplinary Team Meeting (MDT)

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 Cervical Cancer QPI Document applies to cases diagnosed from 1st October 2021 onwards.

December 2018 (v3.0)
This document was updated following formal review of the Cervical Cancer Quality Performance Indicators (QPIs) which took place following analysis of year 3 of the Cervical Cancer QPI data.

The following QPIs have been updated:

- QPI 1 – Radiological Staging
- QPI 2 – Positron Emission Tomography/Computed Tomography (PET/CT)
- QPI 3 – Multi-disciplinary Team Meeting (MDT)

Please note the Clinical Trial and Research Study Access has now been added into each tumour specific QPI document (See QPI 8 – 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 – 9 and the appendices have also been updated.

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

August 2016 (v2.0)
This document was updated following baseline review of the Cervical Cancer QPIs which took place following analysis of year 1 of the Cervical Cancer data. As a result, the following QPIs have been updated:

- QPI 1 – Radiological Staging
- QPI 3 – Multidisciplinary Team Meeting (MDT)
- QPI 4 – Radical Hysterectomy
- QPI 5 – Surgical Margins

Please note that this version of the Cervical Cancer QPI document applies to cases diagnosed from 1st October 2015.

June 2015 (v1.1)
This document has been updated to ensure accurate measurement of QPI 1: Radiological Staging, as agreed by the QPI Development Group during the QPI development process.

Contents Page

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 Cervical and Endometrial Cancer QPI Development Group was convened in September 2013, chaired by Mr Colin McKay (Consultant Surgeon, NHS Greater Glasgow and Clyde). 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 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 have been 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 Cervical Cancer 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 document have been developed in parallel with the indicators to support monitoring and reporting of the Cervical Cancer QPIs. The latest version of these documents can be found at:

Public Health Scotland Cancer Audit

6. Quality Performance Indicators for Cervical Cancer

QPI 4: Radical Hysterectomy

QPI Title:	Patients with stage IB1–IB2 cervical cancer should undergo radical hysterectomy.
Description:	Proportion of patients with stage IB1-IB2 cervical cancer (as defined by radiology and/or histopathology) who undergo radical hysterectomy.
Rationale and Evidence:	International and national guidance recommends a radical hysterectomy with pelvic lymph node dissection for patients with FIGO 2018 Stage 1B1, 1B2 cervical cancer[2,3]. There is evidence to support the oncological safety for a simple hysterectomy and pelvic lymph node dissection for patients with stage 1A2 cervical cancer and they are therefore excluded from this QPI[3]. Evidence from an international trial (SHAPE study) shows that patients with a cervical tumour which is 2cm or less, stromal invasion <10mm on LLETZ OR < 50% stromal invasion on MRI, with no lymph node metastasis on MRI may be excluded from the requirements of this QPI. Simple hysterectomy and BPLD is non-inferior to radical hysterectomy with respect to pelvic recurrence at 3 years follow up and is therefore an acceptable treatment option for these patients[4,5] In young women quality of life is less impaired after radical hysterectomy than following chemo-radiation therapy[6].
Specifications:	**Numerator:** Number of patients with FIGO stage IB1-IB2 cervical cancer who undergo radical hysterectomy. **Denominator:** All patients with FIGO stage IB1-IB2 cervical cancer. **Exclusions:** • Patients who decline surgery. • Patients who undergo fertility conserving treatment. • Patients having neo adjuvant chemotherapy. • Patient enrolled into surgical trials.
Target:	85% The tolerance within this target allows for situations where surgery is not appropriate, for example where patients have significant co-morbidities. It also accounts for those patients where cervical cancer has been an incidental finding at surgery, or in patients with early stage low risk cervical cancer where radical hysterectomy may not be required.

QPI 5: Surgical Margins

QPI Title:	Patients with surgically treated cervical cancer should have clear resection margins.
Description:	Proportion of patients with cervical cancer who have surgical margins clear of tumour following hysterectomy[a].
Rationale and Evidence:	The quality of radical surgery for cervical cancer has an important influence on local control of the tumour and ultimately survival. Therefore, it is important to optimise and ensure the quality of surgical care for cervical cancer patients. Positive surgical margins increase the risk of reoccurrence, necessitating adjuvant treatment[7,8,9].
Specifications:	**Numerator:** Number of patients with cervical cancer who undergo surgery where surgical margins are clear of tumour. **Denominator:** All patients with cervical cancer who undergo surgery. **Exclusions:** • No exclusions.
Target:	95% The tolerance within this target allows for cases in which it is not clinically possible to achieve a clear surgical margin despite full radiological staging.

[a] As determined by pathology

QPI 7: Chemoradiation

QPI Title:	Patients with cervical cancer undergoing radical radiotherapy should receive concurrent platinum-based chemotherapy.
Description:	Proportion of patients with cervical cancer undergoing radical radiotherapy who receive concurrent chemotherapy.
Rationale and Evidence:	Addition of chemotherapy to radiotherapy has been shown in several randomised trials and in a meta-analysis to improve overall survival[6,7,10,11]. Any patient with cervical cancer considered suitable for radical radiotherapy treatment should have concurrent chemoradiotherapy with a platinum based chemotherapy, if fit enough[6]. Concurrent chemoradiotherapy is the standard treatment for locally advanced cervical cancer (patients with IB3-IVA disease)[2].
Specifications:	**Numerator:** Number of patients with cervical cancer undergoing radical radiotherapy who receive concurrent chemotherapy. **Denominator:** All patients with cervical cancer who undergo radical radiotherapy. **Exclusions:** • No exclusions.
Target:	70% The tolerance within this target allows for patients for whom chemotherapy is contraindicated, for example where patients have significant co-morbidities or fitness levels which preclude chemotherapy.

7. Survival

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

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 Group. 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 Cervical and Endometrial Cancer QPI Groups have not been able to identify sufficient evidence, or determine appropriate measurability specifications, to address all areas felt to be of key importance in the treatment of cervical cancer, and therefore in improving the quality of care for patients affected by cervical cancer.

The following areas for future consideration have been raised across the lifetime of the Cervical Cancer QPIs.

- Brachytherapy in the treatment of cervical cancer.

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 3 and 4 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 Group
  - 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 (PHS)
    - Publish national comparative report on tumour specific QPIs and survival for three 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.
- Identify and share good practice.
- In conjunction with constituent NHS Boards identify regional and local actions required to develop an action plan to address regional issues identified.
- Review and monitor progress against agreed actions.
- Provide assurance to NHS Board Chief Executive Officers and Scottish Cancer Strategic Board 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.

10. References

1. Scottish Government (2016). Beating Cancer: Ambition and Action (accessed December 2016). Available online from: https://www.gov.scot/publications/beating-cancer-ambition-action/
2. British Gynaecological Cancer Society (BGCS) Cervical Cancer Guidelines: Recommendations for Practice. (accessed May 2020).
3. Cibula D, Raspollini MR, Planchamp F, et al (2023) ESGO/ESTRO/ESP Guidelines for the management of patients with cervical cancer – Update 2023* International Journal of Gynecologic Cancer 2023;**33:**649-666. Available from: https://pubmed.ncbi.nlm.nih.gov/37127326/
4. Plante M, Kwon JS, Ferguson S, Samouëlian V, Ferron G, Maulard A, et al (2024). Simple versus radical hysterectomy in women with low-risk cervical cancer. N Engl J Med 2024;390:819–829. Available from: https://www.nejm.org/doi/full/10.1056/NEJMoa2308900
5. Schmeler et al. ConCerv: a prospective trial of conservative surgery for low risk early stage cervical cancer. IJGC 2021;31:1317-1325. Available from: https://pubmed.ncbi.nlm.nih.gov/34493587/
6. Scottish Intercollegiate Guidelines Network (2008). Management of Cervical Cancer: a National Clinical Guideline, 2008 Jan 1. (accessed December 2012).
7. Greer et al (2010). Cervical Cancer: Clinical Practice Guidelines in Oncology. Journal of the National Comprehensive Cancer Network. 12,1388-416.
8. Green et al (2005). Concomintant chemotherapy and radiation therapy for cancer of the unterine cervix. The Cochrane Library 2005, Issue 3. (accessed January 2014) Available online from: https://www.ncbi.nlm.nih.gov/pubmed/11687152
9. Peters et al (2000). Concurrent Chemotherapy and Pelvic Radiatio Therapy Compared with Pelvic Radiation Therapy Alone as Adjuvant Therapy After Radical Surgery in High Risk Early Stage Cancer of the Cervix. Journal of Clinical Oncology. 18(8), 1606-1613.
10. McCann et al (2013).The impact of close surgical margins after radical hysterectomy for early stage cervical cancer. Gynecological Oncology. 128(1), 44-48.
11. Verleye et al (2006) Quality Assurance for radical hysterectomy for cervical cancer: the view of the European Organization for Research and Treatment of Cancer – Gynecological Cancer Group (EORTC-GCG). Annals of Oncology. 20, 1631-1638.
12. Brouwers M, Kho ME, Browman GP, Burgers JS, Cluzeau F, Feder G, Fervers B, Graham ID, Grimshaw J, Hanna S, Littlejohns P, Makarski J, Zitzelsberger L for the AGREE Next Steps Consortium (2010). AGREE II: Advancing guideline development, reporting and evaluation in healthcare. Can Med Assoc J. 182(18), E839-E842 (accessed August 2013). Available online from: http://www.cmaj.ca/content/182/18/E839.full.pdf+html?maxtoshow=&hits=10&RESU%20LTFORMAT=&fulltext=brouwers&searchid=1&FIRSTINDEX=0&volume=182&issue=%2018&resourcetype=HWCIT%2520%2520%2520

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 Cervical Cancer QPIs and a search narrative were defined and agreed by the Cervical and Endometrial Cancer QPI Development Group. The table below shows the final search criteria used in the literature search.

Inclusion	Exclusion
Cervical cancer types: • Primary cervical cancer (including: squamous, adenocarcinoma and adenosquamous carcinoma) *Interventions*: • Diagnosis • Staging • Surgical management of disease • Non-surgical management of disease (chemotherapy, radiotherapy, brachytherapy) *Age range:* Adults only *Date:* *Language:* *Document type:* Clinical guidelines	• Pre-cancerous conditions including: cervical intra-epithelial neoplasia (CIN) and glandular intra-epithelial neoplasia (GIN) *Related cancers:* • Secondary/malignant cervical • Neuroendocrine carcinomas • Lymphomas • Cervical sarcomas *Interventions*: • 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) • Prevention • Primary care/referral • Recurrent disease/relapsed disease management • Screening • Symptom management (e.g. nausea and vomiting, neutropenic sepsis)

Table 1 – Cervical Cancer 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.

Thirty two guidelines were appraised for quality using the AGREE II instrument[12]. This instrument assesses the methodological rigour used when developing a guideline. Eleven of the guidelines were recommended for use. A further 4 NHS accredited guidelines where included without appraisal. Overall, 7 guidelines for the management of cervical cancer were recommended for use.

Indicator Development

The Cervical and Endometrial 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 April 2014 where the Cervical Cancer 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 cervical cancer and the wider public were given the opportunity to influence the development of Cervical Cancer 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 Cervical and Endometrial QPI Development Group and used to produce and refine the final indicators.

Cervical and Endometrial Cancer QPI Development Group Membership (2014)

Name	Designation	Cancer Network/Base
Lorna Bruce	Audit/IT Facilitator	SCAN
Kevin Burton	Consultant Gynaecological Oncologist	WoSCAN / NHS Greater Glasgow and Clyde
Kevin Campbell	Project Manager	WoSCAN
Moira Campbell	Patient Representative	
Mary Cairns (liaising with David Parkin)	Consultant Gynaecological Oncologist	NOSCAN / NHS Grampian
Richard Casasola	Consultant Clinical Oncologist	NOSCAN / NHS Tayside
Scott Fegan	Consultant Gynaecological Oncologist	SCAN / NHS Lothian and NHS Fife
Janet Galloway	Patient Representative	
Maria-Lena Gregoriades	Consultant Radiologist	SCAN / NHS Fife

Name	Designation	Cancer Network/Base
Morton Hair	Consultant Gynaecological Oncologist	WoSCAN / NHS Greater Glasgow and Clyde
Rosie Harrand	Consultant Clinical Oncologist	WoSCAN / NHS Greater Glasgow and Clyde
Sophie Hepple	Consultant Radiologist	WoSCAN / NHS Greater Glasgow and Clyde
Simon Herrington	Consultant Pathologist	NOSCAN / NHS Tayside
Michelle Hilton-Boon	Programme Manager	Healthcare Improvement Scotland
Natasha Inglis	Consultant Pathologist	NOSCAN / NHS Highland
Annie Kennedy	Consultant Clinical Oncologist	NOSCAN / NHS Grampian
Cameron Martin	Consultant Gynaecologist and Subspecialist in Gynaecological Oncology	SCAN / NHS Lothian
Erica McGaughay	Clinical Nurse Specialist	NOSCAN / NHS Tayside
Colin McKay	Group Chair	WoSCAN / NHS Greater Glasgow and Clyde
Maureen McKay	Patient Representative	
Ethel Mclean	Audit Facilitator	WoSCAN / NHS Arran and Ayrshire
Rosie Millar	Macmillan Gynae Clinical Nurse Specialist	SCAN / NHS Grampian
Kathryn Morton	Clinical Pathologist	WoSCAN / NHS Forth Valley
Emma Ramage	Consultant Radiologist	NOSCAN / NHS Grampian
Azmat Sadozye	Consultant Clinical Oncologist	WoSCAN / NHS Greater Glasgow and Clyde
Nadeem Siddiqui	Consultant Gynaecological Oncologist	WoSCAN / NHS Greater Glasgow and Clyde
Smutra Shanbhag	Consultant Gynaecological Oncologist	WoSCAN / NHS Greater Glasgow and Clyde
Allison Stillie	Consultant Clinical Oncologist	SCAN/ NHS Lothian
Evelyn Thomson	Regional Manager (Cancer)	WoSCAN
Alistair Williams	Reader in Pathology	SCAN / NHS Lothian
Mark Zahra	Consultant Clinical Oncologist	SCAN / NHS Lothian

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

Appendix 2: Cervical Cancer QPI Formal Reviews

Formal review of the Cervical Cancer QPIs was undertaken for the first time in June 2018 following reporting of 3 years of national QPI data. A Formal Review Group was convened, chaired by Mr James Powell, Consultant Hepatopancreatobiliary (HPB) Cancer Surgeon. Membership of this group is outlined below.

Cervical and Endometrial Cancer Formal Review Group Membership (2018)

Name	Designation	Cancer Network / Base
James Powell (Chair)	Consultant HPB Surgeon	SCAN / NHS Lothian
Kevin Burton	MCN Clinical Lead / Consultant Gynaecological Oncologist	WoSCAN / NHS Greater Glasgow & Clyde
Kevin Campbell	MCN Manager	WoSCAN / NHS Greater Glasgow & Clyde
Jen Doherty	Project Co-ordinator	National Cancer Quality Programme
Ann-Maree Kennedy	Consultant Clinical Oncologist	NOSCAN / NHS Grampian
Cameron Martin	MCN Clinical Lead / Consultant Gynaecological Oncologist	SCAN / NHS Lothian
Wendy McMullen	Consultant Obstetrician and Gynaecologist	NOSCAN / NHS Tayside
Azmat Sadozye	Clinical Director / Consultant Clinical Oncologist	WoSCAN / NHS Greater Glasgow & Clyde
Alison Stillie	Consultant Clinical Oncologist	SCAN / NHS Lothian
Lorraine Stirling	Project Officer	National Cancer Quality Programme
Christine Urquhart	Audit Manager	NOSCAN
Mark Zahra	Consultant Clinical Oncologist	SCAN / NHS Lothian

Formal review of the Cervical Cancer 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

2nd Cycle Formal Review

The 2nd cycle of formal review commenced in July 2021. This review was more selective and focussed on ensuring the ongoing clinical relevance of the QPIs. A Formal Review Group was convened, with Ioanna Nixon, Consultant Clinical Oncologist, West of Scotland Cancer Network appointed as Clinical Advisor/Chair to the group. Membership of this group is outlined below.

Cervical and Endometrial Cancer Formal Review Group Membership (2021)

Name	Designation	Cancer Network / Base
Ioanna Nixon (Chair)	Consultant Clinical Oncologist	WoSCAN
Kevin Burton	MCN Clinical Lead	WoSCAN
Enhsun Choi	Radiologist	WoSCAN
Jen Doherty	Project Co-ordinator	National Cancer Quality Programme
Sophie Hepple	Consultant Radiologist	WoSCAN
Rosie Harrand	Consultant Clinical Oncologist	WoSCAN
Ann-Maree Kennedy	MCN Clinical Lead	NCA
Cameron Martin	MCN Clinical Lead	SCAN
Julie McMahon	Information Analyst	WoSCAN
Alison Stillie	Consultant Clinical Oncologist	SCAN
Lorraine Stirling	Project Officer	National Cancer Quality Programme
Evelyn Thomson	Regional Manager (Cancer)	WoSCAN)

Formal review of the Cervical Cancer 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

3rd Cycle Formal Review

The 3rd cycle of formal review commenced in June 2024. Mr Graham Mackay, Consultant Surgeon and Regional Cancer Clinical Lead, WoSCAN was appointed as Clinical Advisor/Chair to the group. Membership of this group is outlined below:

Cervical and Endometrial Cancer QPI Formal Review Group Membership (2024)

Name	Designation	Cancer Network
Graham Mackay (Chair)	Consultant Surgeon & Regional Cancer Clinical	WoSCAN
Sarah Bell	Consultant Pathologist	WoSCAN
Jen Doherty	Project Co-ordinator	National Cancer Quality Programme
Stanka Easton	Senior Cancer Infomation Analyst	SCAN

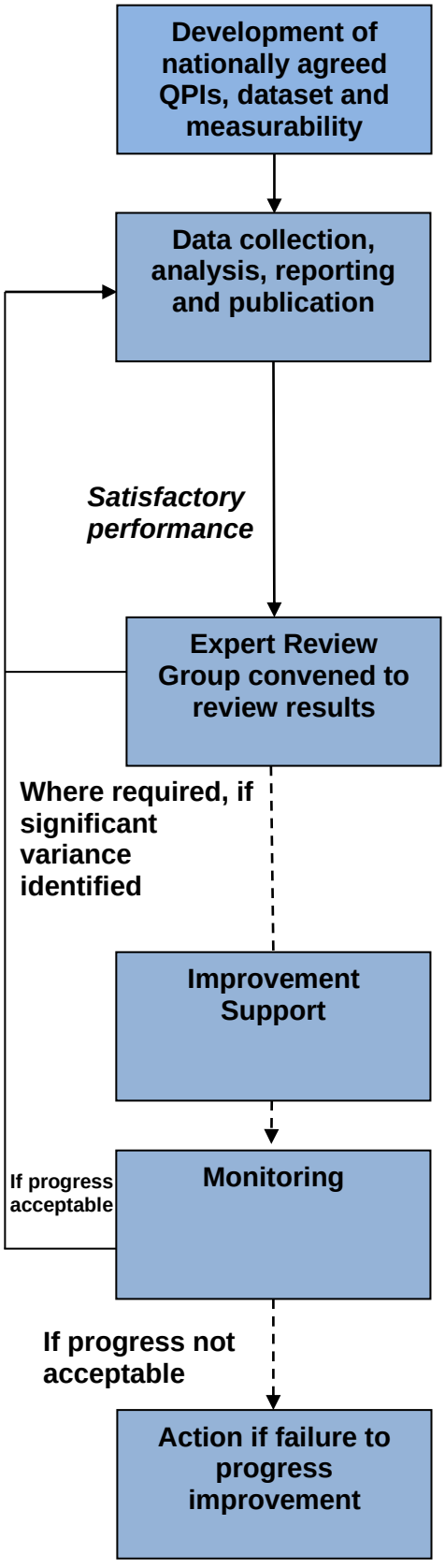
Name	Designation	Cancer Network
Nidal Ghaoui	Clinical Lead	SCAN
Mahalakshmi Gurumurthy	Clinical Lead	NCA
Rosie Harrand	Consultant Clinical Oncologist	WoSCAN
Ann-Maree Kennedy	Consultant Clinical Oncologist	NCA
Rhona Lindsay	Clinical Lead	WoSCAN
Julie McMahon	Information Analyst	WoSCAN
Alison Stillie	Consultant Clinical Oncologist	SCAN
Lorraine Stirling	Project Officer	National Cancer Quality Programme

Formal review of the Cervical Cancer 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).



1. National QPI Development Stage

- QPIs developed by QPI development groups, which include representation from Regional Cancer Networks, Healthcare Improvement Scotland, PHS, patient representatives and the Cancer Coalition.

2. Data Analysis Stage:

- NHS Boards and Regional Cancer Advisory Groups (RCAGs)* collect data and analyse on yearly basis using nationally agreed measurability criteria and produce action plans to address areas of variance, see appendix 4.
- Submit yearly reports to PHS for collation and publication every 3 years.
- National comparative report approved by NHS Boards and RCAGs.
- PHS produce comparative, publicly available, national report consisting of trend analysis of 3 years data and survival analysis.

3. Expert Review Group Stage (for 3 tumour types per year):

- Expert group, hosted by Healthcare Improvement Scotland, review comparative national results.
- Write to RCAGs highlighting areas of good practice and variances.
- Where required NHS Boards requested to submit improvement plans for any outstanding unresolved issues with timescales for improvement to expert group.
- Improvement plans ratified by expert group and Scottish Cancer Strategic Board.

4. Improvement Support Stage:

- Where required Healthcare Improvement Scotland provide expertise on improvement methodologies and support.

5. Monitoring Stage:

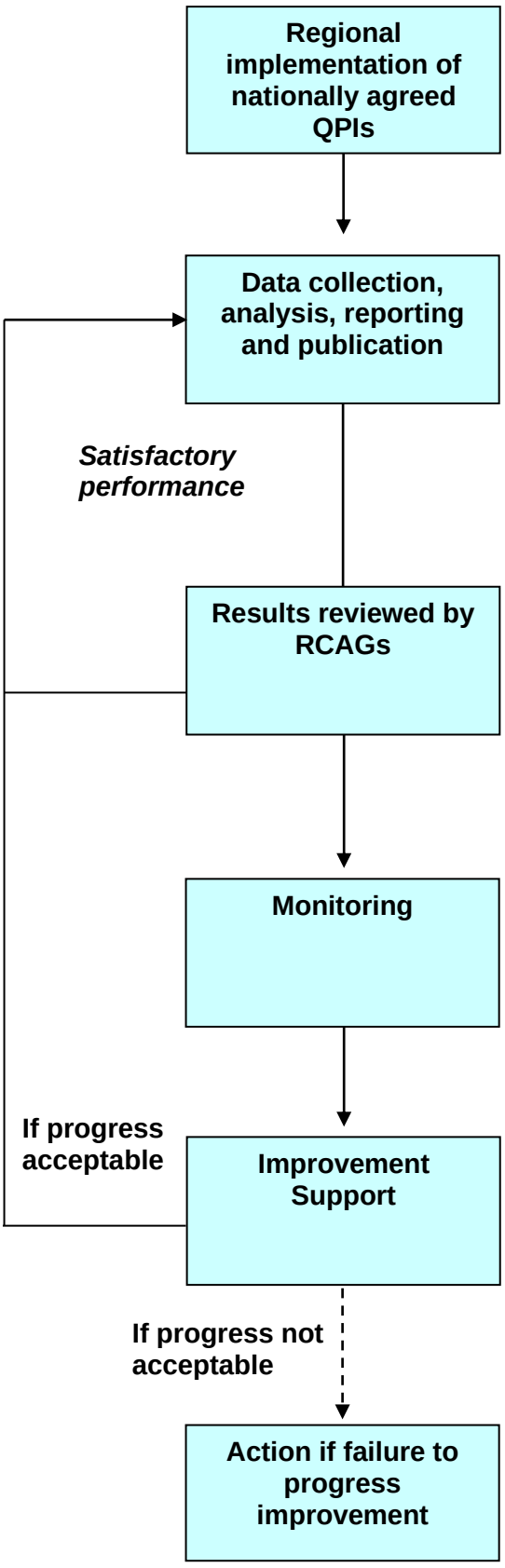
- RCAGs work with Boards to progress outstanding actions, monitor improvement plans and submit progress report to Healthcare Improvement Scotland.
- Healthcare Improvement Scotland report to Scottish Cancer Strategic Board as to whether progress is acceptable**.**

6. Escalation Stage:

- If progress not acceptable, Healthcare Improvement Scotland will visit the service concerned and work with the RCAG and Board to address issues.
- Report submitted to Scottish Cancer Strategic Board and escalation with a proposal to take forward to Scottish Government Health Department.

**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 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

Abdomen	The abdomen contains the stomach, liver, kidneys, and bladder. In women it also contains the ovaries and uterus.
Bilateral	Affecting both the right and left sides of the body.
Bilateral Salpingo-Oopherectomy	A bilateral salpingo-oophorectomy is a surgery in which both of a woman's ovaries are removed, along with the fallopian tubes.
Brachytherapy	Brachytherapy is a specific type of radiotherapy where the treatment is given directly into, or very close to, the tumour.
Chemotherapy	The use of drugs that kill cancer cells, or prevent or slow their growth.
Computed Tomography (CT)	An x-ray imaging technique, which allows detailed investigation of the internal organ of the body.
Co-morbidities	The presence of one or more additional disorders or diseases.
Contraindication/ Contraindicated	A symptom or medical condition that makes a particular treatment or procedure inadvisable because a person is likely to have a bad reaction.
Diagnosis/Diagnosed	The process of identifying a disease, such as cancer, from its signs and symptoms.
External Beam Radiotherapy (EBRT)	The most common form of radiotherapy. An external source of radiation is pointed at a particular part of the patient's body.
First-line/Primary treatment	Initial treatment used to reduce or treat a cancer.
Histological/ Histopathogical/Histology	The study of the structure, composition and function of tissues under the microscope, and their abnormalities.
Laparoscopic Surgery	Laparoscopic surgery, also called minimally invasive surgery or keyhole surgery, is a surgical technique in which operations in the abdomen are performed through small incisions (usually 0.5–1.5 cm) as opposed to the larger incisions.
Magnetic Resonance Imaging (MRI)	A procedure in which radio waves and a powerful magnet linked to a computer is used to create detailed pictures of areas inside the body. These pictures can show the difference between normal and diseased tissue.
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 any specific region, age group, disease or other classification, usually expressed as deaths per 1000, 10,000 or 100,000.
Multi-disciplinary 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 decided.
Palliative	Anything which serves to alleviate symptoms due to the underlying cancer but is not expected to cure it.
Pathological	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 post mortem.

Pathologist	A doctor who identifies diseases by studying cells and tissues under a microscope.
Pelvic/Pelvis	Having to do with the pelvis (the lower part of the abdomen located between the hip bones).
Positron emission tomography – computed tomography (PET/CT)	An imaging technique that produces a three-dimensional image of functional processes in the body by combining positron emission tomography
Progression	In medicine, the course of a disease, such as cancer, as it becomes worse or spreads in the body.
Radical Hysterectomy	During a radical hysterectomy the womb and surrounding tissues are removed, including the fallopian tubes, part of the vagina, ovaries, lymph glands and fatty tissue.
Radical Radiotherapy	Radiotherapy given with curative intent.
Radiology	The medical specialty that employs the use of imaging to both diagnose and treat disease visualized within the human body.
Radiological	Of, relating to, or concerning radiology or the equipment used in radiology.
Resect	To perform surgery to cut out part of (a bone, an organ, or other structure or part)
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.
Surgery/Surgical resection	Surgical removal of the tumour/lesion.
Surgical intervention	A surgical measure with the purpose of improving health or altering the course of disease.
Surgical Margin	Surgical margin, refers to the visible normal tissue or skin margin that is removed with the surgical excision of a tumour, growth, or malignancy.Surgical margin in a surgery report defines the visible margin or free edge of "normal" tissue seen by the surgeon with the naked eye. Surgical margin as read in a pathology report defines the histological measurement of normal or unaffected tissue surrounding the visible tumour under a microscope on a glass mounted histology section. A "narrow" surgical margin implies that the tumor exists very close to the surgical margin, and a "wide" surgical margin implies the tumor exists far from the cut edge or the surgical margin.
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.
Tumour size	The size of a cancer measured by the amount of space taken up by the tumour.
Vaginal brachytherapy (VBT)	Vaginal brachytherapy or vaginal vault brachytherapy is done by placing a small, radioactive pellet within a special tube into the vagina for a few minutes.