Choice of urinary diversion after radical cystectomy: A UK perspective

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Chapter 8 Discussions

The rationale for Shared Decision Making (SDM) in healthcare has already been discussed in details at the beginning of this thesis (Chapter 1). Observed variations in healthcare service provision and uptake, along with the gradual shift from a paternalistic to a more collaborative patient-clinician relationship, have fostered the development of SDM. Glover's classical study on tonsillectomy rates among school children (Glover 2008) is one the earliest of research efforts in demonstrating these variations, and over eight decades onwards these variations have remained commonplace globally. These variations can either be warranted or unwarranted, with the latter referring to variations in the utilisation of healthcare services which cannot be explained by variations in patient illness and preferences. The occurrence of unwarranted healthcare variations can be attributed to shortfalls in effective care and patient safety, preference-sensitive care and supply-sensitive care.

Urinary diversion after radical cystectomy is a type of preference-sensitive care, where legitimate options (conduit and neobladder) exist but evidence for the superiority of one option over the other(s) is insufficient; this leaves the best diversion option being the one that is most congruent with patient preferences. As the literature and this thesis have elucidated to, there remains many questions on how preference-sensitive healthcare decisions such as that concerning this thesis are made, with particular uncertainties around how patients form their preferences. The application of SDM aims at counteracting the potential drivers for unwarranted healthcare variations already identified by the relevant body of research, with some clear evidence of success. Some of these drivers are pertinent to choice of urinary diversion, which will be discussed later in the chapter.

This chapter discusses the main findings concerning this thesis, which were generated from the cross analyses of the findings drawn from the three research components: SWPHO-BAUS Radical Cystectomy Dataset Analysis (SWPHO-BAUS Analysis), Needs Assessment Questionnaire Survey and Qualitative Interviews.

8.1 Variations in neobladder use within the UK is notable and potentially unwarranted

Variations in neobladder use after radical cystectomy exist even among the few large academic centres renowned for their expertise in this urinary diversion procedure (range of neobladder use = 39.1 – 74%), and the overall neobladder use among these centres was noticeably higher when compared to that recorded for the wider populations e.g. that from the Swedish Registry and the US SEER Database reported neobladder use as 9 - 19% (Hatumann et al 2013; Gore et al 2006; Chapter 1). SWPHO-BAUS analysis conducted for this thesis demonstrated an even lower rate of neobladder use of 6.4% for the UK. In most cases within the UK, the consultant surgeon who performs radical cystectomy also usually performs the urinary diversion procedure after cystectomy; he/she is also the clinician who offers the options of urinary diversion and initiates relevant discussions with the patient concerned, with input from the Multidisciplinary Team (MDT) (Chapter 1).

The author hereby does not intend to be repetitive and overlabour on the findings for the SWPHO-BAUS analysis, their plausible explanations and the limitations of the analysis itself, as these have been covered in detail in the relevant results chapter (Chapter 4). The focus of this section is to discuss the implications of the analysis' findings, in the context of the whole thesis. As mentioned before, the analysis agreed with other studies investigating into the potential predictors for neobladder use (Gore et al 2006; Hounsome et al 2013), in that age and male gender were independently associated with higher neobladder use; and in contrast, deprivation status was not associated with neobladder use whilst pre-operative disease stage was only weakly associated (Chapter 4 Sections 4.2.1 and 4.2.2). Such disparities were likely to be caused by difference in study sample size and scale used for measuring deprivation. The impact of radical cystectomy caseload on neobladder use was not assessed in the analysis but according to the other studies the caseload predicted a higher neobladder use (Gore et al 2006; Hounsome et al 2013); as explained before, the author felt that due to the issue of poor cystectomy case capture by the SWPHO-BAUS rendered the test of association between cystectomy caseload and neobladder use imprecise. The extra time and financial resources demanded for more accurately assessing this association was outside the resource confines of the research concerning this thesiserefore, on balance the author did not

investigate into the association between radical cystectomy caseload and neobladder use. , investigating the association between neobladder use and cystectomy caseload with the SWPHO-BAUS Dataset data would be unlikely to yield a meaningful finding.

A strength of this analysis was that it investigated the association between neobladder use and several patient pre-operative clinical characteristics which had not been studied by the other studies but been widely considered as absolute and relative contraindications for neobladder in the literature, including clinical guidelines (Chapter 1); these included pre-operative renal function, fitness for surgery, radiotherapy and urinary continence status; better renal function, higher level of fitness for surgery and radiotherapy-naivety and complete continence of urine were also independently associated with higher neobladder use (Chapter 4 Sections 4.2.2. and 4.2.3). The analysis reflected that the UK-based surgeons adopted the research evidence to a certain extent, when considering the eligibility of a patient for having a choice between conduit and neobladder. Whilst the author was aware of the nested, hierarchical nature of the data (i.e. consultant-within- centres-within-cancer networks) and the potential interactions among patient characteristics (e.g. advancing age with decreased level of fitness), such were not incorporated into the analysis. This was due to the analysis' remit to only show trends of association between neobladder use and a range of patient characteristics, rather than identifying independent predictors for neobladder use. As a result the author considered the univariate analysis conducted for this analysis was already fit for purpose.

Another strength of this analysis was that it demonstrated notable variations in neobladder use across all the three healthcare organisational levels (consultant, centre and cancer networks), even after all the patient characteristics were held constant and random effects contributed by the organisational level itself was considered (i.e. residual variation; Chapter 4 Section 4.3). The strongest evidence for the presence of this variation was at the consultant level (Chapter 4 Section 4.3). As mentioned before, this might signify that there was large variation in individual consultants' beliefs in which patient would be suitable for neobladder and therefore, how they selected and counselled patients for neobladder. At the centre level, the homogenisation of professional opinion on neobladder use might have been present and subsequently resulted in a more subtle evidence of variation in neobladder use. Some cancer networks might have a much higher concentration higher volume

centres than the others, hence the evidence for variation in neobladder use among cancer networks had once again become more obvious.

A mentioned in the relevant results chapter (Chapter 4 Section 4.4), before undertaking the actual analysis it was already known that the data of the SWPHO-BAUS dataset were of compromised quality, mainly due to the dataset's poor case capture for radical cystectomy. There was also a notable proportion of cases with unknown diversion method (Chapter 3) excluded from the analysis. These data quality related issues further exacerbated the problems of imprecision and decreased power of the analysis, and such were common to the Hounsome's study (Hounsome et al 2013) which also used the dataset. Nonetheless, as mentioned SWPHO-BAUS Dataset was considered the best available resource for investigating variation in neobladder use within UK on a population scale, for the reasons detailed in Methods (Chapter 3). HES was a much more comprehensive dataset for radical cystectomy, but for the associated diversion it was only coded for conduit; there was no existent ICD-10 code for neobladder or any other diversion type, and the time, administrative and financial resources required to identify from all the cystectomy cases associated specifically with neobladder were unavailable. Therefore, in order to obtain a more accurate idea about variation in neobladder use within the UK, efforts need to be invested in improving the quality of the relevant data.

Before discussing the plausible reasons for the residual regional variations of the magnitudes demonstrated by the analysis, it is helpful to revisit the equation for geographical variation in healthcare postulated by Mulley and colleagues (Mulley et al 2012), based on their study on a number of other studies on variations in healthcare intervention delivery and uptake across a diverse range of healthcare settings:

$$V_{TOT} \text{ approx.} = V_{DD\text{-}WTD} + V_{PM} \qquad \text{(Mulley et al 2012, p. 20)}$$

V_{TOT} stands for total geographical variation for a given healthcare intervention, whereas $V_{DD\text{-}WTD}$ and V_{PM} stand for variation in clinicians' opinions on the intervention and variation in the misdiagnosis in patient preferences respectively; Mulley et al further asserted that the variation in aggregate health states ('patient illness') and that created by accurate patient preferences for intervention-related outcomes were so small which would not have contributed much to $V_{TOT,}$ thus omitted from the equation.

To put the above equation in the thesis' context, $V_{DD\text{-}WTD}$ would likely to have been large due to the lack of available strong evidence which demonstrated the superiority of neobladder over conduit in terms of outcomes available on the comparative merits (both clinical and Health-related Quality of Life, HRQoL), and vice versa. However, the author believes that there would have been several other factors suggested as contributory to preference-sensitive surgical care in the literature, which were also operational in the equation and contributed to V_{TOT} (Birkmeyer et al 2013). These factors included the surgeon's willingness to refer on for expertise (i.e. to another surgeon/centre with expertise in neobladder) and environmental factors in the National Health Service (NHS) including technology diffusion (adoption of neobladder at surgeon and organisational level), local training frameworks, supply of surgeons who perform neobladder and the regulatory frameworks (e.g. cancer waiting time targets).

Since the introduction of neobladder as an alternative urinary diversion to conduit in the 1990s (Studer et al 1996; Hautmann et al 1997), there has been no level one evidence available; the only formalised guideline/clinical consensus on urinary diversion in the context of radical cystectomy to-date was published by the European Association of Urology in 2013 (Hautmann et al 2013), which had largely drawn upon the Level 2-3 evidence. There were numerous studies on the outcomes of conduit and neobladder scattered in the literature, but most of these were small to moderate sized retrospective, single institution series (Lee et al 2014; Nabi et al 2005, Sogni et al 2008, Hautmann et al 2007, 2013). The evidence for longer term follow-up was also lacking for neobladder, with the longest period of 10 years for neobladder (Jin et al 2012; Nam et al 2013; Osawa et al 2013). Another issue with the available evidence on the two urinary diversion was that the study populations of those studies comparing the outcomes of conduit with that of neobladder (or other diversion) were not demographically matched, which have made the results less precise and convincing (Nabi et al 2005; Somani et al 2009).

As indicated by Brouwers and colleagues (Brouwers et al 2009), 'the potential benefits of clinical practice guidelines are only as good as the quality of clinical practice guidelines'. Undoubtedly, the quality of research evidence encompassed within the guidelines has direct bearing their uptake. However, as elucidated by knowledge translation (KT) research, the quality of evidence alone cannot drive forward its uptake, but is also dependent on the development process of the

evidence, its perceived messages to its users, and also the factors related to its application against the users' perceived clinical practice norms and contexts (Palda et al 2007; Grimshaw et al 2004, 2006; Grol et al 1998, 2001). Knowledge Translation is defined as:

> "a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products and strengthen the health care system" (CIHR)

With the current uncertainties surrounding the quality of evidence on neobladder, clinicians' opinions on the relative merits of neobladder and therefore patient suitability for neobladder are bound to vary. One may expect neobladder use will increase as the quality of the relevant supporting evidence for its use accumulates. However, the subsequent uptake of neobladder will also be dependent on the other considerations mentioned above with KT research, along with those factors contributing to variation in surgical care previously mentioned above e.g. supply of surgeons performing neobladder and the regulatory frameworks (cancer waiting times). Even with the unequivocal proof that neobladder is the superior diversion method and an encouraging clinical environment for its use, the uptake of neobladder may not increase.

Relative to the conduit, neobladder is an innovation and this fact in itself can hamper the progress of its own uptake in clinical practice. This situation concerns the areas of technology diffusion and local training frameworks and looking to the body of KT research, it may be explained by humans' inherent nature to adhere to the familiar and become complacent with satisfactory results thus stop seeking for improvements (Van de Ven 1985; March and Simon 1958). Conduit is arguably a technically simpler procedure with a simpler recovery and care routine (perhaps from more of clinicians' perspective), and it has accrued an abundance of outcome data supporting its use over time; it is therefore understandable why some clinicians (especially surgeons) instinctively favour conduit. Adoption of neobladder by a surgeon into his/her surgical practice may start with an open mind to innovation in general, but its actual use in clinical practice may only be materialised after substantial training in the procedure, backed by a track record of satisfactory outcomes and patient satisfaction, being backed by a supportive local clinical environment e.g. trained nursing staffs on the wards and high dependency units, a relaxed local cancer

waiting time target and a local organisational culture which would endorse innovation (Denis et al 2001; Robert et al 2009; York Consortium 2009; Akenroye 2012). There are multiple higher level organisational factors suggested in the literature which would have hampered the uptake of neobladder, ranging from financial prioritisation to lack of formal, systematic approach which would foster the uptake (Robert et al 2009; York Consortium 2009).

Referring back to Mulley's equation for variation in healthcare (Mulley et al 2012), one of its elements yet to be discussed is V_{PM} (variation in the misdiagnosis in patient preferences outcomes). The degree of variation in neobladder use observed at each organisational level would unlikely to have been due to genuine differences in accurately diagnosed patient preferences in the choice of urinary diversion, given how widespread the problem of patient preference misdiagnosis is, particularly in the case of preference-sensitive decision making (which the choice between conduit and neobladder is). A Cochrane review (Stacey et al 2014) demonstrated how the use of patient decision aids (PDAs) had significantly improved patient knowledge and clarified values relating to intervention outcomes, thus helped addressing patient preference misdiagnosis across a wide range of preference-sensitive healthcare decisions. As far as the author is concerned, the body of work concerning this thesis is the only research attempt to explore into the decision making process concerning urinary diversion after radical cystectomy; furthermore, there is no patient decision support or PDA for the choice between conduit and neobladder after radical cystectomy. A lack of understanding on how patient formed their preferences over their diversion options is implicated here and therefore makes patient preferences being accurately ascertained unlikely.

The author also considers that both variation in clinicians' beliefs and attitudes towards neobladder and that in patient preference misdiagnosis are large; these variations together with those factors contributing to preference-sensitive surgical care aforementioned, had culminated the variation in neobladder use of such magnitudes in the UK. More importantly, as stated before such variations may potentially be unwarranted and should be rectified.

As discussed in details in Chapter 1 (Introduction), SDM is the potential remedy for unwarranted variations in healthcare; prior to rectifying the observed variations in neobladder use in UK with SDM, an understanding of the decision making process concerning the choice of urinary diversion in today's NHS is necessary. Through

conducting a needs assessment of this decision making process with mixed methods, the author gained insights into some of the decisional needs required to be addressed; such insights can subsequently afford pragmatic implantation of SDM in the DM process, which should in time reduce the unwarranted variation in neobladder use within the UK. The following sections contain discussions on further main findings from the needs assessment i.e. the remaining bulk of the research concerning this thesis, generated from cross-interpretations of the findings from the quantitative needs assessment survey and the qualitative semi-structured interviews.

8.2 Gaps in patient knowledge for choice in urinary diversion after radical cystectomy exist

An element for making a quality healthcare decision by the ideals of SDM is the acquisition of an optimal amount of relevant information. The surgeons are the main and perhaps the very first source of information on urinary diversion for patients awaiting radical cystectomy, and the information may be enhanced further through encounters with the specialist nurses and individuals outside the responsible clinical team, as well as exposure to supplemental information materials in assorted formats (Chapter 6, Sections 6.2 – 6.4; Chapter 7 Sections 7.2 – 7.4). Before further discussions on the knowledge gap demonstrated by this thesis' work, it is perhaps useful to state that it was outside the remit of the work undertaken for this thesis to evaluate what constituted the optimal/the minimal level of relevant knowledge required for a making a quality decision on diversion by SDM standards; neither did this work aim to formally investigate into what would constitute relevant patient knowledge for this decision, or to formally assess the level of patient knowledge. A number of decisional quality (DQ) measurement tools are available though, some of which include a formal assessment of the level of patient knowledge specific to a healthcare decision (Sepucha and Fowler 2013; Chapter 1). To date there is no such a DQ measurement tool available for the decision on urinary diversion after radical cystectomy.

What the research conducted for this thesis provided was a broad overview on patients' knowledge acquired for the choice of urinary diversion after radical cystectomy. From the survey and interview findings, there was certainly room for enhancement of this patient knowledge. Although the overall level of patient

satisfaction with information in relation to both diversion methods was high (Chapter 5, Section 5.1.2) and in general the clinicians would inform their patients very often if not every time, about the information relevant to both diversion methods; however, not ALL patients who encountered the choice of diversion were very satisfied and clinicians did not necessarily inform their patients every time about all the information areas relevant to each diversion methods. This situation is unacceptable according to the ideals of SDM.

With specific regards to the patient survey, not every patient respondent reported maximum level of satisfaction with all information areas discussed for each of the two diversion options. Moreover, the percentages of very satisfied or satisfied patients vary among different information areas for a given specific diversion option; there was also a discrepancy in the percentage of very satisfied or satisfied patients between the two diversion options for each information area (Chapter 5, Section 5.1.2). Also of note was that, for both diversion options, benefits, risks and course of recovery were the three information areas with the highest percentages of very satisfied or satisfied patients; on the other hand, employment/retirement, leisure/sport and sex were the topics with the fewest for conduit patients; as for the neobladder patients, peer support rather than employment/retirement had become one of the three information areas with the fewest very satisfied or satisfied patients. Such findings indicated that the clinicians might have placed more emphasis on more clinically-orientated topics such as benefits, risks and course of recovery; this argument was supported by the fact that these three information areas were incidentally the ones well-covered (covered every time/very often) by the highest percentages of clinicians (Chapter 5, Section 5.2.2). As discussed later, employment/retirement and leisure/sports are among the many important considerations in the choice of diversion from patients' perspective (Chapter 6, Section 6.5.3 'Bob', 'Ed', 'Jim' and 'Dave'). Information provision and discussion with patients on these two areas (and indeed on all the other areas listed in the survey and any other ones concerning individual patients) should not be trivialised or ignored. The topic of sex was associated with the fewest patients who were very satisfied or satisfied. Furthermore, sex is a significant part of peoples' normality, and surgery which would lead to a significant change to body image (conduit with the formation of a urostomy) may also have a significant consequent impact on sexual life. The literature has largely focussed on the inter-relationships between bowel stomas, body image and impact on sexuality and sexual life (Sharpe et al 2011,

Black 2004, Manderson 2005, Brown and Randle 2005) but one can deduce that many of these findings would still hold true if urostomy was researched into.

For any one topic discussed for one of the two diversion option, some patients bound to be more satisfied than the others with the topic-specific information provided; instead of labouring over how many unsatisfied as opposed to satisfied patients there were, a more constructive question to ask here is why should some patients be less satisfied? Two plausible reasons for this were offered by the interview data; one being the perceived insufficiency in the amount and depth of information for a more informed, less biased comparison of the relative merits and disadvantages of the two diversion options (Chapter 6, Section 6.5.3 p. 30 'George'; p.31 'Tony'); the other being patient dissatisfaction with the delivery of information, which may include timing and languages used, and the perceived clinicians' manners in which the information was provided (Chapter 6, Section 6.5.3 p. 30 'George'). Another possible reason for reduced satisfaction was that the information provided was perceivably negative e.g. undesirable outcome of urinary incontinence when discussing about risks. Statistical testing (Wilcoxon test, Chapter 5 Tables 5 and 6) did not demonstrate any significant difference in the level of satisfaction between the two diversions across all topics, but this could be due to artefacts associated with analysing with a relatively small study population.

Perhaps a more worrisome finding from the survey was that there were few instances where certain topics were not discussed for either diversion option (Chapter 5, Section 5.1 Tables 3 and 4). There was no further elaboration on the reasons for such in the surveys or the interviews. Some assumptions can be made here. Patients might not recall having discussed these topics with their responsible clinical team, and that the responsible clinicians in the team (the surgeons and the nurses) assuming that each other have already covered the topics without checking with the patient (Chapter 7, p.14 'Oscar' and 'Donna'). The lack of communication between the surgeons and the nurses and clarity over each other roles can lead to patient misinformation, as well as patients' overall satisfaction with their care (Moret et al 2008).

With specific regards to the clinician survey, information coverage (by percentages and Wilcoxon test) was higher for conduit than for neobladder. This could be secondary to the differential roles among the clinician respondents; for instance, 11.9% of the nurse respondents (Chapter 5, Section 5.2.2 p. 23) declared that they

were stoma nurse specialists, hence it was outside their remits to discuss with patients about neobladder; some of the nurse and surgeon respondents might have under/or not discussed about neobladder as they might have delegated the task to their colleagues who have the expertise in the procedure. However, of course there remains the possibility that the surgeon and nurse respondents assumed that each other have already covered topics about neobladder. It was also interesting to note that nurse respondents reported not only better coverage for all topics for both diversion, but particularly so for topics concerning post-discharge care and patient's psycho-social wellbeing e.g. body appearances better than the surgeons respondents (Chapter 5,Section 5.2.2, Tables 5 and 6); this again could be due to the perceived roles of the nurse respondents, and due to their roles they were given more time in their organisation with the patients, to ensure coverage of these issues; moreover, perhaps nurses were trained to be more holistic in their approach to patient care, especially during consultations? (Stein 1967, 1990; Sweet and Norman 1995; Hughes 1988)

The variation in the level of satisfaction reported for each information area discussed for the respective diversion option might also be attributed to the variation in patient satisfaction with the amount and quality of that information (e.g. depth and readability) (Coulter et al 1999, Godolphin 2001) and the manner in which information was delivered (Weiman 1998). Another potential explanation was that some patients were experiencing regrets from negative outcomes related to certain information areas discussed, which led to reported dissatisfaction with the corresponding information; association between post-decisional regrets from negative treatment outcomes and dissatisfaction with the corresponding treatment-related information had been established in the literature (Sheehan et al 2007, Vogel et al 2007).

Nonetheless, patients are not necessarily well informed even all the topics were discussed every time and they were maximally satisfied with the corresponding information, as exemplified by the qualitative interview data (Chapter 6, Section 6.2.1.2 'George', 'Martin', 'Carol', 'Dave'; Section 6.5.1 'Martin, 'Steve', 'Wife of Fred', 'Greg', 'Pete'; Section Section 6.5.3 'Dave', 'Tony'). Preparing patients well for participation in SDM in terms of knowledge is much beyond simply providing them (if not overwhelming them) with an abundance of relevant, accurate information. Patients have varying individual information needs; and in order for patients to make a quality decision by SDM standards, they need to retain, understand and be

encouraged to use the information to address their personal values and preferences (Joseph-Williams et al 2013). Unfortunately, information concerning the choice of diversion is complex and large in amount; and by nature humans are not good at dealing with complexity, remembering and reflecting complex information (Johnson 1983; Van da Ven 1983). Therefore, to ensure the utility of patient knowledge especially in the choice of urinary diversion after radical cystectomy can be a real challenge. Given the gravity of the decision to individual patients, clinicians should endeavour to enhance the level of relevant patient knowledge and its utility. Some of the clinicians interviewed reported a number of ways to improve patient knowledge, including having more than one clinician delivering information related to the diversion options, over separate consultations (Chapter 7. Section 7.2.1, 'Nancy', 'Linda', 'Helen'); using an aide-memoire documenting the information discussed during the consultation (Chapter 7, Section 7.2.1, 'Sue') and the use of supplemental information resources, which is discussed further below. Some clinicians also reported assessing patient knowledge for the choice, but this was conducted informally (e.g. asking patients if they understood about certain recovery routines, clarifying with patients their questions related to the diversion options) (Chapter 7 Section 7.2.1, 'Linda', 'Helen'). A formal assessment tool of patient knowledge may ensure the comprehensiveness and accuracy of patient knowledge acquired for choice. Indeed, the interview data highlighted multiple instances where patients were misinformed and this would in turn lead to a choice of diversion based on biased and if not, erroneous ideas (for example Chapter 6 Sections 6.5.2, 'Martin', 'Ken', 'Steve', 'Wife of Fred, 'Pete'), Another way reported by the clinicians interviewed to enhance patient knowledge in the context of urinary diversion after radical cystectomy was to provide them with realistic benefits and risks associated with each of the two diversion procedures concerned, with the aid of demonstrative appliances, former patients' experiences and by making clear to patients about local outcomes associated with each of the two diversion procedures (Chapter 6 Section 6.2.2 'Mike', 'Steve', 'Ed', 'Arlene'; Chapter 7 Section 7.2.1 'Kumar', 'Freda', 'Nancy', 'Donna').

8.3 Use of supplemental information materials may help enhancing patient knowledge and therefore promoting SDM in practice

Supplemental information materials differ in their authorship, readership, format and quality. In terms of authorship, this ranges from professional bodies to laymen.

However, the main emphasis should be on quality rather than authorship, and authorship does not necessarily confer quality. No assessment into the commonly used information materials was made, as this was outside the remit of the research concerning this thesis. According to the patients and clinicians interviewed, such materials could not replace a face-to-face patient-clinician and/or patient-former patient encounters, where information regarding diversion options was provided and/or exchanged (Chapter 6 Section 6.4, 'Tony' and 'Brian'; Chapter 7 Section 7.4 'Ena'). Nonetheless, when selected and used appropriately these supplemental information materials could be invaluable for making a quality decision on which diversion to proceed with, in accordance to SDM ideals (Chapter 7 Section 7.4 'Bob's wife' and 'Tony'). The quality of these materials may be judged on many domains (layout, readability, language used etc.); there are already numerous evaluative scales available, such as EQIP and DISCERN (Moult et al 2004; Charnock et al 1999). In the context of SDM, many supplemental information materials are of poor quality (Goldophin 2001; Coulter 1999), with the common pitfalls of lacking in relevant or including biased information on treatment options and patronising language (Chapter 6, 6.4 'Sharon' and 'Pete').

The layout of the information material can also lead to biased information provision, particularly when there is more than one healthcare option, as illustrated by the interviews; for instance, the 'well presented, nicely packaged' commercialised information/training pack for urostomy (Chapter 7 Section 7.4 'Freda', 'Oscar')and separated information booklets for each corresponding diversion, hence no side-by-side comparison of the information about the two diversion options available (Chapter 6 Section 6.4 'Pete').

Overall the current literature is supportive for the use of supplemental information materials (Shepherd et al 2008) in healthcare decision making, but it also advises that their use should be coupled with due considerations on individual patient characteristics, such as education and literacy level, ethnic and cultural background and the nature of the decision (e.g. urgent versus non-urgent; surgery versus medical therapy). Another consideration regarding the use of these materials is the timing of their provision to patients. This consideration is also applicable to the use of patient decision support such as PDAs. Some clinicians interviewed reported concerns over exacerbating patient's anxiety when providing the relevant materials too early i.e. before the consultation when the issue of urinary diversion would be mentioned

(Chapter 7, Section 7.4 ‘Jane’). Indeed, there are ambiguities over the optimal timing of administration of supplemental information materials/PDAs in the literature, which indicates a need for further research into this area.

Supplemental information materials also vary in formats, and there bound to be varying personal preferences over format. In general, as demonstrated by the survey, the written format was reported as very helpful or helpful by the greatest number of clinician and patient respondents (Chapter 5 Section 5.2.4). The variation in personal preference over format could be secondary to availability, access and user-friendliness. Availability issue was raised with the materials in both the DVDs/Video and Audio formats, by both the patients and clinicians surveyed (Chapter 5 Sections 5.1.4 and 5.2.4). It was also interesting to note that significantly more nurse respondents found DVDs/Videos and Audios very helpful or helpful. This could be due to their relative familiarity with the access and use of materials in these formats. In the interviews some clinicians expressed the view that patients of older age and lower socio-economic class might not find more technologically based information materials requiring helpful (Chapter 7 Section 7.4, ‘Niran’, ‘Freda’); this could be due to stereotyping on some clinicians’ part, but there was also evidence in the interview supporting the clinicians’ views (Chapter 6 Section 6.4 ‘Bill’ – no access to Internet due to his socio-economic circumstances).

The written format was seemingly the most favoured format, perhaps due to the ease to navigate (Chapter 6, Section 6.3 ‘Bob’s wife’) and relatively lower cost for production. In the ideal world, a given supplemental information material should be available in all formats; but in a healthcare system where financial resources in particular are rationed, and the best format would probably be the most cost-effective format. The data also demonstrated that both patients and clinicians were generally less enthusiastic about the use of internet information, and this could be due to their concerns over information quality and credibility (Chapter 6 6.4 ‘Jim’; Chapter 7 Section 7.4 ‘Nancy’, ‘Niran’). Internet information in general is of varying quality (Eyesenbach et al 2002); uncontrolled access to Internet information can negatively impact on clinician-patient relationship, with patients having erroneous pre-conceptions about their healthcare options, making the discussions around these options with their clinicians challenging; extra time and efforts might need to be afforded by the clinicians to clarify patients’ misconceptions prior to making the relevant healthcare decision (McMullan 2006; Murray 2003); as put across by one

clinician interviewee's perspective, the use of internet information by patients had translated in a 'logistical nightmare' (Chapter 7 Section 7.4 'Nancy'). A more robust system co-developed by patients and clinicians such as NHS Choices is required for the decision concerning urinary diversion after radical cystectomy, to evaluate the quality and utility of supplemental information materials which could be relevant to the decision; as a result recommendations can be made to patients facing the choice of diversion, to make the best use of the best available materials.

When asked about the preferred future format for a purposely-constructed decision support for the choice of diversion after radical cystectomy, most of the respondents (both patients and clinicias) in the survey once again chose the written format (Chapter 5 Sections 5.1.7 and 5.2.11). No one chose Audios perhaps due to the concern over the lack of visual prompts. Nonetheless, a combination of different formats should be considered, as indicated by the respondents (Chapter 5 Sections 5.1.7 and 5.2.11)

Another point to be made is that a distinction needs to be drawn between supplemental information leaflets and formal decision support e.g. PDAs; the former is for informed decision making, whilst the latter for SDM; and the difference between informed decision making and SDM is that the latter incorporate knowledge and clarified personal preferences in reaching a healthcare decision (Elwyn et al 2010). Indeed, conflation about informed decision making and SDM is still commonplace, as demonstrated by the patients and clinicians involved in this research and in other healthcare contexts (Marteau 2009). This issue needs to be urgently addressed which would otherwise hasten the progress of SDM implementation in the decision concerning this thesis and in general.

8.4 Surgeon's opinion trumps patient's choice of urinary diversion

The title of the seminal paper by Cathy Charles (Charles et al 1997), 'Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango)', in itself implied that at least two parties should be involved with each other in a collaborative fashion, in order to reach a healthcare decision . However, it

appeared that in the decision regarding the choice of urinary diversion after radical cystectomy within UK, the tango was dominated by the surgeons who would perform the operation. In the UK's context, there should be three fundamental parties involved in the decision, including the operating surgeons, the counselling specialist nurses and the patients. However, it is usual practice for the operating surgeon to make the initial decision whether the patient is suitable for either diversion options holds the initial discussion with the patient about the choice of diversion.

With reference to Chapter 1 (Introduction) and the earlier discussions on variation in neobladder use (Chapter 9 Section 9.1), there remain many uncertainties over which of the diversion options is superior, confounded by some ambiguities over the contra-indications to formation of neobladder. Within the confines of the current evidence, it can be challenging for the operating surgeons to decide which patient would be eligible for choice i.e. having a choice between conduit and neobladder and variation in surgeons' opinion over choice eligibility is to be expected. The interview data suggested that surgeons' concerns over anticipated clinical outcomes associated with neobladder drove the surgeons' decision on whether a patient would be suitable for a choice, and the factors considered by the surgeons in their determination of a patient's eligibility for choice could categorised into that related to 1) patient characteristics and 2) surgeon and organisational characteristics. Patient characteristics include age, medical fitness, as well as the perceived patient's motivation and physical capacity to care for neobladder, whereas surgeon and organisational characteristics include surgeons' and the organisations' set up (Chapter 6 Section 6.2.1.3 'Steve'; Chapter 7 Sections 7.1.1 and 7.1.2).

As in the literature (Hautmann et al 2013, Lee et al 2014) old age per se was not an absolute contraindication but there are potential associations between advancing age and negative outcomes of neobladder. For instance, the elderly are generally less medically fit, with deteriorated level of eye-hand co-ordination and possible existing cognitive impairment, which hampers the progress of achieving a functional neobladder with a set of complicated initial care routine (Chapter 1, Section 1.1.4). Overall the outcomes in the more elderly patients selected for neobladder, particularly those concerning the functions of the neobladder, remain highly debatable. In the literature there is evidence that good outcomes can be achieved in octogenerians (Sogni et al 2008; Saika et al 2008; Hautmann et al 2011; Taneka et al 2009; Kassoul et al 2010), but these studies were conducted in pioneering high

volume centres for neobladder, with high volume surgeons and vigorous, regimented peri-operative care arrangements and experienced clinical staff supporting neobladder use; neobladder patients from these centres also tend to be of higher risk of developing negative outcomes in the current clinical attitude (elderly/female/more co-morbidities). Therefore, the generally reserved attitude among clinicians (particularly the operating surgeons) towards offering more elderly patients neobladder in addition to conduit is perhaps understandable (Chapter 7 Section 7.1 'William', 'Niran', 'James'). Accrued good surgical outcomes and experience with the surgeon and his/her organisation can boost the surgeon's confidence in the neobladder operation, leading to changing thresholds in patient selection for neobladder e.g. operating in older patients (Chapter 7 Section 7.1 'William', 'Niran'). However, the interview data suggested that some of the more experienced surgeons oversaw patient's chronological age and look for other indicators for the suitability of neobladder (Chapter 7 Section 7.1 'William'), but it remains unclear how many of the surgeons would adopt this attitude. Indeed in the literature, some authors raised the importance to focus on medical fitness rather than chronological age of a patient, when considering his/her suitability for having a choice between neobladder and conduit (Lee et al 2014).

Another point for discussion regarding age was that some of the clinicians interviewed reported ambivalence towards advancing age when considered offering of neobladder. As mentioned above, good outcomes with neobladder were achievable with patients who are more elderly at the time of the operation, but these outcomes were reported in pioneering centres with the expertise on neobladder. Perhaps a more interesting question to ask would be: what would happen to now the younger, fitter neobladder patients when they have become older and frailer, physically and/or mentally incapable to manage their neobladder and complications? This is a largely unanswered question due to lack of longer-term follow-up data on neobladder as mentioned above. Some clinicians may hold a rather sceptical outlook on long term outcomes on neobladder – as one of the surgeons interviewed expressed, 'we could storing up a whole load of problems' (Chapter 7 Section 7.1 'Karl).

With regards to outcomes of neobladder, there bound to be variations among different surgeons and centres as discussed above. During the discussions regarding diversion options, the surgeon's disclosure of personal versus literature

based outcomes is contributory to both informed decision making and SDM. This disclosure concerns the quality of patient knowledge which would inevitably impact on the quality of the decision over diversion, in SDM terms. The interview data suggested that some surgeons interviewed were honest about their own outcomes to their patients (Chapter 7 Section 7.2 'Kumar', 'James') and were willing to refer patients to their colleagues in another centre with more expertise in neoladder. However, there were no data suggesting how the discussions regarding local outcomes and referral were materialised. Moreover, some of the surgeons interviewed reported that their patients did not take to the referral for the neobladder procedure in another centre, even when offered (Chapter 7 Section 7.2.2, 'James'); this was only in partial agreement with the current evidence (Robertson and Dixon 2009; Dixon et al 2010), which showed nearly half of the patients who were provided with the choice between local and non-local providers for specialist input, would accept the latter. Also of note was that the more elderly or and educated patients were shown to be more willing and ready to take on non-local providers, whereas those who were without access to a car were less likely to do so. The underlying reasons for uptake of out-of-area referral for a healthcare service (including choice of diversion) may be dependent on the nature of the referral, the relative specialism and quality related to the service offered, age and socio-economic circumstances of individual patients. Such circumstances may become barriers to accessing higher quality healthcare in another location, and are potentially modifiable at an organisational level e.g. subsidising patient and family transport. There is also the question of whether patient's value in staying with the same clinician (surgeon) and attitudes towards access to own family/social network would impact on the uptake of out-of-area referral. There has been some evidence some patients prefer to stay with the clinicians with whom they have an established trustful relationship, regardless of the clinicians' ability to offer the best quality of healthcare by clinical outcome measures (Conner-Spady et al 2008). A clinician's (surgeon's) willingness to refer may also depend on the adoption of 'practice-makes-perfect' versus selective referral systems (Luft et al 1987). A surgeon who wishes to build up his/her neobladder practice may be less inclined to refer patients to centres with higher practice; however, this must be balanced against important, ethical considerations such as the acceptability of complication figures, given that literature has already considered a proportional relationship between neobladder outcomes and case-volume of a surgeon and/or a centre. This poses a 'Catch-22' situation, where

patients choosing to undergo the neobladder procedure may be better served in the hands of high volume surgeons/centres, but inexperienced surgeons/centres need to increase case volume in order to improve outcomes. Whether the patient's locality has the appropriate level of clinical support would also influence a surgeon's decision in offering neobladder (Chapter 7 Section 7.1 'Peter').

Whilst there is evidence to guide the surgeons on patient selection for neobladder based on measurable patient characteristics such as age, medical fitness, there are no objective measures on motivation to care for neobladder. In the literature 'lack of motivation to care for neobladder' is considered as an absolute contra-indication for neobladder (Lee et al 2014) but assessment of this by the clinicians, as the interview data indicate, is somewhat subjective and at times based on the patient's outer appearances and lifestyle (e.g. alcoholism) (Chapter 7 Section 7.1, 'Anil', 'Emma', 'James'). A patient who is deemed under-motivated by the clinicians may not have been offered the choice and actively persuaded to elect for conduit instead. An interesting view by a surgeon interviewed about motivation was that, motivation is required to care for either diversion, if a patient is not engaged then he/she unlikely to look after any of the diversion well (Chapter 7 Section 7.1 'Oscar'). However, the consequences of not looking after neobladder well would be potentially life-threatening (neobladder rupture) particularly when the patient is hypercontinent, and patient safety is perhaps the main concern of many clinicians in their judgement if a patient is suitable for neobladder, as well as conduit (Chapter 7 Section 7.1 'Jane' and 'Ena').

8.5 Inter-professional relationship influences the choice of diversion

Further data from this research indicated that although the surgeon and nurse respondents generally acknowledged each other's positive impact on the decision making process, (Chapter 5 Section 5.1.3), their inter-professional dynamics had not always been harmonious (Chapter 7 7.2.1 'Peter', 'Freda', 'Emma'). Given that the level of inter-professional collaboration is proportional to patient outcomes (Larson 1999; Baggs et al 1999; Frank 2009), it is imperative to identify factors and strategies for sustaining a constructive relationship between the surgeons and the nurses, in and outside the realm of SDM. Sometimes disagreement and negotiation between the two professional parties are necessary for patients' best interest, and from the perspective of some of the nurses interviewed, their surgeon colleagues tended to

have a prior preference over which diversion they wished their patients to proceed with; subsequently the surgeons framed their information provision around the diversion options to patients, mooted their idea of the preferred diversion in patients' mind (Chapter 6 Section 6.2.1 'Terry', 'Steve', 'Ed'; Chapter 7 Section 7.1 'William' and Section 7.2.1 'Emma'). Some patients would then conform to the surgeon's wish against the backdrop of power imbalance in the doctor-patient relationship. Some of the nurses interviewed reported addressing this power imbalance to a certain extent, by their advocating patient's views and preferences in the decision regarding diversion to their surgeon colleagues (Chapter 7 Section 7.2.1 'Nancy'). With reference to the SDM literature, trust of patients in their doctors, patients undervaluing their own knowledge as well as their wish to be viewed as 'good patients' (by conforming to doctors and not asking questions or providing their own opinions) were the main patient reported barriers to SDM (Joseph-Williams et al 2013). The experience of surgeons may also play a role in SDM in the context of this decision regarding diversion. Some of the nurses interviewed reported of their struggles with having their opinions acknowledged regarding their patients' preferences and professional views on patients' suitability for diversion, particularly with the older and/or more experienced surgeons (Chapter 7 Section 7.2.1, 'Freda). This can be linked to the literature finding that the younger and/or less experienced surgeons were apprehensive of their older, more experienced trainers in participating in SDM, from their training experience with them (Zenuer et al 2014)**.**

8.6 Others outside the responsible clinical team are also influential in the decision making process

Many patients who were involved in this research reported the input from both the responsible clinical team and those outside the team as helpful in decision making process. Interestingly, among those patient respondents who selected their responsible clinicians as helpful, approximately half of them selected both their surgeons and nurses with another 41% only selecting their surgeons (Chapter 5 Section 5.1.3). This in part highlighted once again the power imbalance in the patient-doctor relationship.

With regards to the others outside the responsible clinical team, both the clinicians and patients involved in this research reported spouse, former patients and family members/relatives/friends as helpful in the decision making process (Chapter 5 Sections 5.1.3 and 5.2.3; Chapter 6 Sectios 6.3.1 and 6.3.2). The interview data suggested that spouse and family members helped to enhance patient knowledge relevant for the decision on diversion through knowledge clarification, helping patients to retain information and obtaining additional relevant information with use of technology and social network (Chapter 6 Section 6.3.1 'Ian', 'Terry', 'Carol'). Therefore, spousal and family input should not be underestimated; for certain health conditions such as that for dementia and end of life care, it was clear from the relevant research that involvement of spouse, family and carers were imperative for good decision making in patient care (Simnoff 2013).

With particular regards to spousal influence – it is not a new subject in medical decision making (Miller et al 2014). From the interview data, some of the spousal interactions constituted negotiated decision making (Chapter 6 section 6.3.1 'Steve', 'Mike's wife; Chapter 7 Section 7.3 'Sue' 'Norman'), but in other cases the spouse kept quiet in order to minimise his/her influences on the patient's decision (Chapter 6 Section 6.3.1 'Mike's wife). Spousal involvement is frequently studied in the research on the impact of bowel stoma. It is well known that the decision to undergo stoma forming surgery places significant physical and emotional demands on the spouse; furthermore, spousal support, both physical and psychosocial, is central to stoma patients' recovery (Mansson et al 1991; Altschuler et al 2009; Persson 2004) and certainly impacts on spousal intimacy (Burnham et al 1977; Manderson 2005; Danielson et al 2013). The effects of stoma formation on spousal relationship are profound, and some research evidence demonstrated that this relationship would be modified to a certain extent, with gender role re-negotiations between the spouses, in an attempt to preserve the known 'normality' before surgery (Manderson 2005).

Another group of influential individuals outside the responsible clinical team are the former patients. As suggested by the interview data, they can provide lived experiences but whether such are facilitative for decision making in the context of SDM remains debatable experiences (Chapter 6 Section 6.3.2 'Martin', 'Ed', 'Jim' and 'Mike'). Some of the clinicians interviewed raised the question of which former patients should be put in touch with the pre-operative patients, with concerns over some of the former patients providing unrealistic pictures and biased opinions about

the diversion they were living with (Chapter 7 7.3 ‘Norman’). Those clinicians interviewed and in support of pre-operative encounters with former patients reported that pre-operative patients should be exposed to both conduit and neobladder patients, with or without complications in order to get a more balanced comparison of the two diversion options (Chapter 7 7.3 ‘Niran’). Nonetheless, there is currently no guidance on but what constitutes a balanced view and how to objectively obtain such a view. For instance, how many former patients and what kind of former patients should a pre-operative patients meet? Should the pre-operative and the former patients be matched demographically and/or socioeconomically? These are just a couple of the many questions to be answered in the matter of using former patients’ stories in the contexts of this research and SDM.

In current literature, the use of patient stories in formal decision support e.g. PDAs is contentious as no guidelines on how to select patient stories, and the use of patient stories in itself can be in tension with the central ideals of SDM, with regards to provision of unbiased patient information (Butow 2005). Furthermore, the use of patient stories runs the danger of patients fixating to the former patient’s experiences rather than the underlying message regarding risks and benefits (Chaiken 1980). The impact of patient stories may also depend on their persuasiveness, and ‘vividness’ increased pervasiveness. Emotional interest, proximity and concreteness of information all lend information its credibility and vividness thus pervasiveness, but it is difficult to assess these mediators for pervasiveness a variety of scales are available for use. Another criticism regarding the use of patient stories is that, often hypothetical scenarios with normal populations are used to construct these stories; such varied in length and most of these stories did not provide guidance on how to make a good decision in SDM terms (Winterbottom et al 2008).

8.7 Current decision making process regarding diversion options has incorporated some features of SDM

Some data of this research indicated that some features of SDM had already been incorporated into the current pre-operative consultation procession for urinary diversion after radical cystectomy. Firstly, holding more than one consultation with patients about the diversion; Secondly, nurses and surgeons were consulting with patients, with engagement of other individuals outside the responsible clinical team

(Chapter 7 Section 7.2.1 ‘Linda’, ‘ Abigail’, ‘Nancy’, ‘Donna’, Section 7.3); these two features of consultation process realise the theory of distributed healthcare decision making (Rapley 2008), where a decision is made over several consultations over time, with encounters with different parties and different technologies employed to reach the decision. Moreover, some of the clinicians interviewed reported explicitly asking the patients to explain their choice, in order to elicit and understand their preferences. (Chapter 7 Section 7.2.1, ‘Nancy’, ‘Linda’). However, it is unclear from the data how systematic and comprehensive the clinicians are in their attempts to elicit patients’ preferences. One of the surgeons interviewed also reported asking his patients to defer in confirming decision over which diversion to proceed with (Chapter 7 Section 7.2.1 ‘Norman’). Afterall, in the literature explicitly asking patients to defer decision for a more detailed consideration over option available to them is pertinent to SDM (Makoul and Clayman 2006, Stigglebout 2012).

Pre-operative patient education on the care routines for each diversion can facilitate SDM in the context of urinary diversion after radical cystectomy. The education is usually delivered by the nurses, which includes a simulated life with urostomy and idea about and/or experience of intermittent self-catheterisation (ISC); it helps managing patients’ expectations about living with either diversion and allows a more realistic comparison between the two diversion options (Chapter 6 Section 6.2.2; Chapter 7 Section). Moreover, as discussed previously, teaching patients about urostomy care and ISC also provide patients the chance to adjust to these care routines. In all, pre-operative patient education on diversion care routines can enhance patient’s readiness to participate in the decision making process, more in accordance to the standards of SDM (Measuring SDM NHS right Care 2012).

The advantages of teaching ISC are as outlined above, and there is a variation in how ‘hands-on’ the teaching is as delivered by the nurses. Some of the nurses interviewed reported certain circumstances where they felt justified for not asking patients to physically perform ISC competently before surgery, for instance significant lower urinary tract symptoms from the bladder cancer and the propensity to bleed from the cancer lesion (Chapter 7 Section 7.2.1 ‘Helen’). There were instances where ISC was not taught or even mentioned at all, and the reasons were perhaps less justifiable, which included the lack of time to fit in teaching session before surgery and the perceived low risk for the need of ISC from local experience (Chapter 7, Section 7.2.1 ‘Stephen’ and ‘Helen’). Patients undergoing neobladder

might have underestimated the risk of requiring ISC, as well as the physical and mental challenges of ISC, should it become a necessity (Chapter 6 Section 6.1.2 ‘Bill’).

8.8 Patients choose the diversion which is expected to best match with their known normality

As suggested by the interview data, patients consider a number of factors in choosing a diversion and their deliberation can in part shaped by the information provided by their responsible clinicians (Chapter 6 Sections 6.2.1, 6.4, 6.5; Chapter 7 Section 7.2). They demonstrated a tendency to choose the diversion which would cause the least anticipated disruption to their known normality. This normality includes body image, being free or significantly debilitated from complications from surgery, survival through surgery, work life and hobby, and intimacy.

With specific regards to external body appearance, the interview data suggested that an individual patient’s self-perceived level of acceptancewith the presence of a stoma was very much implicated in the choice between conduit and neobladder (Chapter 6 Section 6.5.1 ‘Ian’, ‘Bill’, ‘Sharon’; Section 6.5.3 ‘Ken’, ‘Ed’). The issue of stigma related to stoma has long been known in the literature (Sontag et al 1977, MacDonald et al 1988, Briggs et al 1977); and among those who live with a stoma, they often experience a major shift in body image (Slater 1992, Jenks et al 1997, Persson and Helstrom 2002, Nordstrom and Nyman 1991), negative impact on sexual life they are often in tension with managing their public and private self (Kelly 1992; Helman 1995). Those who perceive themselves as being able to successfully conceal the stoma when presenting their public self would perhaps be more open to the idea of conduit, with balancing of personal values on other outcomes related to each of the diversion option (Chapter 6 6.5.1 ‘Ian’, ‘Bill’, ‘Sharon). Coping strategies employed are often surrounding concealment, for instance, with clothing (Chapter 6 6.5.1 ‘Sharon’) (Helman 2005) but even with successful concealment, a sense of having a secret, ‘looking normal but not being so’ and the worry about being ridiculed often remain (Kelly 1991 and 1992). Indeed, with time many people living with a stoma reported psycho-social adjustments to life with a stoma over time, and the level of self-care and amount of social support are the main predictors of the cope level of person living with a stoma (Knowles et al 2014; Brown and Rendall 2005).

Another main consideration is urinary incontinence. However, as suggested by the interview data, what underlies the impact of urinary incontinence on choice of diversion is again, stigma and its management. It is well known in the literature that urinary incontinence can significantly impact on patients' quality of life, partly due to perceived stigma (Paterson 2000; Bradway 2003; Heintz et al 2013; Avery et al 2013). It is interesting to note that some of the interviewed patients suggested varying confidence with managing incontinence/staying dry with each respective diversion option (Chapter 6 Section 6.5.3 'Sharon', 'Bill').

Apart from pelvic floor exercise, intermittent self-catheterisation (ISC) is another means to control urinary incontinence for neobladder. As discussed before, ISC is an invasive procedure and some patients may be so overwhelmed by the idea of ISC and therefore did not even deliberate further on neobladder (Chapter 6 Section 6.5.3 'George', 'Dave'). Apart from the apparent physical discomfort caused by the act of ISC, the sense of fear and embarrassment of performing ISC (Chapter 6 Section 6.5.3 'Ken', 'Ed') are often associated with ISC (Achterberg et al 2008; Logan et al 2008). However, there is also evidence in the literature that thorough education and support from the healthcare professionals would help patients cope with ISC better (Ramm et al 2011; Shaw et al 2013). However, as implicated by the interview data, there were other patient considerations about the potential need for ISC and these were more practical-based, such as that the impact of ISC on work and hobby, and sleep quality (Chapter 6 Section 6.5.3 'Bob', 'Jim', 'Dave').

Living with a stoma and having long-term urinary incontinence are akin to having 'visible chronic conditions', and such would invoke two initial responses: automatic disclosure or covering. With the former, some individuals may become genuinely unconcerned about being discredited by having a stoma or leakage, whilst the others silently suffering from stress then either isolate themselves or concealed themselves (Joachim and Acorn 2000). Perhaps patients' anticipated psycho-social acceptance with stoma and urinary leakage are what lies beneath the choice of diversion.

Other issues considered by patients, as highlighted by the interview data, included the surgeon's/hospital's experience with a given diversion method, length of operation and their perceived risks and their significance of the respective diversion method (Chapter 6, Section 6.2.1.2). As discussed previously, how patients consider their options is largely dependent on their interactions with the responsible clinical team and those outside the team; and from such interactions knowledge specific to

the diversions was gained but unfortunately, not all patients would necessarily be well informed to make the decision on diversion.

8.9 Support for patients to participate in shared decision making for the choice of diversion can be improved

In this research, many patients reported feeling very supported in the decision making process and only one patient reported not being involved to the point desired (Chapter 5 Section 5.1.5 and 5.1.8); however, it remains undetermined what the level of discrepancy was between patient preferred and perceived level of involvement, which in retrospect was a design deficit with the patient needs assessment survey (see further discussion in limitations in the next chapter). In the literature, there is a wide variation in patients' desired level of participation in decision making and the dependent factors are age, sex and the nature of the clinical problem (Robinson and Thomson 2001; Levinson et al 2004; Tariman et al 2009). Therefore, it is difficult to generalise patients' preferred level of participation in healthcare decision making. All clinician respondents who answered the question regarding preferred level of patient involvement in the survey reported preferring some input from the patients; this finding contrasted with the reported views of some of the clinicians interviewed, who stated that the ultimate decision rests with them based on good clinical practice (Chapter 7 Section 7.5.1 'Jane', 'Stephen'); however, sometimes clinicians' perceived best interests for patients do not match with what patients desired, as highlighted by the East Kilbride vs Montgomery case (The Supreme Court March 2015) where the diabetic mother was not made aware of the material risks of vaginal delivery versus that of Caesarian section in her case, and SDM is in fact a medico-legal requirements in both the UK and in other parts of the world.

In parts of the survey and in the interview process, the Control Preference Scale (CPS) was used to elicit clinician and patient control over the ownership of the choice of urinary diversion after radical cystectomy. When reflecting on the survey design, it could have been more useful to ask both patients and clinicians respectively preferred and perceived control, to allow for more detailed population-based comparison between these two types of control, within each group and between groups. In the interview process, as mentioned in Chapters 6 and 7, CPS was mainly used to elicit patients' and clinicians' views on patient engagement and SDM

relating to choice of diversion and in general. After its design and validation, CPS has been frequently used as a proxy measure of patients/clinicians reported control over a healthcare decision in certain research settings. However, it has been adapted for but not necessarily validated for use in research settings or in real clinical contexts. Moreover, many different methods for administration have been described and there is no consensus on the best method so far (Degner et al 1997, Singh et al 2010, Politi et al 2013). There is also some recent evidence showing that the level of engagement in a decision making process does not necessarily equate the level of control over the decision i.e. 'deliberation versus determination' (Elwyn et al 2010; Levinson et al 2005; Mazur et al 1997).

Lastly, when asked about their views about how to increase engagement in the decision making process, especially for those who seemingly did not wish to engage, both patients and clinicians volunteered some views which indicated conflation between informed decision making and SDM (Chapter 6 Section 6.6.2 'George', 'Tony', 'Ken'; 'Chapter 7 Section 7.5 'Emma', 'Peter'), and the main solution proposed being providing patient more and/or in-depth information regarding the diversion/healthcare options. Several years ago it was evident that even among the academics in the field of SDM there were confusions between the two concepts (Whitney et al 2003, Moumjid et al 2007); however more recently, the distinction between SDM and informed decision has become clearer. With SDM, information exchange is a two-way process, with an emphasis of patients realising, and vocalising their preferences to their clinicians after being informed; on the other hand, informed decision making patients are informed by the healthcare professionals, but there is no explicit patient preferences discussions and the flow of information tends to be one way, from the clinicians to the patients (Marteau 2009). When designing a future decision support for the choice of diversion or any other healthcare decision making contexts, it is important to clarify with the potential users for the decision support about their understanding of SDM and provide further training on application of SDM as appropriate.

The next chapter concerns the limitations of individual components of this research, as well as conclusions and implications for clinical practice and future research.

Chapter 9 Limitations and Conclusions

9.1 Limitations

9.1.1 SWPHO-BAUS Radical Cystectomy Dataset Analysis

The main limitations of this analysis have already been discussed in details in the corresponding results chapter (Chapter 4). Without being too repetitive, these were primarily concerned with data quality and included:

- Poor case-capture of radical cystectomy and therefore the power and precision of the analysis were compromised
- Further loss of cases for analysis due to non-specification of diversion used, thus further impairing the overall power and precision of the analysis
- Smaller sample size than that used in a later, similar analysis drawing from the same dataset (Hounsome et al 2013) and therefore less powerful statistically and generalizable in comparison

As discussed before, the author considered it a shared responsibility to improve the quality of data of this analysis between clinicians and the designated public bodies (i.e. SWPHO and HES). The surgeons volunteered their data for the SWPHO dataset and a more robust local data support and audit system to ensure complete, accurate data entry. On the other hand, there is an urgent need to assign codes to distinguish one diversion procedure from another, not only for research but also the overall need for clinical governance.

9.1.2 Needs Assessment Survey

Given the time and administrative resource constraints on this research, the patient sample for this survey was a convenient sample drawn from the OTIS study, which included two of the centres from which the patient interviewees were recruited . As a result, inevitably a small number of the patient respondents in the survey were probably also the patient interviewees. As for the clinician survey, access to the eligible clinician respondents was dependent on the voluntary and at times, paid help from the administrators for the relevant professional bodies (BAUS, BAUN and WCET UK). The administrators were not able to identify the clinicians who were involved with radical cystectomy and diversion due to a combination of lack of time and information for the identification; on the other hand, the time and financial costs for accurate identification of eligible clinicians were simply prohibitively high. As a result, the author was reliant on the clinicians to self-identify themselves as eligible for the survey and

volunteered to respond. Moreover, like all self-reporting surveys there exists the inherent non-response, recall and non-truth reporting biases and the latter two are difficult to control.

Another limitation of the survey was concerned its question design. There were issues which were not highlighted by the pilot of the survey. In the patient survey, some of the items for questions related satisfaction with knowledge provision by clinicians could be more detailed (e.g. explaining what constituted 'daily care' and 'sexual matters'). Moreover, it should be noted satisfaction was a very superficial surrogate marker for information quality and this was reflected by the interview data. With regards to the clinician survey, frequency of discussion was a very rough and partial measure of quality of the information provided by the clinicians. The question regarding additional information material was a 'double-question' in that, it was asking about the availability as well as perceived usefulness. This was perhaps confusing for some respondents, leading to a high non-response rate when compared to that for the other questions in the survey. It was probably more useful to ask two separate questions, with the first one asking about availability and the second one asking about the level of usefulness. Regarding the questions on patient perceived support and feeling when encountering choice, perhaps it would have been more efficient by combining the two questions with the use of the Decisional Conflict Scale (O' Connor et al 1995). Finally, the question on perceived engagement in the decision was somewhat leading. As debated in the discussion chapter, a perhaps more useful way to ask patients about their level of engagement in the decision making process was to ask about preferred and perceived level of engagement in the process; the corresponding questions regarding patient engagement could then be put to the clinicians (in the clinician survey only preferred level of patient engagement was asked); in this way the responses from patients and from clinicians could be compared, and discrepancy in preferred and perceived engagement between the these two groups could be determined.

9.1.3 Qualitative interviews

The data collected during the interviews were accounts of the respondents' experiences with, and views about, the decision making process concerning the choice of urinary diversion after radical cystectomy. These accounts were representation of truth but not necessarily the actual truth. Recall issues and the author's identity outside research (as a clinician) were also implicated in the accounts provided by the respondents.

The author explored with the respondents the information provided during the pre-operative consultation(s) on the choice of urinary diversion; however, the data collected on knowledge provision were primarily descriptions of the information provided to the patients rather than the information exchange between the patients and clinicians. To capture more detailed, realistic record of the information provided and exchanged during the consultation, as well as

the manner in which the consultation was conducted, ethnographic study methods (e.g. real time documentation of direct observation by writing or audiovisual recording) could be employed. However, ethnographic study would not have been able to gain the breadth of information collected by the semi-structured interviews conducted. Since the research concerning this thesis was exploratory in nature, and given the potential wide variation in the experience and views of the respondents, the interview method was selected.

The author was also a novice qualitative researcher. During the interviewing process, although there were opportunities to explore issues pertinent to the decision making process, some of these were not necessarily followed through by the author due to her lack of experience in qualitative interviewing and awareness. These missed opportunities were particularly apparent during some of her earlier interviews. However, through working with the experienced research associate colleague, the author had much benefited from reflecting on the data during data discussion sessions, and subsequently was able to refine the questions asked and more responsive to the cues provided by the respondents, in order to explore issues related to the decision making process further in the later interviews. The author and the research associate were different in professional background, but the difference provided much stimulus for insightful discussions on the data and therefore, was a great advantage rather than a limitation to this research.

9.1.4 Timing of research components

Timing of research components (or the non-synchrony of such) was not a limitation per se, but its implications should be given further considerations. The literature review and the SWPHO-BAUS dataset analysis were conducted independently; the analysis was intended to take place at more or less at the same time as the review and early on in the overall research process, but due to the time required to obtain approval from both SWPHO and BAUS, the analysis took place later than expected. Nonetheless, this delay would not have impacted much on explaining the decision making process concerned, since these two components were intended to individually add insights into the decision making process.

On the other hand, the patient needs assessment questionnaire meant the responses from that could not be fully utilised to inform the development of the qualitative semi-structured interview schedules, nor to refine the questions to be asked at later interviews. This was because the ethics and organisational approvals were only obtained after the interview process had been well underway; the questions asked during the patient interviews could have been more precise, insightful and relevant to the decision making process and the

potential improvement which could be made, against the ideals of SDM. However, the situation had to be accepted as it would be inappropriate to ask recruited patients to wait for an excessively long period of time before their interviews were scheduled.

9.2 Conclusions

This research, with the use of mixed methodology and methods, achieved its aim to better understand the decision making process concerning urinary diversion after radical cystectomy in the UK in SDM terms. Several decisional needs were highlighted and these were concerned with knowledge and expectations, values, as well as support and resources; furthermore, the potential challenges in and solutions for satisfying such needs were suggested. With regards to the specific objectives of this research:

9.2.1 To describe the variation of neobladder use in the UK

As demonstrated by the findings of the SWPHO-BAUS Dataset Analysis (Chapter 4), even after holding constant all the differences in the demographic and clinical characteristics between the patients, and allowing for the random variation in neobladder use that existed between surgeons, centres and cancer networks, the magnitude of the residual variation in the use was still unexpectedly high at each of these three organisational levels. This evoked the question if the variation was largely unwarranted and could not be explained by the differences in aggregate patient health state and accurately determined patient preference for each of the two diversion methods studies (conduit and neobladder). The findings from the dataset analysis provided the ground for the further research query presented in this thesis, into how the said decision making process 'measured up' against the SDM ideals.

9.2.2 To gain insights into the decisional needs for choosing urinary diversion after radical cystectomy in the UK

The Ottawa Decision Support Framework (ODSF) introduced several decisional needs to be addressed, in order to make a quality healthcare decision. In this research, knowledge and support for decision making were the key ones to be improved on. Transfer of knowledge relevant to the decision concerning urinary diversion after radial cystectomy remained largely unidirectional, from the clinicians to the patients. In particular, the responsible surgeons appeared to be the gatekeepers of the clinical information relevant to the decision; furthermore, the power imbalance in the surgeon-patient relationship was strongly implicated in not only the amount and type of clinical information provided, but also the manner in which

the information was transmitted to the patients. There were clear instances where the patients were misinformed and in general, the clinicians did not have formalised systems in place to check patients' knowledge for the decision, nor that to elicit patients' values and preferences for the choice of diversion.

The surgeons and nurses worked together in counselling patients before their cystectomy and diversion, but the ways in which they collaborate can be more co-ordinated. For instances, some surgeons and nurses had never observed each other's consultations and this would risk overwhelming patients with the information, providing patients with contradictory information, or not providing patients with certain information, as both the surgeons and nurses would assume this information had been covered by each other. There were also signs of tension in the dynamics between the surgeons and nurses which might affect constructive discussions about patients' choice of diversion. Moreover, at times nurses' feedback on patients' views appeared to be undervalued by the surgeons, and this would hamper quality decision making.

Other individuals such as spouse and families could also be facilitative in the decision making process, mainly through additional information gathering and clarification. The discussions between patients, their spouses and families could also stimulate patient to further deliberate about their preferences for choice of diversion. With regards to former patients, they could certainly provide valuable lived experiences with each of the two diversion options, but like elsewhere in the literature the value of patient stories in SDM terms is still a largely debatable subject. Moreover, there was a shortage of former neobladder patients to provide post-operative experiences.

The quality of additional information materials for diversion remains unknown as no formal assessment has been made to date. However, from the research findings, these would not replace face-to-face discussions on choice of diversion and individuals generally prefer those in printed formats; both clinicians and patients were guarded about the use of web-based information materials primarily due to their dubious quality and access. There was also an inclination from the clinicians to produce and use local information materials based on local performance data.

In general, both the patients and clinicians were supportive of the idea of having SDM and a future decision support; however, on further exploration regarding their understanding of SDM and how to enhance the current decision making process, there was conflation between 'informed decision making' and 'shared decision making', where both the patients and

clinicians stated increasing the amount and depth of information would translate into better quality decision making.

9.2.3 To understand the aspects taken into account by patients when they were choosing a method of urinary diversion after radical cystectomy

The patients interviewed in this research reported multiple aspects which they would take into account when choosing between conduit and neobladder. These aspects were largely shaped by the information they acquired mainly from surgeons, but also from the nurses, spouses and families, former patients and additional information materials. The aspects which the patients deliberated over constitute their normality, and the research findings suggested that the patients would choose whichever one diversion method would cause the least anticipated disruption to their known normality.

Body image, the length, complexity and caseload of the diversion procedure, as well as management of urinary incontinence were all given due considerations by the patients interviewed. Stigma was strongly implicated in the patients' deliberation over the shift of body image and management of urinary incontinence. With regards to conduit, the patients debated over their own anticipated success of concealment of the urostomy bag and urinary leakage, and the impact of the presence of the urostomy on their relationship with the outside world. Urinary leakage itself is held with many negative connotations by the society, and the patients' enthusiasm to remain 'noticeably' dry was evident in this research. Linked closely to urinary incontinence management was toileting routines, and in turns these routines were associated with both stigma and daily life pragmatics. Stigma associated with toileting routines was particularly prominent among the male patients; to some of them emptying their urostomy bag in the public toilets was more acceptable then performing intermittent self-catheterisation (ISC). The invasive nature of ISC was also sufficiently off-putting for some patients to give up on the idea of neobladder, but as the interview data further suggested, pre-operative education of ISC could help patient to adjust and be more prepared about ISC. Potential interference with hobby and work associated with each of the two diversion options' care routines was also considered by the patients interviewed. Intimacy issue was expected to be an important factor but the discussions around this were very limited. This was probably because the issue was not explored meaningfully with the patients, rather than the patients not considering intimacy as an issue in the choice of diversion.

9.3 Implications for clinical practice and research

9.3.1 Research evidence on outcomes of neobladder

Clearly the clinical evidence on neobladder as the better alternative diversion option to conduit requires to be strengthened, as to better guide the clinicians to discuss with their pre-cystectomy patients who among them would be suitable to have a choice between the two diversion options. More quality evidence is required on both clinical and health-related quality of life outcomes. Whilst accepting that conducting randomised controlled trial comparing conduit and neobladder would be impossible, due to ethical implications, then perhaps the academic and clinician communities can focus on generating the next best level evidence, via multi-centred, prospective studies on neobladder.

9.3.2 Enhancing patient knowledge relevant for the choice of diversion

As already discussed, some of the interviewed patients appeared to be misinformed and made their choice of diversion based on misinformation. On the other hand, what constitutes a relevant information base for making the choice of diversion has not been formally studied. It would be beneficial to patient knowledge enhancement if the patients, their spouses and families, and their responsible clinical team (the surgeons and nurses) hold a multidisciplinary focus group to discuss what information and its depth would be the minimum required for making the choice. The findings from such discussions could inform the development of a formal decision support specific to the choice of diversion after radical cystectomy, specific to the healthcare context of UK/other countries. Furthermore, these findings can also aid the development of a decisional quality measurement tool specific to this decision on urinary diversion, used for evaluation of the impact on decisional quality with the use of the future decision support (e.g. Patient Decision Aid - PDA). A validated decision support can provide not only relevant, quality information for the choice of diversion, but can also elicit patient preferences and values consciously for the choice. Of course, there are various shapes and forms of decision support, from decision coaching to PDAs.

The existing additional information materials used are numerous and of varying quality. Research efforts should be afforded into assessing the quality of these materials and improve if necessary. Tailoring of information materials for local population use is also important, with the incorporation of information on local outcomes of the respective diversion option. How to tailor information materials for local patient populations should again be a joint research venture between the local clinicians and patients. Just as with the additional information materials, when to administer a decision support is crucial to its uptake and its function in enhancing the quality of decision; this would pose as another area of research in the implementation of a future decision support specific to the decision on urinary diversion.

9.3.3 Knowledge is not power – enhancing patient engagement in the decision making process

Even the patients are armed with all the information required for making the choice of urinary diversion, SDM may still not be truly 'worked' into the decision making process. As informed by the research findings, there was much need to ensure the patient, their families and responsible clinicians all have a common understanding on what SDM really means and its benefits. The clinicians, especially the surgeons, should also be made further aware of their 'power of suggestions' – patients' choice of diversion is largely based on the information provided by them. Observational study of patient-clinician encounter may highlight to the clinicians how their presence and the way they transmit the information would impact on the overall decision making process; and as a result, the clinicians may learn of certain ways of communications would foster unbiased information transmission and patient engagement in the consultation process, where the patients are empowered to voice their preferences and values.

Furthermore, formal training of clinicians in assessing individual patients' knowledge and information needs at each encounter is also much needed. There is also a need to encourage a dialogue between the surgeons and nurses to understand each other's roles and challenges faced, so that their information provision during their consultation can be more streamlined and coherent. An enhanced dialogue among specialist nurses of varying roles (e.g. stoma nurses and continence advisers) may also achieve the same benefits.

The patients should also be encouraged to engage in the decision making process more in line with the SDM ideals. There has already been some general efforts by the NHS and other organisations such as the Health Foundation, with their 'Ask 3 Questions' campaign, in order to put the message across to patients that it is perfectly acceptable and desirable to ask questions regarding their healthcare decision. Amidst the gravity of cancer diagnosis and the urgency to perform surgery to clear the disease, both the patients and clinicians must be reminded of the importance in investing the time in information exchange rather information provision: the clinicians provide the information relevant to the diversion option and acknowledge patients' preferences, and the patients provide feedback to their clinicians on their understanding of the diversion options.

Lastly, there is evidence that outcomes of neobladder are satisfactory in centres experienced with the procedure, and this is perhaps due to a combination of accrued surgical expertise, experienced ward care and follow-up care at home. Performing neobladders in these experienced centres only is perhaps justifiable, but efforts must be made at the local level to offer patients the choice to be referred to an experienced centre for the surgery. On an

organisational level, resources should also be put in place to aid patients who wish to undergo neobladder in another centre throughout their treatment journey.

The author believed that the body of research presented in this thesis demonstrated the need for further improvement in the current decision making process concerning urinary diversion after radical cystectomy in UK's healthcare context, in terms of the ideals of SDM. There were observed uncertainties how well patients were informed about the choice of diversion and the power imbalance, mainly between patients and their responsible surgeons. Moreover, the research also highlighted how the process may be improved and the potential challenges encountered in the improvement process. Along with the identified aspects which the patients considered in the choice of diversion, this research represents the groundwork for the construction and implementation of a formal decision support for improving the said decision making process, as to ultimately improve the quality of the decision.

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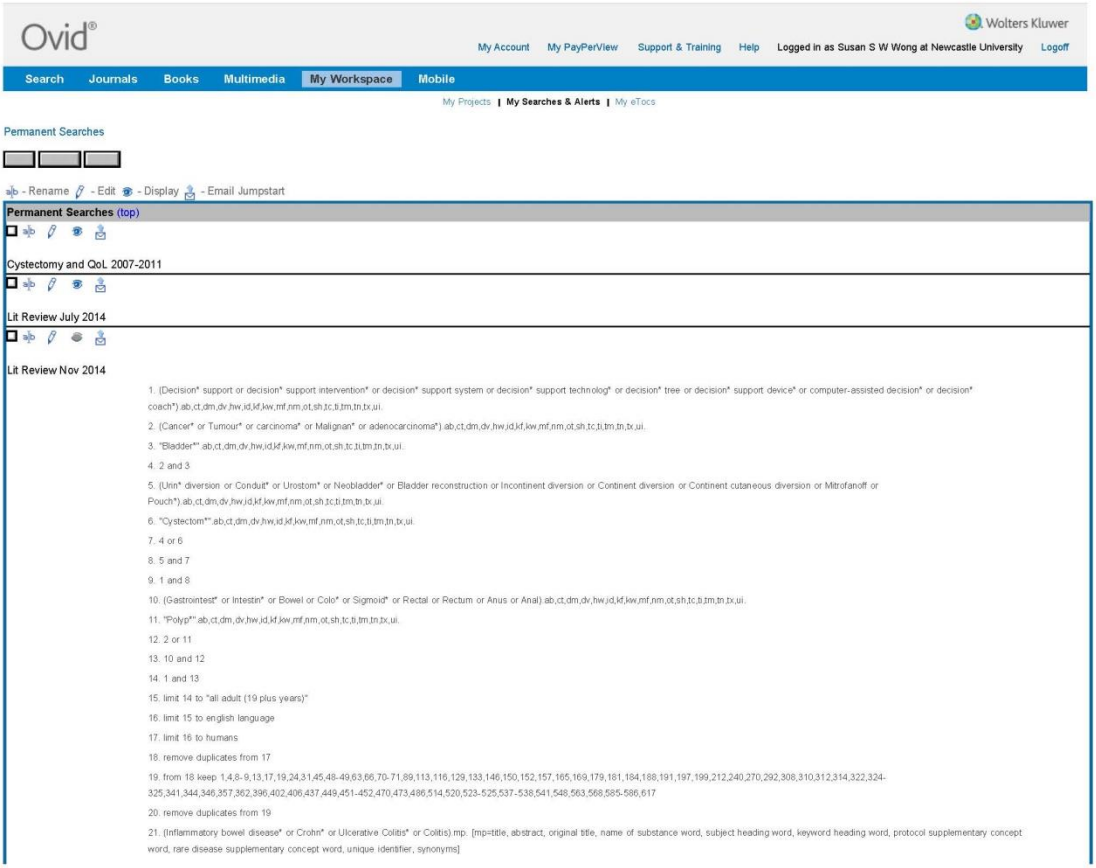
APPENDICES

Appendix 1 – Search Strategy

Ovid: Saved Searches



22. 1 and 21

23. limit 22 to "all adult (19 plus years)"

24. limit 23 to english language

25. limit 24 to humans

26. remove duplicates from 25

27. from 26 keep 4-5,13,16,19-20,27,44,53,77

28. (Shared Decision Making or Decision Making or Decision Making Process*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

29. 8 and 28

30. limit 29 to "all adult (19 plus years)"

31. limit 30 to english language

32. limit 31 to humans

33. remove duplicates from 32

34. from 33 keep 1-2,8,11,27,34,48,71-72

35. (Stoma* or Ostom* or Pouch* or Bowel Continuit*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

36. 13 and 35

37. 28 and 36

38. limit 37 to "all adult (19 plus years)"

39. limit 38 to english language

40. limit 39 to humans

41. remove duplicates from 40

42. from 41 keep 6,10,15,19-20,22,25,34,42,48,53,59,61,95,112,115,117,121,129,134,140,142,147,153,177,195,226,243,254,295,310,319,352,354,358,370-372,400,409,437,444,446,460,466,494

43. 21 and 35

44. 28 and 43

45. limit 44 to "all adult (19 plus years)"

46. limit 45 to english language

47. limit 46 to humans

48. remove duplicates from 47

49. from 48 keep 17,21-22,71,90,93

50. (Concordance* or Choice Match* or Option Match* or Choice Align* or Option Align*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

51. 8 and 50

52. 36 and 50

53. limit 52 to "all adult (19 plus years)"

54. limit 53 to english language

55. limit 54 to humans

56. remove duplicates from 55

57. from 56 keep 36,88,90

58. 43 and 50

59. (Informed choice* or Choice behaviour or Informed decision or Informed consent or Value* or Preference*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

60. 8 and 59

61. limit 60 to "all adult (19 plus years)"

62. limit 61 to english language

63. limit 62 to humans
64. remove duplicates from 63
65. from 64 keep 131,159,196,203,211
66. (Informed choice* or Choice behaviour or Informed decision or Informed consent or Value* or Preference*).ab,ti,tx.
67. (Gastrointest* or Intestin* or Bowel or Colo* or Sigmoid* or Rectal or Rectum or Anus or Anal).ab,ti,tx.
68. (Cancer* or Tumour* or carcinoma* or Malignan* or adenocarcinoma* or Polyp*).ab,ti,tx.
69. (Stoma* or Ostom* or Pouch* or Bowel Continuit*).ab,ti,tx.
70. 67 and 68
71. 69 and 70
72. 66 and 71
73. limit 72 to "all adult (19 plus years)"
74. limit 73 to english language
75. limit 74 to humans
76. remove duplicates from 75
77. from 76 keep 8,66,137,145,157,180,234,244,384,405,449,504,506,638,644,828
78. (Inflammatory bowel disease* or Crohn* or Ulcerative Colitis* or Colitis*).ab,ti,tx.
79. 69 and 78
80. 66 and 79
81. limit 80 to "all adult (19 plus years)"
82. limit 81 to english language
83. limit 82 to humans
84. remove duplicates from 83
85. from 84 keep 153,165,278
86. (Understand* or Inform* or Knowledge* or Comprehen* or Recall* or Recollect* or Memor* or Retain* or Retention* or Cognit*).ab,ti,tx.
87. 8 and 86
88. limit 87 to "all adult (19 plus years)"
89. limit 88 to english language
90. limit 89 to humans
91. remove duplicates from 90
92. from 91 keep 24,82,128,150,231,380,411,419,427,468,522
93. 71 and 86
94. limit 93 to "all adult (19 plus years)"
95. limit 94 to english language
96. limit 95 to humans
97. remove duplicates from 96
98. from 97 keep 7,9,71-72,78,83-85,110-111,128,168,203,272,276,297,312,350,415,516,555,604,614,625,682,740,778,836,848,992,1049,1301,1397,1400,1431,1523,1537,1546,1636,1641,1923,2309,2401,2407-2408
99. 79 and 86
100. limit 99 to "all adult (19 plus years)"
101. limit 100 to english language
102. limit 101 to humans
103. remove duplicates from 102
104. from 103 keep 73,97,135,173,183,245-246,290,408,453,466,545,549
105. (Risk Communication* or Risk Presentation* or Risk Graphic* or Communicat*).ab,ct,dm,dv,hw,id,kf,kw,mf,nm,ot,sh,tc,ti,tm,tn,tx,ui.
106. 8 and 105
107. 71 and 105

108. limit 107 to "all adult (19 plus years)"
109. limit 108 to english language
110. limit 109 to humans
111. remove duplicates from 110
112. from 111 keep 15,50,72
113. 79 and 105
114. limit 113 to "all adult (19 plus years)"
115. limit 114 to english language
116. limit 115 to humans
117. remove duplicates from 116
118. 9 or 20 or 27
119. remove duplicates from 118
120. 34 or 42 or 49
121. remove duplicates from 120
122. 51 or 57 or 58
123. remove duplicates from 122
124. 65 or 77 or 85
125. remove duplicates from 124
126. 92 or 98 or 104
127. remove duplicates from 126
128. 106 or 112 or 117
129. remove duplicates from 128
130. 119 or 121 or 123 or 125 or 127 or 129
131. remove duplicates from 130
132. from 131 keep 5,7,13-14,19,21,26-27,30-31,33-40,45-49,51-54,59-61,64,66,68,72-74,76,78,81-83,86,89-90
133. from 131 keep 115,118-119,121-122,125,128,130,135,137,140,154,157-158,163,173,181,184-186,192,196
134. from 131 keep 207,214,220,230,236,238,240,250,252,260,262,264-265,267,270,273,277,279-280,282,295-298,304,306,315,318

Stoma and QoL

Appendix 2 – Patient Questionnaire

OTIS Additional Questionnaire

A SURVEY OF PATIENTS' VIEWS ON DECISION SUPPORT FOR CHOOSING URINE DRAINAGE (DIVERSION) METHOD WITH BLADDER REMOVAL

PLEASE READ THIS PAGE CAREFULLY FIRST

Background:

Patients may undergo bladder removal surgery for various conditions, such as bladder cancer. After the bladder is removed, there are different methods to drain urine away from the body (urine diversion). The two main urinary diversion methods are:

1) **Urostomy (Ileal Conduit):**

   Urine drains through an opening on the tummy - 'Urostomy', into an external bag which needs to be changed regularly.

2) **Substitute Bladder (Neobladder):**

   An artificial bladder is made from some of your bowel. This can store urine, which is like a normal bladder and you can empty it by straining or with the help from inserting a thin tube (catheter).

Sometimes a patient is offered only one method of diversion due to clear reasons such as concerns about medical fitness and disease involvement with the waterpipe ('urethra'). However, at other times a patient is suitable for either diversion method. Each of the two methods above can affect an individual patient differently and making the choice between the two can be difficult. We would like to develop more support to help our patients in the future to choose the diversion method that best suits them.

This survey will help us to do this. Thank you very much for your involvement.

ALL SURVEY RESPONSES WILL BE KEPT ANONYMOUS AND CONFIDENTIAL

SECTION I - TO START WITH PLEASE TELL US MORE ABOUT YOURSELF

1. **How many months and/or years ago did you have your bladder removal surgery? (Please specify):**

   ___ MONTHS ___ YEARS

2. **<u>When you had your bladder removal surgery</u>, which age group did you belong to? (Please choose one response with a tick [✓]):**

   ☐ **39 years or less**

   ☐ **40-49 years**

   ☐ **50-59 years**

   ☐ **60-69 years**

   ☐ **70 years or more**

3. **Are you: (Please choose one response with a tick [✓]**

   ☐ **Male**

   ☐ **Female**

4. **Which method of urine diversion did you have along with bladder removal? (Please choose one response with a tick [✓]):**

   ☐ **Urostomy (ileal conduit)**

   ☐ **Substitute Bladder (Neobladder)**

5. Were <u>both</u> urine diversion methods (Urostomy <u>and</u> Substitute Bladder) available to you before you went into hospital for bladder removal surgery? (Please choose one response with a tick [✓])

☐ **YES** ⟹ **PLEASE GO TO THE NEXT QUESTION (QUESTION 6).**

☐ **NO** ⟹ **PLEASE GO TO THE LAST PAGE (QUESTION 18).**

SECTION II - INFORMATION AND SUPPORT BEFORE YOUR SUGERY

6. <u>Information on Urostomy</u>:

How satisfied were you with the information given about <u>Urostomy</u> by your surgeon and his/her team before your surgery? (Please choose one response for <u>each information area</u> with a tick [✓]):

Level of Satisfaction → / Information Area ↓	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	No Information Provided
Benefits	☐	☐	☐	☐	☐	☐
Complications/Risks	☐	☐	☐	☐	☐	☐
Course of recovery	☐	☐	☐	☐	☐	☐
Peer support (groups/individual)	☐	☐	☐	☐	☐	☐
Daily care after surgery	☐	☐	☐	☐	☐	☐
Appliances (e.g. bags, catheters)	☐	☐	☐	☐	☐	☐
Employment/Retirement	☐	☐	☐	☐	☐	☐
Leisure activities/Sports	☐	☐	☐	☐	☐	☐
Body appearance after surgery	☐	☐	☐	☐	☐	☐
Sexual matters	☐	☐	☐	☐	☐	☐

7. <u>Information on Substitute Bladder</u>:

How satisfied were you with the information given about <u>Substitute Bladder</u> by your surgeon and his/her team before your surgery? (Please choose one response with a tick [✓] for <u>each information area</u>):

Level of Satisfaction ⇨ / Information Area ⇩	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	No Information Provided
Benefits	☐	☐	☐	☐	☐	☐
Complications/Risks	☐	☐	☐	☐	☐	☐
Course of recovery	☐	☐	☐	☐	☐	☐
Peer support (groups/individual)	☐	☐	☐	☐	☐	☐
Daily care after surgery	☐	☐	☐	☐	☐	☐
Appliances (e.g. bags, catheters)	☐	☐	☐	☐	☐	☐
Employment/Retirement	☐	☐	☐	☐	☐	☐
Leisure activities/Sports	☐	☐	☐	☐	☐	☐
Body appearance after surgery	☐	☐	☐	☐	☐	☐
Sexual matters	☐	☐	☐	☐	☐	☐

8. Would you have liked information on any other areas? (Please choose a response with a tick [✓]):

☐ **Yes. (Please comment further):**

_____

_____

_____

_____

☐ **No.**

9. Thinking back, who helped you to make the choice of urine diversion method? (Please tick [✓] as many options as applicable):

☐ **Surgeon**

☐ **Specialist Nurse/Stoma Nurse**

☐ **Spouse**

☐ **Other family members/friends**

☐ **Other patients who had gone through similar surgery**

☐ **Patient Support Groups**

☐ **Others (Please state relationship/role/profession):**

_____

10. <u>Was there anyone else who could have helped you</u>, if available, to make the choice of urine diversion method? (Please choose a response with a tick [✓]):

☐ **Yes (Please state relationship/role/profession):**

_____

☐ **No**

11. How helpful were the following information materials to you when you were making the choice of urine diversion method? (Please choose one response with a tick [✓] for <u>each material</u>).

Level of Helpfulness ⇨ / Materials ⇩	Very Helpful	Helpful	Neutral	Not particularly helpful	Not helpful at all	Don't know - material was not available to me
Internet (Websites)	☐	☐	☐	☐	☐	☐
Leaflets/Booklets	☐	☐	☐	☐	☐	☐
DVDs/Videos	☐	☐	☐	☐	☐	☐
Audio CDs	☐	☐	☐	☐	☐	☐
Other (Please state below): _____	☐	☐	☐	☐	☐	☐

12. <u>Any other materials you would have liked to have</u>, to help you reach the choice of urine diversion? (Please choose a response with a tick [✓]):

☐ **Yes (Please state material type):**

_____

☐ **No**

13. Overall, how supported did you feel in the process of reaching the choice of urine diversion method? (Please choose one response with a tick [✓]):

Very supported	Supported	Neutral	Unsupported	Totally unsupported
☐	☐	☐	☐	☐

14. When you faced having to choose between the urine diversion methods, how did you feel? (Please tick [✓] as many options as applicable):

☐ **Positive**

☐ **Relieved**

☐ **Distressed/Upset**

☐ **Worried what could go wrong with each choice**

☐ **Worried about the impact of each choice on yourself or people close to you (significant others)**

☐ **Wondering what would be important to you in life after surgery**

☐ **Wavering between the choices**

☐ **Wanted to delay the decision**

☐ **Physically stressed (tense muscles, racing heartbeat, lost sleep etc.)**

☐ **Other (Please comment further):**

_____

_____

15. We are hoping to build support material which provides information on both urine diversion methods and highlights the opinions each individual patient may have. This will then help patients in the future to choose a urine diversion method with their bladder removal surgery like you had to do. Which formats of decision support material would you prefer most? (Please choose <u>one</u> response with a tick [✓]):

☐ **Internet (Websites)**

☐ **Booklet**

☐ **DVD/Videos**

☐ **Audio tapes/CDs**

☐ **Others (can be combination of above, please state):**

_____

SECTION III - MAKING THE DECISION ON URINE DIVERSION METHOD

16. Were you involved <u>as much as you would have liked</u>, in reaching a decision on the urine diversion method to proceed with?

(Please choose <u>one</u> response and mark with a [✓]):

☐ **Yes ⇨ PLEASE GO TO THE LAST PAGE (QUESTION 18).**

☐ **No ⇨ PLEASE GO TO NEXT QUESTION (QUESTION 17).**

17. Thinking back, how involved <u>would you have liked to have been</u>, in reaching a decision on the urine diversion method to proceed with?

(Please choose the <u>one</u> response that best describes how you would have liked the decision made with a tick [✓]):

☐ **I would have liked to make the decision about which urine diversion method I would have.**

☐ **I would have liked to make the final decision about the urine diversion method after seriously considering the opinion from my surgeon's and his/her team.**

☐ **I would have liked to share with my surgeon along with his/her team the responsibility for deciding which urine diversion method was best for me.**

☐ **I would have liked my surgeon and his/her team made the final decision on which urine diversion method would be used, but seriously considered my opinion.**

☐ **I would have liked to leave all decisions regarding urine diversion method to my surgeon and his/her team.**

18. Any additional comments?

_____

_____

_____

_____

_____

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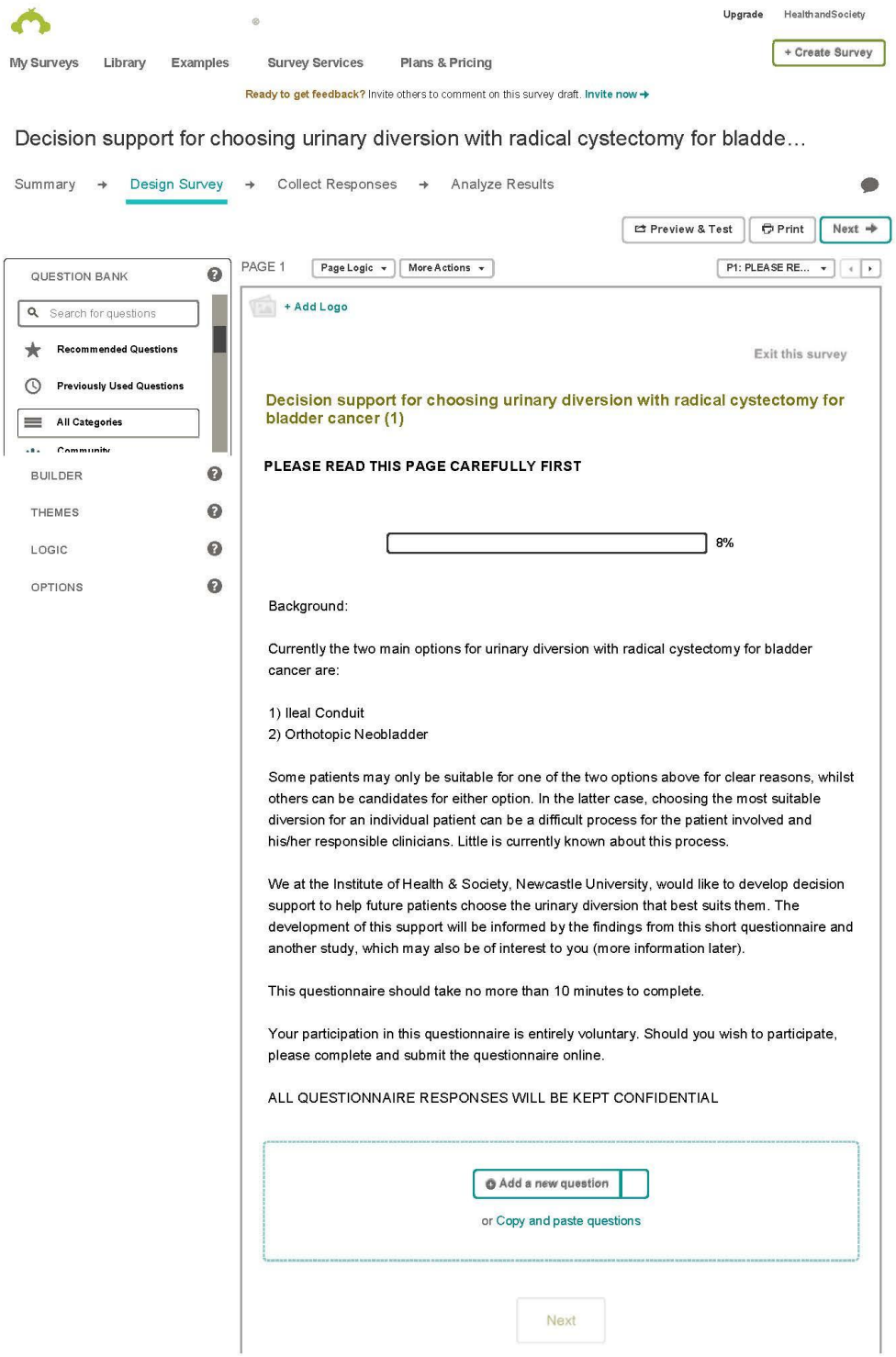
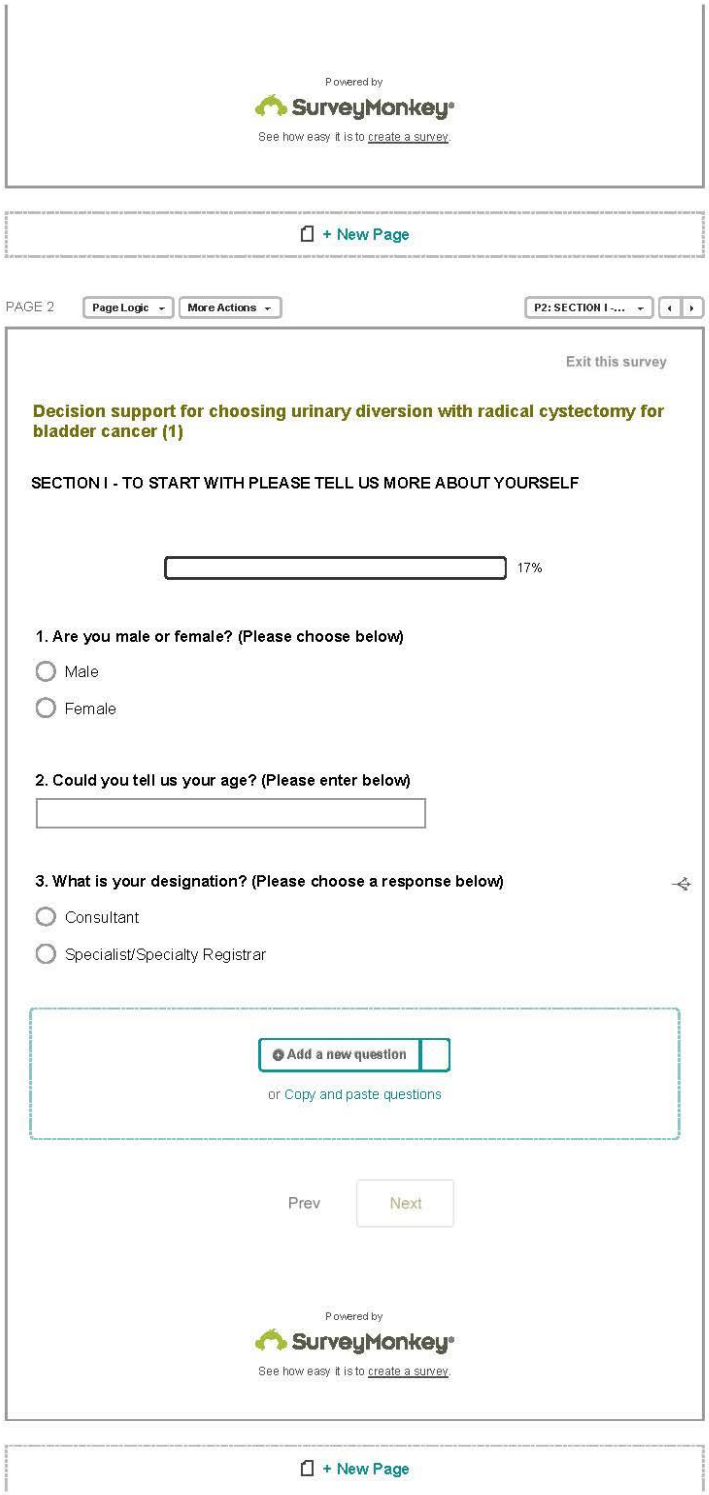
_____

THANK YOU VERY MUCH! PLEASE RETURN THIS QUESTIONNAIRE IN THE PRE-PAID ENVELOPE PROVIDED

Appendix 3 – Clinician Questionnaire

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PAGE 2
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More Actions
P2: SECTION I -...
Exit this survey
Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)
SECTION I - TO START WITH PLEASE TELL US MORE ABOUT YOURSELF
17%
1. Are you male or female? (Please choose below)
Male
Female
2. Could you tell us your age? (Please enter below)
3. What is your designation? (Please choose a response below)
Consultant
Specialist/Specialty Registrar
Add a new question
or Copy and paste questions
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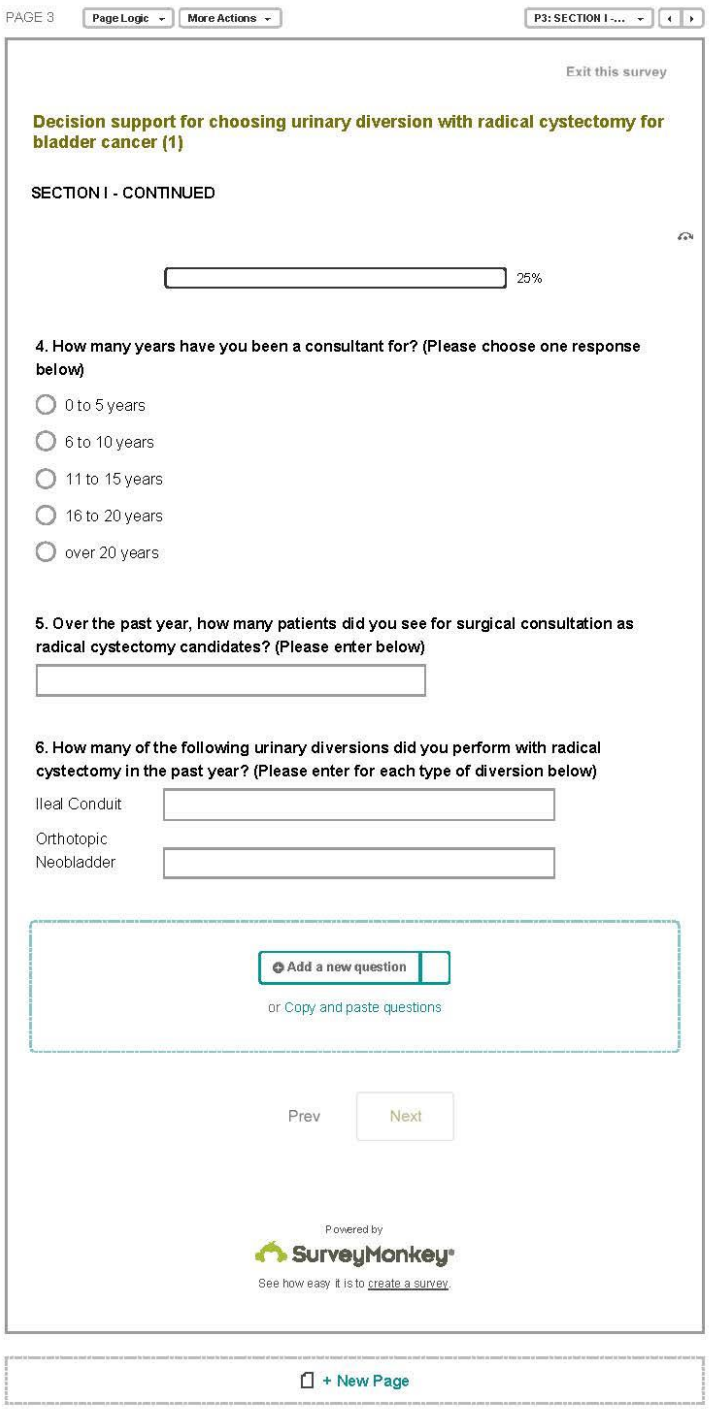
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P3: SECTION I -...
Exit this survey
Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)
SECTION I - CONTINUED
25%
4. How many years have you been a consultant for? (Please choose one response below)
0 to 5 years
6 to 10 years
11 to 15 years
16 to 20 years
over 20 years
5. Over the past year, how many patients did you see for surgical consultation as radical cystectomy candidates? (Please enter below)
6. How many of the following urinary diversions did you perform with radical cystectomy in the past year? (Please enter for each type of diversion below)
Ileal Conduit
Orthotopic Neobladder
Add a new question
or Copy and paste questions
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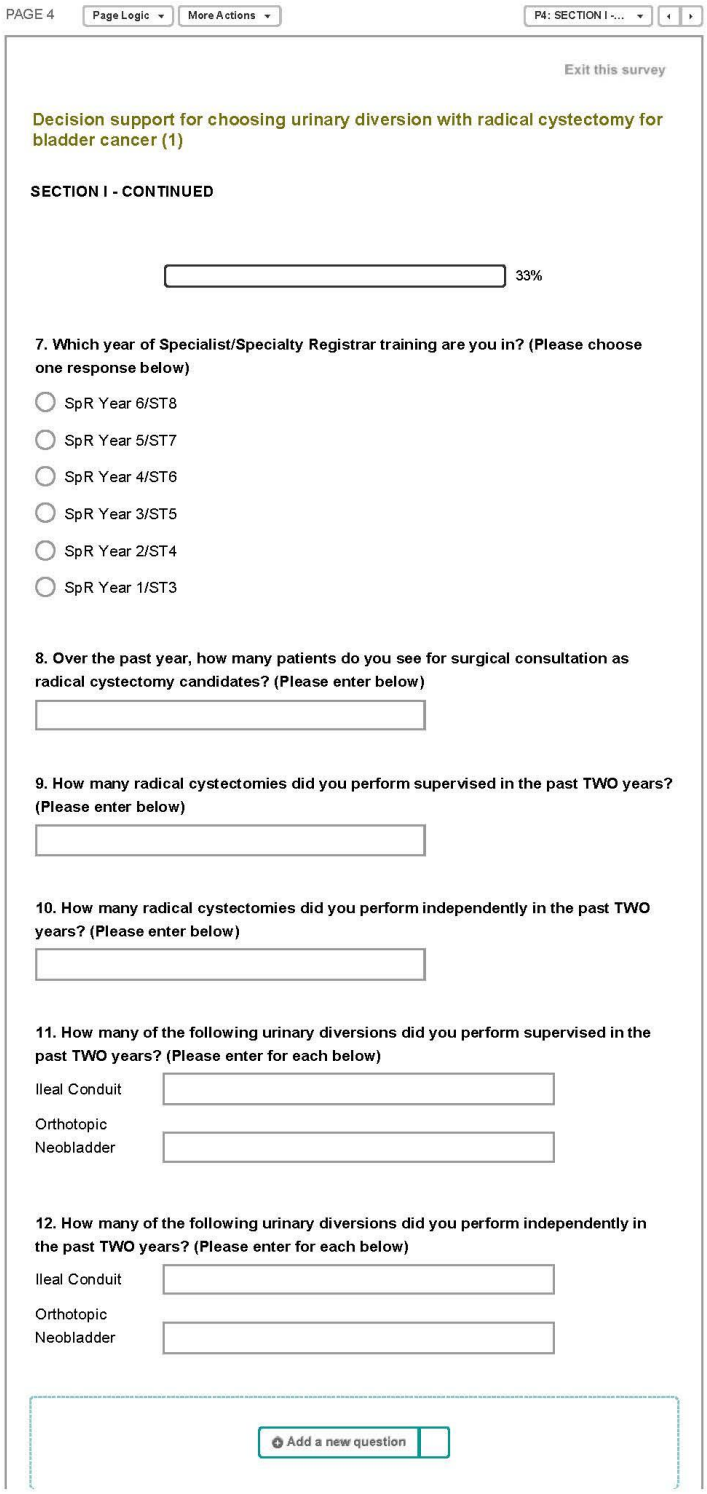
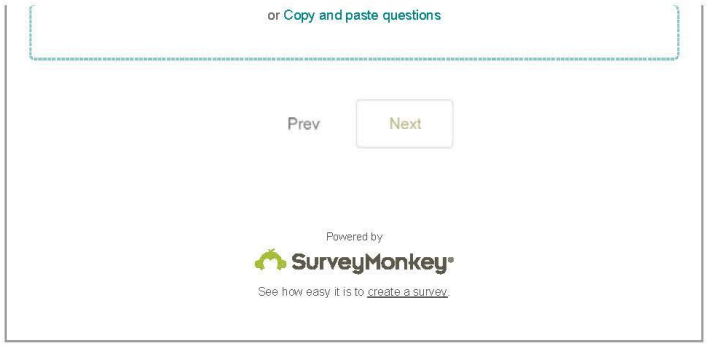

PAGE 4
Page Logic
More Actions
P4: SECTION I -...
Exit this survey
Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)
SECTION I - CONTINUED
33%
7. Which year of Specialist/Specialty Registrar training are you in? (Please choose one response below)
SpR Year 6/ST8
SpR Year 5/ST7
SpR Year 4/ST6
SpR Year 3/ST5
SpR Year 2/ST4
SpR Year 1/ST3
8. Over the past year, how many patients do you see for surgical consultation as radical cystectomy candidates? (Please enter below)
9. How many radical cystectomies did you perform supervised in the past TWO years? (Please enter below)
10. How many radical cystectomies did you perform independently in the past TWO years? (Please enter below)
11. How many of the following urinary diversions did you perform supervised in the past TWO years? (Please enter for each below)
Ileal Conduit
Orthotopic Neobladder
12. How many of the following urinary diversions did you perform independently in the past TWO years? (Please enter for each below)
Ileal Conduit
Orthotopic Neobladder
Add a new question



PAGE 5 Page Logic More Actions P5: SECTION II -...

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Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)

SECTION II - INFORMATION AND SUPPORT BEFORE SURGERY

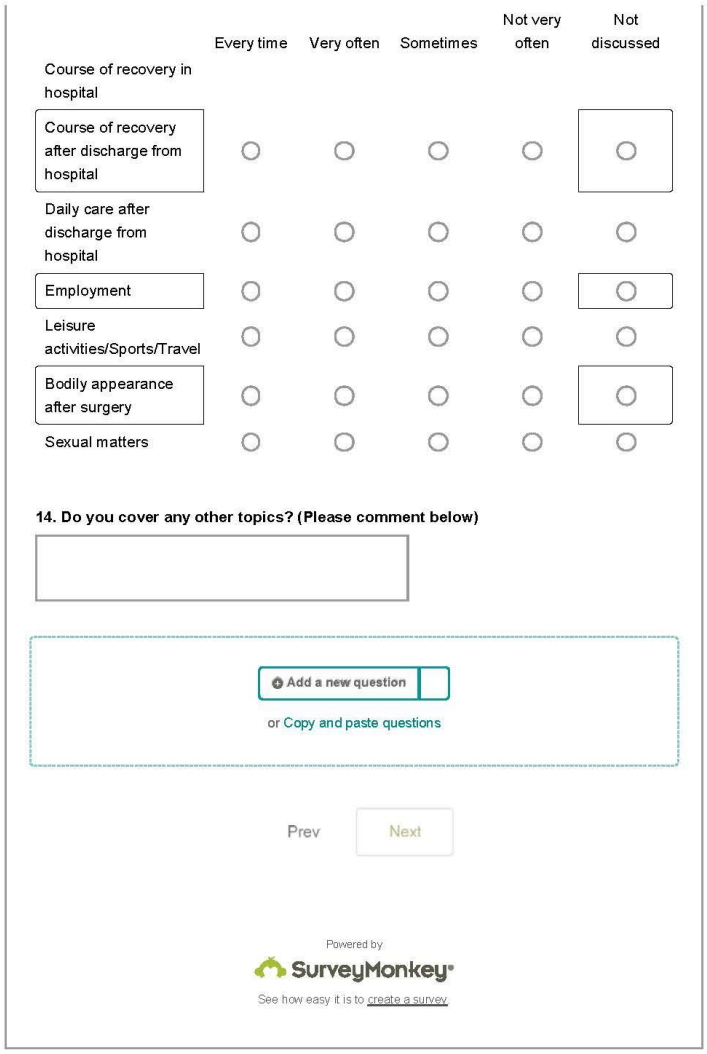
42%

As previously mentioned, a patient may only be suitable for one of the two options for urinary diversion, due to some clear reasons. On the other hand, sometimes a patient is suitable for either diversion option.

FOR A PATIENT WITH A CHOICE BETWEEN THE TWO URINARY DIVERSION OPTIONS:

13. How often do you cover the following topics when you discuss ILEAL CONDUIT with your patient during the pre-surgery consultation? (Please choose one response for each topic below)

	Every time	Very often	Sometimes	Not very often	Not discussed
Technical description of ileal conduit formation	○	○	○	○	○
Benefits of having ileal conduit	○	○	○	○	○
Adverse outcomes of ileal conduit	○	○	○	○	○
Probabilities of obtaining the benefits of ileal conduit	○	○	○	○	○
Probabilities of adverse outcomes of ileal conduit	○	○	○	○	○
	○	○	○	○	○


Every time
Very often
Sometimes
Not very often
Not discussed
Course of recovery in hospital
Course of recovery after discharge from hospital
Daily care after discharge from hospital
Employment
Leisure activities/Sports/Travel
Bodily appearance after surgery
Sexual matters
14. Do you cover any other topics? (Please comment below)
Add a new question
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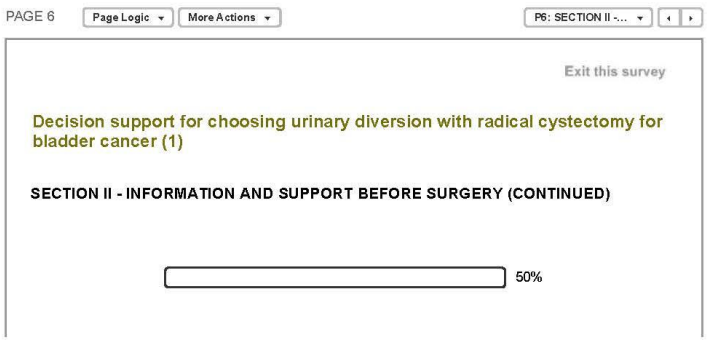
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More Actions
P6: SECTION II -...
Exit this survey
Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)
SECTION II - INFORMATION AND SUPPORT BEFORE SURGERY (CONTINUED)
50%

15. How often do you cover the following topics when you discuss ORTHOTOPIC NEOBLADDER with your patient during the pre-surgery consultation? (Please choose one response for each topic below)

	Every time	Very often	Sometimes	Not very often	Not discussed
Technical description of orthotopic neobladder formation	○	○	○	○	○
Benefits of having orthotopic neobladder	○	○	○	○	○
Adverse outcomes of orthotopic neobladder	○	○	○	○	○
Probabilities of obtaining the benefits of orthotopic neobladder	○	○	○	○	○
Probabilities of adverse outcomes of orthotopic neobladder	○	○	○	○	○
Course of recovery in hospital	○	○	○	○	○
Course of recovery after discharge from hospital	○	○	○	○	○
Daily care after discharge from hospital	○	○	○	○	○
Employment	○	○	○	○	○
Leisure activities/Sports/Travel	○	○	○	○	○
Bodily appearance after surgery	○	○	○	○	○
Sexual matters	○	○	○	○	○

16. Do you cover any other topics? (Please comment below)

Add a new question

or Copy and paste questions

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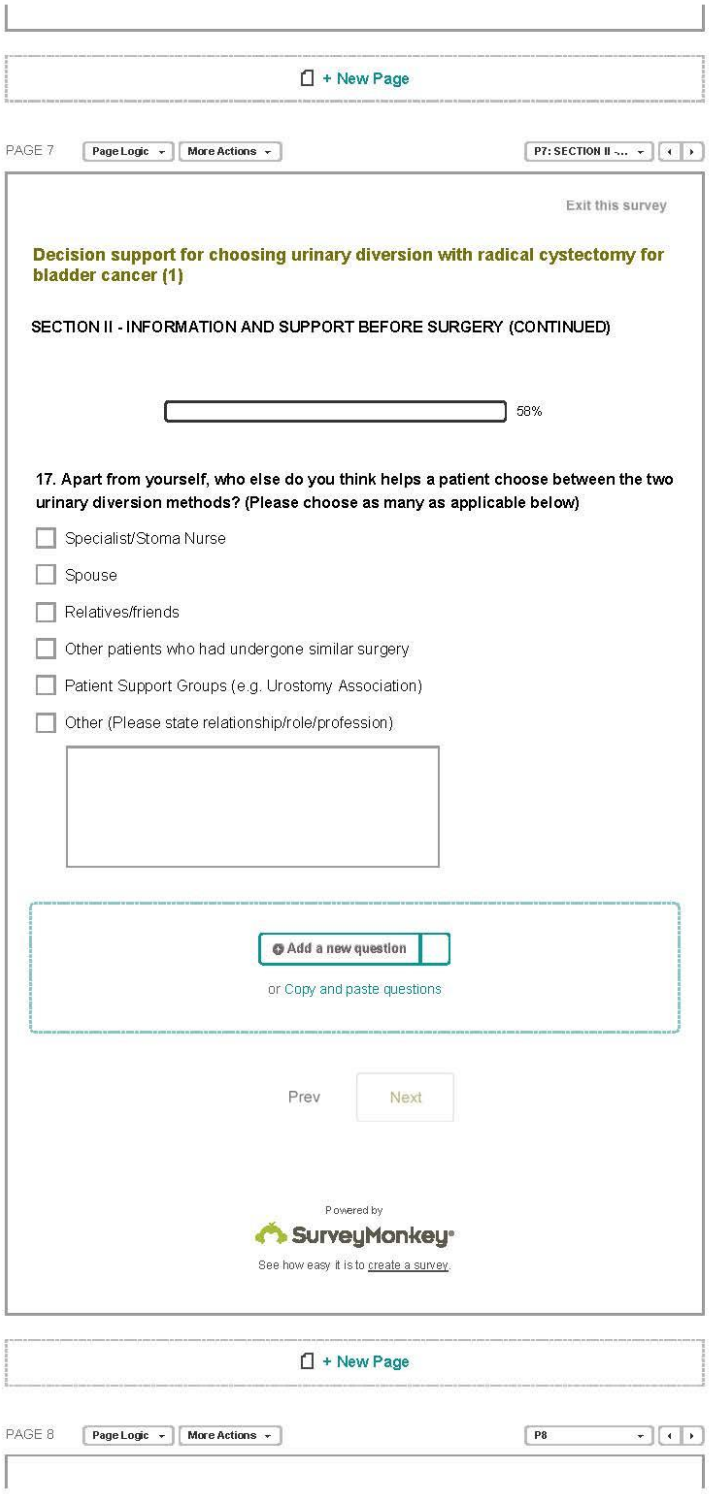
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P7: SECTION II ...
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Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)
SECTION II - INFORMATION AND SUPPORT BEFORE SURGERY (CONTINUED)
58%
17. Apart from yourself, who else do you think helps a patient choose between the two urinary diversion methods? (Please choose as many as applicable below)
Specialist/Stoma Nurse
Spouse
Relatives/friends
Other patients who had undergone similar surgery
Patient Support Groups (e.g. Urostomy Association)
Other (Please state relationship/role/profession)
Add a new question
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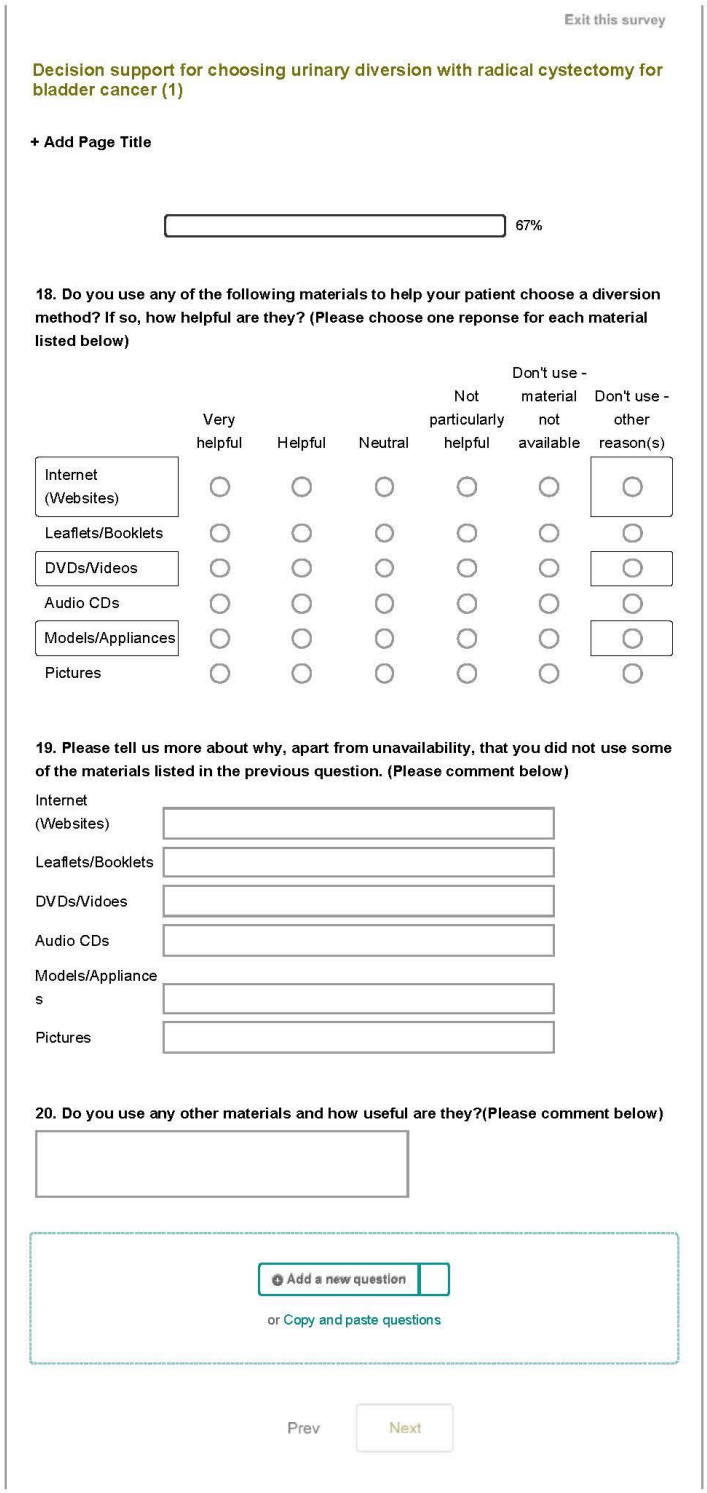

Exit this survey

Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)

+ Add Page Title

67%

18. Do you use any of the following materials to help your patient choose a diversion method? If so, how helpful are they? (Please choose one reponse for each material listed below)

	Very helpful	Helpful	Neutral	Not particularly helpful	Don't use - material not available	Don't use - other reason(s)
Internet (Websites)	○	○	○	○	○	○
Leaflets/Booklets	○	○	○	○	○	○
DVDs/Videos	○	○	○	○	○	○
Audio CDs	○	○	○	○	○	○
Models/Appliances	○	○	○	○	○	○
Pictures	○	○	○	○	○	○

19. Please tell us more about why, apart from unavailability, that you did not use some of the materials listed in the previous question. (Please comment below)

Internet (Websites)

Leaflets/Booklets

DVDs/Vidoes

Audio CDs

Models/Appliances

Pictures

20. Do you use any other materials and how useful are they?(Please comment below)

Add a new question

or Copy and paste questions

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PAGE 9 Page Logic More Actions P9: SECTION II -...

Exit this survey

Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)

SECTION II - INFORMATION AND SUPPORT BEFORE SURGERY (CONTINUED)

75%

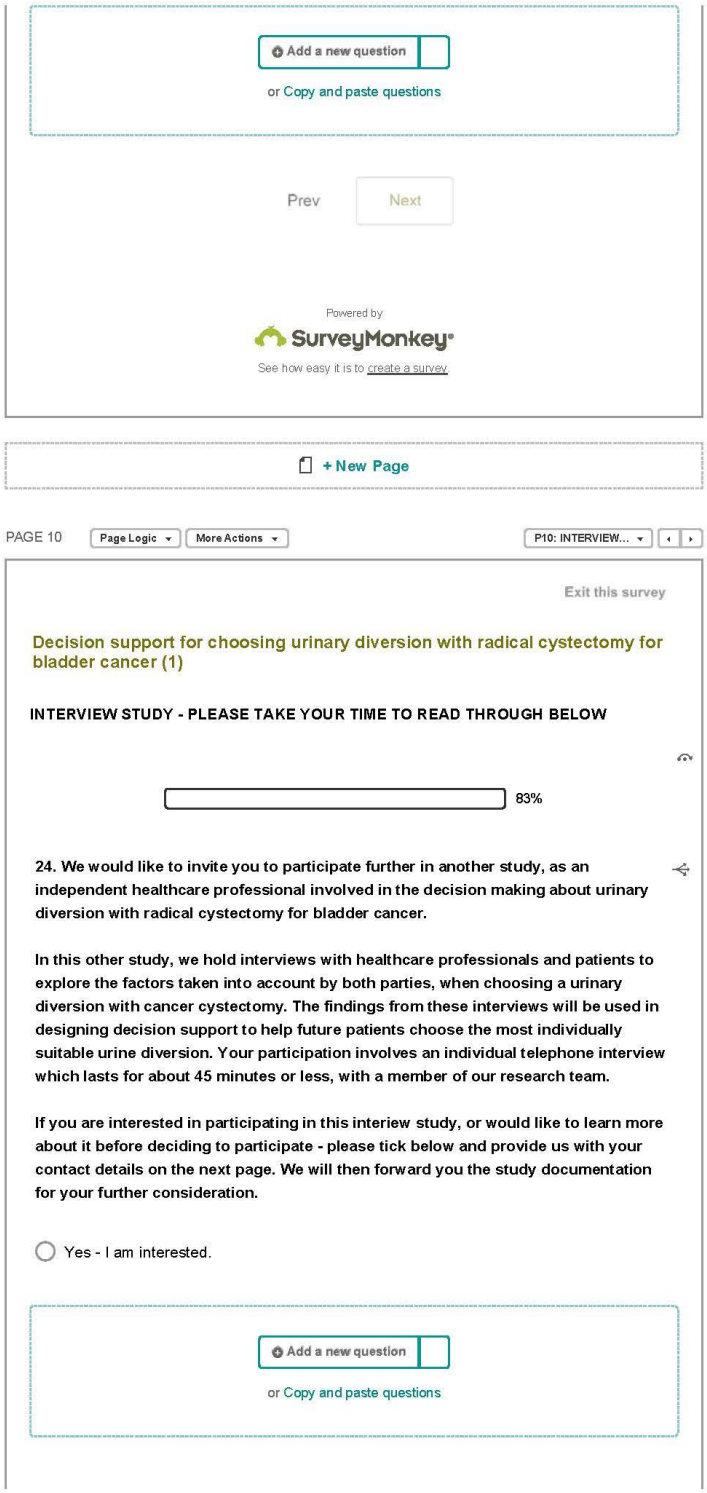
21. In order to help future patients choose a diversion that suits them best, we are hoping to develop decision support which provides information on the two urinary diversion options and determines what is important to patients. Which is your most preferred format of support? (Please choose one response below)

- ○ Internet (Websites)
- ○ Leaflets/Booklets
- ○ DVD/Videos
- ○ Audiotapes/CDs
- ○ Other (can be combination of above, please state below)

22. Which one of the following statements would you most agree with? (Please choose one response below)

- ○ I would prefer to leave the decision about the diversion to my patient
- ○ I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion
- ○ I would prefer that my patient and I make the decision about the diversion jointly
- ○ I would prefer to make the decision about the diversion, after seriously considering my patient's opinion
- ○ I would prefer to make the decision about the diversion

23. Any additional comments? (Please provide below)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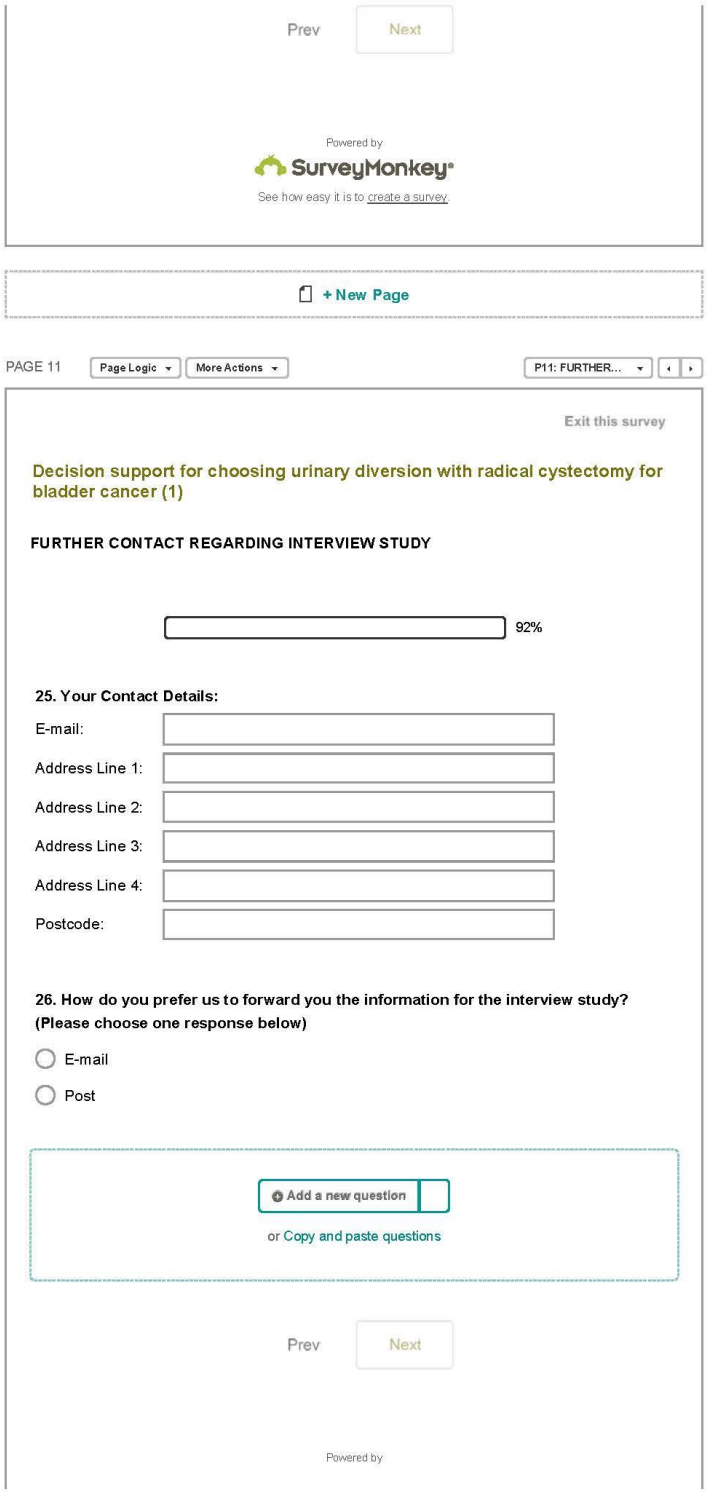
P10: INTERVIEW...
Exit this survey
Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)
INTERVIEW STUDY - PLEASE TAKE YOUR TIME TO READ THROUGH BELOW
83%
24. We would like to invite you to participate further in another study, as an independent healthcare professional involved in the decision making about urinary diversion with radical cystectomy for bladder cancer.
In this other study, we hold interviews with healthcare professionals and patients to explore the factors taken into account by both parties, when choosing a urinary diversion with cancer cystectomy. The findings from these interviews will be used in designing decision support to help future patients choose the most individually suitable urine diversion. Your participation involves an individual telephone interview which lasts for about 45 minutes or less, with a member of our research team.
If you are interested in participating in this interiew study, or would like to learn more about it before deciding to participate - please tick below and provide us with your contact details on the next page. We will then forward you the study documentation for your further consideration.
Yes - I am interested.
Add a new question
or Copy and paste questions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More Actions
P11: FURTHER...
Exit this survey
Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)
FURTHER CONTACT REGARDING INTERVIEW STUDY
92%
25. Your Contact Details:
E-mail:
Address Line 1:
Address Line 2:
Address Line 3:
Address Line 4:
Postcode:
26. How do you prefer us to forward you the information for the interview study? (Please choose one response below)
E-mail
Post
Add a new question
or Copy and paste questions
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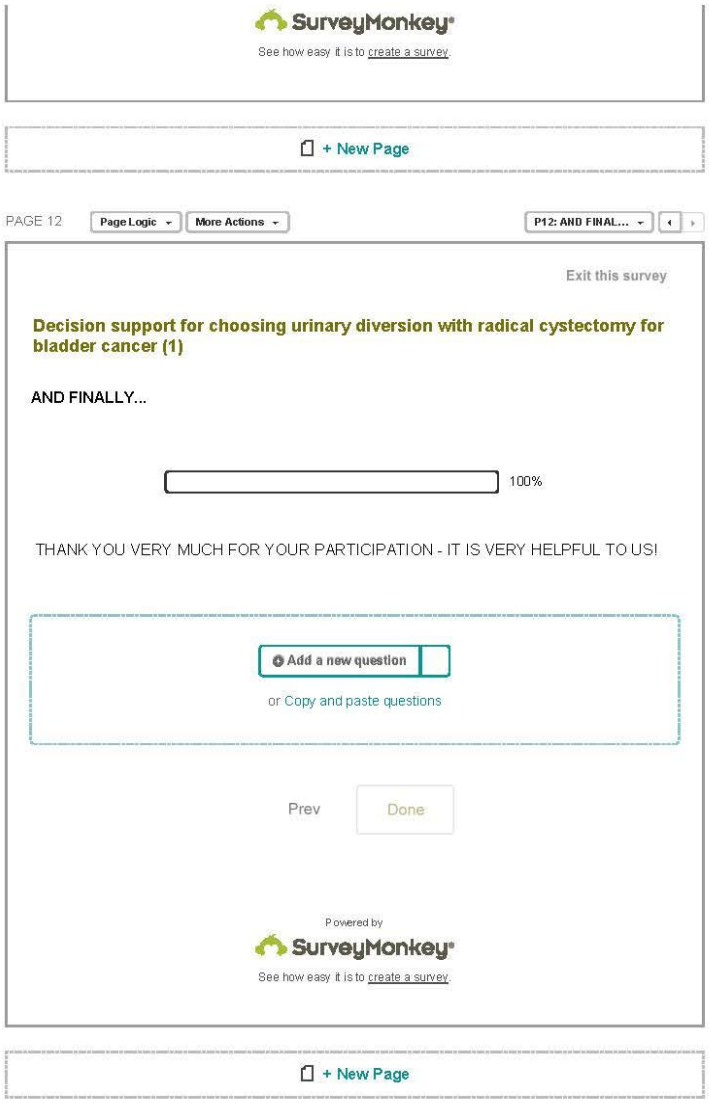
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See how easy it is to create a survey.
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PAGE 12
Page Logic
More Actions
P12: AND FINAL...
Exit this survey
Decision support for choosing urinary diversion with radical cystectomy for bladder cancer (1)
AND FINALLY...
100%
THANK YOU VERY MUCH FOR YOUR PARTICIPATION - IT IS VERY HELPFUL TO US!
Add a new question
or Copy and paste questions
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Done
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Appendix 4 – HES Non-Disclosure Agreement

Appendix C1: HES Non-Disclosure Agreement Form - Sensitive tabulations

This form is appropriate for requesting tabulations of HES data that are sensitive. For example, the table may contain consultant level data or have small numbers, which cannot be suppressed in the normal manner, in the cells.

Organisation: Institute of Health and Society, Newcastle University

Responsible lead contact: Susan Wong

Data custodian (senior officer): Richard Thomson

HES reference (for HES Team use):

Project: Choosing urinary drainage procedure with cystectomy for bladder cancer
(please provide a description of the intended project and how you propose to use and/or publish the analysis of the HES data – publication of the raw data is prohibited)

The aim of the project entitled above is to improve the decision making process for patients who were choosing between two options of urinary drainage procedure, namely ileal conduit diversion and orthotopic neobladder, to proceed along with radical cystectomy (surgical bladder removal) for bladder cancer. In order to demonstrate regional variation in the UK in the usage of each mentioned drainage option, and any demographic and/or clinical factors which might be associated with such variation, the dataset owned by the British Association of Urological Surgeons (BAUS) and managed by SWPHO has been obtained for further analysis. On closer examination of this dataset, however, the question of case capture was posed. The HES data to be requested this time is for identifying instances of unsatisfactory degree of capture, by comparing the total numbers of radical cystectomy registered by the BAUS/SWPHO dataset and that by HES. Instances of unsatisfactory case capture in the BAUS/SWPHO dataset are to be excluded for further analysis.

Only the analysis of the BAUS/SWPHO data aided by the HES data to be requested will be published.

HES data to be provided:
(attach an example outline or sketch of the table required if possible/appropriate)

For each trust/provider, the number of radical cystectomy for bladder cancer undertaken in per year, from 2004 to End of July 2010 inclusive.

Sensitivities:

(retain or delete as appropriate to the data required)

Consultant team data:

- Pseudonymised consultant code is unpublished and must not be released in any way that may enable the identification of individual consultants.
- Should identifiable consultant data (ie the raw GMC code, not anonymised) be investigated, which will only be provided in case of justifiable concern about outcomes, the consultant(s) concerned should be made aware that this is happening.

Patients must not be identified:

- Patient information from HES must not be used to identify (or recognise) individual patients and must be handled with proper regard to the confidentiality of individuals.
- Any published HES figure(s) at a local level must be based on no fewer than 6 cases or else suppressed (eg replaced with an asterisk, with a note "* in this table means a figure between 1 and 5". Zero is allowed). Low-level analyses might facilitate the identification of individual patients, especially with local knowledge. Care should be taken to ensure that values may not be more closely calculated by differencing from sub-totals. For practical purposes, any geographic reference smaller than Strategic Health Authority should be considered local

Deaths data:

- HES data cannot be used to determine the cause of death of a patient while in hospital. Deaths recorded on the HES database are classified according to the main diagnosis for which the patient was being treated during their stay in hospital, and may not necessarily be the underlying cause of death. The Office for National Statistics (ONS) collects information on the cause of death, wherever it occurs, based on the death certificate, and should be the source of data for analyses on cause of death.

I agree:

- that there is a business need for this work requiring data with the sensitivities indicated above.
- to abide by the instructions given against the sensitivities.
- that the data will be stored with proper safeguards to prevent unauthorised access. Note: This condition is subject to unannounced site inspections by The NHS Information Centre for health and social care (The NHS IC) staff to ensure that measures are satisfactory.
- that the work will not be used for other purposes without the permission of the HES team.
- that the data will not be copied or transferred to any third party without the written consent of the HES Team. Note: output based on the data may be shared provided it abides by the rules above.
- to give prior notice of intention to publish HES data to the HES Team and where feasible provide a copy of the published work. Any published work containing HES data must acknowledge the source: "Hospital Episode Statistics, The NHS Information Centre for health and social care".
- to inform the HES Team immediately if custodianship of the data should change.

Signed __ __  _____

Name _Susan Wong_____

Date _20.09.12_____

HES Information Governance:

Email: information.governance@ic.nhs.uk

Tel: 0113 254 7054
Fax: 0113 254 7299

Please complete and return this form to the address above or fax it. The HES data can only be sent once the signed agreement is received.

Appendix 5 – Case Capture

Column Labels											Column Labels										
	20	20	20	20	20	20	20	(blan	Grand Tot	Subtotal 2004-200	20	20	20	20	20	20	20	(blan	Grand Tot	Subtotal 2004-200	Case Capture 2004-2009
	7	**3**	**3**						**16**	**16**	No Entry								0	0	0.0%
	1	3	2	2					8	8									0	0	0.0%
	6		1	1					8	8									0	0	0.0%
	3	**4**							**7**	7	**0**	**0**	**0**	**0**	**0**	**0**	**2**		2	0	0.0%
	3	4							7	7									0	0	0.0%
	15	**15**	**15**	**27**	**19**	**25**	**20**		**136**	**116**	No Entry								0	0	0.0%
	15	9		20	3				47	47									0	0	0.0%
		6	15	7	16	25	20		89	69									0	0	0.0%
	9	**12**	**6**	**9**	**11**	**10**	**5**		**62**	**57**									0	0	0.0%
	5	8	6	9	11	10	5		54	49	2	1	0	0	0	0	0		3	3	6.1%
	3	4							7	7									0	0	0.0%
	1								1	1									0	0	0.0%
	14	**12**	**11**	**6**	**10**	**11**	**11**		**75**	**64**	**14**	**14**	**16**	**6**	**6**	**9**	**2**		67	65	101.6%
	13	9							22	22									0	0	0.0%
		3	11	6	10	11	11		52	41									0	0	0.0%
	1								1	1									0	0	0.0%
	8	**2**							**10**	**10**	No Entry								0	0	0.0%
	8	2							10	10									0	0	0.0%
	2	**9**		**1**					**12**	**12**									0	0	0.0%
	2	9		1					12	12	0	1	1	4	0	0	0		6	6	50.0%
	8								**8**	**8**	No Entry								0	0	0.0%
	8								8	8									0	0	0.0%
	6	**8**	**6**	**1**	**2**	**1**			**24**	**24**									0	0	0.0%
	6	8	3	1		1			19	19	7	0	0	0	0	0	0		7	7	36.8%
			3		2				5	5									0	0	0.0%
	8	**3**	**5**	**7**	**1**				**24**	**24**	0	0	0	0	1	0	0		1	1	4.2%
	8	3	5	7	1				24	24									0	0	0.0%
	16	**14**	**17**	**20**	**20**	**20**	**12**		**119**	**107**	**12**	**12**	**13**	**9**	**20**	**17**	**1**		84	83	77.6%
	16	14	17	20	20	20	12		119	107									0	0	0.0%
	6	**7**	**13**	**16**	**17**	**28**	**9**		**96**	**87**									0	0	0.0%
	6	7	13	16	11				53	53									0	0	0.0%
					6	28	9		43	34	0	1	0	1	9	18	5		34	29	85.3%
	4	**8**	**3**	**4**					**19**	**19**	**0**	**1**	**0**	**0**	**0**	**0**	**0**		1	1	5.3%
	4	8	3	4					19	19									0	0	0.0%
	9	**10**	**14**	**16**	**17**	**9**	**3**		**78**	**75**	**1**	**8**	**1**	**0**	**0**	**0**	**0**		10	10	13.3%
	8	2							10	10									0	0	0.0%
	1				1				2	2									0	0	0.0%
		8	14	16	16	9	3		66	63									0	0	0.0%
	2	**6**	**13**	**6**					**27**	**27**									0	0	0.0%
		1							1	1									0	0	0.0%
	2	5	3						10	10	0	0	0	3	0	1	0		4	4	40.0%
			10	6					16	16									0	0	0.0%
	17	**35**	**41**	**43**	**50**	**46**	**25**		**257**	**232**	No Entry								0	0	0.0%
	17	35	41	43	50	46	25		257	232									0	0	0.0%
			1	**1**	**6**	**28**	**6**		**42**	**36**	No Entry								0	0	0.0%
				1	6	28	6		41	35									0	0	0.0%
			1						1	1									0	0	0.0%
	1								**1**	**1**	No Entry								0	0	0.0%
	1								1	1									0	0	0.0%
	6								**6**	**6**	**0**	**1**	**4**	**3**	**4**	**3**	**0**		15	15	250.0%
	6								6	6									0	0	0.0%
	10	**11**	**24**	**27**	**38**	**26**	**15**		**151**	**136**	**12**	**18**	**15**	**14**	**37**	**23**	**2**		121	119	87.5%
	10	11	24	26	38	26	15		150	135									0	0	0.0%
				1					1	1	0	0	0	0	0	1	0		1	1	100.0%
	4	**7**	**8**	**14**	**14**	**21**	**14**		**82**	**68**									0	0	0.0%
	4	7	8	14	14	21	14		82	68	2	0	0	0	1	0	0		3	3	4.4%
	5	**4**	**2**	**1**					**12**	**12**	No Entry								0	0	0.0%
	5	4	2	1					12	12									0	0	0.0%
	5	**11**	**3**						**19**	**19**	No Entry								0	0	0.0%
			2						2	2									0	0	0.0%
	5	11	1						17	17									0	0	0.0%
	6	**6**	**3**						**15**	**15**	No Entry								0	0	0.0%
	6	6	3						15	15									0	0	0.0%
	6	**10**	**16**		**4**	**4**	**1**		**41**	**40**	No Entry								0	0	0.0%
	6	10	16		4	4	1		41	40									0	0	0.0%
	10	**12**	**22**	**25**	**30**	**22**	**16**		**137**	**121**	**9**	**11**	**29**	**29**	**24**	**20**	**0**		122	122	100.8%
	10	12	22	25	30	22	16		137	121									0	0	0.0%
	19	**18**	**15**	**4**					**56**	**56**	**21**	**21**	**17**	**5**	**0**	**0**	**1**		65	64	114.3%
	19	18	15	4					56	56									0	0	0.0%
	2					**1**			**3**	**3**									0	0	0.0%
	2					1			3	3	**1**	**1**	**1**	**1**	**0**	**0**	**0**		4	4	133.3%
	10	**12**	**4**	**12**	**4**	**5**	**13**		**60**	**47**	No Entry								0	0	0.0%
	10	12	4	12	4	5	13		60	47									0	0	0.0%
	2								**2**	**2**	No Entry								0	0	0.0%
	2								2	2									0	0	0.0%
	14	**13**	**9**	**16**	**11**	**15**	**3**		**81**	**78**	No Entry								0	0	0.0%
	14	13	9	16	11	15	3		81	78									0	0	0.0%
	12	**18**	**10**	**8**	**9**	**8**	**11**		**76**	**65**									0	0	0.0%
	3	7	6	8	1				25	25									0	0	0.0%
	9	11	4						24	24									0	0	0.0%
					8	8	11		27	16									0	0	0.0%
	9	**15**	**15**	**22**	**12**	**22**	**8**		**103**	**95**	**1**	**1**	**3**	**4**	**11**	**0**	**0**		20	20	21.1%
	2	5	6						13	13									0	0	0.0%
	7	10	9	22	12	22	8		90	82									0	0	0.0%
	12	**6**	**1**						**19**	**19**	No Entry								0	0	0.0%
	10		1						11	11									0	0	0.0%
	1								1	1									0	0	0.0%
	1	6							7	7									0	0	0.0%
	3	**2**							**5**	**5**	No Entry								0	0	0.0%
	3	2							5	5									0	0	0.0%
	7	**6**	**5**						**18**	**18**	No Entry								0	0	0.0%
	7	5	5						17	17									0	0	0.0%
		1							1	1									0	0	0.0%
	19	**15**	**24**	**25**	**27**	**24**	**12**		**146**	**134**	No Entry								0	0	0.0%
	11	14	23	25	27	24	12		136	124									0	0	0.0%
	8	1	1						10	10									0	0	0.0%
		1			**1**		**2**		**4**	**2**	No Entry								0	0	0.0%
							2		2	0									0	0	#DIV/0!
		1			1				2	2									0	0	0.0%
	5	**2**							**7**	**7**	**1**	**7**	**0**	**1**	**0**	**0**	**0**		9	9	128.6%
	5	2							7	7									0	0	0.0%
	3	**3**	**3**	**4**					**13**	**13**	No Entry								0	0	0.0%
	3	3	4						13	13									0	0	0.0%
	14	**7**	**14**	**31**	**30**	**34**	**20**		**150**	**130**	**0**	**0**	**1**	**9**	**8**	**22**	**16**		56	40	30.8%
	14	7	14	31	30	33	20		149	129									0	0	0.0%
						1			1	1									0	0	0.0%
	3	**1**							**4**	**4**	**5**	**9**	**1**	**0**	**0**	**0**	**0**		15	15	375.0%
	3	1							4	4									0	0	0.0%
		7	**3**	**2**					**12**	**12**	No Entry								0	0	0.0%
		7	3	2					12	12									0	0	0.0%
	25	**25**	**11**	**16**	**17**	**5**	**8**		**107**	**99**	No Entry								0	0	0.0%
	17	21	11	16	17	5	8		95	87									0	0	0.0%
	8	4							12	12									0	0	0.0%
	15	**9**	**15**	**3**	**1**	**2**	**3**		**48**	**45**	No Entry								0	0	0.0%
				2	1	2	3		8	5									0	0	0.0%
	15	9	15	1					40	40									0	0	0.0%
	13	**16**	**13**	**19**	**36**	**38**	**15**		**150**	**135**									0	0	0.0%
	13	16	13	19	36	38	15		150	135	14	15	12	13	16	1	0		71	71	52.6%
	20	**25**	**33**	**19**	**28**	**50**	**24**		**199**	**175**									0	0	0.0%
	20	25	33	19	27	38	22		184	162									0	0	0.0%
					1	12	2		15	13	0	0	0	0	0	0	1		1	0	0.0%

Appendix 6 – Patient Interview Information Sheet

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

UNIVERSITY OF NEWCASTLE

INFORMATION SHEET FOR PATIENTS

[Study site: 1]

[Unique identification number:]

Decision making about bladder removal for cancer –

An interview study

We would like to invite you to take part in a research study. Before you decide we would like to explain why the research is being done and what it would involve. Please take time to read this information and discuss it with others if you wish. Please ask us if anything is not clear or if you would like more information. At the end of this leaflet you will find details on how to contact us.

Part 1 tells you the purpose of this study and what will happen if you take part:

- Why is the research being done?
- Why have I been asked to take part?
- Do I have to take part?
- What will happen if I agree to take part?
- Will I receive any expenses or payments?
- What are the possible risks and benefits of taking part?
- Will my taking part in the study be kept confidential?

Part 2 gives you more detailed information about the conduct of the study:

- What will happen if I change my mind about taking part?
- Will my taking part in the study be kept confidential?
- Will my General Practitioner (GP) be informed if I take part?
- What will happen to the results of the study?
- Who is organising and funding the research?
- Who has reviewed the study?

- What happens next?
- How to contact us?

Part 1: Purpose of this study and what will happen if you take part

Why is the research being done?

This study is part of a wider research project to develop a decision aid to help patients choose the method for draining urine after the bladder has been removed for cancer. Currently, there are two options of urinary drainage when the bladder is removed:

3) Urostomy (also known ileal conduit diversion):

In this approach urine drains through an opening on the tummy (stoma) into an external bag which needs to be changed regularly.

4) Substitute bladder (orthotopic neobladder):

In this approach an artificial bladder is made from some of your bowels. This can store urine, which like a normal bladder and you can then drain the urine by straining or inserting a thin tube (catheter).

Each approach can affect patients differently and making the choice can be difficult. How people choose between the two approaches is poorly understood. This study is led by Dr Susan Wong, Professor Richard Thomson, Dr Catherine Exley and Professor Robert Pickard.

This part of the study involves individual interviews to explore how doctors, nurses and patients make this choice. The findings of the interviews will help us design a decision aid to help patients and their healthcare professionals make better informed choices.

Why have I been asked to take part?

You have been asked because you are about to have bladder surgery for cancer, and you may have been involved in making a decision about the method of draining urine.

Do I have to take part?

Taking part in an interview is entirely voluntary it is up to you to decide whether to take part. If you agree to take part, we will obtain your consent at the time of the interview. You are free to refuse to take part in this study, without giving a reason and without your medical care or legal rights being affected. If you do not want to be involved your decision will be treated with respect and entirely without prejudice.

What will happen if I agree to take part?

If you agree, our research team at Newcastle University will be in touch to arrange an interview time with you. Interviews will take place face-to-face with a researcher from our team. Notes may also be taken during the interview by the researcher. Each interview will last for about an hour and be recorded by an audio-recorder. We will meet you at a time and place that suits you, for example at your home. You are welcome to have someone with you during the discussion e.g. a family member or a friend. Should your companion clearly express the wish to be interviewed, we will ask him/her to sign a consent form prior to proceeding with the interview.

Before the interview starts, the researcher will answer any questions you may have about the study and will ask you to sign a consent form. During the interview, you may be asked questions on:

- How you chose the method of draining urine.
- Your views on the information provided by doctors and nurses, how much you were involved and the support available when you were making the choice above.
- What might better help a patient to make this choice.

We will also ask if we can keep your contact details for taking part in further studies in the future to:

1) Discuss the findings from the interviews.

2) Discuss ways to incorporate the findings into a decision aid.

Personal contact details will be held confidentially and securely, and will be held only to contact you to ask if you would take part in a future study. You will again be able to choose to help or not if approached again.

Will I receive any expenses or payments?

The research team will pay you any out of pocket travel expenses if you provide us with a receipt.

What are the possible risks of taking part?

Every effort will be made to ensure your comfort and well-being during the interview. If you become tired we will take a break and ask you if you would like to continue.

It is possible that some of the topics in the interview may be difficult or upsetting. You do not have to talk about those topics if you do not want to. If you would like to discuss any distressing or upsetting issues further, we can inform a member of the clinical team at Freeman Hospital, Newcastle-upon-Tyne who is responsible for your care with your permission. Please remember that you are free to stop taking part in the interview at anytime, and this will not affect your current or future treatment or your legal rights.

Should you raise issues of concerns demonstrated in your care, we will encourage you to bring this to the attention of your local Patient Advice and Liaison Services (PALS) and the managerial level in charge of your hospital team. We will provide the relevant contact details if necessary. If you prefer not to approach your hospital directly, we can suggest the use of National Patient Safety Agency (NPSA) system. You can also ask us to raise your concerns to the relevant parties on your behalf, if you prefer. When clear unprofessional practice has been demonstrated by your team, it is in our duty as the research team to report this to the director of research governance at the hospital trust involved and the General Medical Council.

What are the possible benefits of taking part?

Whilst there may be no personal benefit to you in taking part, the findings may help improve the ways the choices that patients make in future.

Will my taking part in the study be kept confidential?

YES - All information about your participation in the study will be strictly confidential. More details on confidentiality are included in Part 2 of this leaflet.

This completes Part 1 of this information leaflet. If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2: **Detailed information about the conduct of the study**

What will happen if I change my mind about taking part?

If you agree to be interviewed but later decide that you don't want to, please contact a member of our research team using the details at the end of this leaflet, quoting your unique identification number that is printed at the top of the first page of this leaflet.

You are also free to leave the interview at any time, without giving a reason and without your medical care or legal rights being affected. At this point we can also destroy any information you have provided in the interview, but we will ask for your permission to continue to use the information that we have collected up until the point you leave the interview. However, once we have typed up and anonymised *(your name and any identifying particulars will not be included)* the information collected in the interview it will not be possible to delete the contribution of one participant without losing other potentially important information.

Will my taking part in the study be kept confidential?

YES. We will not share details of your participation in the study with anyone outside the research team. Your name or any other information that could identify you will not appear in any reports, publications or presentations based on findings from the study. After the interview has finished, all data (audio-recordings and notes) will be typed up and anonymised (your name and any identifying particulars will not be included). The recording of the interview will be destroyed once it is typed up and checked for accuracy. Any direct quotes from participants who take part in the interviews would only be quoted as coming from "a participant" or a participant with a certain label, like "one participant [patient] said."

In accordance with Newcastle University's policy, the computer files generated from the interviews will be stored in password protected university computer network. Any paper versions of interview data (including notes taken at the interview) will be anonymised, and will be kept in a locked filing cabinet in the Institute of Health and Society at Newcastle University, and will only be available to members of the research team. The paper and computer files of the information collected in the interviews will be held by Newcastle University for 10 years then securely destroyed.

Will my General Practitioner (GP) be informed if I take part?

We will not contact your GP regarding your participation in the study.

What will happen to the results of the study?

We will publish the findings in a report and scientific journals, and present them at scientific meetings. Any information that could potentially identify you will not be included in any report or publication.

Who is organising and funding the research?

The sponsor of the research is Newcastle University and Newcastle upon Tyne Hospitals NHS Foundation Trust. The study is also part of a wider educational research project funded by the National Institute of Health Research (NIHR).

Who has reviewed the study?

This study has been reviewed and given favourable opinion by the Newcastle & North Tyneside Research Ethics Committee 2.

What happens next?

If you would like to take part, please give your contact details on the reply slip of the invitation letter enclosed and return it in the self-addressed envelope. We will contact you by phone to arrange for the interview. We will explain the study and answer any questions you may have about the study. On the day of the interview,

you will be asked to sign a consent form and we will clarify any queries you have related to the study.

How to contact us

If you have any concerns about the study, or would like more information, please contact a member of the study team:

Dr Susan Wong (Clinical Research Associate)
Telephone: 0191 2223818
Email: *s.wong@ncl.ac.uk*

Dr Mabel Lie (Research Associate)
Telephone: 0191 2225874
Email: *m.l.s.lie@ncl.ac.uk*

Mr. Mark Johnson

Consultant Urological Surgeon

Telephone: 0191 2231030

Department of Urology,

Freeman Hospital,

Newcastle upon Tyne

NE7 7DN

Alternatively, please contact your local Patient Advice an you have other concerns or complaints about the study:

Freepost: RLTC-SGHH-EGXJ
North of Tyne PALS
The Old Stables
Grey's Yard
Morpeth
Northumberland
NE61 1QD

Freephone: 0800 032 0202

Lastly, for more independent advice, you may wish to contact:

Urostomy Association
18 Foxglove Avenue
Uttoxeter
Staffordshire
ST14 8UN

Telephone: 01889 563191
Registered Charity no: 1131072

Thank you for taking the time to read this information.

Appendix 7 – Patient Interview Invitation

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

UNIVERSITY OF NEWCASTLE

LETTER OF INVITATION: PATIENTS

[Date of Letter:]

Dear [ ]

The urology team at Freeman Hospital, Newcastle-upon-Tyne who has been looking after you and our research team based in the Institute of Health and Society at Newcastle University would like to invite you, as a patient who is about to undergo bladder removal surgery and may have been involved in making a decision about the method of urine drainage, to take part in this interview study.

Decision making about bladder removal for cancer - An interview study

Our study is part of a larger research project named 'Designing Decision Aid to Facilitate Choice of Urinary Drainage Procedure after Cystectomy for Bladder Cancer'. This part of the project is led by

Dr Susan Wong, Professor Richard Thomson, Dr Catherine Exley and Professor Robert Pickard.

We aim to hold interviews with patients and healthcare professionals, in order to identify the aspects taken into account by both groups when choosing a urine drainage method with bladder removal for cancer. The findings from the interviews will be used to build decision aid to help patients to choose the most individually suitable urine drainage method. Your participation will involve an individual face-to-face interview with a researcher from our team.

Attached is an information sheet about this study which sets out in more detail what your involvement would entail, and why the study is being done. If you are interested in participating, please complete and return the reply slip below by post using the self-addressed envelope enclosed. Please note that participation in this study is entirely voluntary and you are free to refuse to take part, without giving a reason and without your medical care or legal rights being affected.

If you have any questions or would like any further details, please do not hesitate to contact us.

Yours sincerely,

Dr Susan Wong (Clinical Research Associate)

Telephone: 0191 2223818
Email: s.wong@ncl.ac.uk

Dr Mabel Lie (Research Associate)
Telephone: 0191 2225874
Email: m.l.s.lie@ncl.ac.uk

Institute of Health & Society
Baddiley-Clark Building
Newcastle University
Richardson Road
Newcastle upon Tyne
NE2 4AX

Mr. Mark Johnson

Consultant Urological Surgeon

Telephone: 0191 2231030

Department of Urology,

Freeman Hospital,

Newcastle upon Tyne

NE7 7DN

Enc. Reply Slip

✂ ----------

I am willing to participate in the study, however I understand that I am free to withdraw from the study at any time and with no reason. I understand a researcher will contact me to arrange a suitable time and place for the interview.

Name: _____

Signature: _____

Contact details (work): (email, telephone or other)

_____

_____

_____

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

UNIVERSITY OF NEWCASTLE

PATIENTS: CONSENT FORM (Appendix 8)

Site Number: [1]
Participant Identification Number: [ ]

Decision making about bladder removal for cancer - An interview study

Name of Researcher(s):	**Please initial each box**
1. I confirm that I have read and understood the information sheet dated 5th August, 2010 (Version 1.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation in the face-to-face interview is voluntary and that I am free to withdraw my participation at any time without giving any reason, without my medical or legal rights being affected.	☐
3. I understand that data collected during the study will be looked at by individuals from the research team based at Newcastle University, and that all information will remain anonymous and confidential, and that no personal information will be used which may identify me in the final report or scientific publications.	☐
4. I agree to allow the researcher to audio-record the interview. I understand that anything that can personally identify me will be removed from the typed transcripts of the interview, and that the transcripts will be used for qualitative analysis.	☐
5. I understand that once transcribed, the audio-recordings will be destroyed and transcripts stored in locked files in accordance with the Data Protection Act.	☐
6. I agree to my contact details being recorded on password protected computers located in the Institute of Health and Society at Newcastle University for the purposes of inviting me to participate in further related studies such as survey, and communicating study results.	☐
7. I agree to take part in the above study.	☐

Name of Participant	Date	Signature
Name of Person Taking Consent:	Date	Signature

When completed: 1 copy for staff member; 1 copy for researcher file

Appendix 9 – Recruited Patients for Interview: Characteristics

Interviewer ID	SiteName	StudyPatientID	Degner Choice	StudyEntryDate	StudyEntryTime	RunningTotal	Gender	DOB	Age	Ethnicity	Pre-/Post-op	Time to/from op	Diversion Type	Interview Location
1	FRH	FP1	1	15/11/2010	2pm	1	M		68	White British	Post	2 years 10 months	Conduit	Home
1	FRH	FP2	3	23/11/2010	1pm	2	F		54	White British	Post	1 year 6 months	Neobladder	FRH
1	FRH	FP3	4	18/01/2011	11.30am	3	M		59	White British	Post	1 year 4 months	Conduit	Home
1	FRH	FP4	4	24/01/2011	2pm	4	M		67	White British	Post	2 months	Conduit	Home
2	FRH	FP5	A	18/02/2011	2pm	5	M		68	White British	Post	2 years 2 months	Conduit	Home
2	FRH	FP7	A/B	23/02/2011	11am	7	F		62	White British	Post	1 year 3 months	Neobladder	Home
2	SRH	SP1	A	02/03/2011	1pm	11	M		58	White British	Post	6 months	Conduit	Home
2	FRH	FP6	A but C	08/03/2011	3pm	6	F		60	White British	Post	2 years 7 months	Conduit	Home
1	FRH	FP8	4	08/03/2011	2pm	8	M		70	White British	Post	1 year	Conduit	Home
1	FRH	FP10	2	11/03/2011	4pm	10	M		53	White British	Post	1 year 2 months	Neobladder	Home
1	FRH	FP9	5	11/03/2011	2pm	9	M		65	White British	Post	11 months	Conduit	Home
1	SRH	SP2	2	15/03/2011	1pm	13	M		58	White British	Post	3 months	Conduit	Home
1	SRH	SP3	3 - SP3; 2 - Wife	16/03/2011	2pm	12	M		54	White British	Post	4 months	Conduit	Home
2	JCUH	JP1	B	26/04/2011	3pm	14	M		72	White British	Pre	2 weeks before	Neobladder	Home
1	FRH	FP11	2 (actual); 2 (ideal)	21/07/2011	11am	15	M		Early 50s	White British	Pre	5 days	Conduit	Home
2	JCUH	JP1 (2)		08/08/2011	3pm	17	M		72	White British	Post	3 months	Neobladder	Home
2	JCUH	JP2		08/08/2011	11am	16	M		47	White British	Post	3 months	Neobladder	Home
2	FRH	FP12		04/10/2011	3pm	18	M		63	White British	Post	3 months	Conduit	Home
1	FRH	FP13	2 (actual); 2 (ideal)	28/10/2011	3pm	20	F		56	White British	Pre	5 days	Conduit	FRH
1	RHH	RP1		02/11/2011	2pm	21	M		51	North African British	Pre	2 days	Neobladder	Home
1	SRH	SP4	2	03/11/2011	2pm	19	F		71	White British	Post	6 months	Conduit	Home
1	RHH	RP2		15/11/2011	2pm	22	M		67	White British	Post	4 months	Conduit	Home
1	RHH	RP3		22/11/2011	11am	23	M		59	White British	Post	5 months	Conduit	Home
1	RHH	RP4		30/11/2011	11am	27	M		69	White British	Post	1 year 2 months	Neobladder	Home
1	RHH	RP5	2 (actual); 2 (ideal)	30/11/2011	2pm	28	M		63	White British	Pre	6 days	Conduit	Home
1	JCUH	JP3		25/01/2012	3.30pm	27	M		Mid 60s	White British	Pre	2.5 weeks before	Conduit	Home
1	RHH	RP6		26/01/2012	11am	24	M		64	White British	Post	4 months	Conduit	Home
1	RHH	RP7		31/01/2012	11am	25	M		53	White British	Post	4 months	Neobladder	Home

Appendix 10 – Clinician Interview Information Sheet

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

UNIVERSITY OF NEWCASTLE

INFORMATION SHEET FOR CLINICIANS

[Study site: 1]

[Unique identification number:]

Decision making about urinary diversion with radical cystectomy for cancer - An interview study

We would like to invite you to take part in a research study. Before you decide we would like to explain why the research is being done and what it would involve. Please take time to read this information and discuss it with others if you wish. Please ask us if anything is not clear or if you would like more information. At the end of this leaflet you will find details on how to contact us.

Part 1 tells you the purpose of this study and what will happen if you take part:

- Why is the research being done?
- Why have I been asked to take part?
- Do I have to take part?
- What will happen if I agree to take part?
- Will I receive any expenses or payments?
- What are the possible risks and benefits of taking part?
- Will my taking part in the study be kept confidential?

Part 2 gives you more detailed information about the conduct of the study:

- What will happen if I change my mind about taking part?
- Will my taking part in the study be kept confidential?
- Will my General Practitioner (GP) be informed if I take part?
- What will happen to the results of the study?
- Who is organising and funding the research?
- Who has reviewed the study?

- What happens next?
- How to contact us?

Part 1: Purpose of this study and what will happen if you take part

Why is the research being done?

This study is part of a wider research project to develop a decision aid to help patients choose the urinary diversion method after radical cystectomy for cancer. Currently, the two methods of diversion most commonly offered are ileal conduit diversion and orthotopic neobladder reconstruction. Each method can affect patients differently and making the choice can be difficult. How patients choose between the two approaches is poorly understood. This study is led by Dr Susan Wong, Professor Richard Thomson, Dr Catherine Exley and Professor Robert Pickard.

This part of the study involves individual, interviews to explore how healthcare professionals and patients make this choice. The findings of the interviews will help us design a decision aid to help patients and their healthcare professionals make better informed choices.

Why have I been asked to take part?

You have been asked because you are a healthcare professional involved in the decision making about urinary diversion when radical cystectomy is performed for bladder cancer.

Do I have to take part?

Taking part in an interview is entirely voluntary it is up to you to decide whether to take part. If you agree to take part, we will obtain your consent at the time of the interview. You are free to refuse to take part in this study, without giving a reason and without your employment or legal rights being affected. If you do <u>not</u> want to be involved in this study your decision will be treated with respect and entirely without prejudice.

What will happen if I agree to take part?

If you agree, our research team at Newcastle University will be in touch with you again to arrange for an interview, and ask you to assist in recruiting patients for interviews. We will communicate with you on a separate occasion regarding the details of patient recruitment.

Interviews will take place face-to-face with a researcher from our team. Notes may also be taken during the interview by the researcher. Each interview will last for about an hour and be recorded by an audio-recorder. We will meet you at a time and place within your work premise that suits you.

Before the interview starts, the researcher will answer any questions you may have about the study and will ask you to sign a consent form. During the interview, you may be asked questions on:

- Aspects you considered in selecting a urinary diversion method for a patient when radical cystectomy is performed for cancer.
- Your experience on communication and engagement with patients, when deciding which urinary diversion to proceed with in the context of radical cystectomy.
- What may help you and a patient to decide on the urinary diversion to adopt.

We will also ask if we can keep your contact details for taking part in further studies in the future to:

1) Discuss the findings from the interviews.

2) Discuss ways to incorporate the findings into a decision aid.

Personal contact details will be held confidentially and securely, and will be held only to contact you to ask if you would take part in a future study. You will again be able to choose to help or not if approached again.

Will I receive any expenses or payments?

There will be no financial incentive for taking part in the research.

What are the possible risks of taking part?

Every effort will be made to ensure your comfort and well-being during the interview. If you become tired we will take a break and ask you if you would like to continue.

It is possible that taking part in an interview may raise some potentially controversial issues or may cause you to recall distressing experiences from your clinical work.

What are the possible benefits of taking part?

Whilst there may be no personal benefit to you in taking part, the findings may help improve the ways the choices that patients make in future.

Will my taking part in the study be kept confidential?

YES - All information about your participation in the study will be strictly confidential. More details on confidentiality are included in Part 2 of this leaflet.

This completes Part 1 of this information leaflet. If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2: **Detailed information about the conduct of the study**

What will happen if I change my mind about taking part?

If you agree to participate (interview and patient recruitment) but later decide that you no longer wish to, please contact a member of our research team using the details at the end of this leaflet, quoting your unique identification number that is printed at the top of the first page of this leaflet.

You are also free to leave the interview at any time, without giving a reason and without your medical care or legal rights being affected. At this point we can also destroy any information you have provided in the interview, but we will ask for your permission to continue to use the information that we have collected up until the point you leave the interview. However, once we have typed up and anonymised *(your name and any identifying particulars will <u>not</u> be included)* the information collected in the interview it will not be possible to delete the contribution of one participant without losing other potentially important information.

Will my taking part in the study be kept confidential?

YES. We will not share details of your participation in the study with anyone outside the research team. Your name or any other information that could identify you will not appear in any reports, publications or presentations based on findings from the study. After the interview has finished, all data (audio-recordings and notes) will be typed up and anonymised (your name and any identifying particulars will not be included). The recording of the interview will be destroyed once it is typed up and checked for accuracy. Any direct quotes from participants who take part in the interviews would only be quoted as coming from "a participant" or a participant with a certain label, like "one participant [surgeon/nurse] said."

In accordance with Newcastle University's policy, the computer files generated from the interviews will be stored in password protected university computer network. Any paper versions of interview data (including notes taken at the interview) will be anonymised, and will be kept in a locked filing cabinet in the Institute of Health and Society at Newcastle University, and will only be available to members of the research team. The paper and computer files of the information collected in the interviews will be held by Newcastle University for 10 years then securely destroyed.

What will happen to the results of the study?

We will publish the findings in a report and scientific journals, and present them at scientific meetings. Any information that could potentially identify you will not be included in any report or publication.

Who is organising and funding the research?

The sponsor of the research is Newcastle University and Newcastle upon Tyne Hospitals NHS Foundation Trust. The study is also part of a wider educational research project funded by the National Institute of Health Research (NIHR).

Who has reviewed the study?

This study has been reviewed and given favourable opinion by Newcastle & North Tyneside Research Ethics Committee 2.

What happens next?

If you agree to take part, please provide your contact details (e-mail address and contact telephone number) via e-mail, or on the reply slip of the invitation letter enclosed and return the slip by post. A member of our research team will soon contact you by phone to arrange for an interview to take place. We will explain the study and answer any questions you may have about the study. Before we proceed with the interview on the day, you will be asked to sign a consent form and we will clarify any queries you have related to the study.

How to contact us

If you have any concerns about the study, or would like more information, please contact a member of the study team:

Dr Susan Wong (Clinical Research Associate)
Telephone: 0191 2223818
Email: *s.wong@ncl.ac.uk*

Dr Mabel Lie (Research Associate)
Telephone: 0191 2225874
Email: *m.l.s.lie@ncl.ac.uk*

Thank you for taking the time to read this information.

Mr. Mark Johnson

Consultant Urological Surgeon

Telephone: 0191 2231030

Department of Urology,

Freeman Hospital,

Newcastle upon Tyne

NE7 7DN

Appendix 11 – Clinician Interview Invitation

Research Team
Susan S W Wong - NIHR Research Fellow
Cath Exley - Senior Lecturer
Robert Pickard - Professor of Urology
Richard Thomson - Professor of Public health

Dear [ ]

RE: A questionnaire survey of clinicians' views on decision support for choosing between ileal conduit and orthotopic neobladder with radical cystectomy

We are a group of researchers based at the Institute of Health & Society, Newcastle University, and in conjunction with the Oncology Section of BAUS, would like to invite you to participate in this short questionnaire survey. It is a self-completed, web-based survey and is part of a wider research project, which aims to develop formal support for bladder cancer patients who will undergo radical cystectomy to help them make a choice between ileal conduit and orthotopic neobladder) that best suits them. You have been invited since you are a urologist involved in the decision making about urinary diversion when radical cystectomy is performed for bladder cancer. The survey takes 15-20 minutes to complete and it asks your views on the current support you have available for helping patients make the choice of diversion, and potential ways to improve the support.

We understand that sometimes a patient is suitable for only one of the two diversion options mentioned because of patient health or cancer factors; at other times however, a patient can be a candidate for either option. In the latter case, choosing the most suitable diversion on an individual level can be a difficult process for both the patient concerned and his/her responsible clinicians. To date, little is known about this choice-making process. The findings from this survey and other components of the project including qualitative interviews and workshops will inform the content of the decision support we are going to develop.

At the end of the survey there is a brief introduction to the subsequent interview study and you will have the opportunity to express your interest in taking part as an independent healthcare professional.

Please note that participation in this survey is entirely voluntary. Should you decide to participate, please follow the link below and follow the instructions.

http://www.surveymonkey.com/s/XKFN57M

The survey is hosted on the password-protected SurveyMonkey™ system and all data collected will be automatically anonymised. Only participants who indicate their interest in taking part in the interview phase will be identifiable by giving their e mail address. Any publication generated from the survey will therefore report on aggregate data only and no individual respondents will be identified.

Thank you ever so much for your time, and if you have any queries please do not hesitate to contact us.

Kind Regards,

Susan S W Wong (Clinical Research Associate)

Telephone:
0191 222 3818 (Work)

Email: ***s.wong@ncl.ac.uk***

Address:
Institute of Health & Society
Baddiley-Clark Building
Newcastle University
Richardson Road
Newcastle upon Tyne
NE2 4AX

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

UNIVERSITY OF NEWCASTLE

CLINICIANS: CONSENT FORM (Appendix 12: Local)

Site Number: [1]
Participant Identification Number: [ ]

Decision making about urinary diversion with radical cystectomy for cancer - An interview study

Name of Researcher(s): **Please initial each box**

8. I confirm that I have read and understand the information sheet dated 4th June, 2010 (Version 1.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

9. I understand that my participation in the face-to-face interview is voluntary and that I am free to withdraw my participation at any time without giving any reason, without my employment or legal rights being affected. ☐

10. I understand that data collected during the study will be looked at by individuals from the research team based at Newcastle University, and that all information will remain anonymous and confidential, and that no personal information will be used which may identify me in the final report or scientific publications. ☐

11. I agree to allow the researcher to audio-record the interview. I understand that anything that can personally identify me will be removed from the typed transcripts of the interview, and that the transcripts will be used for qualitative analysis. ☐

12. I understand that once transcribed, the audio-recordings will be destroyed and transcripts stored in locked files in accordance with the Data Protection Act. ☐

13. I agree to my contact details being recorded over on password protected computers located in the Institute of Health and Society at Newcastle University for the purposes of inviting me to participate in further related studies such as validation workshop, and communicating study results. ☐

14. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person Taking Consent:	Date	Signature

When completed: 1 copy for staff member; 1 copy for researcher file

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

UNIVERSITY OF NEWCASTLE

CLINICIANS: CONSENT FORM (Appendix 13: Non-Local)

Site Number: [4]
Participant Identification Number: [ ]

Decision making about urinary diversion with radical cystectomy for cancer - An interview study

Name of Researcher(s): **Please initial each box**

15. I confirm that I have read and understand the information sheet dated 4th June, 2010 (Version 1.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

16. I understand that my participation in the face-to-face interview is voluntary and that I am free to withdraw my participation at any time without giving any reason, without my employment or legal rights being affected. ☐

17. I understand that data collected during the study will be looked at by individuals from the research team based at Newcastle University, and that all information will remain anonymous and confidential, and that no personal information will be used which may identify me in the final report or scientific publications. ☐

18. I agree to allow the researcher to audio-record the interview. I understand that anything that can personally identify me will be removed from the typed transcripts of the interview, and that the transcripts will be used for qualitative analysis. ☐

19. I understand that once transcribed, the audio-recordings will be destroyed and transcripts stored in locked files in accordance with the Data Protection Act. ☐

20. I agree to my contact details being recorded over on password protected computers located in the Institute of Health and Society at Newcastle University for the purposes of inviting me to participate in further related studies such as validation workshop, and communicating study results. ☐

21. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person Taking Consent:	Date	Signature

When completed: 1 copy for staff member; 1 copy for researcher file

Appendix 14 – Recruited Clinicians for Interview: Characteristics (Local)

StudyClinicianID	Degner Choice 1	Degner Choice 2	StudyEntryDate	StudyEntryTime	RunningTotal	Gender	Seniority	Ethnicity	Surgeon/Specialist Nurse	Interview Location
FC1	3	3	23/11/2010	10am	1	F		White British	SN	FRH
C1	4	2	08/12/2010	1pm	2	F		White British	SN	Wansbeck General
C2	4	3	13/01/2011	2pm	3	F		White British	SN	FRH
FC2	C	B	14/01/2011	2pm	4	M		White British	Surgeon	FRH
FC3	2	2	03/02/2011	1pm	5	F		White British	SN	Home
FC4	B	A	10/02/2011	9am	6	M		White British	Surgeon	FRH
FC5	B/C	B	14/02/2011	11am	7	M		Asian British	Surgeon	FRH
SC1	C	B	02/03/2011	3.30 pm	8	M		White British	Surgeon	SRH
JC2	4	3	07/03/2011	4pm	9	M		White British	Surgeon	JCUH
JC1	B	A	23/03/2011	2.30pm	10	F		White British	Surgeon	JCUH
JC3	Scale not used	Scale not used	13/04/2011	10.30pm	11	F		White British	Surgeon	JCUH
SC2	E	A	31/08/2011	11am	12	F		White British	SN	SRH
JC4	B	B	05/09/2011	2pm	13	F		White British	SN	JCUH
RC1	B	B	06/12/2011	10am	14	M		White British	Surgeon	
RC2	B	A	06/12/2011	2pm	15	F		White British	SN	
RC3	B	B	13/02/2012	2pm	16	M		Non-white British	Surgeon	

Appendix 14 – Recruited Clinicians for Interview: Characteristics (Non- Local: Surgeons)

Gender	Age	Yrs of Experience	No. Cystectomy counselled last yr	IC counselled	ON counselled	Degner	Add Comments	Date info sent	Date Reminder	Participation Y/N	Consent Hardcopy prior to interview Y/N	Date, time interview	Interviewer	Degner1	Degner 2
Female	40	0 to 5 years	10	8	0	I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	999	07.09.11	N/A	Y	N/51. Consent sent on 19.10.11.	19.09.11, 12pm	SW	D	C
Male	45	0 to 5 years	10	4	6	I would prefer that my patient and I make the decision about the diversion jointly	well designed leaflets/booklets are very valuable, but equally important is to have the same information available on websites that are carefully designed in a user friendly way so that lay person find easy.	07.09.11	N/A	Y	N/54. Consent sent on 19.10.11.	04.10.11, 2.30pm	SW	C	C
Male	40	0 to 5 years	10	9	1	I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	I think leaflets and booklets are still the most applicable as many older people still do not use the internet. However an internet source of information should also be developed as this will obviously turn into the major source of information as time progresses. Pictures and DVD's etc should just be incorporated into the website. I think it is also important to remember continent diversion as a viable option of diversion for all patients who are not suitable for orthotopic for cancer reasons. This material should be developed at the same time as IC and orthotopic.	07.09.11	N/A	Y	N/52. Consent sent by ML.	25.10.11, 10.30am	ML	?	?
Male	47	6 to 10 years	35	28	7	I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	I leave the final decision to the patient together with our nurse specialist	07.09.11	23.09.11						
Male	44	6 to 10 years	17	14	3	I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	999	07.09.11	N/A	Y	N/56. Consent sent by ML.	28.09.11, 10am	ML	D	D
Male	51	6 to 10 years	18	18	0	I would prefer that my patient and I make the decision about the diversion jointly	999	07.09.11	23.09.11	Y	N/59. Consent sent on 19.10.11.	05.10.11, 11am	SW	C	C
Male	47	6 to 10 years	21	18	3	I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	In my experience having access to a bank of patients willing to speak to new patients considering the options is invaluable.	07.09.11	N/A	Y	N/55. Card sent.	05.10.11, 9.30am	SW	C	C
Female	48	11 to 15 years	15	15	999	I would prefer that my patient and I make the decision about the diversion jointly	A large proportion of my cystectomy patients are elderly +/-not very IT literate so written information needs to be available	07.09.11 OOO							
Male	47	11 to 15 years	12	8	4	I would prefer that my patient and I make the decision about the diversion jointly	999	07.09.11	23.09.11						
Male	52	11 to 15 years	75	48	4	I would prefer to leave the decision about the diversion to my patient	The patient should choose the diversion, having been informed, rather than persuaded, provided that both options look reasonable and sensible to us.	07.09.11	23.09.11						
Male	53	16 to 20 years	0	0	6	I would prefer to leave the decision about the diversion to my patient	999	07.09.11	23.09.11						
Male	50	16 to 20 years	18	15	3	I would prefer that my patient and I make the decision about the diversion jointly	999	07.09.11	23.09.11						
Male	57	over 20 years	55	31	9	I would prefer to leave the decision about the diversion to my patient	I would prefer to allow the patient to decide but this is heavily influenced by many factors as well as my opinion and advice - What are the patients own motivators? How much value do they assign to various aspects of their future? I fear that most patients are still most influenced by what I say - the shift in my own prejudice towards allowing orthotopic to be the default position has been closely mirrored by the increasing proportion of patients submitting themselves for this option.	07.09.11 OOO	N/A	Y	N/57. Card sent.	9am, 10.10.11	SW	B	?:E
Male	61	over 20 years	10	7	3	I would prefer that my patient and I make the decision about the diversion jointly	999	07.09.11	N/A	Y	N/53. Consent sent on 19.10.11.	13.10.11, 4pm	SW	?	B
Male	53	16 to 20 years	18	15	3	I would prefer that my patient and I make the decision about the diversion jointly	999	29.09.11	18.10.11						
Male	54	16 to 20 years	30	25	5	I would prefer that my patient and I make the decision about the diversion jointly	999	29.09.11	18.10.11						
Male	62	16 to 20 years	12	6	2	I would prefer that my patient and I make the decision about the diversion jointly	999	29.09.11	18.10.11						
Male	52	11 to 15 years	25	19	2	I would prefer that my patient and I make the decision about the diversion jointly	999	29.09.11	18.10.11						
Male	50	11 to 15 years	20	14	6	I would prefer to make the decision about the diversion, after seriously considering my patient's opinion	999	29.09.11	18.10.11						
Male	53	16 to 20 years	60	35	25	I would prefer that my patient and I make the decision about the diversion jointly	999	29.09.11	N/A	Y	N/58				
Male	47	11 to 15 years	20	15	5	I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	999	29.09.11	18.10.11						

Appendix 14 – Recruited Clinicians for Interview: Characteristics (Non- Local: Nurses)

Gender	Age	Yrs of Experience	No. Cystectomy counselled last yr	IC counselled	ON counselled	Region	Degner	Add Comments	Date info sent	Date Reminder	Participation Y/N	Consent Hardcopy prior to Interview Y/N	Date and Time Interview	Interviewer	Degner 1	Degner 2
Female	38	0 to 5 years	3	999	999	Guernsey	I would prefer to leave the decision about the diversion to my patient	I think it is important that the patient is given all the required information from the different Specialists but ultimately, the Surgeon and the patient need to discuss which option is going to have the best outcome for them and their future needs. Also, the Surgeon has a lot more considerations to think about regarding the patients performance status.	08.09.11	N/A	Y	N/N3. Card sent.	10.10.11, 11am	SW	B	?:
Female	46	6 to 10 years	16	10	6	Slough	I would prefer to leave the decision about the diversion to my patient	When I first counsel patients re the pros & cons of each form of surgery, there seems to be a lack of awareness from them relating to the possible complications of neo-bladder surgery - e.g. possibility of incontinence or need for self-catheterisation. I don't really feel that I should be the first person they hear this information from. Having a urostomy does sometimes seem to be presented to patients as a less favourable option by their surgeon. I would certainly prefer it if their surgeon gave them a more balanced view of both types of surgery before they came to see me, especially since my initial contact with them is sometimes only a week or two before their operation. This leaves patients with very little time to make an informed decision - especially if they then wish to make contact with former patients to hear their experiences first.	08.09.11	N/A	Y	N/N2. Consent sent by ML.	13.10.11, 3.15pm	ML	A	?
Female	51	6 to 10 years	10	10	0	Tooting	I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	sometimes we are told that a patient is deciding between diversion options, but has never been referred to us as the stoma nurses. I do not feel that they have been given enough information on ileal conduit, if they have not met us to make a fully informed choice.	08.09.11	23.09.11 e-mailed. Need post.	Y	N/N5				
Female	48	11 to 15 years	8	6	2		I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	Pt must be the one to decide but for some the practicalities of option may not be suitable to all and at this point I would want the pt to think hard about the decision understanding all that is involved.	08.09.11	23.09.11						
Female	59	over 20 years	6	5	1	W. Sussex	I would prefer to leave the decision about the diversion to my patient	We must leave the final decision to the patient having talked about all the risks, benefits etc.	08.09.11	23.09.11						
Female	55	over 20 years	22	15	6	London	I would prefer that my patient and I make the decision about the diversion jointly	999	08.09.11	23.09.11		N/N4. Consent and card sent.	5pm, 24.09.11	SW	?	?
Female	45	6 to 10 years	10	5	5	Brighton	I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	it is important that pts have the information and your experence in order for them to make a decision for them	08.09.11	23.09.11 e-mailed with WCET UK in error. Need post.						
Female	55	6 to 10 years	28	25	3	Belfast	I would prefer that my patient and I make the decision about the diversion jointly	I have found that there is quite some inconsistency in the information available reagarding post-operative and discharge care for patients with neobladder reconstruction. Therefore a more balanced view and information would be helpful	08.09.11	23.09.11						
Female	45	16 to 20 years	Approx. 50	35	15	Swansea	I would prefer to leave the decision about the diversion to my patient	999	08.09.11	23.09.11	Y	N/N6. Consent sent 08.11.11.	08.11.11, 2pm. 01792 703526	SW	B	B
Female	50	11 to 15 years	10	3	7	Manchester	I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	999	08.09.11	N/A	Y	N/N1. Card sent.	24.10.11, 2pm	SW	B	B
Female	33	0 to 5 years	Approx. 15	Approx. 15	4		I would prefer to leave the decision about the diversion to my patient	I provide all the advantages and disadvantages of the procedure, providing leaflets and booklets and visual aids and when I provided all the facts would leave the decision with my patient and be there to support them in whatever they choose	08.09.11	23.09.11						
Male	37	11 to 15 years	12	11	1		I would prefer to leave the decision about the diversion to my patient	999	08.09.11	23.09.11						
Female	46	6 to 10 years	32	26	3		I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion	999	29.09.11	18.10.11						
Female	46	16 to 20 years	12 to 15	12 to 15	8		I would prefer to leave the decision about the diversion to my patient (If medically fit enough for neobladder)	Some patients do not have a choice of neobladder as the operation is longer; if not fit so would not get to choose	29.09.11. Prefers post.	18.10.11. Posted						
Female	45	6 to 10 years	4	4	999		I would prefer to leave the decision about the diversion to my patient	Patient to make own decision after information given for informed decision by patient	29.09.11	18.10.11						
Female	51	11 to 15 years	12	12	999		I would prefer to leave the decision about the diversion to my patient	999	29.09.11	18.10.11	N (as hospital does not perform radical cystectomy anymore)					
Female	49	11 to 15 years	10	10	999		I would prefer that my patient and I make the decision about the diversion jointly	To ensure the patient is fully informed befor they make a decision	29.09.11	18.10.11	Y	N/N8				
Female	47	16 to 20 years	22	15	5 (2 Neo + Mitrofanoff)	London	I would prefer to leave the decision about the diversion to my patient	To previous question I would leave the choice to the pa tients once they have had an opportunity to be provided with information on all options.	16.11.11	N/A	Y	N/N7. Consent sent 28.11.11	10 am, 28.11.11	SW	B	B

Appendix 15 – Interview Guides: Patients

Decision making about bladder removal for cancer – An interview study

Patient interview schedule

Introductory

1. Introduce researcher and purpose of the study.

2. Obtain written consent to proceed and to audio-record the interview conversation.

3. Remind interviewee about confidentiality, anonymity and disposal of all interview information, according to University's regulations and Data Protection Act (1998).

4. Remind Interviewee that they are free to stop or withdraw at anytime.

Questions

1. I understand you had a chat with your surgeon before going into hospital for the bladder removal surgery. Can you recall what was covered with your surgeon during the chat?

    - Probe:

    - About bladder removal
    - About urinary drainage (urine diversion)
    - The option(s) of diversion methods mentioned
    - About talking with Specialist Nurses after seeing the surgeon

(If only one method mentioned, stress that sometimes for clear reasons e.g. the location of the bladder growth, concerns for medical fitness etc. a patient is not suitable for other methods. Then mention otherwise there would have been two urine diversion methods available: urostomy and neobladder)

2. How did you feel when you when you were advised that the bladder should be removed?

3. When you were faced with two choices of urine diversion methods, how did you feel? (For patients with two choices only).

4. When you were choosing/if you had a chance to choose between the options of urine diversion methods, what did/would you take into account?

    - Probe:

    - Benefits (survival)/Risks (recurrence), complications
    - Recovery, rehabilitation, self-help groups, follow-up
    - Daily management, supplies, care arrangements
    - Impact on significant others
    - Work, leisure/sports/travel
    - Self-identity, body image, sexual matters
    - Likelihood of disease progression
    - Impact on overall quality of life
    - The most important factor to the patient
    - Rank most important/least important factors

5. What did you think of the information given to you about your surgery by your surgeon and his/her team?

    - Probe:

    - What information, the amount and helpfulness of information on bladder removal and/or diversion(s)
    - Information given should cover all the factors stated above, in Question 2.
    - Any additional information the patient would like
    - Anything now known would have been beneficial to know before the surgery?

6. Were there any materials you came across before your surgery that were helpful?

    - Probe:

    - Leaflets/booklets, DVDs, Audio-CDs etc.
    - Anything the patient would have liked to have.
    - Where did the patient get the information.

7. Who helped you/ to choose between the urine diversion methods?

    - Probe:

    - Surgeon/Specialist Nurses/Spouse/Family/Friends/Others
    - Who were the most helpful/influential?
    - Who would you have preferred help or more help from?

8. We are trying to encourage future patients like yourself have more say, when it comes to deciding on management/treatments. How important do you think this is? What do you think can help with this?

9. Also, we are trying to build some material helping future patients to choose a diversion method that best suits them when the diseased bladder is to be removed. Do you have any suggestions? (Probe: format and the way the material should be used)

10. How involved did you feel in the whole discussion about your surgery?

11. How involved would you prefer to be (Flashcard)?

Use Degner Control Preference Scale:

- **I would prefer to make the decision about which urine diversion method I would have.**
- **I would prefer to make the final decision about the urine diversion method after seriously considering the opinion from my surgeon's and his/her team.**
- **I would prefer my surgeon along with his/her team and I shared the responsibility for deciding which urine diversion method was best for me.**
- **I would prefer my surgeon and his/her team made the final decision on which urine diversion method would be used, but seriously considered my opinion.**
- **I would prefer to leave all decisions regarding urine diversion method to my surgeon and his/her team.**
- **If patient feels not as involved as he/she would have liked, ask how much he/she would prefer.**

12. How do you feel about your surgery now (for post-surgery patients only)

- Probe:

- Overall satisfaction, regrets, level of cope etc.
- Would make the same decision again? If not , why not?

13. Are there any other issues you would like to mention?

Appendix 15 – Interview Guides: Clinicians - Surgeons

Decision making about urinary diversion with radical cystectomy for cancer - An interview study

Clinician (Surgeon) interview schedule

Introductory

5. Introduce researcher and purpose of the study.

6. Obtain written consent to proceed and to audio-record the interview conversation.

7. Remind interviewee about confidentiality, anonymity and disposal of all interview information, according to University's regulations and Data Protection Act (1998).

8. Remind Interviewee that they are free to stop or withdraw at anytime.

Questions

14. To begin with, can you tell me something about yourself? How long have you been a consultant?

15. What is your experience of performing/observing ileal conduits and neobladders so far?

16. What is your experience of being involved in decisions about urinary diversions with radical cystectomy? What would you say was the level of your involvement?

    (Encourage surgeon to provide examples)

17. How do you decide on the urinary diversions to offer? (Probe: how to decide to offer one or both diversions)

    - Probe:

        - Which diversion recommended most often and why.

- Try to elicit clinical and non-clinical characteristics for the above, including time required for each procedure.

18. You have mentioned the following factors in your decision (list factors) - which would you say is the most important/least important?

19. What is your typical pre-surgery chat with a patient undergoing radical cystectomy with urinary diversion like?

- Probe

- Any companions?
- Topics covered
- Level of input from patient and his/her companions? Use Degner Control Preference Scale (CPS) for patient (P). (Flashcard)

- **P made the decision about which urine diversion method P would have.**
- **P made the final decision about the urine diversion method after seriously considering the opinion from surgeon's and his/her team.**

- **Surgeon along with his/her team and P shared the responsibility for deciding which urine diversion method was best for me.**

- **Surgeon and his/her team made the final decision on which urine diversion method would be used, but seriously considered P's opinion.**

- **P left all decisions regarding urine diversion method to surgeon and his/her team.**

- What are some of the reactions you get from the patient and his/her company when you tell them about bladder removal and the diversion(s)?

20. What information do you give a pre-cystectomy patient, on the cystectomy itself and the diversion(s)?

21. Are any materials given to a pre-cystectomy patient in your practice? If so, what are they? What do you think of their usefulness?

- Probe:

- Leaflets/booklets, DVDs, Audio-CDs etc.
- The amount and helpfulness of these materials.

22. Who else are influential in helping the patient to reach a decision in the choice between the two diversion options?

- Probe:

  - Specialist Nurses/Spouse/Family/Friends/Others
  - (Of those you have mentioned, who have you found to have been most influential? - Can be asked with Question 3)
  - What do you think of their role and level of involvement?

23. What do you prefer in terms of involvement, when deciding which urine diversion method to proceed with? (For patients suitable for both diversion methods) (Flashcard)

- **Use Degner CPS adapted for Clinicians:**

  I would prefer to leave the decision about the diversion to my patient

  I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion

  I would prefer that my patient and I make the decision about the diversion jointly.

  I would prefer to make the decision about the diversion, after seriously considering my patient's opinion.

  I would prefer to make the decision about the diversion.

24. Do you think it is a good idea to encourage future cystectomy (radical) patients who are suitable for both diversion methods to have more say in deciding on the diversion method to go with.

- Probe:

  - If yes, what could facilitate this?
  - If not, why not?

25. Also, we are trying to develop some material helping future patients to choose a diversion method that best suits them when the diseased bladder is to be removed. Do you have any suggestions? (Probe: format and the way the material should be used)

26. Are there any other issues you would like to mention?

Appendix 15 – Interview Guides: Clinicians - Nurses

Decision making about urinary diversion with radical cystectomy for cancer - An interview study

Clinician (Specialist Nurse) interview schedule

Introductory

9. Introduce researcher and purpose of the study.

10. Obtain written consent to proceed and to audio-record the interview conversation.

11. Remind interviewee about confidentiality, anonymity and disposal of all interview information, according to University's regulations and Data Protection Act (1998).

12. Remind Interviewee that they are free to stop or withdraw at anytime.

Questions

27. To start, can you tell me something about yourself: fpr examplehow long have you been a specialist nurse?

28. What has your experience been of counselling radical cystectomy patients so far?

29. Have you been involved in decisions about urinary diversions with radical cystectomy? If so how?

    (Encourage specialist nurse to provide examples)

30. Has a patient changed his/her mind about the diversion to proceed with, after speaking to you?

31. Say you have a patient who is to undergo radical cystectomy with urinary diversion. How would you advise him/her? (Probe: about patients with and without both choices of diversion)

32. You have mentioned the following factors in the advice you give (name them) - which would you say is the most important?

33. How do you see your role in helping patients reach a decision?

34. How do most patients see your role? And how does the consultant see your role?

35. What is your typical pre-surgery chat with a patient undergoing radical cystectomy with urinary diversion like?

- Probe

  - Any companions?
  - Topics covered
  - Usual level of input from patient and his/her companions? Use Degner Control Preference Scale (CPS) for patient (P). (Flashcard)

- **P makes the decision about which urine diversion method P would have.**

- **P makes the final decision about the urine diversion method after seriously considering the opinion from surgeon's and his/her team.**

- **Surgeon along with his/her team and P shares the responsibility for deciding which urine diversion method was best for me.**

- **Surgeon and his/her team makes the final decision on which urine diversion method would be used, but seriously considered P's opinion.**

- **P leaves all decisions regarding urine diversion method to surgeon and his/her team.**

8. From your experience, what have been some of the reactions of your patients and their company when you discuss with them about bladder removal and the diversion(s)?

36. What information do you give a pre-cystectomy patient, on the cystectomy itself and the diversion(s)?

37. Are any materials given to a pre-cystectomy patient in your practice? If so, what are they? What do you think of their usefuleness?

- Probe:

  - Leaflets/booklets, DVDs, Audio-CDs etc.
  - The amount and helpfulness of these materials.

38. Who else are helpful/influential to the patient in reaching a decision regarding the choice between the two diversion options?

    - Probe:

      - Surgeon/Spouse/Family/Friends/Others
      - (Of those you have mentioned, who have you found to have been most helpful/influential? - Can be asked with Question 3)

39. If it was down to you alone, how involved would you prefer to be when deciding on the urine diversion method to proceed with? (For patients suitable for both diversion methods)

    - Probe:

      - Use Degner CPS adapted for Clinicians (Flashcard):

I would prefer to leave the decision about the diversion to my patient

I would prefer that my patient makes the decision about the diversion, after seriously considering my opinion

I would prefer that my patient and I make the decision about the diversion jointly.

I would prefer to make the decision about the diversion, after seriously considering my patient's opinion.

I would prefer to make the decision about the diversion.

40. Do you think it is a good idea to encourage future cystectomy (radical) patients who are suitable for both diversion methods to have more say in deciding on the diversion method to go with.

    - Probe:

      - If yes, what could facilitate this?

- If not, why not?

41. Also, we are trying to build some material helping future patients to choose a diversion method that best suits them when the diseased bladder is to be removed. Do you have any suggestions? (Probe: format and the way the material should be used)

42. Are there any other issues you would like to mention?

Appendix 16 – SWPHO Dataset Analysed

Px ID	Cons ID	Centre	Centre ID	(HES) Centre Case	Centre Caseload	Network ID	(HES) Network Caseload	Network Caseload	Sex	Age	Indication	Diversion
1	1	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	999	Muscle invasive TCC	Ileal Conduit
2	1	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	74	Muscle invasive TCC	Ileal Conduit
3	1	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	48	Muscle invasive TCC	Ileal Conduit
4	1	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	72	Primary CIS	Ileal Conduit
5	1	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		F	81	Muscle invasive TCC	Ileal Conduit
6	1	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	59	Muscle invasive TCC	Orthotopic
7	1	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	45	Muscle invasive TCC	Orthotopic
8	2	(Ashington)	1	9		36	405		M	62	Muscle invasive TCC	Ileal Conduit
9	2	(Ashington)	1	9		36	405		M	69	Muscle invasive TCC	Ileal Conduit
10	2	(Ashington)	1	9		36	405		F	77	Uncontrolled superficial disease	Orthotopic
11	2	(Ashington)	1	9		36	405		M	63	Muscle invasive TCC	Ileal Conduit
12	2	Cumberland Infirmary; West Cumberland Hospita	17	1		36	405		F	65	Muscle invasive TCC	Ileal Conduit
13	2	Freeman Hospital	23	258		36	405		M	77	Muscle invasive TCC	Ileal Conduit
14	2	Freeman Hospital	23	258		36	405		M	68	Primary adenocarcinoma	Ileal Conduit
15	2	Freeman Hospital	23	258		36	405		M	77	Muscle invasive TCC	Ileal Conduit
16	2	Freeman Hospital	23	258		36	405		M	79	Muscle invasive TCC	Ileal Conduit
17	2	Freeman Hospital	23	258		36	405		M	999	Muscle invasive TCC	Ileal Conduit
18	2	Freeman Hospital	23	258		36	405		F	75	Muscle invasive TCC	Ileal Conduit
19	2	Freeman Hospital	23	258		36	405		M	72	Salvage after radiotherapy	Ileal Conduit
20	2	Freeman Hospital	23	258		36	405		M	59	Muscle invasive TCC	Ileal Conduit
21	2	Freeman Hospital	23	258		36	405		M	999	Uncontrolled superficial disease	Ileal Conduit
22	2	Freeman Hospital	23	258		36	405		F	76	Muscle invasive TCC	Ileal Conduit
23	2	Freeman Hospital	23	258		36	405		M	75	Uncontrolled superficial disease	Ileal Conduit
24	2	Freeman Hospital	23	258		36	405		M	67	Muscle invasive TCC	Ileal Conduit
25	2	Freeman Hospital	23	258		36	405		M	66	Uncontrolled superficial disease	Ileal Conduit
26	2	Freeman Hospital	23	258		36	405		M	66	Uncontrolled superficial disease	Ileal Conduit
27	2	Freeman Hospital	23	258		36	405		F	70	Uncontrolled superficial disease	Ileal Conduit
28	2	Freeman Hospital	23	258		36	405		M	999	Muscle invasive TCC	Ileal Conduit
29	2	Freeman Hospital	23	258		36	405		M	62	Muscle invasive TCC	Ileal Conduit
30	2	Freeman Hospital	23	258		36	405		M	63	Muscle invasive TCC	Ileal Conduit
31	2	Freeman Hospital	23	258		36	405		F	55	Uncontrolled superficial disease	Ileal Conduit
32	2	Freeman Hospital	23	258		36	405		M	70	Muscle invasive TCC	Ileal Conduit
33	2	Freeman Hospital	23	258		36	405		M	74	Muscle invasive TCC	Ileal Conduit
34	2	Freeman Hospital	23	258		36	405		M	67	Uncontrolled superficial disease	Ileal Conduit
35	2	Freeman Hospital	23	258		36	405		M	67	Muscle invasive TCC	Ileal Conduit
36	2	Freeman Hospital	23	258		36	405		F	76	Muscle invasive TCC	Ileal Conduit
37	2	Freeman Hospital	23	258		36	405		M	79	Primary CIS	Ileal Conduit
38	2	Freeman Hospital	23	258		36	405		F	62	Uncontrolled superficial disease	Ileal Conduit
39	2	Freeman Hospital	23	258		36	405		M	72	Uncontrolled superficial disease	Ileal Conduit
40	2	Freeman Hospital	23	258		36	405		F	61	Muscle invasive TCC	Ileal Conduit
41	2	Freeman Hospital	23	258		36	405		M	80	Muscle invasive TCC	Ileal Conduit
42	2	Freeman Hospital	23	258		36	405		M	79	Muscle invasive TCC	Ileal Conduit
43	2	Freeman Hospital	23	258		36	405		F	80	Uncontrolled superficial disease	Ileal Conduit
44	2	Freeman Hospital	23	258		36	405		M	76	Muscle invasive TCC	Ileal Conduit
45	2	Freeman Hospital	23	258		36	405		M	77	Muscle invasive TCC	Ileal Conduit
46	2	Freeman Hospital	23	258		36	405		M	61	Muscle invasive TCC	Ileal Conduit
47	2	Freeman Hospital	23	258		36	405		M	73	Muscle invasive TCC	Ileal Conduit
48	2	Freeman Hospital	23	258		36	405		F	74	Muscle invasive TCC	Ileal Conduit
49	2	Freeman Hospital	23	258		36	405		M	59	Squamous cell Ca	Orthotopic

50	2	Freeman Hospital	23	258		36	405		M	70	Muscle invasive TCC	Ileal Conduit
51	2	Freeman Hospital	23	258		36	405		M	56	Muscle invasive TCC	Ileal Conduit
52	2	Freeman Hospital	23	258		36	405		M	64	Muscle invasive TCC	Ileal Conduit
53	2	Freeman Hospital	23	258		36	405		M	72	Muscle invasive TCC	Ileal Conduit
54	2	Freeman Hospital	23	258		36	405		M	50	Muscle invasive TCC	Ileal Conduit
55	2	Freeman Hospital	23	258		36	405		F	69	Muscle invasive TCC	Ileal Conduit
56	2	Freeman Hospital	23	258		36	405		M	70	Uncontrolled superficial disease	Ileal Conduit
57	2	Freeman Hospital	23	258		36	405		M	75	Muscle invasive TCC	Ileal Conduit
58	2	Freeman Hospital	23	258		36	405		M	81	Muscle invasive TCC	Ileal Conduit
59	2	Freeman Hospital	23	258		36	405		M	70	Muscle invasive TCC	Orthotopic
60	2	Freeman Hospital	23	258		36	405		M	73	Uncontrolled superficial disease	Orthotopic
61	2	Freeman Hospital	23	258		36	405		M	999	Muscle invasive TCC	Ileal Conduit
62	2	Freeman Hospital	23	258		36	405		M	83	Salvage after radiotherapy	Ileal Conduit
63	2	Freeman Hospital	23	258		36	405		M	54	Muscle invasive TCC	Ileal Conduit
64	2	Freeman Hospital	23	258		36	405		M	49	Primary adenocarcinoma	Ileal Conduit
65	2	Freeman Hospital	23	258		36	405		M	64	Uncontrolled superficial disease	Ileal Conduit
66	2	Freeman Hospital	23	258		36	405		M	68	Uncontrolled superficial disease	Ileal Conduit
67	2	Freeman Hospital	23	258		36	405		M	67	Muscle invasive TCC	Ileal Conduit
68	2	Freeman Hospital	23	258		36	405		M	79	Muscle invasive TCC	Ileal Conduit
69	2	Freeman Hospital	23	258		36	405		M	60	Muscle invasive TCC	Orthotopic
70	2	Freeman Hospital	23	258		36	405		M	52	Uncontrolled superficial disease	Ileal Conduit
71	2	Freeman Hospital	23	258		36	405		M	72	Muscle invasive TCC	Ileal Conduit
72	2	Freeman Hospital	23	258		36	405		M	58	Muscle invasive TCC	Ileal Conduit
73	2	Freeman Hospital	23	258		36	405		F	62	Muscle invasive TCC	Ileal Conduit
74	2	Freeman Hospital	23	258		36	405		M	73	Uncontrolled superficial disease	Ileal Conduit
75	2	Freeman Hospital	23	258		36	405		F	75	Uncontrolled superficial disease	Ileal Conduit
76	2	Freeman Hospital	23	258		36	405		F	51	Uncontrolled superficial disease	Ileal Conduit
77	2	Freeman Hospital	23	258		36	405		M	76	Primary adenocarcinoma	Orthotopic
78	2	Freeman Hospital	23	258		36	405		M	61	Muscle invasive TCC	Ileal Conduit
79	2	Freeman Hospital	23	258		36	405		F	48	Muscle invasive TCC	Orthotopic
80	2	Freeman Hospital	23	258		36	405		F	74	Uncontrolled superficial disease	Ileal Conduit
81	2	Freeman Hospital	23	258		36	405		F	68	Uncontrolled superficial disease	Orthotopic
82	2	Freeman Hospital	23	258		36	405		M	63	Muscle invasive TCC	Ileal Conduit
83	2	Freeman Hospital	23	258		36	405		M	72	Uncontrolled superficial disease	Ileal Conduit
84	2	Freeman Hospital	23	258		36	405		M	69	Uncontrolled superficial disease	Ileal Conduit
85	2	Freeman Hospital	23	258		36	405		M	57	Muscle invasive TCC	Orthotopic
86	2	Freeman Hospital	23	258		36	405		M	48	Muscle invasive TCC	Orthotopic
87	2	Freeman Hospital	23	258		36	405		F	71	Uncontrolled superficial disease	Ileal Conduit
88	2	Freeman Hospital	23	258		36	405		M	70	Muscle invasive TCC	Ileal Conduit
89	2	Freeman Hospital	23	258		36	405		M	70	Muscle invasive TCC	Ileal Conduit
90	2	Freeman Hospital	23	258		36	405		M	58	Primary adenocarcinoma	Ileal Conduit
91	2	Freeman Hospital	23	258		36	405		M	999	Muscle invasive TCC	Ileal Conduit
92	2	Freeman Hospital	23	258		36	405		M	74	Muscle invasive TCC	Ileal Conduit
93	2	Freeman Hospital	23	258		36	405		M	80	Uncontrolled superficial disease	Ileal Conduit
94	2	Freeman Hospital	23	258		36	405		F	71	Uncontrolled superficial disease	Ileal Conduit
95	2	Freeman Hospital	23	258		36	405		M	71	Muscle invasive TCC	Ileal Conduit
96	2	Freeman Hospital	23	258		36	405		M	76	Uncontrolled superficial disease	Ileal Conduit
97	2	Freeman Hospital	23	258		36	405		M	78	Uncontrolled superficial disease	Orthotopic
98	2	Freeman Hospital	23	258		36	405		M	76	Uncontrolled superficial disease	Ileal Conduit
99	2	Freeman Hospital	23	258		36	405		M	65	Muscle invasive TCC	Ileal Conduit

100	2	Freeman Hospital	23	258		36	405		F	76	Squamous cell Ca	Ileal Conduit
101	2	Freeman Hospital	23	258		36	405		M	60	Muscle invasive TCC	Orthotopic
102	2	Freeman Hospital	23	258		36	405		F	60	Muscle invasive TCC	Ileal Conduit
103	2	Freeman Hospital	23	258		36	405		F	999	Uncontrolled superficial disease	Ileal Conduit
104	2	Freeman Hospital	23	258		36	405		M	53	Uncontrolled superficial disease	Ileal Conduit
105	2	Freeman Hospital	23	258		36	405		M	57	Uncontrolled superficial disease	Orthotopic
106	2	Freeman Hospital	23	258		36	405		M	69	Uncontrolled superficial disease	Ileal Conduit
107	2	Freeman Hospital	23	258		36	405		M	61	Muscle invasive TCC	Ileal Conduit
108	2	Freeman Hospital	23	258		36	405		M	76	Muscle invasive TCC	Ileal Conduit
109	2	Freeman Hospital	23	258		36	405		M	60	Muscle invasive TCC	Ileal Conduit
110	2	Freeman Hospital	23	258		36	405		M	61	Muscle invasive TCC	Ileal Conduit
111	2	Freeman Hospital	23	258		36	405		M	999	Muscle invasive TCC	Ileal Conduit
112	2	Freeman Hospital	23	258		36	405		M	67	Uncontrolled superficial disease	Ileal Conduit
113	2	Freeman Hospital	23	258		36	405		M	78	Uncontrolled superficial disease	Ileal Conduit
114	2	Freeman Hospital	23	258		36	405		M	77	Muscle invasive TCC	Ileal Conduit
115	2	Freeman Hospital	23	258		36	405		M	61	Muscle invasive TCC	Ileal Conduit
116	2	Freeman Hospital	23	258		36	405		M	68	Muscle invasive TCC	Ileal Conduit
117	2	Freeman Hospital	23	258		36	405		F	71	Sarcoma	Ileal Conduit
118	2	Freeman Hospital	23	258		36	405		M	61	Uncontrolled superficial disease	Ileal Conduit
119	2	Freeman Hospital	23	258		36	405		F	73	Muscle invasive TCC	Ileal Conduit
120	2	Freeman Hospital	23	258		36	405		M	72	Muscle invasive TCC	Ileal Conduit
121	3	North Bristol NHSTrust (Southmead)	37	313		28	351		M	70	Muscle invasive TCC	Ileal Conduit
122	3	North Bristol NHSTrust (Southmead)	37	313		28	351		M	62	Other	Ileal Conduit
123	4	Hillingdon Hospital	28	6		21	6		F	58	Squamous cell Ca	Ileal Conduit
124	4	Hillingdon Hospital	28	6		21	6		F	62	999	Ileal Conduit
125	5	Hereford Hospitals NHS Trust	27	8		29	31		M	56	Muscle invasive TCC	Ileal Conduit
126	6	Basildon Hospital	6	12		38	164		F	69	Muscle invasive TCC	Ileal Conduit
127	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	79	Primary CIS	Ileal Conduit
128	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	57	Muscle invasive TCC	Ileal Conduit
129	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	72	Muscle invasive TCC	Ileal Conduit
130	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	72	Primary CIS	Ileal Conduit
131	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	58	Muscle invasive TCC	Ileal Conduit
132	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	76	Muscle invasive TCC	Ileal Conduit
133	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	50	Muscle invasive TCC	Ileal Conduit
134	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	62	Muscle invasive TCC	Orthotopic
135	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	47	Muscle invasive TCC	Ileal Conduit
136	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	73	Muscle invasive TCC	Ileal Conduit
137	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	52	Uncontrolled superficial disease	Ileal Conduit
138	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	65	Muscle invasive TCC	Ileal Conduit
139	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	68	Primary CIS	Ileal Conduit
140	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	68	Uncontrolled superficial disease	Ileal Conduit
141	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	999	Muscle invasive TCC	Ileal Conduit
142	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	79	Muscle invasive TCC	Ileal Conduit
143	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	77	Muscle invasive TCC	Ileal Conduit
144	7	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	72	Squamous cell Ca	Ileal Conduit
145	8	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		F	62	999	Orthotopic
146	8	New Cross Hospital	35	37		35	226		M	56	999	Orthotopic
147	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		F	69	Muscle invasive TCC	Ileal Conduit
148	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	75	Muscle invasive TCC	Ileal Conduit
149	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	66	Secondary adenocarcinoma	Ileal Conduit

150	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	72	Muscle invasive TCC	Ileal Conduit
151	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		F	82	999	Ileal Conduit
152	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	69	Uncontrolled superficial disease	Ileal Conduit
153	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	74	Muscle invasive TCC	Ileal Conduit
154	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	82	Uncontrolled superficial disease	Ileal Conduit
155	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	82	999	Ileal Conduit
156	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	999	Uncontrolled superficial disease	Orthotopic
157	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	78	Muscle invasive TCC	Ileal Conduit
158	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	71	Muscle invasive TCC	Orthotopic
159	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		F	61	999	Ileal Conduit
160	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	84	999	Ileal Conduit
161	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	76	999	Ileal Conduit
162	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	56	999	Orthotopic
163	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	56	Uncontrolled superficial disease	Orthotopic
164	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	85	Muscle invasive TCC	Ileal Conduit
165	8	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	61	Muscle invasive TCC	Ileal Conduit
166	8	Royal Cornwall Hospital	50	6		26	205		M	68	Muscle invasive TCC	Orthotopic
167	8	Sandwell District General Hospital	62	9		11	102		M	74	Muscle invasive TCC	Ileal Conduit
168	8	Sandwell District General Hospital	62	9		11	102		M	32	Primary adenocarcinoma	Orthotopic
169	9	Rotherham District General Hospital	47	20		8	261		M	68	Muscle invasive TCC	Ileal Conduit
170	9	Rotherham District General Hospital	47	20		8	261		F	57	Muscle invasive TCC	Ileal Conduit
171	9	Rotherham District General Hospital	47	20		8	261		M	61	Muscle invasive TCC	Ileal Conduit
172	9	Rotherham District General Hospital	47	20		8	261		F	65	Muscle invasive TCC	Ileal Conduit
173	9	Rotherham District General Hospital	47	20		8	261		M	58	Muscle invasive TCC	Ileal Conduit
174	9	Rotherham District General Hospital	47	20		8	261		M	58	Muscle invasive TCC	Ileal Conduit
175	9	Royal Liverpool University Hospital	54	53		3	140		F	71	Muscle invasive TCC	Ileal Conduit
176	9	Royal Liverpool University Hospital	54	53		3	140		M	54	Other	Ileal Conduit
177	9	Royal Liverpool University Hospital	54	53		3	140		M	69	Muscle invasive TCC	Ileal Conduit
178	9	Royal Liverpool University Hospital	54	53		3	140		F	55	Muscle invasive TCC	Orthotopic
179	9	Royal Liverpool University Hospital	54	53		3	140		F	71	Other	Ileal Conduit
180	9	Royal Liverpool University Hospital	54	53		3	140		M	65	Muscle invasive TCC	Ileal Conduit
181	9	Royal Liverpool University Hospital	54	53		3	140		M	46	999	Ileal Conduit
182	9	Royal Liverpool University Hospital	54	53		3	140		F	999	999	Ileal Conduit
183	9	Royal Liverpool University Hospital	54	53		3	140		F	60	Muscle invasive TCC	Ileal Conduit
184	9	Royal Liverpool University Hospital	54	53		3	140		M	77	999	Ileal Conduit
185	9	Royal Liverpool University Hospital	54	53		3	140		M	74	Uncontrolled superficial disease	Ileal Conduit
186	9	Royal Liverpool University Hospital	54	53		3	140		M	73	Other	Ileal Conduit
187	9	Royal Liverpool University Hospital	54	53		3	140		M	56	Muscle invasive TCC	Ileal Conduit
188	9	Royal Liverpool University Hospital	54	53		3	140		M	71	Muscle invasive TCC	Ileal Conduit
189	9	Royal Liverpool University Hospital	54	53		3	140		M	39	Muscle invasive TCC	Ileal Conduit
190	9	Royal Liverpool University Hospital	54	53		3	140		M	48	Primary adenocarcinoma	Ileal Conduit
191	9	Royal Liverpool University Hospital	54	53		3	140		M	72	Muscle invasive TCC	Ileal Conduit
192	9	Royal Liverpool University Hospital	54	53		3	140		M	66	Muscle invasive TCC	Ileal Conduit
193	9	Royal Liverpool University Hospital	54	53		3	140		M	63	Muscle invasive TCC	Ileal Conduit
194	9	Southport & Ormskirk NHS Trust	66	21		3	140		M	75	Muscle invasive TCC	Ileal Conduit
195	9	Southport & Ormskirk NHS Trust	66	21		3	140		F	70	Salvage after radiotherapy	Ileal Conduit
196	9	Southport & Ormskirk NHS Trust	66	21		3	140		M	73	Muscle invasive TCC	Ileal Conduit
197	9	Whiston Hospital	80	12		3	140		M	59	Muscle invasive TCC	Ileal Conduit
198	9	Whiston Hospital	80	12		3	140		M	60	Muscle invasive TCC	Ileal Conduit
199	9	Whiston Hospital	80	12		3	140		M	71	Other	Ileal Conduit

200	9	Whiston Hospital	80	12		3	140		M	60	Muscle invasive TCC	Ileal Conduit
201	9	Whiston Hospital	80	12		3	140		F	68	Muscle invasive TCC	Ileal Conduit
202	10	Walsgrave Hospital	76	9		12	22		M	74	Salvage after radiotherapy	Ileal Conduit
203	10	Walsgrave Hospital	76	9		12	22		M	66	Muscle invasive TCC	Ileal Conduit
204	10	Walsgrave Hospital	76	9		12	22		M	65	Muscle invasive TCC	Ileal Conduit
205	11	University College Hospital London	72	38		22	118		F	45	Primary CIS	Orthotopic
206	11	University College Hospital London	72	38		22	118		M	61	Uncontrolled superficial disease	Ileal Conduit
207	12	Hemel Hempstead General Hospital; Mount Verni	26	1		20	69		999	82	Muscle invasive TCC	Ileal Conduit
208	12	Hemel Hempstead General Hospital; Mount Verni	26	1		20	69		M	63	Uncontrolled superficial disease	Ileal Conduit
209	12	Hemel Hempstead General Hospital; Mount Verni	26	1		20	69		F	62	Muscle invasive TCC	Ileal Conduit
210	12	Hemel Hempstead General Hospital; Mount Verni	26	1		20	69		M	69	Muscle invasive TCC	Ileal Conduit
211	12	Hemel Hempstead General Hospital; Mount Verni	26	1		20	69		F	75	Primary CIS	Ileal Conduit
212	12	Hemel Hempstead General Hospital; Mount Verni	26	1		20	69		M	74	Muscle invasive TCC	Ileal Conduit
213	12	Hemel Hempstead General Hospital; Mount Verni	26	1		20	69		999	68	Muscle invasive TCC	Ileal Conduit
214	12	Hemel Hempstead General Hospital; Mount Verni	26	1		20	69		M	78	Muscle invasive TCC	Ileal Conduit
215	12	Watford General Hospital	78	68		20	69		M	75	Salvage after radiotherapy	Ileal Conduit
216	13	Airedale General Hospital	2	7		6	384		M	83	Salvage after radiotherapy	Ileal Conduit
217	13	Airedale General Hospital	2	7		6	384		M	72	Muscle invasive TCC	Ileal Conduit
218	13	Bradford Royal Infirmary	7	107		6	384		M	65	Muscle invasive TCC	Ileal Conduit
219	13	Bradford Royal Infirmary	7	107		6	384		M	73	Muscle invasive TCC	Ileal Conduit
220	13	Bradford Royal Infirmary	7	107		6	384		F	75	Squamous cell Ca	Ileal Conduit
221	13	Bradford Royal Infirmary	7	107		6	384		F	76	Muscle invasive TCC	Ileal Conduit
222	13	Bradford Royal Infirmary	7	107		6	384		M	73	Primary CIS	Ileal Conduit
223	13	Bradford Royal Infirmary	7	107		6	384		F	61	Muscle invasive TCC	Ileal Conduit
224	13	Bradford Royal Infirmary	7	107		6	384		F	65	Muscle invasive TCC	Ileal Conduit
225	13	Bradford Royal Infirmary	7	107		6	384		M	83	Muscle invasive TCC	Ileal Conduit
226	13	Bradford Royal Infirmary	7	107		6	384		M	999	Muscle invasive TCC	Ileal Conduit
227	13	Bradford Royal Infirmary	7	107		6	384		F	66	Squamous cell Ca	Ileal Conduit
228	13	Bradford Royal Infirmary	7	107		6	384		F	66	Muscle invasive TCC	Ileal Conduit
229	13	Bradford Royal Infirmary	7	107		6	384		M	80	Muscle invasive TCC	Ileal Conduit
230	13	Bradford Royal Infirmary	7	107		6	384		M	70	Muscle invasive TCC	Ileal Conduit
231	13	Bradford Royal Infirmary	7	107		6	384		F	72	Muscle invasive TCC	Ileal Conduit
232	13	Bradford Royal Infirmary	7	107		6	384		M	65	Muscle invasive TCC	Ileal Conduit
233	13	Bradford Royal Infirmary	7	107		6	384		M	43	Squamous cell Ca	Ileal Conduit
234	13	Bradford Royal Infirmary	7	107		6	384		M	55	Squamous cell Ca	Ileal Conduit
235	13	Bradford Royal Infirmary	7	107		6	384		M	59	Muscle invasive TCC	Ileal Conduit
236	13	Bradford Royal Infirmary	7	107		6	384		M	66	Muscle invasive TCC	Ileal Conduit
237	13	Bradford Royal Infirmary	7	107		6	384		M	58	Muscle invasive TCC	Orthotopic
238	13	Bradford Royal Infirmary	7	107		6	384		F	75	Salvage after radiotherapy	Ileal Conduit
239	13	Bradford Royal Infirmary	7	107		6	384		M	61	Muscle invasive TCC	Ileal Conduit
240	13	Bradford Royal Infirmary	7	107		6	384		M	63	Muscle invasive TCC	Ileal Conduit
241	13	Bradford Royal Infirmary	7	107		6	384		M	64	Uncontrolled superficial disease	Ileal Conduit
242	13	Bradford Royal Infirmary	7	107		6	384		M	77	Muscle invasive TCC	Ileal Conduit
243	13	Bradford Royal Infirmary	7	107		6	384		M	78	Muscle invasive TCC	Ileal Conduit
244	13	Bradford Royal Infirmary	7	107		6	384		M	74	Muscle invasive TCC	Ileal Conduit
245	13	Huddersfield Royal Infirmary	28	10		6	384		M	71	Muscle invasive TCC	Ileal Conduit
246	13	Huddersfield Royal Infirmary	28	10		6	384		M	72	Muscle invasive TCC	Ileal Conduit
247	13	Huddersfield Royal Infirmary	28	10		6	384		M	62	Muscle invasive TCC	Ileal Conduit
248	14	Southampton General Hospital	64	95		31	307		M	63	Uncontrolled superficial disease	Ileal Conduit
249	14	Southampton General Hospital	64	95		31	307		F	999	Muscle invasive TCC	Ileal Conduit

250	14	Southampton General Hospital	64	95		31	307		M	73	Uncontrolled superficial disease	Ileal Conduit
251	14	Southampton General Hospital	64	95		31	307		F	999	Salvage after radiotherapy	Ileal Conduit
252	14	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
253	14	Southampton General Hospital	64	95		31	307		M	999	Uncontrolled superficial disease	Ileal Conduit
254	14	Southampton General Hospital	64	95		31	307		F	999	Muscle invasive TCC	Ileal Conduit
255	14	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
256	14	Southampton General Hospital	64	95		31	307		F	999	Muscle invasive TCC	Ileal Conduit
257	14	Southampton General Hospital	64	95		31	307		M	999	Squamous cell Ca	Ileal Conduit
258	14	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
259	14	Southampton General Hospital	64	95		31	307		M	999	Other	Ileal Conduit
260	14	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
261	14	Southampton General Hospital	64	95		31	307		M	70	Uncontrolled superficial disease	Ileal Conduit
262	15	New Cross Hospital	35	37		35	226		M	75	Muscle invasive TCC	Ileal Conduit
263	15	New Cross Hospital	35	37		35	226		M	71	Uncontrolled superficial disease	Ileal Conduit
264	15	New Cross Hospital	35	37		35	226		F	61	Squamous cell Ca	Ileal Conduit
265	15	New Cross Hospital	35	37		35	226		M	60	Muscle invasive TCC	Ileal Conduit
266	15	New Cross Hospital	35	37		35	226		M	62	Muscle invasive TCC	Ileal Conduit
267	15	New Cross Hospital	35	37		35	226		M	64	Muscle invasive TCC	Ileal Conduit
268	15	New Cross Hospital	35	37		35	226		F	47	Squamous cell Ca	Ileal Conduit
269	15	New Cross Hospital	35	37		35	226		F	71	Muscle invasive TCC	Ileal Conduit
270	15	New Cross Hospital	35	37		35	226		M	64	Muscle invasive TCC	Ileal Conduit
271	15	New Cross Hospital	35	37		35	226		M	65	Other	Ileal Conduit
272	15	New Cross Hospital	35	37		35	226		F	72	Muscle invasive TCC	Ileal Conduit
273	15	New Cross Hospital	35	37		35	226		M	76	Uncontrolled superficial disease	Ileal Conduit
274	15	New Cross Hospital	35	37		35	226		M	70	Muscle invasive TCC	Ileal Conduit
275	15	New Cross Hospital	35	37		35	226		M	56	Muscle invasive TCC	Ileal Conduit
276	15	New Cross Hospital	35	37		35	226		M	46	Muscle invasive TCC	Orthotopic
277	15	New Cross Hospital	35	37		35	226		F	61	Uncontrolled superficial disease	Ileal Conduit
278	15	New Cross Hospital	35	37		35	226		M	68	Other	Ileal Conduit
279	15	New Cross Hospital	35	37		35	226		M	66	Muscle invasive TCC	Ileal Conduit
280	15	New Cross Hospital	35	37		35	226		M	55	Muscle invasive TCC	Ileal Conduit
281	15	New Cross Hospital	35	37		35	226		F	61	Squamous cell Ca	Ileal Conduit
282	15	New Cross Hospital	35	37		35	226		M	57	Muscle invasive TCC	Ileal Conduit
283	15	New Cross Hospital	35	37		35	226		F	59	Uncontrolled superficial disease	Ileal Conduit
284	15	New Cross Hospital	35	37		35	226		M	59	Muscle invasive TCC	Ileal Conduit
285	15	New Cross Hospital	35	37		35	226		F	67	Primary CIS	Ileal Conduit
286	15	New Cross Hospital	35	37		35	226		F	59	Muscle invasive TCC	Ileal Conduit
287	15	New Cross Hospital	35	37		35	226		M	69	Muscle invasive TCC	Ileal Conduit
288	15	New Cross Hospital	35	37		35	226		M	54	Uncontrolled superficial disease	Ileal Conduit
289	15	New Cross Hospital	35	37		35	226		F	75	Muscle invasive TCC	Ileal Conduit
290	15	New Cross Hospital	35	37		35	226		F	69	Muscle invasive TCC	Ileal Conduit
291	15	New Cross Hospital	35	37		35	226		F	59	Primary CIS	Ileal Conduit
292	15	New Cross Hospital	35	37		35	226		M	61	Muscle invasive TCC	Ileal Conduit
293	15	New Cross Hospital	35	37		35	226		M	76	999	Ileal Conduit
294	15	New Cross Hospital	35	37		35	226		M	68	Muscle invasive TCC	Ileal Conduit
295	15	New Cross Hospital	35	37		35	226		F	68	Gynaecological Ca	Ileal Conduit
296	15	New Cross Hospital	35	37		35	226		M	71	Muscle invasive TCC	Ileal Conduit
297	15	New Cross Hospital	35	37		35	226		M	66	Other	Ileal Conduit
298	15	New Cross Hospital	35	37		35	226		F	68	Other	Ileal Conduit
299	15	New Cross Hospital	35	37		35	226		M	56	Muscle invasive TCC	Orthotopic

300	15	New Cross Hospital	35	37		35	226		M	47	Muscle invasive TCC	Ileal Conduit
301	15	New Cross Hospital	35	37		35	226		F	77	Muscle invasive TCC	Ileal Conduit
302	15	New Cross Hospital	35	37		35	226		M	65	Sarcoma	Ileal Conduit
303	15	New Cross Hospital	35	37		35	226		F	70	Muscle invasive TCC	Ileal Conduit
304	15	New Cross Hospital	35	37		35	226		M	65	Muscle invasive TCC	Ileal Conduit
305	16	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		F	38	Muscle invasive TCC	Ileal Conduit
306	16	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	76	Primary CIS	Ileal Conduit
307	16	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	70	Primary CIS	Ileal Conduit
308	16	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		F	64	Primary adenocarcinoma	Ileal Conduit
309	16	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	999	Uncontrolled superficial disease	Ileal Conduit
310	16	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	57	Primary CIS	Ileal Conduit
311	16	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	68	Muscle invasive TCC	Ileal Conduit
312	16	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	999	Salvage after radiotherapy	Ileal Conduit
313	17	Barnet & Chase Farm Hospital	5	64		22	118		M	70	Muscle invasive TCC	Ileal Conduit
314	18	University Hospital of North Stafford	74	104		35	226		M	62	Muscle invasive TCC	Ileal Conduit
315	18	University Hospital of North Stafford	74	104		35	226		F	60	Muscle invasive TCC	Ileal Conduit
316	18	University Hospital of North Stafford	74	104		35	226		F	999	Other	Ileal Conduit
317	18	University Hospital of North Stafford	74	104		35	226		F	52	Salvage after radiotherapy	Ileal Conduit
318	18	University Hospital of North Stafford	74	104		35	226		F	73	Muscle invasive TCC	Ileal Conduit
319	18	University Hospital of North Stafford	74	104		35	226		M	78	Muscle invasive TCC	Ileal Conduit
320	18	University Hospital of North Stafford	74	104		35	226		F	999	Muscle invasive TCC	Ileal Conduit
321	18	University Hospital of North Stafford	74	104		35	226		M	76	Uncontrolled superficial disease	Ileal Conduit
322	18	University Hospital of North Stafford	74	104		35	226		F	54	Secondary adenocarcinoma	Ileal Conduit
323	18	University Hospital of North Stafford	74	104		35	226		M	77	Muscle invasive TCC	Ileal Conduit
324	18	University Hospital of North Stafford	74	104		35	226		F	52	Gynaecological Ca	Ileal Conduit
325	18	University Hospital of North Stafford	74	104		35	226		F	55	Squamous cell Ca	Ileal Conduit
326	18	University Hospital of North Stafford	74	104		35	226		M	56	Muscle invasive TCC	Ileal Conduit
327	18	University Hospital of North Stafford	74	104		35	226		F	63	Gynaecological Ca	Ileal Conduit
328	18	University Hospital of North Stafford	74	104		35	226		F	60	Muscle invasive TCC	Ileal Conduit
329	18	University Hospital of North Stafford	74	104		35	226		M	74	Muscle invasive TCC	Ileal Conduit
330	18	University Hospital of North Stafford	74	104		35	226		M	74	Muscle invasive TCC	Ileal Conduit
331	19	Royal Bournemouth Hospital	49	57		27	60		F	70	Squamous cell Ca	Ileal Conduit
332	19	Royal Bournemouth Hospital	49	57		27	60		M	64	Muscle invasive TCC	Ileal Conduit
333	19	Royal Bournemouth Hospital	49	57		27	60		M	66	Muscle invasive TCC	Ileal Conduit
334	19	Royal Bournemouth Hospital	49	57		27	60		F	60	Muscle invasive TCC	Ileal Conduit
335	19	Royal Bournemouth Hospital	49	57		27	60		M	76	Salvage after radiotherapy	Ileal Conduit
336	19	Royal Bournemouth Hospital	49	57		27	60		M	64	Uncontrolled superficial disease	Ileal Conduit
337	19	Royal Bournemouth Hospital	49	57		27	60		M	71	Uncontrolled superficial disease	Ileal Conduit
338	19	Royal Bournemouth Hospital	49	57		27	60		M	69	Uncontrolled superficial disease	Ileal Conduit
339	19	Royal Bournemouth Hospital	49	57		27	60		M	999	Other	Ileal Conduit
340	19	Royal Bournemouth Hospital	49	57		27	60		M	65	Muscle invasive TCC	Ileal Conduit
341	19	Royal Bournemouth Hospital	49	57		27	60		M	75	Uncontrolled superficial disease	Ileal Conduit
342	19	Royal Bournemouth Hospital	49	57		27	60		M	63	Primary CIS	Orthotopic
343	19	Royal Bournemouth Hospital	49	57		27	60		M	64	Primary CIS	Ileal Conduit
344	19	Royal Bournemouth Hospital	49	57		27	60		M	68	Other	Ileal Conduit
345	19	Royal Bournemouth Hospital	49	57		27	60		F	77	Muscle invasive TCC	Ileal Conduit
346	19	Royal Bournemouth Hospital	49	57		27	60		M	999	Salvage after radiotherapy	Ileal Conduit
347	19	Royal Bournemouth Hospital	49	57		27	60		M	55	Salvage after radiotherapy	Ileal Conduit
348	19	Royal Bournemouth Hospital	49	57		27	60		M	69	Muscle invasive TCC	Ileal Conduit
349	20	Southampton General Hospital	64	95		31	307		F	80	Squamous cell Ca	Ileal Conduit

350	20	Southampton General Hospital	64	95		31	307		F	999	Muscle invasive TCC	Ileal Conduit
351	20	Southampton General Hospital	64	95		31	307		M	999	Other	Ileal Conduit
352	20	Southampton General Hospital	64	95		31	307		M	54	Muscle invasive TCC	Ileal Conduit
353	20	Southampton General Hospital	64	95		31	307		F	78	Muscle invasive TCC	Ileal Conduit
354	20	Southampton General Hospital	64	95		31	307		M	999	Other	Ileal Conduit
355	21	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	69	Sarcoma	Ileal Conduit
356	21	Royal Marsden Hospital	55	63		25	63		F	999	Muscle invasive TCC	Ileal Conduit
357	22	Southampton General Hospital	64	95		31	307		F	999	Muscle invasive TCC	Ileal Conduit
358	22	Southampton General Hospital	64	95		31	307		F	999	Muscle invasive TCC	Ileal Conduit
359	22	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
360	22	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
361	999	Bradford Royal Infirmary	7	107		6	384		M	66	Muscle invasive TCC	Ileal Conduit
362	999	Bradford Royal Infirmary	7	107		6	384		M	999	Muscle invasive TCC	Ileal Conduit
363	999	Bradford Royal Infirmary	7	107		6	384		M	61	Muscle invasive TCC	Ileal Conduit
364	999	Bradford Royal Infirmary	7	107		6	384		F	999	Muscle invasive TCC	Ileal Conduit
365	999	Bradford Royal Infirmary	7	107		6	384		M	75	Muscle invasive TCC	Ileal Conduit
366	999	Bradford Royal Infirmary	7	107		6	384		F	61	Uncontrolled superficial disease	Ileal Conduit
367	999	Bradford Royal Infirmary	7	107		6	384		M	44	Squamous cell Ca	Ileal Conduit
368	999	Bradford Royal Infirmary	7	107		6	384		M	999	Muscle invasive TCC	Ileal Conduit
369	999	Bradford Royal Infirmary	7	107		6	384		M	74	Muscle invasive TCC	Ileal Conduit
370	999	Bradford Royal Infirmary	7	107		6	384		M	68	Muscle invasive TCC	Ileal Conduit
371	999	Bradford Royal Infirmary	7	107		6	384		M	60	Muscle invasive TCC	Ileal Conduit
372	999	Bradford Royal Infirmary	7	107		6	384		M	69	Muscle invasive TCC	Ileal Conduit
373	999	Bradford Royal Infirmary	7	107		6	384		M	70	999	Ileal Conduit
374	999	Bradford Royal Infirmary	7	107		6	384		F	72	Muscle invasive TCC	Ileal Conduit
375	999	Bradford Royal Infirmary	7	107		6	384		M	69	Muscle invasive TCC	Ileal Conduit
376	999	Bradford Royal Infirmary	7	107		6	384		M	64	Muscle invasive TCC	Ileal Conduit
377	999	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	72	999	Ileal Conduit
378	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	82	Other	Ileal Conduit
379	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	71	Muscle invasive TCC	Ileal Conduit
380	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	76	Other	Ileal Conduit
381	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	67	Muscle invasive TCC	Ileal Conduit
382	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	60	Other	Ileal Conduit
383	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	57	Muscle invasive TCC	Ileal Conduit
384	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	74	Muscle invasive TCC	Ileal Conduit
385	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	73	Muscle invasive TCC	Ileal Conduit
386	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	71	Other	Ileal Conduit
387	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	66	Muscle invasive TCC	Ileal Conduit
388	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	53	Uncontrolled superficial disease	Ileal Conduit
389	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	78	Uncontrolled superficial disease	Ileal Conduit
390	999	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	79	Other	Ileal Conduit
391	999	Derriford Hospital	19	72		26	205		M	66	Primary CIS	Ileal Conduit
392	999	Derriford Hospital	19	72		26	205		F	73	Squamous cell Ca	Ileal Conduit
393	999	Derriford Hospital	19	72		26	205		M	71	Muscle invasive TCC	Ileal Conduit
394	999	Derriford Hospital	19	72		26	205		M	65	Primary CIS	Ileal Conduit
395	999	Derriford Hospital	19	72		26	205		M	69	Uncontrolled superficial disease	Ileal Conduit
396	999	Derriford Hospital	19	72		26	205		M	76	Other	Ileal Conduit
397	999	Derriford Hospital	19	72		26	205		M	67	Uncontrolled superficial disease	Ileal Conduit
398	999	Derriford Hospital	19	72		26	205		M	66	Muscle invasive TCC	Ileal Conduit
399	999	Derriford Hospital	19	72		26	205		M	70	Uncontrolled superficial disease	Ileal Conduit

400	999	Guy's & Thomas's Hospital	25	130		24	149		F	999	Muscle invasive TCC	Ileal Conduit
401	999	Guy's & Thomas's Hospital	25	130		24	149		M	999	Uncontrolled superficial disease	Ileal Conduit
402	999	Guy's & Thomas's Hospital	25	130		24	149		M	999	Uncontrolled superficial disease	Ileal Conduit
403	999	Guy's & Thomas's Hospital	25	130		24	149		F	999	Muscle invasive TCC	Ileal Conduit
404	999	Guy's & Thomas's Hospital	25	130		24	149		M	999	Uncontrolled superficial disease	Ileal Conduit
405	999	Guy's & Thomas's Hospital	25	130		24	149		M	999	Muscle invasive TCC	Ileal Conduit
406	999	Guy's & Thomas's Hospital	25	130		24	149		M	999	Muscle invasive TCC	Ileal Conduit
407	999	Guy's & Thomas's Hospital	25	130		24	149		F	999	Muscle invasive TCC	Ileal Conduit
408	999	Guy's & Thomas's Hospital	25	130		24	149		M	999	Muscle invasive TCC	Ileal Conduit
409	999	Hemel Hempstead General Hospital; Mount Vern	26	1		20	69		M	77	Salvage after radiotherapy	Ileal Conduit
410	999	Leicester General Hospital	33	97		39	345		M	71	Other	Ileal Conduit
411	999	Leicester General Hospital	33	97		39	345		F	66	Muscle invasive TCC	Ileal Conduit
412	999	Leicester General Hospital	33	97		39	345		M	39	Muscle invasive TCC	Orthotopic
413	999	Leicester General Hospital	33	97		39	345		M	46	Muscle invasive TCC	Orthotopic
414	999	Leicester General Hospital	33	97		39	345		F	48	Other	Ileal Conduit
415	999	New Cross Hospital	35	37		35	226		M	70	Muscle invasive TCC	Ileal Conduit
416	999	New Cross Hospital	35	37		35	226		F	70	Salvage after radiotherapy	Ileal Conduit
417	999	New Cross Hospital	35	37		35	226		M	74	Muscle invasive TCC	Ileal Conduit
418	999	New Cross Hospital	35	37		35	226		M	999	Muscle invasive TCC	Ileal Conduit
419	999	New Cross Hospital	35	37		35	226		M	999	Primary adenocarcinoma	Ileal Conduit
420	999	New Cross Hospital	35	37		35	226		M	68	Uncontrolled superficial disease	Ileal Conduit
421	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	72	999	Ileal Conduit
422	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	79	Muscle invasive TCC	Ileal Conduit
423	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	76	Uncontrolled superficial disease	Ileal Conduit
424	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	71	Muscle invasive TCC	Ileal Conduit
425	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	70	Muscle invasive TCC	Ileal Conduit
426	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	57	Uncontrolled superficial disease	Ileal Conduit
427	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	82	Muscle invasive TCC	Ileal Conduit
428	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	82	Primary CIS	Ileal Conduit
429	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	81	Uncontrolled superficial disease	Ileal Conduit
430	999	North Bristol NHSTrust (Southmead)	37	313		28	351		F	79	Muscle invasive TCC	Ileal Conduit
431	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	69	Sarcoma	Ileal Conduit
432	999	North Bristol NHSTrust (Southmead)	37	313		28	351		F	80	Muscle invasive TCC	Ileal Conduit
433	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	75	Muscle invasive TCC	Ileal Conduit
434	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	72	Uncontrolled superficial disease	Ileal Conduit
435	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	82	Muscle invasive TCC	Ileal Conduit
436	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	73	999	Ileal Conduit
437	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	59	Uncontrolled superficial disease	Ileal Conduit
438	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	72	Muscle invasive TCC	Ileal Conduit
439	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	61	Uncontrolled superficial disease	Ileal Conduit
440	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	79	Muscle invasive TCC	Ileal Conduit
441	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	76	Muscle invasive TCC	Ileal Conduit
442	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	70	Muscle invasive TCC	Ileal Conduit
443	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	47	Muscle invasive TCC	Ileal Conduit
444	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	65	Muscle invasive TCC	Ileal Conduit
445	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	64	Muscle invasive TCC	Ileal Conduit
446	999	North Bristol NHSTrust (Southmead)	37	313		28	351		F	51	Muscle invasive TCC	Ileal Conduit
447	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	77	Muscle invasive TCC	Ileal Conduit
448	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	79	Muscle invasive TCC	Ileal Conduit
449	999	North Bristol NHSTrust (Southmead)	37	313		28	351		F	71	Salvage after radiotherapy	Ileal Conduit

450	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	62	Muscle invasive TCC	Ileal Conduit
451	999	North Bristol NHSTrust (Southmead)	37	313		28	351		F	58	Muscle invasive TCC	Ileal Conduit
452	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	86	Muscle invasive TCC	Ileal Conduit
453	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	59	Muscle invasive TCC	Ileal Conduit
454	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	68	Muscle invasive TCC	Ileal Conduit
455	999	North Bristol NHSTrust (Southmead)	37	313		28	351		F	71	Muscle invasive TCC	Ileal Conduit
456	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	74	Muscle invasive TCC	Ileal Conduit
457	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	66	Uncontrolled superficial disease	Ileal Conduit
458	999	North Bristol NHSTrust (Southmead)	37	313		28	351		F	69	Muscle invasive TCC	Ileal Conduit
459	999	North Bristol NHSTrust (Southmead)	37	313		28	351		F	69	Muscle invasive TCC	Ileal Conduit
460	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	77	Uncontrolled superficial disease	Ileal Conduit
461	999	North Bristol NHSTrust (Southmead)	37	313		28	351		M	71	Uncontrolled superficial disease	Ileal Conduit
462	999	Princess Alexandra Hospital, Harlow	44	14		22	118		M	72	Uncontrolled superficial disease	Ileal Conduit
463	999	Royal Cornwall Hospital	50	6		26	205		F	74	Muscle invasive TCC	Ileal Conduit
464	999	Royal Cornwall Hospital	50	6		26	205		F	76	Muscle invasive TCC	Ileal Conduit
465	999	Royal Cornwall Hospital	50	6		26	205		M	55	Muscle invasive TCC	Ileal Conduit
466	999	Royal Hampshire County Hospital	53	15		31	307		M	999	Muscle invasive TCC	Ileal Conduit
467	999	Royal Hampshire County Hospital	53	15		31	307		M	79	Uncontrolled superficial disease	Ileal Conduit
468	999	Royal Hampshire County Hospital	53	15		31	307		M	999	Muscle invasive TCC	Ileal Conduit
469	999	Royal Hampshire County Hospital	53	15		31	307		M	999	Muscle invasive TCC	Ileal Conduit
470	999	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		F	68	Secondary adenocarcinoma	Ileal Conduit
471	999	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		F	73	Muscle invasive TCC	Ileal Conduit
472	999	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	69	Muscle invasive TCC	Ileal Conduit
473	999	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		F	74	Muscle invasive TCC	Ileal Conduit
474	999	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	53	Muscle invasive TCC	Ileal Conduit
475	999	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	75	Muscle invasive TCC	Ileal Conduit
476	999	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	78	Other	Ileal Conduit
477	999	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	64	Muscle invasive TCC	Ileal Conduit
478	999	Southampton General Hospital	64	95		31	307		M	999	Salvage after radiotherapy	Ileal Conduit
479	999	Southampton General Hospital	64	95		31	307		F	999	Muscle invasive TCC	Ileal Conduit
480	999	Southampton General Hospital	64	95		31	307		F	999	999	Ileal Conduit
481	999	Southampton General Hospital	64	95		31	307		M	999	Squamous cell Ca	Ileal Conduit
482	999	Southampton General Hospital	64	95		31	307		M	999	Primary CIS	Ileal Conduit
483	999	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
484	999	Taunton And Somerset Hospital	69	11		28	351		M	65	Muscle invasive TCC	Ileal Conduit
485	999	Taunton And Somerset Hospital	69	11		28	351		M	75	Muscle invasive TCC	Ileal Conduit
486	999	University Hospital of North Durham	73	1		36	405		M	67	Other	Ileal Conduit
487	999	Yeovil District Hospital	81	19		28	351		M	67	Squamous cell Ca	Ileal Conduit
488	23	North Bristol NHSTrust (Southmead)	37	313		28	351		999	79	Muscle invasive TCC	Ileal Conduit
489	24	Great Western Hospital, Swindon	24	7		30	167		M	60	Muscle invasive TCC	Ileal Conduit
490	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	81	Muscle invasive TCC	Ileal Conduit
491	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	64	Salvage after radiotherapy	Ileal Conduit
492	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	65	Uncontrolled superficial disease	Ileal Conduit
493	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	71	Muscle invasive TCC	Ileal Conduit
494	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	65	Uncontrolled superficial disease	Orthotopic
495	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	84	999	Ileal Conduit
496	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	53	Muscle invasive TCC	Orthotopic
497	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	74	Muscle invasive TCC	Ileal Conduit
498	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	77	Uncontrolled superficial disease	Ileal Conduit
499	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	72	Muscle invasive TCC	Ileal Conduit

500	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	62	Muscle invasive TCC	Ileal Conduit
501	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	58	Muscle invasive TCC	Ileal Conduit
502	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	52	Muscle invasive TCC	Ileal Conduit
503	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	64	Muscle invasive TCC	Ileal Conduit
504	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	71	999	Ileal Conduit
505	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	56	Muscle invasive TCC	Orthotopic
506	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	66	Muscle invasive TCC	Orthotopic
507	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	68	Muscle invasive TCC	Ileal Conduit
508	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	60	Muscle invasive TCC	Orthotopic
509	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	73	Uncontrolled superficial disease	Ileal Conduit
510	24	North Bristol NHSTrust (Southmead)	37	313		28	351		999	999	Muscle invasive TCC	Orthotopic
511	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	73	Uncontrolled superficial disease	Ileal Conduit
512	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	57	Muscle invasive TCC	Ileal Conduit
513	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	999	999	Ileal Conduit
514	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	60	Uncontrolled superficial disease	Ileal Conduit
515	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	79	Muscle invasive TCC	Ileal Conduit
516	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	60	Other	Ileal Conduit
517	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	45	Muscle invasive TCC	Ileal Conduit
518	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	49	Muscle invasive TCC	Ileal Conduit
519	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	72	Squamous cell Ca	Ileal Conduit
520	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	62	999	Orthotopic
521	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	74	999	Ileal Conduit
522	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	73	Other	Ileal Conduit
523	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	77	Muscle invasive TCC	Ileal Conduit
524	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	74	Muscle invasive TCC	Ileal Conduit
525	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	65	999	Ileal Conduit
526	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	65	999	Ileal Conduit
527	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	60	Muscle invasive TCC	Orthotopic
528	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	72	Salvage after radiotherapy	Ileal Conduit
529	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	47	Muscle invasive TCC	Orthotopic
530	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	999	Muscle invasive TCC	Ileal Conduit
531	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	64	Muscle invasive TCC	Ileal Conduit
532	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	70	Muscle invasive TCC	Ileal Conduit
533	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	78	Primary CIS	Ileal Conduit
534	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	63	Muscle invasive TCC	Ileal Conduit
535	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	75	Muscle invasive TCC	Ileal Conduit
536	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	67	Other	Ileal Conduit
537	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	64	Muscle invasive TCC	Ileal Conduit
538	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	79	Muscle invasive TCC	Ileal Conduit
539	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	77	Muscle invasive TCC	Ileal Conduit
540	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	75	Muscle invasive TCC	Ileal Conduit
541	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	78	Salvage after radiotherapy	Ileal Conduit
542	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	70	Muscle invasive TCC	Ileal Conduit
543	24	North Bristol NHSTrust (Southmead)	37	313		28	351		F	77	Muscle invasive TCC	Ileal Conduit
544	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	75	Muscle invasive TCC	Ileal Conduit
545	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	72	Muscle invasive TCC	Ileal Conduit
546	24	North Bristol NHSTrust (Southmead)	37	313		28	351		M	999	Salvage after radiotherapy	Orthotopic
547	24	Taunton And Somerset Hospital	69	11		28	351		M	53	Muscle invasive TCC	Orthotopic
548	24	Taunton And Somerset Hospital	69	11		28	351		F	75	Squamous cell Ca	Ileal Conduit
549	24	Weston - Super - Mare General Hospital	79	1		28	351		M	72	Muscle invasive TCC	Ileal Conduit

550	24	Weston - Super - Mare General Hospital	79	1		28	351		F	58	Squamous cell Ca	Ileal Conduit
551	24	Yeovil District Hospital	81	19		28	351		F	65	Salvage after radiotherapy	Ileal Conduit
552	24	Yeovil District Hospital	81	19		28	351		M	71	Muscle invasive TCC	Ileal Conduit
553	24	Yeovil District Hospital	81	19		28	351		M	74	999	Ileal Conduit
554	24	Yeovil District Hospital	81	19		28	351		M	67	Uncontrolled superficial disease	Ileal Conduit
555	24	Yeovil District Hospital	81	19		28	351		M	68	Muscle invasive TCC	Ileal Conduit
556	24	Yeovil District Hospital	81	19		28	351		M	61	Muscle invasive TCC	Ileal Conduit
557	24	Yeovil District Hospital	81	19		28	351		M	76	Muscle invasive TCC	Ileal Conduit
558	25	Bromley Hospital	9	19		24	149		M	65	Muscle invasive TCC	Ileal Conduit
559	26	Nottingham City Hospital	40	75		39	345		999	999	Gynaecological Ca	Ileal Conduit
560	26	Nottingham City Hospital	40	75		39	345		F	41	Gynaecological Ca	Ileal Conduit
561	26	Nottingham City Hospital	40	75		39	345		M	999	Uncontrolled superficial disease	Ileal Conduit
562	26	Nottingham City Hospital	40	75		39	345		F	75	Squamous cell Ca	Ileal Conduit
563	26	Nottingham City Hospital	40	75		39	345		999	999	Muscle invasive TCC	Ileal Conduit
564	26	Nottingham City Hospital	40	75		39	345		F	999	Squamous cell Ca	Ileal Conduit
565	26	Nottingham City Hospital	40	75		39	345		M	66	Primary CIS	Ileal Conduit
566	26	Nottingham City Hospital	40	75		39	345		M	62	Muscle invasive TCC	Ileal Conduit
567	26	Nottingham City Hospital	40	75		39	345		999	67	Muscle invasive TCC	Orthotopic
568	26	Nottingham City Hospital	40	75		39	345		M	58	Muscle invasive TCC	Orthotopic
569	26	Nottingham City Hospital	40	75		39	345		999	999	Muscle invasive TCC	Ileal Conduit
570	26	Nottingham City Hospital	40	75		39	345		M	60	Muscle invasive TCC	Orthotopic
571	26	Nottingham City Hospital	40	75		39	345		F	61	Muscle invasive TCC	Ileal Conduit
572	26	Nottingham City Hospital	40	75		39	345		M	74	Primary CIS	Ileal Conduit
573	26	Nottingham City Hospital	40	75		39	345		999	999	Gynaecological Ca	Ileal Conduit
574	26	Nottingham City Hospital	40	75		39	345		999	999	Muscle invasive TCC	Ileal Conduit
575	26	Nottingham City Hospital	40	75		39	345		M	77	Salvage after radiotherapy	Ileal Conduit
576	26	Nottingham City Hospital	40	75		39	345		M	56	Squamous cell Ca	Ileal Conduit
577	26	Nottingham City Hospital	40	75		39	345		M	75	Salvage after radiotherapy	Ileal Conduit
578	26	Nottingham City Hospital	40	75		39	345		M	999	Salvage after radiotherapy	Ileal Conduit
579	26	Nottingham City Hospital	40	75		39	345		M	76	Primary CIS	Ileal Conduit
580	26	Nottingham City Hospital	40	75		39	345		M	54	Muscle invasive TCC	Ileal Conduit
581	26	Nottingham City Hospital	40	75		39	345		M	71	Muscle invasive TCC	Ileal Conduit
582	26	Nottingham City Hospital	40	75		39	345		M	77	Muscle invasive TCC	Ileal Conduit
583	26	Nottingham City Hospital	40	75		39	345		M	76	Uncontrolled superficial disease	Ileal Conduit
584	26	Nottingham City Hospital	40	75		39	345		999	999	Salvage after radiotherapy	Ileal Conduit
585	26	Royal Bolton Hospital NHS Foundation Trust	48	24		2	101.00		M	74	Muscle invasive TCC	Ileal Conduit
586	27	Castle Hill Hospital	11	135		7	144		F	999	Muscle invasive TCC	Ileal Conduit
587	28	Portsmouth Hospitals NHS Trust	43	150		31	307		999	81	Muscle invasive TCC	Ileal Conduit
588	29	Freeman Hospital	23	258		36	405		M	75	Uncontrolled superficial disease	Ileal Conduit
589	30	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	65	999	Orthotopic
590	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	62	999	Orthotopic
591	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	76	Muscle invasive TCC	Ileal Conduit
592	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	52	999	Orthotopic
593	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	72	Uncontrolled superficial disease	Ileal Conduit
594	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		F	71	Muscle invasive TCC	Ileal Conduit
595	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	64	Other	Ileal Conduit
596	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	53	Muscle invasive TCC	Orthotopic
597	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	72	999	Ileal Conduit
598	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	60	Muscle invasive TCC	Ileal Conduit
599	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	73	999	Ileal Conduit

600	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	77	Muscle invasive TCC	Ileal Conduit
601	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	62	Uncontrolled superficial disease	Ileal Conduit
602	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	999	999	Ileal Conduit
603	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	77	999	Ileal Conduit
604	30	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	78	Muscle invasive TCC	Ileal Conduit
605	31	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	77	Muscle invasive TCC	Ileal Conduit
606	31	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	51	Muscle invasive TCC	Ileal Conduit
607	31	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	77	Muscle invasive TCC	Ileal Conduit
608	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	71	Muscle invasive TCC	Ileal Conduit
609	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	73	Other	Ileal Conduit
610	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	71	Muscle invasive TCC	Ileal Conduit
611	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	76	Other	Ileal Conduit
612	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	59	Muscle invasive TCC	Ileal Conduit
613	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	80	Muscle invasive TCC	Ileal Conduit
614	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	72	Muscle invasive TCC	Ileal Conduit
615	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	71	Muscle invasive TCC	Ileal Conduit
616	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	56	Muscle invasive TCC	Ileal Conduit
617	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	76	Primary CIS	Ileal Conduit
618	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	65	Muscle invasive TCC	Ileal Conduit
619	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	65	Muscle invasive TCC	Ileal Conduit
620	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	77	Muscle invasive TCC	Ileal Conduit
621	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	42	Squamous cell Ca	Ileal Conduit
622	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	74	Other	Ileal Conduit
623	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	79	Muscle invasive TCC	Ileal Conduit
624	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	85	Muscle invasive TCC	Ileal Conduit
625	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	60	Other	Ileal Conduit
626	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	72	Muscle invasive TCC	Ileal Conduit
627	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	75	Other	Ileal Conduit
628	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	60	Other	Ileal Conduit
629	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	57	Other	Ileal Conduit
630	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	60	Other	Ileal Conduit
631	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	65	Other	Ileal Conduit
632	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	61	Primary CIS	Ileal Conduit
633	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	67	Primary CIS	Ileal Conduit
634	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	58	Other	Ileal Conduit
635	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	59	Other	Ileal Conduit
636	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	62	Muscle invasive TCC	Ileal Conduit
637	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	74	Other	Ileal Conduit
638	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	66	Muscle invasive TCC	Orthotopic
639	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	69	Muscle invasive TCC	Ileal Conduit
640	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	67	Muscle invasive TCC	Ileal Conduit
641	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	67	Muscle invasive TCC	Ileal Conduit
642	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	74	Squamous cell Ca	Ileal Conduit
643	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	77	Other	Ileal Conduit
644	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	79	Other	Ileal Conduit
645	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	71	Other	Ileal Conduit
646	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	79	Salvage after radiotherapy	Ileal Conduit
647	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	78	Muscle invasive TCC	Ileal Conduit
648	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	78	Muscle invasive TCC	Ileal Conduit
649	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	94	Muscle invasive TCC	Ileal Conduit

650	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	58	Muscle invasive TCC	Ileal Conduit
651	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	64	Other	Ileal Conduit
652	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	64	Muscle invasive TCC	Ileal Conduit
653	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	42	Other	Ileal Conduit
654	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	56	Other	Ileal Conduit
655	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	67	Other	Ileal Conduit
656	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	66	Muscle invasive TCC	Ileal Conduit
657	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	76	Muscle invasive TCC	Ileal Conduit
658	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	63	Muscle invasive TCC	Ileal Conduit
659	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	64	Muscle invasive TCC	Ileal Conduit
660	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	62	Muscle invasive TCC	Ileal Conduit
661	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	77	Muscle invasive TCC	Ileal Conduit
662	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	70	Other	Ileal Conduit
663	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	77	Other	Ileal Conduit
664	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	77	Muscle invasive TCC	Ileal Conduit
665	32	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	79	Muscle invasive TCC	Ileal Conduit
666	33	Pilgrim Hospital	41	29		39	345		M	75	Muscle invasive TCC	Ileal Conduit
667	33	Pilgrim Hospital	41	29		39	345		M	72	Primary adenocarcinoma	Ileal Conduit
668	33	Pilgrim Hospital	41	29		39	345		M	83	Primary CIS	Ileal Conduit
669	33	Pilgrim Hospital	41	29		39	345		F	72	Muscle invasive TCC	Ileal Conduit
670	33	Pilgrim Hospital	41	29		39	345		M	64	Muscle invasive TCC	Ileal Conduit
671	33	Pilgrim Hospital	41	29		39	345		M	77	Primary adenocarcinoma	Ileal Conduit
672	33	Pilgrim Hospital	41	29		39	345		M	71	Muscle invasive TCC	Ileal Conduit
673	33	Pilgrim Hospital	41	29		39	345		M	73	Other	Ileal Conduit
674	33	Pilgrim Hospital	41	29		39	345		M	76	Muscle invasive TCC	Ileal Conduit
675	34	Freeman Hospital	23	258		36	405		M	69	Muscle invasive TCC	Ileal Conduit
676	35	North Bristol NHSTrust (Southmead)	37	313		28	351		M	75	Muscle invasive TCC	Ileal Conduit
677	36	Freeman Hospital	23	258		36	405		F	71	Muscle invasive TCC	Ileal Conduit
678	36	Freeman Hospital	23	258		36	405		M	58	Muscle invasive TCC	Orthotopic
679	36	Freeman Hospital	23	258		36	405		M	71	Uncontrolled superficial disease	Ileal Conduit
680	36	Freeman Hospital	23	258		36	405		M	79	Muscle invasive TCC	Ileal Conduit
681	36	Freeman Hospital	23	258		36	405		M	62	Uncontrolled superficial disease	Orthotopic
682	36	Freeman Hospital	23	258		36	405		F	76	Muscle invasive TCC	Ileal Conduit
683	36	Freeman Hospital	23	258		36	405		M	73	Uncontrolled superficial disease	Ileal Conduit
684	36	Freeman Hospital	23	258		36	405		M	74	Muscle invasive TCC	Ileal Conduit
685	36	Freeman Hospital	23	258		36	405		F	63	Uncontrolled superficial disease	Ileal Conduit
686	36	Freeman Hospital	23	258		36	405		M	73	Muscle invasive TCC	Ileal Conduit
687	36	Freeman Hospital	23	258		36	405		F	999	Primary CIS	Ileal Conduit
688	36	Freeman Hospital	23	258		36	405		F	74	Muscle invasive TCC	Ileal Conduit
689	36	Freeman Hospital	23	258		36	405		M	75	Muscle invasive TCC	Ileal Conduit
690	36	Freeman Hospital	23	258		36	405		M	72	Uncontrolled superficial disease	Ileal Conduit
691	36	Freeman Hospital	23	258		36	405		M	60	Uncontrolled superficial disease	Ileal Conduit
692	36	Freeman Hospital	23	258		36	405		M	66	Muscle invasive TCC	Ileal Conduit
693	36	Freeman Hospital	23	258		36	405		M	61	Primary adenocarcinoma	Ileal Conduit
694	36	Freeman Hospital	23	258		36	405		M	78	Muscle invasive TCC	Ileal Conduit
695	36	Freeman Hospital	23	258		36	405		F	64	Muscle invasive TCC	Ileal Conduit
696	36	Freeman Hospital	23	258		36	405		M	71	Uncontrolled superficial disease	Ileal Conduit
697	36	Freeman Hospital	23	258		36	405		M	74	Uncontrolled superficial disease	Ileal Conduit
698	36	Freeman Hospital	23	258		36	405		M	71	Muscle invasive TCC	Ileal Conduit
699	36	Freeman Hospital	23	258		36	405		M	76	Muscle invasive TCC	Ileal Conduit

700	36	Freeman Hospital	23	258		36	405		F	71	Muscle invasive TCC	Ileal Conduit
701	36	Freeman Hospital	23	258		36	405		M	66	Muscle invasive TCC	Ileal Conduit
702	36	Freeman Hospital	23	258		36	405		F	74	Uncontrolled superficial disease	Ileal Conduit
703	36	Freeman Hospital	23	258		36	405		F	72	Muscle invasive TCC	Ileal Conduit
704	36	Freeman Hospital	23	258		36	405		F	68	Muscle invasive TCC	Ileal Conduit
705	36	Freeman Hospital	23	258		36	405		F	67	Primary CIS	Ileal Conduit
706	36	Freeman Hospital	23	258		36	405		M	57	Uncontrolled superficial disease	Orthotopic
707	36	Freeman Hospital	23	258		36	405		M	75	Uncontrolled superficial disease	Ileal Conduit
708	36	Freeman Hospital	23	258		36	405		M	61	Muscle invasive TCC	Ileal Conduit
709	36	Freeman Hospital	23	258		36	405		F	70	Uncontrolled superficial disease	Ileal Conduit
710	36	Freeman Hospital	23	258		36	405		M	69	Muscle invasive TCC	Ileal Conduit
711	36	Freeman Hospital	23	258		36	405		M	53	Uncontrolled superficial disease	Ileal Conduit
712	36	Freeman Hospital	23	258		36	405		F	67	Muscle invasive TCC	Ileal Conduit
713	36	Freeman Hospital	23	258		36	405		F	74	Muscle invasive TCC	Ileal Conduit
714	36	Freeman Hospital	23	258		36	405		F	80	Uncontrolled superficial disease	Ileal Conduit
715	36	Freeman Hospital	23	258		36	405		M	76	Muscle invasive TCC	Ileal Conduit
716	36	Freeman Hospital	23	258		36	405		M	70	Muscle invasive TCC	Ileal Conduit
717	36	Freeman Hospital	23	258		36	405		F	71	Muscle invasive TCC	Ileal Conduit
718	36	Freeman Hospital	23	258		36	405		M	64	Uncontrolled superficial disease	Ileal Conduit
719	36	Freeman Hospital	23	258		36	405		M	62	Uncontrolled superficial disease	Ileal Conduit
720	36	Freeman Hospital	23	258		36	405		M	83	Muscle invasive TCC	Ileal Conduit
721	36	Freeman Hospital	23	258		36	405		F	78	Primary CIS	Ileal Conduit
722	36	Freeman Hospital	23	258		36	405		F	52	Primary adenocarcinoma	Orthotopic
723	36	Freeman Hospital	23	258		36	405		M	53	Uncontrolled superficial disease	Ileal Conduit
724	36	Freeman Hospital	23	258		36	405		F	78	Squamous cell Ca	Ileal Conduit
725	36	Freeman Hospital	23	258		36	405		M	68	Muscle invasive TCC	Orthotopic
726	36	Freeman Hospital	23	258		36	405		F	67	Muscle invasive TCC	Ileal Conduit
727	36	Freeman Hospital	23	258		36	405		M	74	Muscle invasive TCC	Ileal Conduit
728	36	Freeman Hospital	23	258		36	405		M	56	Uncontrolled superficial disease	Orthotopic
729	37	Castle Hill Hospital	11	135		7	144		M	71	Salvage after radiotherapy	Ileal Conduit
730	37	Castle Hill Hospital	11	135		7	144		M	63	Muscle invasive TCC	Ileal Conduit
731	37	Castle Hill Hospital	11	135		7	144		M	72	Salvage after radiotherapy	Ileal Conduit
732	37	Castle Hill Hospital	11	135		7	144		F	79	Muscle invasive TCC	Ileal Conduit
733	37	Castle Hill Hospital	11	135		7	144		M	61	Muscle invasive TCC	Ileal Conduit
734	37	Castle Hill Hospital	11	135		7	144		M	69	Muscle invasive TCC	Ileal Conduit
735	37	Castle Hill Hospital	11	135		7	144		M	53	Salvage after radiotherapy	Ileal Conduit
736	37	Castle Hill Hospital	11	135		7	144		M	53	Muscle invasive TCC	Orthotopic
737	37	Castle Hill Hospital	11	135		7	144		M	76	Muscle invasive TCC	Ileal Conduit
738	37	Castle Hill Hospital	11	135		7	144		M	73	Uncontrolled superficial disease	Ileal Conduit
739	37	Castle Hill Hospital	11	135		7	144		F	76	Muscle invasive TCC	Ileal Conduit
740	37	Castle Hill Hospital	11	135		7	144		M	46	Muscle invasive TCC	Ileal Conduit
741	37	Castle Hill Hospital	11	135		7	144		F	58	Uncontrolled superficial disease	Ileal Conduit
742	37	Castle Hill Hospital	11	135		7	144		M	79	Muscle invasive TCC	Ileal Conduit
743	37	Castle Hill Hospital	11	135		7	144		M	70	Primary CIS	Ileal Conduit
744	37	Castle Hill Hospital	11	135		7	144		M	56	Muscle invasive TCC	Ileal Conduit
745	37	Castle Hill Hospital	11	135		7	144		M	47	Muscle invasive TCC	Ileal Conduit
746	37	Castle Hill Hospital	11	135		7	144		M	79	Salvage after radiotherapy	Ileal Conduit
747	37	Castle Hill Hospital	11	135		7	144		M	61	Muscle invasive TCC	Ileal Conduit
748	37	Castle Hill Hospital	11	135		7	144		M	59	Uncontrolled superficial disease	Ileal Conduit
749	37	Castle Hill Hospital	11	135		7	144		M	58	999	Ileal Conduit

750	37	Castle Hill Hospital	11	135		7	144		M	80	Uncontrolled superficial disease	Ileal Conduit
751	37	Castle Hill Hospital	11	135		7	144		M	60	Muscle invasive TCC	Ileal Conduit
752	37	Scarborough Hospital	63	9		7	144		M	73	Muscle invasive TCC	Ileal Conduit
753	38	Bradford Royal Infirmary	7	107		6	384		M	57	Muscle invasive TCC	Orthotopic
754	39	Hereford Hospitals NHS Trust	27	8		29	31		M	64	Primary CIS	Ileal Conduit
755	39	Hereford Hospitals NHS Trust	27	8		29	31		M	57	Muscle invasive TCC	Ileal Conduit
756	39	Hereford Hospitals NHS Trust	27	8		29	31		M	65	Muscle invasive TCC	Ileal Conduit
757	39	Hereford Hospitals NHS Trust	27	8		29	31		M	72	Muscle invasive TCC	Ileal Conduit
758	39	Hereford Hospitals NHS Trust	27	8		29	31		M	71	Muscle invasive TCC	Ileal Conduit
759	39	Hereford Hospitals NHS Trust	27	8		29	31		F	62	Muscle invasive TCC	Ileal Conduit
760	39	Hereford Hospitals NHS Trust	27	8		29	31		M	75	Muscle invasive TCC	Ileal Conduit
761	39	Hereford Hospitals NHS Trust	27	8		29	31		M	73	Muscle invasive TCC	Ileal Conduit
762	39	Hereford Hospitals NHS Trust	27	8		29	31		F	78	Muscle invasive TCC	Ileal Conduit
763	40	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	70	Muscle invasive TCC	Ileal Conduit
764	40	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	72	Muscle invasive TCC	Orthotopic
765	41	Royal Hampshire County Hospital	53	15		31	307		M	86	Muscle invasive TCC	Ileal Conduit
766	41	Royal Hampshire County Hospital	53	15		31	307		F	69	Muscle invasive TCC	Ileal Conduit
767	41	Royal Hampshire County Hospital	53	15		31	307		M	62	Primary CIS	Ileal Conduit
768	41	Royal Hampshire County Hospital	53	15		31	307		M	76	Muscle invasive TCC	Ileal Conduit
769	41	Royal Hampshire County Hospital	53	15		31	307		M	69	Muscle invasive TCC	Ileal Conduit
770	41	Royal Hampshire County Hospital	53	15		31	307		M	76	Uncontrolled superficial disease	Ileal Conduit
771	41	Royal Hampshire County Hospital	53	15		31	307		F	999	Muscle invasive TCC	Ileal Conduit
772	41	Royal Hampshire County Hospital	53	15		31	307		M	82	Muscle invasive TCC	Ileal Conduit
773	41	Royal Hampshire County Hospital	53	15		31	307		M	64	Muscle invasive TCC	Ileal Conduit
774	42	Nottingham City Hospital	40	75		39	345		F	60	Muscle invasive TCC	Ileal Conduit
775	42	Nottingham City Hospital	40	75		39	345		M	50	Muscle invasive TCC	Ileal Conduit
776	42	Nottingham City Hospital	40	75		39	345		M	66	Muscle invasive TCC	Ileal Conduit
777	42	Nottingham City Hospital	40	75		39	345		M	67	Salvage after radiotherapy	Ileal Conduit
778	42	Nottingham City Hospital	40	75		39	345		F	79	Muscle invasive TCC	Ileal Conduit
779	42	Nottingham City Hospital	40	75		39	345		M	76	Muscle invasive TCC	Ileal Conduit
780	42	Nottingham City Hospital	40	75		39	345		M	72	Muscle invasive TCC	Ileal Conduit
781	42	Nottingham City Hospital	40	75		39	345		M	75	Muscle invasive TCC	Ileal Conduit
782	42	Nottingham City Hospital	40	75		39	345		M	67	Secondary adenocarcinoma	Ileal Conduit
783	42	Nottingham City Hospital	40	75		39	345		M	68	Muscle invasive TCC	Ileal Conduit
784	42	Nottingham City Hospital	40	75		39	345		F	47	Primary adenocarcinoma	Ileal Conduit
785	42	Nottingham City Hospital	40	75		39	345		M	74	Uncontrolled superficial disease	Ileal Conduit
786	43	Dorset County Hospital	21	3		27	60		F	68	Muscle invasive TCC	Ileal Conduit
787	43	Dorset County Hospital	21	3		27	60		M	63	Muscle invasive TCC	Ileal Conduit
788	43	Salisbury District Hospital	61	35		31	307		M	60	Muscle invasive TCC	Ileal Conduit
789	43	Salisbury District Hospital	61	35		31	307		M	76	Muscle invasive TCC	Ileal Conduit
790	43	Salisbury District Hospital	61	35		31	307		M	67	Muscle invasive TCC	Ileal Conduit
791	43	Salisbury District Hospital	61	35		31	307		M	76	Muscle invasive TCC	Ileal Conduit
792	43	Salisbury District Hospital	61	35		31	307		M	60	Muscle invasive TCC	Ileal Conduit
793	43	Salisbury District Hospital	61	35		31	307		M	61	Muscle invasive TCC	Orthotopic
794	43	Salisbury District Hospital	61	35		31	307		M	68	Muscle invasive TCC	Ileal Conduit
795	43	Salisbury District Hospital	61	35		31	307		M	75	Muscle invasive TCC	Ileal Conduit
796	43	Salisbury District Hospital	61	35		31	307		M	999	Muscle invasive TCC	Ileal Conduit
797	43	Salisbury District Hospital	61	35		31	307		M	73	Other	Ileal Conduit
798	43	Salisbury District Hospital	61	35		31	307		M	70	Salvage after radiotherapy	Ileal Conduit
799	43	Salisbury District Hospital	61	35		31	307		M	69	Muscle invasive TCC	Ileal Conduit

800	43	Salisbury District Hospital	61	35		31	307		M	69	Muscle invasive TCC	Ileal Conduit
801	43	Salisbury District Hospital	61	35		31	307		M	44	Muscle invasive TCC	Ileal Conduit
802	43	Salisbury District Hospital	61	35		31	307		F	65	Muscle invasive TCC	Ileal Conduit
803	43	Salisbury District Hospital	61	35		31	307		F	61	Other	Ileal Conduit
804	43	Salisbury District Hospital	61	35		31	307		F	75	Primary adenocarcinoma	Ileal Conduit
805	43	Salisbury District Hospital	61	35		31	307		F	68	Muscle invasive TCC	Ileal Conduit
806	43	Salisbury District Hospital	61	35		31	307		M	78	Uncontrolled superficial disease	Ileal Conduit
807	43	Salisbury District Hospital	61	35		31	307		M	76	Uncontrolled superficial disease	Ileal Conduit
808	43	Salisbury District Hospital	61	35		31	307		M	57	Uncontrolled superficial disease	Ileal Conduit
809	43	Salisbury District Hospital	61	35		31	307		M	56	Muscle invasive TCC	Ileal Conduit
810	43	Salisbury District Hospital	61	35		31	307		M	76	Other	Ileal Conduit
811	43	Salisbury District Hospital	61	35		31	307		M	80	Muscle invasive TCC	Ileal Conduit
812	43	Salisbury District Hospital	61	35		31	307		M	81	Salvage after radiotherapy	Ileal Conduit
813	43	Salisbury District Hospital	61	35		31	307		M	53	Muscle invasive TCC	Ileal Conduit
814	43	Salisbury District Hospital	61	35		31	307		F	73	Muscle invasive TCC	Ileal Conduit
815	43	Salisbury District Hospital	61	35		31	307		F	62	Primary adenocarcinoma	Ileal Conduit
816	43	Salisbury District Hospital	61	35		31	307		M	63	Muscle invasive TCC	Orthotopic
817	43	Salisbury District Hospital	61	35		31	307		M	77	Salvage after radiotherapy	Ileal Conduit
818	43	Salisbury District Hospital	61	35		31	307		M	64	Primary CIS	Orthotopic
819	43	Salisbury District Hospital	61	35		31	307		M	49	Muscle invasive TCC	Ileal Conduit
820	43	Salisbury District Hospital	61	35		31	307		F	75	Muscle invasive TCC	Ileal Conduit
821	43	Salisbury District Hospital	61	35		31	307		M	76	Muscle invasive TCC	Ileal Conduit
822	43	Salisbury District Hospital	61	35		31	307		M	80	Muscle invasive TCC	Ileal Conduit
823	43	Salisbury District Hospital	61	35		31	307		M	69	Secondary adenocarcinoma	Ileal Conduit
824	43	Salisbury District Hospital	61	35		31	307		M	65	Salvage after radiotherapy	Ileal Conduit
825	43	Salisbury District Hospital	61	35		31	307		F	70	Salvage after radiotherapy	Ileal Conduit
826	43	Salisbury District Hospital	61	35		31	307		F	67	Muscle invasive TCC	Ileal Conduit
827	43	Salisbury District Hospital	61	35		31	307		M	72	Muscle invasive TCC	Ileal Conduit
828	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	71	Squamous cell Ca	Ileal Conduit
829	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	63	Muscle invasive TCC	Ileal Conduit
830	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	77	Uncontrolled superficial disease	Ileal Conduit
831	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	69	Muscle invasive TCC	Ileal Conduit
832	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	62	Muscle invasive TCC	Ileal Conduit
833	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	73	Muscle invasive TCC	Ileal Conduit
834	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	65	Muscle invasive TCC	Ileal Conduit
835	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	69	Muscle invasive TCC	Ileal Conduit
836	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	69	Uncontrolled superficial disease	Ileal Conduit
837	44	Southport & Ormskirk NHS Trust	66	21		3	140		F	65	Muscle invasive TCC	Ileal Conduit
838	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	60	Muscle invasive TCC	Ileal Conduit
839	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	68	Muscle invasive TCC	Ileal Conduit
840	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	72	Muscle invasive TCC	Ileal Conduit
841	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	52	Uncontrolled superficial disease	Ileal Conduit
842	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	57	Muscle invasive TCC	Ileal Conduit
843	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	69	Muscle invasive TCC	Ileal Conduit
844	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	73	Muscle invasive TCC	Ileal Conduit
845	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	57	Muscle invasive TCC	Ileal Conduit
846	44	Southport & Ormskirk NHS Trust	66	21		3	140		F	72	Muscle invasive TCC	Ileal Conduit
847	44	Southport & Ormskirk NHS Trust	66	21		3	140		M	58	Uncontrolled superficial disease	Ileal Conduit
848	44	Southport & Ormskirk NHS Trust	66	21		3	140		F	55	Muscle invasive TCC	Ileal Conduit
849	45	James Paget Hospital	29	18		37	52		F	71	Muscle invasive TCC	Ileal Conduit

850	45	James Paget Hospital	29	18		37	52		M	63	Muscle invasive TCC	Ileal Conduit
851	45	James Paget Hospital	29	18		37	52		M	78	Muscle invasive TCC	Ileal Conduit
852	45	James Paget Hospital	29	18		37	52		M	80	Muscle invasive TCC	Ileal Conduit
853	45	James Paget Hospital	29	18		37	52		M	81	Muscle invasive TCC	Ileal Conduit
854	45	James Paget Hospital	29	18		37	52		M	82	Salvage after radiotherapy	Ileal Conduit
855	45	James Paget Hospital	29	18		37	52		M	58	Muscle invasive TCC	Ileal Conduit
856	45	James Paget Hospital	29	18		37	52		M	74	Muscle invasive TCC	Ileal Conduit
857	45	James Paget Hospital	29	18		37	52		M	68	Muscle invasive TCC	Ileal Conduit
858	45	James Paget Hospital	29	18		37	52		F	71	Muscle invasive TCC	Ileal Conduit
859	45	James Paget Hospital	29	18		37	52		F	69	Muscle invasive TCC	Ileal Conduit
860	45	James Paget Hospital	29	18		37	52		M	72	Muscle invasive TCC	Ileal Conduit
861	45	James Paget Hospital	29	18		37	52		M	48	Muscle invasive TCC	Ileal Conduit
862	45	James Paget Hospital	29	18		37	52		M	68	Muscle invasive TCC	Ileal Conduit
863	46	Whiston Hospital	80	12		3	140		F	71	Salvage after radiotherapy	Ileal Conduit
864	47	North Bristol NHSTrust (Southmead)	37	313		28	351		M	84	999	Ileal Conduit
865	47	North Bristol NHSTrust (Southmead)	37	313		28	351		M	83	999	Ileal Conduit
866	47	Weston - Super - Mare General Hospital	79	1		28	351		M	60	999	Ileal Conduit
867	48	Lincoln & Louth NHS Trust	34	8		39	345		F	44	Squamous cell Ca	Ileal Conduit
868	48	Lincoln & Louth NHS Trust	34	8		39	345		M	74	Muscle invasive TCC	Ileal Conduit
869	48	Lincoln & Louth NHS Trust	34	8		39	345		M	62	Muscle invasive TCC	Ileal Conduit
870	48	Lincoln & Louth NHS Trust	34	8		39	345		F	64	Muscle invasive TCC	Ileal Conduit
871	48	Lincoln & Louth NHS Trust	34	8		39	345		M	74	Muscle invasive TCC	Ileal Conduit
872	49	Portsmouth Hospitals NHS Trust	43	150		31	307		M	74	999	Ileal Conduit
873	49	Portsmouth Hospitals NHS Trust	43	150		31	307		M	75	Muscle invasive TCC	Ileal Conduit
874	49	Portsmouth Hospitals NHS Trust	43	150		31	307		M	73	Primary CIS	Ileal Conduit
875	49	Portsmouth Hospitals NHS Trust	43	150		31	307		M	59	999	Ileal Conduit
876	50	Guy's & Thomas's Hospital	25	130		24	149		M	62	Uncontrolled superficial disease	Ileal Conduit
877	50	Guy's & Thomas's Hospital	25	130		24	149		M	53	Uncontrolled superficial disease	Ileal Conduit
878	52	Southampton General Hospital	64	95		31	307		M	73	Muscle invasive TCC	Ileal Conduit
879	52	Southampton General Hospital	64	95		31	307		F	86	Muscle invasive TCC	Ileal Conduit
880	52	Southampton General Hospital	64	95		31	307		M	84	Muscle invasive TCC	Ileal Conduit
881	53	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	77	Muscle invasive TCC	Ileal Conduit
882	53	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	69	Squamous cell Ca	Ileal Conduit
883	53	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	57	Squamous cell Ca	Ileal Conduit
884	53	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	66	Muscle invasive TCC	Ileal Conduit
885	53	Alexandra Hospital; Kidderminster General Hospit	3	23		29	31		M	70	Muscle invasive TCC	Ileal Conduit
886	54	Colchester General Hospital	16	68		38	164		M	71	Muscle invasive TCC	Ileal Conduit
887	54	Colchester General Hospital	16	68		38	164		F	73	Salvage after radiotherapy	Ileal Conduit
888	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	67	Salvage after radiotherapy	Ileal Conduit
889	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	79	Muscle invasive TCC	Ileal Conduit
890	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	71	Muscle invasive TCC	Ileal Conduit
891	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	64	Uncontrolled superficial disease	Ileal Conduit
892	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	59	Muscle invasive TCC	Ileal Conduit
893	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	68	Primary CIS	Ileal Conduit
894	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	74	Muscle invasive TCC	Ileal Conduit
895	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	66	Muscle invasive TCC	Ileal Conduit
896	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	60	Muscle invasive TCC	Ileal Conduit
897	55	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	64	Salvage after radiotherapy	Ileal Conduit
898	56	Castle Hill Hospital	11	135		7	144		F	75	Muscle invasive TCC	Ileal Conduit
899	56	Castle Hill Hospital	11	135		7	144		F	73	Squamous cell Ca	Ileal Conduit

900	56	Castle Hill Hospital	11	135		7	144		M	66	Muscle invasive TCC	Ileal Conduit
901	56	Castle Hill Hospital	11	135		7	144		M	67	Uncontrolled superficial disease	Ileal Conduit
902	56	Castle Hill Hospital	11	135		7	144		M	71	Muscle invasive TCC	Ileal Conduit
903	56	Castle Hill Hospital	11	135		7	144		F	71	Other	Ileal Conduit
904	56	Castle Hill Hospital	11	135		7	144		M	999	Muscle invasive TCC	Ileal Conduit
905	56	Castle Hill Hospital	11	135		7	144		F	58	Salvage after radiotherapy	Ileal Conduit
906	56	Castle Hill Hospital	11	135		7	144		M	65	Salvage after radiotherapy	Ileal Conduit
907	56	Castle Hill Hospital	11	135		7	144		M	66	Muscle invasive TCC	Ileal Conduit
908	56	Castle Hill Hospital	11	135		7	144		M	70	Muscle invasive TCC	Ileal Conduit
909	56	Castle Hill Hospital	11	135		7	144		M	76	Muscle invasive TCC	Ileal Conduit
910	56	Castle Hill Hospital	11	135		7	144		M	78	Salvage after radiotherapy	Ileal Conduit
911	56	Castle Hill Hospital	11	135		7	144		M	69	Muscle invasive TCC	Ileal Conduit
912	56	Castle Hill Hospital	11	135		7	144		M	66	Muscle invasive TCC	Ileal Conduit
913	56	Castle Hill Hospital	11	135		7	144		F	57	Muscle invasive TCC	Ileal Conduit
914	56	Castle Hill Hospital	11	135		7	144		M	76	Salvage after radiotherapy	Ileal Conduit
915	56	Castle Hill Hospital	11	135		7	144		F	44	Muscle invasive TCC	Ileal Conduit
916	56	Scarborough Hospital	63	9		7	144		M	56	Uncontrolled superficial disease	Orthotopic
917	56	Scarborough Hospital	63	9		7	144		M	74	Muscle invasive TCC	Ileal Conduit
918	56	Scarborough Hospital	63	9		7	144		M	64	Primary CIS	Ileal Conduit
919	56	Scarborough Hospital	63	9		7	144		F	53	Muscle invasive TCC	Ileal Conduit
920	57	Leicester General Hospital	33	97		39	345		M	71	Muscle invasive TCC	Ileal Conduit
921	57	Leicester General Hospital	33	97		39	345		M	60	Muscle invasive TCC	Ileal Conduit
922	57	Leicester General Hospital	33	97		39	345		F	60	Salvage after radiotherapy	Ileal Conduit
923	57	Leicester General Hospital	33	97		39	345		F	76	Muscle invasive TCC	Ileal Conduit
924	57	Leicester General Hospital	33	97		39	345		M	68	Uncontrolled superficial disease	Ileal Conduit
925	57	Leicester General Hospital	33	97		39	345		M	69	Muscle invasive TCC	Ileal Conduit
926	57	Leicester General Hospital	33	97		39	345		M	74	999	Ileal Conduit
927	57	Leicester General Hospital	33	97		39	345		F	69	Muscle invasive TCC	Ileal Conduit
928	57	Leicester General Hospital	33	97		39	345		F	75	Muscle invasive TCC	Ileal Conduit
929	57	Leicester General Hospital	33	97		39	345		M	71	Primary CIS	Ileal Conduit
930	57	Leicester General Hospital	33	97		39	345		M	75	Salvage after radiotherapy	Ileal Conduit
931	57	Leicester General Hospital	33	97		39	345		M	54	Uncontrolled superficial disease	Ileal Conduit
932	57	Leicester General Hospital	33	97		39	345		M	77	Salvage after radiotherapy	Ileal Conduit
933	57	Leicester General Hospital	33	97		39	345		M	61	Salvage after radiotherapy	Ileal Conduit
934	57	Leicester General Hospital	33	97		39	345		M	59	Muscle invasive TCC	Ileal Conduit
935	57	Leicester General Hospital	33	97		39	345		M	69	Muscle invasive TCC	Ileal Conduit
936	57	Leicester General Hospital	33	97		39	345		M	79	Uncontrolled superficial disease	Ileal Conduit
937	57	Leicester General Hospital	33	97		39	345		M	73	Uncontrolled superficial disease	Ileal Conduit
938	57	Leicester General Hospital	33	97		39	345		M	74	Other	Ileal Conduit
939	57	Leicester General Hospital	33	97		39	345		F	65	Muscle invasive TCC	Ileal Conduit
940	57	Leicester General Hospital	33	97		39	345		M	65	Muscle invasive TCC	Ileal Conduit
941	57	Leicester General Hospital	33	97		39	345		M	69	Primary CIS	Ileal Conduit
942	57	Leicester General Hospital	33	97		39	345		M	75	Salvage after radiotherapy	Ileal Conduit
943	57	Leicester General Hospital	33	97		39	345		F	74	Primary CIS	Ileal Conduit
944	57	Leicester General Hospital	33	97		39	345		F	70	Uncontrolled superficial disease	Ileal Conduit
945	57	Leicester General Hospital	33	97		39	345		M	54	Muscle invasive TCC	Ileal Conduit
946	57	Leicester General Hospital	33	97		39	345		M	61	Uncontrolled superficial disease	Ileal Conduit
947	57	Leicester General Hospital	33	97		39	345		F	72	Muscle invasive TCC	Ileal Conduit
948	57	Leicester General Hospital	33	97		39	345		M	59	Other	Ileal Conduit
949	57	Leicester General Hospital	33	97		39	345		M	66	Other	Orthotopic

950	57	Leicester General Hospital	33	97		39	345		M	72	Uncontrolled superficial disease	Orthotopic
951	57	Leicester General Hospital	33	97		39	345		M	62	Muscle invasive TCC	Ileal Conduit
952	57	Leicester General Hospital	33	97		39	345		M	64	Muscle invasive TCC	Ileal Conduit
953	57	Leicester General Hospital	33	97		39	345		M	66	Muscle invasive TCC	Ileal Conduit
954	57	Leicester General Hospital	33	97		39	345		M	69	Uncontrolled superficial disease	Ileal Conduit
955	57	Leicester General Hospital	33	97		39	345		M	66	Salvage after radiotherapy	Ileal Conduit
956	57	Leicester General Hospital	33	97		39	345		M	72	Salvage after radiotherapy	Ileal Conduit
957	57	Leicester General Hospital	33	97		39	345		M	72	Muscle invasive TCC	Ileal Conduit
958	58	Kent and Sussex Hospital	30	9		34	9		F	75	Muscle invasive TCC	Ileal Conduit
959	58	Kent and Sussex Hospital	30	9		34	9		M	33	Muscle invasive TCC	Orthotopic
960	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	57	Muscle invasive TCC	Ileal Conduit
961	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	64	Uncontrolled superficial disease	Ileal Conduit
962	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	66	Muscle invasive TCC	Ileal Conduit
963	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	70	Muscle invasive TCC	Ileal Conduit
964	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	62	Muscle invasive TCC	Ileal Conduit
965	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	61	Muscle invasive TCC	Ileal Conduit
966	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	83	Muscle invasive TCC	Ileal Conduit
967	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	72	Muscle invasive TCC	Ileal Conduit
968	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	65	Primary CIS	Ileal Conduit
969	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	65	Muscle invasive TCC	Ileal Conduit
970	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	66	Other	Ileal Conduit
971	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	69	Muscle invasive TCC	Ileal Conduit
972	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	71	Muscle invasive TCC	Ileal Conduit
973	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	57	Muscle invasive TCC	Ileal Conduit
974	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	71	Muscle invasive TCC	Ileal Conduit
975	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	74	Other	Ileal Conduit
976	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	72	Muscle invasive TCC	Ileal Conduit
977	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	60	Primary CIS	Ileal Conduit
978	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	69	Muscle invasive TCC	Ileal Conduit
979	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	74	Muscle invasive TCC	Ileal Conduit
980	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	58	Other	Ileal Conduit
981	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	80	Uncontrolled superficial disease	Ileal Conduit
982	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	60	Muscle invasive TCC	Ileal Conduit
983	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	60	Muscle invasive TCC	Ileal Conduit
984	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	66	Muscle invasive TCC	Ileal Conduit
985	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	67	Uncontrolled superficial disease	Ileal Conduit
986	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	64	Salvage after radiotherapy	Ileal Conduit
987	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	62	Muscle invasive TCC	Ileal Conduit
988	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	62	Muscle invasive TCC	Ileal Conduit
989	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	78	Other	Ileal Conduit
990	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	65	Primary CIS	Ileal Conduit
991	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	72	Muscle invasive TCC	Ileal Conduit
992	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	66	Uncontrolled superficial disease	Ileal Conduit
993	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	69	Muscle invasive TCC	Ileal Conduit
994	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	54	Muscle invasive TCC	Ileal Conduit
995	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	68	Primary CIS	Ileal Conduit
996	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	59	Muscle invasive TCC	Ileal Conduit
997	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	62	Primary CIS	Ileal Conduit
998	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	48	Salvage after radiotherapy	Ileal Conduit
999	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	51	Muscle invasive TCC	Ileal Conduit

1000	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	70	Muscle invasive TCC	Ileal Conduit
1001	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	77	Muscle invasive TCC	Ileal Conduit
1002	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	59	Uncontrolled superficial disease	Ileal Conduit
1003	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	71	Muscle invasive TCC	Ileal Conduit
1004	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	64	Muscle invasive TCC	Ileal Conduit
1005	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	57	Uncontrolled superficial disease	Ileal Conduit
1006	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	66	Muscle invasive TCC	Ileal Conduit
1007	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	67	Other	Ileal Conduit
1008	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	75	Other	Ileal Conduit
1009	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	70	Muscle invasive TCC	Ileal Conduit
1010	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	60	Muscle invasive TCC	Ileal Conduit
1011	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	69	Muscle invasive TCC	Ileal Conduit
1012	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	59	Muscle invasive TCC	Ileal Conduit
1013	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	60	Other	Ileal Conduit
1014	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	74	Muscle invasive TCC	Ileal Conduit
1015	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	67	Muscle invasive TCC	Ileal Conduit
1016	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	70	Muscle invasive TCC	Ileal Conduit
1017	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	69	Uncontrolled superficial disease	Ileal Conduit
1018	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	76	Primary CIS	Ileal Conduit
1019	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	67	Muscle invasive TCC	Ileal Conduit
1020	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	60	Squamous cell Ca	Ileal Conduit
1021	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		F	61	Muscle invasive TCC	Ileal Conduit
1022	59	Doncaster & Bassetlaw Hospitals NHS Trust	20	56		8	261		M	52	Muscle invasive TCC	Ileal Conduit
1023	59	Royal Hallamshire Hospital	52	179		8	261		M	70	Muscle invasive TCC	Ileal Conduit
1024	59	Royal Hallamshire Hospital	52	179		8	261		M	69	Muscle invasive TCC	Ileal Conduit
1025	59	Royal Hallamshire Hospital	52	179		8	261		F	76	Muscle invasive TCC	Ileal Conduit
1026	60	Royal Devon And Exeter Hospital	51	113		26	205		M	65	Uncontrolled superficial disease	Ileal Conduit
1027	60	Royal Devon And Exeter Hospital	51	113		26	205		M	70	Uncontrolled superficial disease	Ileal Conduit
1028	60	Royal Devon And Exeter Hospital	51	113		26	205		M	56	Muscle invasive TCC	Ileal Conduit
1029	60	Royal Devon And Exeter Hospital	51	113		26	205		F	62	Muscle invasive TCC	Ileal Conduit
1030	60	Royal Devon And Exeter Hospital	51	113		26	205		M	999	Muscle invasive TCC	Ileal Conduit
1031	60	Royal Devon And Exeter Hospital	51	113		26	205		M	65	Muscle invasive TCC	Ileal Conduit
1032	60	Royal Devon And Exeter Hospital	51	113		26	205		M	74	Muscle invasive TCC	Ileal Conduit
1033	60	Royal Devon And Exeter Hospital	51	113		26	205		F	78	Muscle invasive TCC	Ileal Conduit
1034	60	Royal Devon And Exeter Hospital	51	113		26	205		M	65	Muscle invasive TCC	Orthotopic
1035	60	Royal Devon And Exeter Hospital	51	113		26	205		F	66	Primary CIS	Ileal Conduit
1036	60	Royal Devon And Exeter Hospital	51	113		26	205		M	74	Uncontrolled superficial disease	Ileal Conduit
1037	60	Royal Devon And Exeter Hospital	51	113		26	205		F	44	Muscle invasive TCC	Ileal Conduit
1038	61	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	62	Muscle invasive TCC	Ileal Conduit
1039	61	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		F	81	Muscle invasive TCC	Ileal Conduit
1040	61	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	70	Muscle invasive TCC	Ileal Conduit
1041	61	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	70	Muscle invasive TCC	Ileal Conduit
1042	62	Churchill Hospital	14	85		30	167		M	999	Muscle invasive TCC	Ileal Conduit
1043	62	Churchill Hospital	14	85		30	167		F	999	Muscle invasive TCC	Ileal Conduit
1044	62	Churchill Hospital	14	85		30	167		F	999	Primary CIS	Ileal Conduit
1045	62	Churchill Hospital	14	85		30	167		M	999	Muscle invasive TCC	Ileal Conduit
1046	62	Churchill Hospital	14	85		30	167		M	999	Muscle invasive TCC	Ileal Conduit
1047	62	Churchill Hospital	14	85		30	167		M	999	Squamous cell Ca	Ileal Conduit
1048	62	Churchill Hospital	14	85		30	167		F	999	Squamous cell Ca	Ileal Conduit
1049	62	Churchill Hospital	14	85		30	167		M	999	Muscle invasive TCC	Ileal Conduit

1050	62	Churchill Hospital	14	85		30	167		M	999	Muscle invasive TCC	Ileal Conduit
1051	62	Churchill Hospital	14	85		30	167		F	999	Muscle invasive TCC	Ileal Conduit
1052	63	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	62	Uncontrolled superficial disease	Ileal Conduit
1053	63	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	70	Muscle invasive TCC	Ileal Conduit
1054	63	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	74	Uncontrolled superficial disease	Ileal Conduit
1055	63	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	60	Muscle invasive TCC	Ileal Conduit
1056	63	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	77	Muscle invasive TCC	Ileal Conduit
1057	64	Warwick Hospital	77	13		12	22		F	71	Muscle invasive TCC	Ileal Conduit
1058	64	Warwick Hospital	77	13		12	22		M	66	Muscle invasive TCC	Ileal Conduit
1059	64	Warwick Hospital	77	13		12	22		M	68	Muscle invasive TCC	Ileal Conduit
1060	64	Warwick Hospital	77	13		12	22		M	68	Squamous cell Ca	Ileal Conduit
1061	64	Warwick Hospital	77	13		12	22		M	74	Muscle invasive TCC	Ileal Conduit
1062	64	Warwick Hospital	77	13		12	22		M	71	Other	Ileal Conduit
1063	64	Warwick Hospital	77	13		12	22		M	59	Squamous cell Ca	Ileal Conduit
1064	64	Warwick Hospital	77	13		12	22		M	68	Muscle invasive TCC	Ileal Conduit
1065	64	Warwick Hospital	77	13		12	22		M	55	Muscle invasive TCC	Ileal Conduit
1066	64	Warwick Hospital	77	13		12	22		M	77	Muscle invasive TCC	Ileal Conduit
1067	65	The Ipswich Hospital	70	34		37	52		M	999	Muscle invasive TCC	Ileal Conduit
1068	66	Royal Bournemouth Hospital	49	57		27	60		M	70	Muscle invasive TCC	Ileal Conduit
1069	66	Royal Bournemouth Hospital	49	57		27	60		M	77	Muscle invasive TCC	Ileal Conduit
1070	66	Royal Bournemouth Hospital	49	57		27	60		M	999	Primary CIS	Ileal Conduit
1071	67	Barnet & Chase Farm Hospital	5	64		22	118		M	74	Muscle invasive TCC	Ileal Conduit
1072	68	Princess Alexandra Hospital, Harlow	44	14		22	118		F	999	999	Ileal Conduit
1073	68	Princess Alexandra Hospital, Harlow	44	14		22	118		F	73	Uncontrolled superficial disease	Ileal Conduit
1074	68	Princess Alexandra Hospital, Harlow	44	14		22	118		M	999	Uncontrolled superficial disease	Ileal Conduit
1075	68	Princess Alexandra Hospital, Harlow	44	14		22	118		M	999	Muscle invasive TCC	Ileal Conduit
1076	68	Princess Alexandra Hospital, Harlow	44	14		22	118		F	64	Uncontrolled superficial disease	Ileal Conduit
1077	69	Victoria Hospital Blackpool	75	19		1	19		999	999	Muscle invasive TCC	Ileal Conduit
1078	69	Victoria Hospital Blackpool	75	19		1	19		M	999	Secondary adenocarcinoma	Ileal Conduit
1079	69	Victoria Hospital Blackpool	75	19		1	19		M	999	Muscle invasive TCC	Ileal Conduit
1080	69	Victoria Hospital Blackpool	75	19		1	19		M	999	Salvage after radiotherapy	Ileal Conduit
1081	70	Royal Liverpool University Hospital	54	53		3	140		M	70	Muscle invasive TCC	Ileal Conduit
1082	70	Royal Liverpool University Hospital	54	53		3	140		M	67	Primary CIS	Ileal Conduit
1083	70	Royal Liverpool University Hospital	54	53		3	140		M	71	Muscle invasive TCC	Ileal Conduit
1084	70	Royal Liverpool University Hospital	54	53		3	140		M	999	Muscle invasive TCC	Ileal Conduit
1085	70	Royal Liverpool University Hospital	54	53		3	140		F	74	Uncontrolled superficial disease	Ileal Conduit
1086	70	Royal Liverpool University Hospital	54	53		3	140		F	67	999	Ileal Conduit
1087	70	Royal Liverpool University Hospital	54	53		3	140		F	70	Muscle invasive TCC	Ileal Conduit
1088	70	Royal Liverpool University Hospital	54	53		3	140		F	999	Muscle invasive TCC	Ileal Conduit
1089	71	Royal Liverpool University Hospital	54	53		3	140		M	55	Muscle invasive TCC	Orthotopic
1090	72	Salford RoyalNHS Foundation Trust	60	44		2	101.00		F	68	Squamous cell Ca	Ileal Conduit
1091	73	Royal Bournemouth Hospital	49	57		27	60		M	79	Salvage after radiotherapy	Ileal Conduit
1092	73	Royal Bournemouth Hospital	49	57		27	60		F	57	Squamous cell Ca	Ileal Conduit
1093	73	Royal Bournemouth Hospital	49	57		27	60		M	70	Muscle invasive TCC	Ileal Conduit
1094	73	Royal Bournemouth Hospital	49	57		27	60		M	76	Muscle invasive TCC	Ileal Conduit
1095	73	Royal Bournemouth Hospital	49	57		27	60		M	57	Muscle invasive TCC	Ileal Conduit
1096	73	Royal Bournemouth Hospital	49	57		27	60		M	69	Muscle invasive TCC	Ileal Conduit
1097	74	Walsgrave Hospital	76	9		12	22		M	53	Muscle invasive TCC	Ileal Conduit
1098	75	North Bristol NHSTrust (Southmead)	37	313		28	351		M	63	Muscle invasive TCC	Ileal Conduit
1099	75	North Bristol NHSTrust (Southmead)	37	313		28	351		M	85	Muscle invasive TCC	Ileal Conduit

1100	75	North Bristol NHSTrust (Southmead)	37	313		28	351		F	70	Muscle invasive TCC	Ileal Conduit
1101	75	Walsgrave Hospital	76	9		12	22		M	75	Sarcoma	Ileal Conduit
1102	76	Portsmouth Hospitals NHS Trust	43	150		31	307		M	77	Muscle invasive TCC	Ileal Conduit
1103	76	Portsmouth Hospitals NHS Trust	43	150		31	307		F	78	Muscle invasive TCC	Ileal Conduit
1104	76	Portsmouth Hospitals NHS Trust	43	150		31	307		M	59	Uncontrolled superficial disease	Ileal Conduit
1105	76	Portsmouth Hospitals NHS Trust	43	150		31	307		M	77	Muscle invasive TCC	Ileal Conduit
1106	77	Kettering General Hospital	31	2		39	345		F	77	Muscle invasive TCC	Ileal Conduit
1107	78	Royal Hampshire County Hospital	53	15		31	307		M	69	Uncontrolled superficial disease	Ileal Conduit
1108	78	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
1109	78	Southampton General Hospital	64	95		31	307		M	999	Salvage after radiotherapy	Ileal Conduit
1110	78	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
1111	78	Southampton General Hospital	64	95		31	307		M	40	Other	Ileal Conduit
1112	78	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
1113	78	Southampton General Hospital	64	95		31	307		F	27	Gynaecological Ca	Ileal Conduit
1114	78	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
1115	78	Southampton General Hospital	64	95		31	307		M	999	Primary CIS	Ileal Conduit
1116	78	Southampton General Hospital	64	95		31	307		M	999	Uncontrolled superficial disease	Ileal Conduit
1117	78	Southampton General Hospital	64	95		31	307		F	999	Gynaecological Ca	Ileal Conduit
1118	78	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
1119	78	Southampton General Hospital	64	95		31	307		M	999	Muscle invasive TCC	Ileal Conduit
1120	78	Southampton General Hospital	64	95		31	307		F	74	Muscle invasive TCC	Ileal Conduit
1121	78	Southampton General Hospital	64	95		31	307		F	999	Muscle invasive TCC	Ileal Conduit
1122	78	Southampton General Hospital	64	95		31	307		F	999	Primary CIS	Ileal Conduit
1123	79	Hemel Hempstead General Hospital; Mount Vern	26	1		20	69		M	65	Muscle invasive TCC	Ileal Conduit
1124	80	Royal Preston Hospital	56	22		2	101.00		M	75	Muscle invasive TCC	Ileal Conduit
1125	81	Hereford Hospitals NHS Trust	27	8		29	31		M	76	Uncontrolled superficial disease	Ileal Conduit
1126	82	(Ashington)	1	9		36	405		M	76	Muscle invasive TCC	Ileal Conduit
1127	82	(Ashington)	1	9		36	405		F	73	Muscle invasive TCC	Ileal Conduit
1128	82	(Ashington)	1	9		36	405		F	70	Uncontrolled superficial disease	Ileal Conduit
1129	82	(Ashington)	1	9		36	405		M	72	Uncontrolled superficial disease	Ileal Conduit
1130	82	(Ashington)	1	9		36	405		999	67	Uncontrolled superficial disease	Ileal Conduit
1131	82	Freeman Hospital	23	258		36	405		M	70	Uncontrolled superficial disease	Ileal Conduit
1132	82	Freeman Hospital	23	258		36	405		M	61	Muscle invasive TCC	Ileal Conduit
1133	82	Freeman Hospital	23	258		36	405		M	59	Muscle invasive TCC	Ileal Conduit
1134	82	Freeman Hospital	23	258		36	405		M	42	Uncontrolled superficial disease	Ileal Conduit
1135	82	Freeman Hospital	23	258		36	405		M	64	Muscle invasive TCC	Ileal Conduit
1136	82	Freeman Hospital	23	258		36	405		M	69	Muscle invasive TCC	Ileal Conduit
1137	82	Freeman Hospital	23	258		36	405		F	64	Uncontrolled superficial disease	Orthotopic
1138	82	Freeman Hospital	23	258		36	405		M	71	Muscle invasive TCC	Ileal Conduit
1139	82	Freeman Hospital	23	258		36	405		F	77	Squamous cell Ca	Ileal Conduit
1140	82	Freeman Hospital	23	258		36	405		M	78	Uncontrolled superficial disease	Ileal Conduit
1141	82	Freeman Hospital	23	258		36	405		M	78	Uncontrolled superficial disease	Ileal Conduit
1142	82	Freeman Hospital	23	258		36	405		M	54	Uncontrolled superficial disease	Ileal Conduit
1143	82	Freeman Hospital	23	258		36	405		M	69	Uncontrolled superficial disease	Ileal Conduit
1144	82	Freeman Hospital	23	258		36	405		M	51	Uncontrolled superficial disease	Ileal Conduit
1145	82	Freeman Hospital	23	258		36	405		M	72	Uncontrolled superficial disease	Ileal Conduit
1146	82	Freeman Hospital	23	258		36	405		M	69	Uncontrolled superficial disease	Ileal Conduit
1147	82	Freeman Hospital	23	258		36	405		M	78	Muscle invasive TCC	Ileal Conduit
1148	82	Freeman Hospital	23	258		36	405		M	57	Uncontrolled superficial disease	Ileal Conduit
1149	82	Freeman Hospital	23	258		36	405		F	80	Other	Ileal Conduit

1150	82	Freeman Hospital	23	258		36	405		M	75	Muscle invasive TCC	Ileal Conduit
1151	82	Freeman Hospital	23	258		36	405		M	70	Uncontrolled superficial disease	Ileal Conduit
1152	82	Freeman Hospital	23	258		36	405		M	77	Uncontrolled superficial disease	Ileal Conduit
1153	82	Freeman Hospital	23	258		36	405		M	69	Primary CIS	Ileal Conduit
1154	82	Freeman Hospital	23	258		36	405		M	63	Uncontrolled superficial disease	Ileal Conduit
1155	82	Freeman Hospital	23	258		36	405		M	67	Muscle invasive TCC	Ileal Conduit
1156	82	Freeman Hospital	23	258		36	405		F	64	Muscle invasive TCC	Ileal Conduit
1157	82	Freeman Hospital	23	258		36	405		M	66	Uncontrolled superficial disease	Ileal Conduit
1158	82	Freeman Hospital	23	258		36	405		M	66	Muscle invasive TCC	Ileal Conduit
1159	82	Freeman Hospital	23	258		36	405		M	69	Muscle invasive TCC	Ileal Conduit
1160	82	Freeman Hospital	23	258		36	405		F	72	Muscle invasive TCC	Ileal Conduit
1161	82	Freeman Hospital	23	258		36	405		M	75	Muscle invasive TCC	Ileal Conduit
1162	82	Freeman Hospital	23	258		36	405		M	999	Uncontrolled superficial disease	Ileal Conduit
1163	82	Freeman Hospital	23	258		36	405		F	75	Muscle invasive TCC	Ileal Conduit
1164	82	Freeman Hospital	23	258		36	405		M	72	Uncontrolled superficial disease	Ileal Conduit
1165	82	Freeman Hospital	23	258		36	405		M	61	Uncontrolled superficial disease	Ileal Conduit
1166	82	Freeman Hospital	23	258		36	405		M	57	Uncontrolled superficial disease	Ileal Conduit
1167	82	Freeman Hospital	23	258		36	405		M	71	Primary CIS	Ileal Conduit
1168	82	Freeman Hospital	23	258		36	405		M	66	Muscle invasive TCC	Orthotopic
1169	82	Freeman Hospital	23	258		36	405		F	67	Squamous cell Ca	Ileal Conduit
1170	82	Freeman Hospital	23	258		36	405		M	59	Muscle invasive TCC	Ileal Conduit
1171	82	Freeman Hospital	23	258		36	405		F	78	Muscle invasive TCC	Ileal Conduit
1172	82	Freeman Hospital	23	258		36	405		F	78	Muscle invasive TCC	Ileal Conduit
1173	82	Freeman Hospital	23	258		36	405		F	68	Uncontrolled superficial disease	Ileal Conduit
1174	82	Freeman Hospital	23	258		36	405		M	76	Muscle invasive TCC	Ileal Conduit
1175	82	Freeman Hospital	23	258		36	405		M	78	Muscle invasive TCC	Ileal Conduit
1176	82	Freeman Hospital	23	258		36	405		M	72	Muscle invasive TCC	Ileal Conduit
1177	82	Freeman Hospital	23	258		36	405		M	79	Uncontrolled superficial disease	Ileal Conduit
1178	82	Freeman Hospital	23	258		36	405		M	59	Muscle invasive TCC	Ileal Conduit
1179	82	Freeman Hospital	23	258		36	405		M	64	Uncontrolled superficial disease	Ileal Conduit
1180	82	Freeman Hospital	23	258		36	405		F	67	Muscle invasive TCC	Ileal Conduit
1181	82	Freeman Hospital	23	258		36	405		M	59	Muscle invasive TCC	Ileal Conduit
1182	82	Freeman Hospital	23	258		36	405		M	80	Squamous cell Ca	Ileal Conduit
1183	82	Freeman Hospital	23	258		36	405		M	76	Muscle invasive TCC	Ileal Conduit
1184	82	Freeman Hospital	23	258		36	405		M	72	Muscle invasive TCC	Ileal Conduit
1185	82	Freeman Hospital	23	258		36	405		M	63	Muscle invasive TCC	Ileal Conduit
1186	82	Freeman Hospital	23	258		36	405		M	61	Uncontrolled superficial disease	Ileal Conduit
1187	82	Freeman Hospital	23	258		36	405		M	66	Muscle invasive TCC	Ileal Conduit
1188	82	Freeman Hospital	23	258		36	405		F	76	Uncontrolled superficial disease	Ileal Conduit
1189	82	Freeman Hospital	23	258		36	405		M	73	Muscle invasive TCC	Ileal Conduit
1190	82	Freeman Hospital	23	258		36	405		M	62	Uncontrolled superficial disease	Ileal Conduit
1191	82	Freeman Hospital	23	258		36	405		M	63	Muscle invasive TCC	Ileal Conduit
1192	82	Freeman Hospital	23	258		36	405		M	61	Uncontrolled superficial disease	Ileal Conduit
1193	82	Freeman Hospital	23	258		36	405		F	56	Muscle invasive TCC	Ileal Conduit
1194	82	Freeman Hospital	23	258		36	405		F	60	Uncontrolled superficial disease	Ileal Conduit
1195	82	Freeman Hospital	23	258		36	405		M	58	Uncontrolled superficial disease	Ileal Conduit
1196	82	Freeman Hospital	23	258		36	405		M	66	Primary CIS	Ileal Conduit
1197	82	Freeman Hospital	23	258		36	405		M	999	Muscle invasive TCC	Ileal Conduit
1198	82	Freeman Hospital	23	258		36	405		M	77	Muscle invasive TCC	Ileal Conduit
1199	82	Freeman Hospital	23	258		36	405		M	42	Uncontrolled superficial disease	Orthotopic

1200	82	Freeman Hospital	23	258		36	405		M	64	Muscle invasive TCC	Ileal Conduit
1201	82	Freeman Hospital	23	258		36	405		M	68	Muscle invasive TCC	Ileal Conduit
1202	82	Freeman Hospital	23	258		36	405		M	46	Muscle invasive TCC	Orthotopic
1203	82	Freeman Hospital	23	258		36	405		M	75	Uncontrolled superficial disease	Ileal Conduit
1204	82	Freeman Hospital	23	258		36	405		M	78	Muscle invasive TCC	Ileal Conduit
1205	82	Freeman Hospital	23	258		36	405		F	77	Muscle invasive TCC	Ileal Conduit
1206	82	Freeman Hospital	23	258		36	405		M	57	Muscle invasive TCC	Ileal Conduit
1207	82	Freeman Hospital	23	258		36	405		M	72	Uncontrolled superficial disease	Ileal Conduit
1208	82	Freeman Hospital	23	258		36	405		F	58	Muscle invasive TCC	Ileal Conduit
1209	82	Freeman Hospital	23	258		36	405		M	74	Muscle invasive TCC	Ileal Conduit
1210	82	Freeman Hospital	23	258		36	405		F	73	Muscle invasive TCC	Ileal Conduit
1211	82	Freeman Hospital	23	258		36	405		M	74	Uncontrolled superficial disease	Ileal Conduit
1212	82	Freeman Hospital	23	258		36	405		M	70	Muscle invasive TCC	Ileal Conduit
1213	82	Freeman Hospital	23	258		36	405		M	71	Muscle invasive TCC	Ileal Conduit
1214	82	Freeman Hospital	23	258		36	405		F	71	Uncontrolled superficial disease	Ileal Conduit
1215	82	Freeman Hospital	23	258		36	405		F	74	Uncontrolled superficial disease	Ileal Conduit
1216	82	Freeman Hospital	23	258		36	405		F	71	Muscle invasive TCC	Ileal Conduit
1217	82	Freeman Hospital	23	258		36	405		M	58	Muscle invasive TCC	Ileal Conduit
1218	82	Freeman Hospital	23	258		36	405		M	67	Uncontrolled superficial disease	Ileal Conduit
1219	82	Freeman Hospital	23	258		36	405		M	51	Uncontrolled superficial disease	Ileal Conduit
1220	82	Freeman Hospital	23	258		36	405		M	50	Squamous cell Ca	Ileal Conduit
1221	82	Freeman Hospital	23	258		36	405		M	69	Uncontrolled superficial disease	Ileal Conduit
1222	83	Nottingham City Hospital	40	75		39	345		M	65	Muscle invasive TCC	Ileal Conduit
1223	84	Colchester General Hospital	16	68		38	164		M	68	Primary CIS	Ileal Conduit
1224	85	York District Hospital	82	58		6	384		M	83	Primary CIS	Ileal Conduit
1225	85	York District Hospital	82	58		6	384		M	79	Muscle invasive TCC	Ileal Conduit
1226	86	Arrowe Park Hospital	4	54		3	140		M	53	Muscle invasive TCC	Orthotopic
1227	87	University College Hospital London	72	38		22	118		M	78	Sarcoma	Ileal Conduit
1228	87	University College Hospital London	72	38		22	118		F	66	Primary CIS	Ileal Conduit
1229	87	University College Hospital London	72	38		22	118		M	77	Muscle invasive TCC	Ileal Conduit
1230	87	University College Hospital London	72	38		22	118		F	57	Muscle invasive TCC	Ileal Conduit
1231	87	University College Hospital London	72	38		22	118		M	74	Sarcoma	Ileal Conduit
1232	87	University College Hospital London	72	38		22	118		M	60	Muscle invasive TCC	Orthotopic
1233	87	University College Hospital London	72	38		22	118		999	999	Muscle invasive TCC	Ileal Conduit
1234	87	University College Hospital London	72	38		22	118		F	64	Muscle invasive TCC	Orthotopic
1235	88	Guy's & Thomas's Hospital	25	130		24	149		M	999	Muscle invasive TCC	Ileal Conduit
1236	88	Guy's & Thomas's Hospital	25	130		24	149		F	47	Muscle invasive TCC	Ileal Conduit
1237	88	Guy's & Thomas's Hospital	25	130		24	149		M	71	Muscle invasive TCC	Ileal Conduit
1238	88	Guy's & Thomas's Hospital	25	130		24	149		M	999	Muscle invasive TCC	Ileal Conduit
1239	88	Guy's & Thomas's Hospital	25	130		24	149		M	64	Muscle invasive TCC	Ileal Conduit
1240	88	Guy's & Thomas's Hospital	25	130		24	149		M	64	Uncontrolled superficial disease	Ileal Conduit
1241	88	Guy's & Thomas's Hospital	25	130		24	149		M	76	Muscle invasive TCC	Ileal Conduit
1242	88	Guy's & Thomas's Hospital	25	130		24	149		M	79	Muscle invasive TCC	Ileal Conduit
1243	88	Guy's & Thomas's Hospital	25	130		24	149		M	65	Muscle invasive TCC	Ileal Conduit
1244	88	Guy's & Thomas's Hospital	25	130		24	149		M	999	Uncontrolled superficial disease	Ileal Conduit
1245	88	Guy's & Thomas's Hospital	25	130		24	149		M	58	Muscle invasive TCC	Ileal Conduit
1246	88	Guy's & Thomas's Hospital	25	130		24	149		M	69	Muscle invasive TCC	Ileal Conduit
1247	88	Guy's & Thomas's Hospital	25	130		24	149		M	62	Muscle invasive TCC	Orthotopic
1248	88	Guy's & Thomas's Hospital	25	130		24	149		M	999	Muscle invasive TCC	Ileal Conduit
1249	88	Guy's & Thomas's Hospital	25	130		24	149		M	999	Muscle invasive TCC	Ileal Conduit

1250	88	Guy's & Thomas's Hospital	25	130		24	149		M	999	Uncontrolled superficial disease	Ileal Conduit
1251	88	Guy's & Thomas's Hospital	25	130		24	149		F	58	Primary CIS	Orthotopic
1252	88	Guy's & Thomas's Hospital	25	130		24	149		M	999	Uncontrolled superficial disease	Ileal Conduit
1253	88	Guy's & Thomas's Hospital	25	130		24	149		M	999	Salvage after radiotherapy	Ileal Conduit
1254	88	Guy's & Thomas's Hospital	25	130		24	149		M	999	Salvage after radiotherapy	Ileal Conduit
1255	88	Guy's & Thomas's Hospital	25	130		24	149		F	999	Other	Ileal Conduit
1256	88	Guy's & Thomas's Hospital	25	130		24	149		M	68	Muscle invasive TCC	Ileal Conduit
1257	88	Guy's & Thomas's Hospital	25	130		24	149		M	68	Uncontrolled superficial disease	Ileal Conduit
1258	88	Guy's & Thomas's Hospital	25	130		24	149		M	63	Muscle invasive TCC	Ileal Conduit
1259	88	Guy's & Thomas's Hospital	25	130		24	149		999	53	Muscle invasive TCC	Orthotopic
1260	88	Guy's & Thomas's Hospital	25	130		24	149		F	75	Muscle invasive TCC	Ileal Conduit
1261	88	Guy's & Thomas's Hospital	25	130		24	149		M	63	Muscle invasive TCC	Ileal Conduit
1262	89	Castle Hill Hospital	11	135		7	144		F	78	Muscle invasive TCC	Ileal Conduit
1263	89	Castle Hill Hospital	11	135		7	144		M	61	Muscle invasive TCC	Ileal Conduit
1264	89	Castle Hill Hospital	11	135		7	144		F	57	Muscle invasive TCC	Ileal Conduit
1265	89	Castle Hill Hospital	11	135		7	144		F	68	Muscle invasive TCC	Ileal Conduit
1266	89	Castle Hill Hospital	11	135		7	144		F	73	Muscle invasive TCC	Ileal Conduit
1267	89	Castle Hill Hospital	11	135		7	144		F	62	Muscle invasive TCC	Ileal Conduit
1268	89	Castle Hill Hospital	11	135		7	144		M	55	Uncontrolled superficial disease	Ileal Conduit
1269	89	Castle Hill Hospital	11	135		7	144		M	80	Muscle invasive TCC	Ileal Conduit
1270	89	Castle Hill Hospital	11	135		7	144		M	75	Muscle invasive TCC	Ileal Conduit
1271	89	Castle Hill Hospital	11	135		7	144		M	73	Primary CIS	Ileal Conduit
1272	89	Castle Hill Hospital	11	135		7	144		M	69	Uncontrolled superficial disease	Ileal Conduit
1273	89	Castle Hill Hospital	11	135		7	144		M	73	Salvage after radiotherapy	Ileal Conduit
1274	89	Castle Hill Hospital	11	135		7	144		F	66	Muscle invasive TCC	Ileal Conduit
1275	89	Castle Hill Hospital	11	135		7	144		M	73	Uncontrolled superficial disease	Ileal Conduit
1276	89	Castle Hill Hospital	11	135		7	144		M	59	Muscle invasive TCC	Ileal Conduit
1277	89	Castle Hill Hospital	11	135		7	144		M	72	Muscle invasive TCC	Ileal Conduit
1278	89	Castle Hill Hospital	11	135		7	144		M	62	Uncontrolled superficial disease	Ileal Conduit
1279	89	Castle Hill Hospital	11	135		7	144		M	68	Muscle invasive TCC	Ileal Conduit
1280	89	Castle Hill Hospital	11	135		7	144		M	67	Uncontrolled superficial disease	Orthotopic
1281	89	Castle Hill Hospital	11	135		7	144		F	58	Muscle invasive TCC	Ileal Conduit
1282	89	Castle Hill Hospital	11	135		7	144		M	81	Uncontrolled superficial disease	Ileal Conduit
1283	89	Castle Hill Hospital	11	135		7	144		F	64	Muscle invasive TCC	Ileal Conduit
1284	89	Scarborough Hospital	63	9		7	144		M	68	Uncontrolled superficial disease	Ileal Conduit
1285	89	Scarborough Hospital	63	9		7	144		F	63	Salvage after radiotherapy	Ileal Conduit
1286	89	Scarborough Hospital	63	9		7	144		M	67	Muscle invasive TCC	Ileal Conduit
1287	90	Salford RoyalNHS Foundation Trust	60	44		2	101.00		F	999	Muscle invasive TCC	Ileal Conduit
1288	90	Salford RoyalNHS Foundation Trust	60	44		2	101.00		F	75	Muscle invasive TCC	Ileal Conduit
1289	90	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	78	Muscle invasive TCC	Ileal Conduit
1290	90	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	67	Muscle invasive TCC	Ileal Conduit
1291	90	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	72	Muscle invasive TCC	Ileal Conduit
1292	90	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	60	Muscle invasive TCC	Ileal Conduit
1293	90	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	78	Muscle invasive TCC	Ileal Conduit
1294	91	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	69	Muscle invasive TCC	Ileal Conduit
1295	92	Lincoln & Louth NHS Trust	34	8		39	345		F	76	Muscle invasive TCC	Ileal Conduit
1296	92	Lincoln & Louth NHS Trust	34	8		39	345		M	52	Uncontrolled superficial disease	Ileal Conduit
1297	92	Pilgrim Hospital	41	29		39	345		M	70	Muscle invasive TCC	Ileal Conduit
1298	92	Pilgrim Hospital	41	29		39	345		M	57	Muscle invasive TCC	Ileal Conduit
1299	92	Pilgrim Hospital	41	29		39	345		F	68	Muscle invasive TCC	Ileal Conduit

1300	92	Pilgrim Hospital	41	29		39	345		M	56	Muscle invasive TCC	Ileal Conduit
1301	93	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	67	Primary CIS	Ileal Conduit
1302	93	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	73	Muscle invasive TCC	Ileal Conduit
1303	93	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	69	Muscle invasive TCC	Ileal Conduit
1304	93	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	66	Muscle invasive TCC	Ileal Conduit
1305	93	Buckinghamshire Hospitals NHS Trust	10	75		30	167		M	71	Muscle invasive TCC	Ileal Conduit
1306	94	Arrowe Park Hospital	4	54		3	140		M	76	Muscle invasive TCC	Ileal Conduit
1307	94	Arrowe Park Hospital	4	54		3	140		M	62	Muscle invasive TCC	Ileal Conduit
1308	94	Arrowe Park Hospital	4	54		3	140		M	52	Muscle invasive TCC	Ileal Conduit
1309	94	Arrowe Park Hospital	4	54		3	140		M	80	Primary adenocarcinoma	Ileal Conduit
1310	94	Arrowe Park Hospital	4	54		3	140		F	68	Other	Ileal Conduit
1311	94	Arrowe Park Hospital	4	54		3	140		M	61	Muscle invasive TCC	Ileal Conduit
1312	94	Arrowe Park Hospital	4	54		3	140		F	63	Primary CIS	Ileal Conduit
1313	94	Arrowe Park Hospital	4	54		3	140		M	55	Uncontrolled superficial disease	Ileal Conduit
1314	94	Arrowe Park Hospital	4	54		3	140		M	69	Muscle invasive TCC	Ileal Conduit
1315	94	Arrowe Park Hospital	4	54		3	140		M	67	Muscle invasive TCC	Orthotopic
1316	94	Arrowe Park Hospital	4	54		3	140		M	63	Muscle invasive TCC	Ileal Conduit
1317	94	Arrowe Park Hospital	4	54		3	140		M	63	Muscle invasive TCC	Ileal Conduit
1318	94	Arrowe Park Hospital	4	54		3	140		F	67	Muscle invasive TCC	Ileal Conduit
1319	94	Arrowe Park Hospital	4	54		3	140		M	57	Muscle invasive TCC	Ileal Conduit
1320	94	Arrowe Park Hospital	4	54		3	140		F	64	Primary adenocarcinoma	Ileal Conduit
1321	94	Arrowe Park Hospital	4	54		3	140		M	58	Muscle invasive TCC	Ileal Conduit
1322	94	Arrowe Park Hospital	4	54		3	140		F	72	Muscle invasive TCC	Ileal Conduit
1323	94	Arrowe Park Hospital	4	54		3	140		M	76	Muscle invasive TCC	Ileal Conduit
1324	94	Arrowe Park Hospital	4	54		3	140		M	56	Muscle invasive TCC	Ileal Conduit
1325	94	Arrowe Park Hospital	4	54		3	140		M	69	Uncontrolled superficial disease	Ileal Conduit
1326	94	Arrowe Park Hospital	4	54		3	140		F	999	Other	Ileal Conduit
1327	94	Arrowe Park Hospital	4	54		3	140		F	65	Uncontrolled superficial disease	Ileal Conduit
1328	94	Arrowe Park Hospital	4	54		3	140		F	69	Other	Ileal Conduit
1329	94	Arrowe Park Hospital	4	54		3	140		F	68	Muscle invasive TCC	Ileal Conduit
1330	94	Arrowe Park Hospital	4	54		3	140		M	53	Muscle invasive TCC	Ileal Conduit
1331	94	Arrowe Park Hospital	4	54		3	140		M	60	Muscle invasive TCC	Ileal Conduit
1332	94	Arrowe Park Hospital	4	54		3	140		M	66	Muscle invasive TCC	Ileal Conduit
1333	94	Arrowe Park Hospital	4	54		3	140		M	52	Squamous cell Ca	Ileal Conduit
1334	95	Royal Shrewsbury Hospital	57	85		35	226		M	79	Muscle invasive TCC	Ileal Conduit
1335	95	Royal Shrewsbury Hospital	57	85		35	226		M	999	Muscle invasive TCC	Ileal Conduit
1336	96	Christie Hospital	13	11		2	101.00		M	75	Muscle invasive TCC	Ileal Conduit
1337	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	68	Primary CIS	Ileal Conduit
1338	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	75	Squamous cell Ca	Ileal Conduit
1339	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	70	Muscle invasive TCC	Ileal Conduit
1340	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		F	72	Squamous cell Ca	Ileal Conduit
1341	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		F	79	Other	Ileal Conduit
1342	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	76	Muscle invasive TCC	Ileal Conduit
1343	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	72	Muscle invasive TCC	Ileal Conduit
1344	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		F	57	Gynaecological Ca	Ileal Conduit
1345	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	70	Muscle invasive TCC	Ileal Conduit
1346	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		F	57	Other	Ileal Conduit
1347	96	Salford RoyalNHS Foundation Trust	60	44		2	101.00		M	65	Muscle invasive TCC	Ileal Conduit
1348	97	Nottingham City Hospital	40	75		39	345		F	80	Muscle invasive TCC	Ileal Conduit
1349	97	Nottingham City Hospital	40	75		39	345		M	68	Muscle invasive TCC	Ileal Conduit

1350	97	Nottingham City Hospital	40	75		39	345		F	999	Primary CIS	Ileal Conduit
1351	97	Nottingham City Hospital	40	75		39	345		M	73	Muscle invasive TCC	Ileal Conduit
1352	97	Nottingham City Hospital	40	75		39	345		M	999	Muscle invasive TCC	Ileal Conduit
1353	97	Nottingham City Hospital	40	75		39	345		F	54	Salvage after radiotherapy	Orthotopic
1354	97	Nottingham City Hospital	40	75		39	345		M	60	Muscle invasive TCC	Ileal Conduit
1355	97	Nottingham City Hospital	40	75		39	345		F	65	Muscle invasive TCC	Ileal Conduit
1356	97	Nottingham City Hospital	40	75		39	345		M	72	Muscle invasive TCC	Ileal Conduit
1357	97	Nottingham City Hospital	40	75		39	345		M	67	Primary CIS	Ileal Conduit
1358	97	Nottingham City Hospital	40	75		39	345		M	76	Muscle invasive TCC	Ileal Conduit
1359	97	Nottingham City Hospital	40	75		39	345		M	60	Primary CIS	Orthotopic
1360	97	Nottingham City Hospital	40	75		39	345		M	79	Muscle invasive TCC	Ileal Conduit
1361	97	Nottingham City Hospital	40	75		39	345		M	77	Muscle invasive TCC	Ileal Conduit
1362	97	Nottingham City Hospital	40	75		39	345		M	62	Primary CIS	Ileal Conduit
1363	97	Nottingham City Hospital	40	75		39	345		M	82	Muscle invasive TCC	Ileal Conduit
1364	97	Nottingham City Hospital	40	75		39	345		F	72	Muscle invasive TCC	Ileal Conduit
1365	97	Nottingham City Hospital	40	75		39	345		F	999	Muscle invasive TCC	Ileal Conduit
1366	97	Nottingham City Hospital	40	75		39	345		M	63	Other	Orthotopic
1367	97	Nottingham City Hospital	40	75		39	345		M	76	Muscle invasive TCC	Ileal Conduit
1368	97	Nottingham City Hospital	40	75		39	345		M	58	999	Ileal Conduit
1369	97	Nottingham City Hospital	40	75		39	345		F	70	Muscle invasive TCC	Ileal Conduit
1370	97	Nottingham City Hospital	40	75		39	345		F	56	Uncontrolled superficial disease	Ileal Conduit
1371	97	Nottingham City Hospital	40	75		39	345		M	67	Muscle invasive TCC	Ileal Conduit
1372	97	Nottingham City Hospital	40	75		39	345		M	999	Muscle invasive TCC	Ileal Conduit
1373	97	Nottingham City Hospital	40	75		39	345		F	72	Salvage after radiotherapy	Ileal Conduit
1374	97	Nottingham City Hospital	40	75		39	345		M	57	Other	Orthotopic
1375	97	Nottingham City Hospital	40	75		39	345		M	51	Muscle invasive TCC	Orthotopic
1376	97	Nottingham City Hospital	40	75		39	345		F	76	Muscle invasive TCC	Ileal Conduit
1377	97	Nottingham City Hospital	40	75		39	345		F	71	Muscle invasive TCC	Ileal Conduit
1378	97	Nottingham City Hospital	40	75		39	345		M	78	Salvage after radiotherapy	Ileal Conduit
1379	97	Nottingham City Hospital	40	75		39	345		M	999	Salvage after radiotherapy	Ileal Conduit
1380	97	Nottingham City Hospital	40	75		39	345		F	73	Muscle invasive TCC	Ileal Conduit
1381	97	Nottingham City Hospital	40	75		39	345		M	55	Muscle invasive TCC	Orthotopic
1382	97	Nottingham City Hospital	40	75		39	345		F	46	Muscle invasive TCC	Ileal Conduit
1383	97	Nottingham City Hospital	40	75		39	345		M	63	Muscle invasive TCC	Ileal Conduit
1384	97	Nottingham City Hospital	40	75		39	345		M	66	Muscle invasive TCC	Ileal Conduit
1385	97	Nottingham City Hospital	40	75		39	345		M	75	Other	Ileal Conduit
1386	97	Nottingham City Hospital	40	75		39	345		M	54	Muscle invasive TCC	Ileal Conduit
1387	97	Nottingham City Hospital	40	75		39	345		M	59	Other	Ileal Conduit
1388	97	Nottingham City Hospital	40	75		39	345		M	65	Muscle invasive TCC	Ileal Conduit
1389	97	Nottingham City Hospital	40	75		39	345		M	69	Muscle invasive TCC	Ileal Conduit
1390	97	Nottingham City Hospital	40	75		39	345		M	72	Primary CIS	Ileal Conduit
1391	97	Nottingham City Hospital	40	75		39	345		F	69	Uncontrolled superficial disease	Ileal Conduit
1392	97	Nottingham City Hospital	40	75		39	345		M	66	Uncontrolled superficial disease	Ileal Conduit
1393	97	Nottingham City Hospital	40	75		39	345		M	74	Muscle invasive TCC	Ileal Conduit
1394	97	Nottingham City Hospital	40	75		39	345		F	999	Gynaecological Ca	Ileal Conduit
1395	97	Nottingham City Hospital	40	75		39	345		M	64	Primary CIS	Ileal Conduit
1396	97	Nottingham City Hospital	40	75		39	345		F	36	Muscle invasive TCC	Ileal Conduit
1397	97	Nottingham City Hospital	40	75		39	345		F	74	Muscle invasive TCC	Ileal Conduit
1398	97	Nottingham City Hospital	40	75		39	345		M	59	Muscle invasive TCC	Ileal Conduit
1399	97	Nottingham City Hospital	40	75		39	345		F	75	Muscle invasive TCC	Ileal Conduit

1400	97	Nottingham City Hospital	40	75		39	345		M	69	Squamous cell Ca	Ileal Conduit
1401	97	Nottingham City Hospital	40	75		39	345		M	65	Primary CIS	Orthotopic
1402	97	Nottingham City Hospital	40	75		39	345		F	56	Muscle invasive TCC	Ileal Conduit
1403	97	Nottingham City Hospital	40	75		39	345		M	62	Muscle invasive TCC	Orthotopic
1404	97	Nottingham City Hospital	40	75		39	345		F	36	Gynaecological Ca	Ileal Conduit
1405	97	Nottingham City Hospital	40	75		39	345		M	53	Muscle invasive TCC	Ileal Conduit
1406	97	Nottingham City Hospital	40	75		39	345		M	76	Other	Ileal Conduit
1407	97	Nottingham City Hospital	40	75		39	345		M	74	Muscle invasive TCC	Ileal Conduit
1408	97	Nottingham City Hospital	40	75		39	345		M	81	Muscle invasive TCC	Ileal Conduit
1409	97	Nottingham City Hospital	40	75		39	345		F	72	Squamous cell Ca	Ileal Conduit
1410	97	Nottingham City Hospital	40	75		39	345		M	74	Uncontrolled superficial disease	Ileal Conduit
1411	97	Nottingham City Hospital	40	75		39	345		M	83	Muscle invasive TCC	Ileal Conduit
1412	97	Nottingham City Hospital	40	75		39	345		999	70	Primary CIS	Ileal Conduit
1413	97	Nottingham City Hospital	40	75		39	345		M	75	Muscle invasive TCC	Ileal Conduit
1414	97	Nottingham City Hospital	40	75		39	345		M	76	Primary CIS	Ileal Conduit
1415	97	Nottingham City Hospital	40	75		39	345		M	69	Other	Ileal Conduit
1416	97	Nottingham City Hospital	40	75		39	345		M	63	Muscle invasive TCC	Ileal Conduit
1417	97	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	50	Uncontrolled superficial disease	Ileal Conduit
1418	98	Kettering General Hospital	31	2		39	345		M	74	Salvage after radiotherapy	Ileal Conduit
1419	99	Royal Liverpool University Hospital	54	53		3	140		M	68	Muscle invasive TCC	Ileal Conduit
1420	99	Royal Liverpool University Hospital	54	53		3	140		M	70	Muscle invasive TCC	Ileal Conduit
1421	99	Royal Liverpool University Hospital	54	53		3	140		M	999	Salvage after radiotherapy	Ileal Conduit
1422	99	Royal Liverpool University Hospital	54	53		3	140		M	65	Muscle invasive TCC	Ileal Conduit
1423	99	Royal Liverpool University Hospital	54	53		3	140		F	61	Muscle invasive TCC	Ileal Conduit
1424	99	Royal Liverpool University Hospital	54	53		3	140		M	57	Muscle invasive TCC	Ileal Conduit
1425	99	Royal Liverpool University Hospital	54	53		3	140		M	71	999	Ileal Conduit
1426	99	Royal Liverpool University Hospital	54	53		3	140		F	71	Muscle invasive TCC	Ileal Conduit
1427	99	Royal Liverpool University Hospital	54	53		3	140		M	52	999	Ileal Conduit
1428	99	Royal Liverpool University Hospital	54	53		3	140		M	57	Muscle invasive TCC	Ileal Conduit
1429	99	Royal Liverpool University Hospital	54	53		3	140		F	61	Muscle invasive TCC	Ileal Conduit
1430	99	Royal Liverpool University Hospital	54	53		3	140		M	71	Muscle invasive TCC	Ileal Conduit
1431	99	Royal Liverpool University Hospital	54	53		3	140		M	72	Muscle invasive TCC	Orthotopic
1432	99	Royal Liverpool University Hospital	54	53		3	140		M	70	Muscle invasive TCC	Ileal Conduit
1433	99	Royal Liverpool University Hospital	54	53		3	140		M	999	Muscle invasive TCC	Ileal Conduit
1434	99	Royal Liverpool University Hospital	54	53		3	140		F	72	Muscle invasive TCC	Ileal Conduit
1435	99	Royal Liverpool University Hospital	54	53		3	140		M	68	999	Ileal Conduit
1436	99	Royal Liverpool University Hospital	54	53		3	140		M	999	Muscle invasive TCC	Ileal Conduit
1437	99	Royal Liverpool University Hospital	54	53		3	140		M	66	Muscle invasive TCC	Ileal Conduit
1438	99	Royal Liverpool University Hospital	54	53		3	140		F	78	Muscle invasive TCC	Ileal Conduit
1439	99	Southport & Ormskirk NHS Trust	66	21		3	140		M	70	Muscle invasive TCC	Ileal Conduit
1440	99	Southport & Ormskirk NHS Trust	66	21		3	140		M	75	Muscle invasive TCC	Ileal Conduit
1441	99	Southport & Ormskirk NHS Trust	66	21		3	140		F	64	Muscle invasive TCC	Ileal Conduit
1442	99	Southport & Ormskirk NHS Trust	66	21		3	140		M	55	Muscle invasive TCC	Orthotopic
1443	99	Southport & Ormskirk NHS Trust	66	21		3	140		M	65	Uncontrolled superficial disease	Ileal Conduit
1444	100	Sandwell District General Hospital	62	9		11	102		999	72	Muscle invasive TCC	Ileal Conduit
1445	100	Sandwell District General Hospital	62	9		11	102		999	57	Sarcoma	Ileal Conduit
1446	101	Pilgrim Hospital	41	29		39	345		F	73	Muscle invasive TCC	Ileal Conduit
1447	101	Pilgrim Hospital	41	29		39	345		M	61	Muscle invasive TCC	Orthotopic
1448	101	Pilgrim Hospital	41	29		39	345		M	55	Muscle invasive TCC	Ileal Conduit
1449	101	Pilgrim Hospital	41	29		39	345		M	69	Muscle invasive TCC	Orthotopic

1450	101	Pilgrim Hospital	41	29		39	345		M	70	Muscle invasive TCC	Ileal Conduit
1451	101	Pilgrim Hospital	41	29		39	345		M	74	Muscle invasive TCC	Ileal Conduit
1452	101	Pilgrim Hospital	41	29		39	345		M	63	Muscle invasive TCC	Ileal Conduit
1453	102	Derriford Hospital	19	72		26	205		M	50	Muscle invasive TCC	Ileal Conduit
1454	102	Derriford Hospital	19	72		26	205		M	69	Muscle invasive TCC	Ileal Conduit
1455	102	Derriford Hospital	19	72		26	205		M	74	Uncontrolled superficial disease	Ileal Conduit
1456	102	Derriford Hospital	19	72		26	205		999	57	Uncontrolled superficial disease	Ileal Conduit
1457	103	Guy's & Thomas's Hospital	25	130		24	149		M	52	Primary CIS	Ileal Conduit
1458	104	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	70	Muscle invasive TCC	Ileal Conduit
1459	104	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	64	Muscle invasive TCC	Ileal Conduit
1460	104	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	67	Muscle invasive TCC	Ileal Conduit
1461	104	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	46	Muscle invasive TCC	Ileal Conduit
1462	104	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	66	Uncontrolled superficial disease	Ileal Conduit
1463	104	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	75	Other	Ileal Conduit
1464	104	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	66	Primary CIS	Ileal Conduit
1465	104	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	70	Uncontrolled superficial disease	Ileal Conduit
1466	104	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	74	Other	Ileal Conduit
1467	105	Freeman Hospital	23	258		36	405		M	83	Uncontrolled superficial disease	Ileal Conduit
1468	105	Freeman Hospital	23	258		36	405		F	72	Uncontrolled superficial disease	Ileal Conduit
1469	105	Freeman Hospital	23	258		36	405		M	70	Uncontrolled superficial disease	Orthotopic
1470	105	Freeman Hospital	23	258		36	405		F	75	Muscle invasive TCC	Ileal Conduit
1471	105	Freeman Hospital	23	258		36	405		F	58	Muscle invasive TCC	Ileal Conduit
1472	105	Freeman Hospital	23	258		36	405		F	65	Uncontrolled superficial disease	Ileal Conduit
1473	105	Freeman Hospital	23	258		36	405		M	56	Muscle invasive TCC	Ileal Conduit
1474	105	Freeman Hospital	23	258		36	405		M	80	Uncontrolled superficial disease	Ileal Conduit
1475	105	Freeman Hospital	23	258		36	405		F	72	Uncontrolled superficial disease	Ileal Conduit
1476	105	Freeman Hospital	23	258		36	405		M	63	Muscle invasive TCC	Ileal Conduit
1477	105	Freeman Hospital	23	258		36	405		M	58	Muscle invasive TCC	Ileal Conduit
1478	107	The Ipswich Hospital	70	34		37	52		F	57	Squamous cell Ca	Ileal Conduit
1479	107	The Ipswich Hospital	70	34		37	52		M	74	Muscle invasive TCC	Ileal Conduit
1480	107	The Ipswich Hospital	70	34		37	52		M	999	Other	Ileal Conduit
1481	107	The Ipswich Hospital	70	34		37	52		F	74	Muscle invasive TCC	Ileal Conduit
1482	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	62	Primary CIS	Ileal Conduit
1483	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	66	Muscle invasive TCC	Ileal Conduit
1484	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	60	Other	Ileal Conduit
1485	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	59	Uncontrolled superficial disease	Ileal Conduit
1486	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	64	Muscle invasive TCC	Ileal Conduit
1487	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	73	Muscle invasive TCC	Ileal Conduit
1488	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	72	Muscle invasive TCC	Ileal Conduit
1489	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	72	Other	Ileal Conduit
1490	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	71	Muscle invasive TCC	Ileal Conduit
1491	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	73	Muscle invasive TCC	Ileal Conduit
1492	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	74	Muscle invasive TCC	Ileal Conduit
1493	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	61	Muscle invasive TCC	Ileal Conduit
1494	108	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	76	Muscle invasive TCC	Ileal Conduit
1495	109	Royal Sussex County Hospital	58	34		33	129		M	74	999	Ileal Conduit
1496	110	Lincoln & Louth NHS Trust	34	8		39	345		F	77	Muscle invasive TCC	Ileal Conduit
1497	111	Pinderfields Hospital	42	94		6	384		M	63	Other	Ileal Conduit
1498	111	Pinderfields Hospital	42	94		6	384		M	71	Muscle invasive TCC	Ileal Conduit
1499	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	76	Uncontrolled superficial disease	Ileal Conduit

1500	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	62	Other	Ileal Conduit
1501	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	62	Uncontrolled superficial disease	Ileal Conduit
1502	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	65	Muscle invasive TCC	Ileal Conduit
1503	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	69	Other	Ileal Conduit
1504	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	78	Primary CIS	Ileal Conduit
1505	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	74	Muscle invasive TCC	Ileal Conduit
1506	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	76	Uncontrolled superficial disease	Ileal Conduit
1507	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	71	Other	Ileal Conduit
1508	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	54	Primary CIS	Ileal Conduit
1509	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	65	Other	Ileal Conduit
1510	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	71	Muscle invasive TCC	Ileal Conduit
1511	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	76	Uncontrolled superficial disease	Ileal Conduit
1512	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	62	Muscle invasive TCC	Ileal Conduit
1513	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	71	Other	Ileal Conduit
1514	112	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	60	Muscle invasive TCC	Ileal Conduit
1515	113	East Sussex Hospitals NHS Trust	22	95		33	129		M	68	Muscle invasive TCC	Ileal Conduit
1516	113	East Sussex Hospitals NHS Trust	22	95		33	129		M	73	Primary CIS	Ileal Conduit
1517	113	East Sussex Hospitals NHS Trust	22	95		33	129		M	76	Muscle invasive TCC	Ileal Conduit
1518	113	East Sussex Hospitals NHS Trust	22	95		33	129		M	72	Muscle invasive TCC	Ileal Conduit
1519	113	East Sussex Hospitals NHS Trust	22	95		33	129		M	81	Muscle invasive TCC	Ileal Conduit
1520	113	East Sussex Hospitals NHS Trust	22	95		33	129		M	71	Muscle invasive TCC	Ileal Conduit
1521	113	East Sussex Hospitals NHS Trust	22	95		33	129		F	75	Primary CIS	Ileal Conduit
1522	113	East Sussex Hospitals NHS Trust	22	95		33	129		F	999	Muscle invasive TCC	Ileal Conduit
1523	113	East Sussex Hospitals NHS Trust	22	95		33	129		F	74	Muscle invasive TCC	Ileal Conduit
1524	114	King George Hospital	32	49		23	49		M	51	Muscle invasive TCC	Orthotopic
1525	114	King George Hospital	32	49		23	49		M	61	Muscle invasive TCC	Orthotopic
1526	115	New Cross Hospital	35	37		35	226		M	82	Muscle invasive TCC	Ileal Conduit
1527	115	New Cross Hospital	35	37		35	226		F	40	Gynaecological Ca	Ileal Conduit
1528	115	New Cross Hospital	35	37		35	226		M	69	Muscle invasive TCC	Ileal Conduit
1529	115	New Cross Hospital	35	37		35	226		M	63	Muscle invasive TCC	Ileal Conduit
1530	115	New Cross Hospital	35	37		35	226		M	65	Muscle invasive TCC	Ileal Conduit
1531	115	New Cross Hospital	35	37		35	226		M	72	Uncontrolled superficial disease	Ileal Conduit
1532	115	New Cross Hospital	35	37		35	226		F	52	Gynaecological Ca	Ileal Conduit
1533	115	New Cross Hospital	35	37		35	226		M	72	Muscle invasive TCC	Ileal Conduit
1534	115	New Cross Hospital	35	37		35	226		F	54	Muscle invasive TCC	Ileal Conduit
1535	115	New Cross Hospital	35	37		35	226		F	70	Muscle invasive TCC	Ileal Conduit
1536	115	New Cross Hospital	35	37		35	226		M	71	Muscle invasive TCC	Ileal Conduit
1537	115	New Cross Hospital	35	37		35	226		M	68	Muscle invasive TCC	Ileal Conduit
1538	115	New Cross Hospital	35	37		35	226		M	62	Muscle invasive TCC	Ileal Conduit
1539	115	New Cross Hospital	35	37		35	226		F	65	Uncontrolled superficial disease	Ileal Conduit
1540	115	New Cross Hospital	35	37		35	226		M	58	Muscle invasive TCC	Ileal Conduit
1541	115	New Cross Hospital	35	37		35	226		M	73	Muscle invasive TCC	Ileal Conduit
1542	115	New Cross Hospital	35	37		35	226		M	71	Muscle invasive TCC	Ileal Conduit
1543	115	New Cross Hospital	35	37		35	226		F	39	Salvage after radiotherapy	Ileal Conduit
1544	115	New Cross Hospital	35	37		35	226		F	63	Gynaecological Ca	Ileal Conduit
1545	115	New Cross Hospital	35	37		35	226		M	63	Primary CIS	Ileal Conduit
1546	115	New Cross Hospital	35	37		35	226		F	52	Squamous cell Ca	Ileal Conduit
1547	115	New Cross Hospital	35	37		35	226		M	67	Muscle invasive TCC	Ileal Conduit
1548	115	New Cross Hospital	35	37		35	226		M	60	Primary CIS	Ileal Conduit
1549	115	New Cross Hospital	35	37		35	226		F	52	Other	Ileal Conduit

1550	115	New Cross Hospital	35	37		35	226		F	40	Salvage after radiotherapy	Ileal Conduit
1551	115	New Cross Hospital	35	37		35	226		M	76	Uncontrolled superficial disease	Ileal Conduit
1552	115	New Cross Hospital	35	37		35	226		F	68	Uncontrolled superficial disease	Ileal Conduit
1553	115	New Cross Hospital	35	37		35	226		M	66	Muscle invasive TCC	Ileal Conduit
1554	115	New Cross Hospital	35	37		35	226		M	74	Muscle invasive TCC	Ileal Conduit
1555	115	New Cross Hospital	35	37		35	226		M	72	Muscle invasive TCC	Ileal Conduit
1556	115	New Cross Hospital	35	37		35	226		F	68	Salvage after radiotherapy	Ileal Conduit
1557	115	New Cross Hospital	35	37		35	226		F	64	Muscle invasive TCC	Ileal Conduit
1558	115	New Cross Hospital	35	37		35	226		M	68	Uncontrolled superficial disease	Ileal Conduit
1559	115	New Cross Hospital	35	37		35	226		M	68	Muscle invasive TCC	Ileal Conduit
1560	115	New Cross Hospital	35	37		35	226		M	62	Muscle invasive TCC	Ileal Conduit
1561	115	New Cross Hospital	35	37		35	226		M	67	Uncontrolled superficial disease	Ileal Conduit
1562	115	New Cross Hospital	35	37		35	226		M	55	Muscle invasive TCC	Ileal Conduit
1563	115	New Cross Hospital	35	37		35	226		M	63	Muscle invasive TCC	Ileal Conduit
1564	116	Royal Preston Hospital	56	22		2	101.00		M	69	Other	Ileal Conduit
1565	116	Royal Preston Hospital	56	22		2	101.00		M	69	Muscle invasive TCC	Ileal Conduit
1566	116	Royal Preston Hospital	56	22		2	101.00		F	48	Squamous cell Ca	Orthotopic
1567	116	Royal Preston Hospital	56	22		2	101.00		M	75	Muscle invasive TCC	Ileal Conduit
1568	116	Royal Preston Hospital	56	22		2	101.00		M	74	Muscle invasive TCC	Ileal Conduit
1569	116	Royal Preston Hospital	56	22		2	101.00		M	72	Muscle invasive TCC	Ileal Conduit
1570	116	Royal Preston Hospital	56	22		2	101.00		M	77	Muscle invasive TCC	Ileal Conduit
1571	116	Royal Preston Hospital	56	22		2	101.00		F	72	Muscle invasive TCC	Ileal Conduit
1572	116	Royal Preston Hospital	56	22		2	101.00		M	51	Muscle invasive TCC	Ileal Conduit
1573	116	Royal Preston Hospital	56	22		2	101.00		F	78	Primary CIS	Ileal Conduit
1574	116	Royal Preston Hospital	56	22		2	101.00		M	50	Muscle invasive TCC	Ileal Conduit
1575	116	Royal Preston Hospital	56	22		2	101.00		M	81	Muscle invasive TCC	Ileal Conduit
1576	116	Royal Preston Hospital	56	22		2	101.00		F	80	Muscle invasive TCC	Ileal Conduit
1577	116	Royal Preston Hospital	56	22		2	101.00		F	62	Muscle invasive TCC	Ileal Conduit
1578	116	Royal Preston Hospital	56	22		2	101.00		M	67	Muscle invasive TCC	Ileal Conduit
1579	116	Royal Preston Hospital	56	22		2	101.00		M	69	Primary CIS	Ileal Conduit
1580	116	Royal Preston Hospital	56	22		2	101.00		M	64	Muscle invasive TCC	Ileal Conduit
1581	116	Royal Preston Hospital	56	22		2	101.00		M	66	Muscle invasive TCC	Ileal Conduit
1582	116	Royal Preston Hospital	56	22		2	101.00		F	40	Gynaecological Ca	Ileal Conduit
1583	116	Royal Preston Hospital	56	22		2	101.00		M	54	Muscle invasive TCC	Orthotopic
1584	116	Royal Preston Hospital	56	22		2	101.00		F	68	Gynaecological Ca	Ileal Conduit
1585	116	Royal Preston Hospital	56	22		2	101.00		999	65	Salvage after radiotherapy	Ileal Conduit
1586	116	Royal Preston Hospital	56	22		2	101.00		M	81	Muscle invasive TCC	Ileal Conduit
1587	116	Royal Preston Hospital	56	22		2	101.00		F	61	Primary CIS	Ileal Conduit
1588	116	Royal Preston Hospital	56	22		2	101.00		M	78	Muscle invasive TCC	Ileal Conduit
1589	116	Royal Preston Hospital	56	22		2	101.00		M	74	Other	Ileal Conduit
1590	116	Royal Preston Hospital	56	22		2	101.00		F	57	Muscle invasive TCC	Ileal Conduit
1591	116	Royal Preston Hospital	56	22		2	101.00		F	75	Muscle invasive TCC	Ileal Conduit
1592	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	999	Secondary adenocarcinoma	Ileal Conduit
1593	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	75	Muscle invasive TCC	Ileal Conduit
1594	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	68	Muscle invasive TCC	Ileal Conduit
1595	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		F	76	Muscle invasive TCC	Ileal Conduit
1596	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	72	Muscle invasive TCC	Ileal Conduit
1597	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		F	77	Salvage after radiotherapy	Ileal Conduit
1598	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	77	Other	Ileal Conduit
1599	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	71	Salvage after radiotherapy	Ileal Conduit
1600	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	73	Muscle invasive TCC	Ileal Conduit
1601	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	53	Other	Ileal Conduit
1602	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	71	Other	Ileal Conduit
1603	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		999	56	Muscle invasive TCC	Ileal Conduit
1604	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	56	Muscle invasive TCC	Ileal Conduit
1605	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	72	Uncontrolled superficial disease	Ileal Conduit
1606	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	59	Muscle invasive TCC	Ileal Conduit
1607	117	Queen Elizabeth Hospital, B'ham	45	93		11	102		M	65	Muscle invasive TCC	Ileal Conduit
1608	118	Leicester General Hospital	33	97		39	345		M	78	Muscle invasive TCC	Ileal Conduit
1609	118	Leicester General Hospital	33	97		39	345		M	66	Uncontrolled superficial disease	Ileal Conduit
1610	118	Leicester General Hospital	33	97		39	345		M	71	Muscle invasive TCC	Ileal Conduit
1611	118	Leicester General Hospital	33	97		39	345		M	76	Salvage after radiotherapy	Ileal Conduit
1612	118	Leicester General Hospital	33	97		39	345		M	72	Muscle invasive TCC	Ileal Conduit
1613	118	Leicester General Hospital	33	97		39	345		M	49	Squamous cell Ca	Orthotopic
1614	118	Leicester General Hospital	33	97		39	345		M	65	Salvage after radiotherapy	Ileal Conduit
1615	118	Leicester General Hospital	33	97		39	345		M	60	999	Ileal Conduit
1616	118	Leicester General Hospital	33	97		39	345		F	77	Squamous cell Ca	Ileal Conduit
1617	118	Leicester General Hospital	33	97		39	345		M	67	Other	Orthotopic
1618	118	Leicester General Hospital	33	97		39	345		M	74	Salvage after radiotherapy	Ileal Conduit
1619	118	Leicester General Hospital	33	97		39	345		M	70	Uncontrolled superficial disease	Ileal Conduit

1610	118	Leicester General Hospital	33	97		39	345		M	71	Muscle invasive TCC	Ileal Conduit
1611	118	Leicester General Hospital	33	97		39	345		M	76	Salvage after radiotherapy	Ileal Conduit
1612	118	Leicester General Hospital	33	97		39	345		M	72	Muscle invasive TCC	Ileal Conduit
1613	118	Leicester General Hospital	33	97		39	345		M	49	Squamous cell Ca	Orthotopic
1614	118	Leicester General Hospital	33	97		39	345		M	65	Salvage after radiotherapy	Ileal Conduit
1615	118	Leicester General Hospital	33	97		39	345		M	60	999	Ileal Conduit
1616	118	Leicester General Hospital	33	97		39	345		F	77	Squamous cell Ca	Ileal Conduit
1617	118	Leicester General Hospital	33	97		39	345		M	67	Other	Orthotopic
1618	118	Leicester General Hospital	33	97		39	345		M	74	Salvage after radiotherapy	Ileal Conduit
1619	118	Leicester General Hospital	33	97		39	345		M	70	Uncontrolled superficial disease	Ileal Conduit
1620	118	Leicester General Hospital	33	97		39	345		M	68	Uncontrolled superficial disease	Ileal Conduit
1621	118	Leicester General Hospital	33	97		39	345		M	66	Muscle invasive TCC	Ileal Conduit
1622	118	Leicester General Hospital	33	97		39	345		M	77	Muscle invasive TCC	Ileal Conduit
1623	118	Leicester General Hospital	33	97		39	345		M	60	Uncontrolled superficial disease	Orthotopic
1624	118	Leicester General Hospital	33	97		39	345		M	69	Squamous cell Ca	Ileal Conduit
1625	118	Leicester General Hospital	33	97		39	345		F	64	Muscle invasive TCC	Ileal Conduit
1626	118	Leicester General Hospital	33	97		39	345		M	74	Primary CIS	Ileal Conduit
1627	118	Leicester General Hospital	33	97		39	345		M	59	Muscle invasive TCC	Ileal Conduit
1628	118	Leicester General Hospital	33	97		39	345		M	69	Muscle invasive TCC	Ileal Conduit
1629	118	Leicester General Hospital	33	97		39	345		M	39	Muscle invasive TCC	Ileal Conduit
1630	118	Leicester General Hospital	33	97		39	345		M	58	Muscle invasive TCC	Ileal Conduit
1631	118	Leicester General Hospital	33	97		39	345		M	57	Uncontrolled superficial disease	Ileal Conduit
1632	118	Leicester General Hospital	33	97		39	345		M	69	Muscle invasive TCC	Ileal Conduit
1633	118	Leicester General Hospital	33	97		39	345		M	999	Muscle invasive TCC	Ileal Conduit
1634	118	Leicester General Hospital	33	97		39	345		M	49	Muscle invasive TCC	Ileal Conduit
1635	118	Leicester General Hospital	33	97		39	345		F	54	Muscle invasive TCC	Ileal Conduit
1636	118	Leicester General Hospital	33	97		39	345		M	77	Muscle invasive TCC	Ileal Conduit
1637	121	Royal Devon And Exeter Hospital	51	113		26	205		F	82	Muscle invasive TCC	Ileal Conduit
1638	121	Royal Devon And Exeter Hospital	51	113		26	205		M	54	Muscle invasive TCC	Orthotopic
1639	121	Royal Devon And Exeter Hospital	51	113		26	205		M	55	Primary CIS	Orthotopic
1640	121	Royal Devon And Exeter Hospital	51	113		26	205		M	79	Salvage after radiotherapy	Ileal Conduit
1641	121	Royal Devon And Exeter Hospital	51	113		26	205		M	63	Uncontrolled superficial disease	Orthotopic
1642	121	Royal Devon And Exeter Hospital	51	113		26	205		M	69	Muscle invasive TCC	Ileal Conduit
1643	121	Torbay Hospital	71	8		26	205		F	48	Muscle invasive TCC	Orthotopic
1644	121	Torbay Hospital	71	8		26	205		F	61	Primary adenocarcinoma	Orthotopic
1645	121	Torbay Hospital	71	8		26	205		M	60	Muscle invasive TCC	Orthotopic
1646	122	Royal Devon And Exeter Hospital	51	113		26	205		M	63	Muscle invasive TCC	Orthotopic
1647	122	Royal Devon And Exeter Hospital	51	113		26	205		M	69	Muscle invasive TCC	Ileal Conduit
1648	122	Torbay Hospital	71	8		26	205		M	76	Muscle invasive TCC	Ileal Conduit
1649	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	70	Muscle invasive TCC	Ileal Conduit
1650	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	79	Salvage after radiotherapy	Ileal Conduit
1651	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	63	Muscle invasive TCC	Ileal Conduit
1652	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	72	Muscle invasive TCC	Ileal Conduit
1653	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	69	Muscle invasive TCC	Ileal Conduit
1654	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	75	Muscle invasive TCC	Ileal Conduit
1655	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	69	Muscle invasive TCC	Ileal Conduit
1656	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	63	Salvage after radiotherapy	Ileal Conduit
1657	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	62	Muscle invasive TCC	Ileal Conduit
1658	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	67	Uncontrolled superficial disease	Ileal Conduit
1659	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	73	Uncontrolled superficial disease	Ileal Conduit

1660	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	73	Uncontrolled superficial disease	Ileal Conduit
1661	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	70	Muscle invasive TCC	Ileal Conduit
1662	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	81	Muscle invasive TCC	Ileal Conduit
1663	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	77	Salvage after radiotherapy	Ileal Conduit
1664	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	79	Muscle invasive TCC	Ileal Conduit
1665	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	63	Muscle invasive TCC	Ileal Conduit
1666	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	74	Muscle invasive TCC	Ileal Conduit
1667	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	72	Muscle invasive TCC	Ileal Conduit
1668	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	68	Muscle invasive TCC	Ileal Conduit
1669	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	71	Muscle invasive TCC	Ileal Conduit
1670	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	65	Primary CIS	Ileal Conduit
1671	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	77	Muscle invasive TCC	Ileal Conduit
1672	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	82	Muscle invasive TCC	Ileal Conduit
1673	123	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	66	Muscle invasive TCC	Ileal Conduit
1674	124	Victoria Hospital Blackpool	75	19		1	19		999	999	Muscle invasive TCC	Ileal Conduit
1675	124	Victoria Hospital Blackpool	75	19		1	19		999	999	Muscle invasive TCC	Ileal Conduit
1676	124	Victoria Hospital Blackpool	75	19		1	19		999	999	Muscle invasive TCC	Ileal Conduit
1677	125	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	65	Muscle invasive TCC	Ileal Conduit
1678	125	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	77	Muscle invasive TCC	Ileal Conduit
1679	125	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		F	59	Muscle invasive TCC	Ileal Conduit
1680	125	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	73	Muscle invasive TCC	Ileal Conduit
1681	125	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	63	Muscle invasive TCC	Orthotopic
1682	125	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	48	Uncontrolled superficial disease	Ileal Conduit
1683	125	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	74	Uncontrolled superficial disease	Ileal Conduit
1684	125	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		M	70	Muscle invasive TCC	Ileal Conduit
1685	125	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		F	69	Muscle invasive TCC	Ileal Conduit
1686	125	North Bristol NHSTrust (Southmead)	37	313		28	351		M	74	Muscle invasive TCC	Ileal Conduit
1687	125	North Bristol NHSTrust (Southmead)	37	313		28	351		M	49	Other	Ileal Conduit
1688	125	North Bristol NHSTrust (Southmead)	37	313		28	351		M	63	Uncontrolled superficial disease	Ileal Conduit
1689	125	North Bristol NHSTrust (Southmead)	37	313		28	351		F	76	Muscle invasive TCC	Ileal Conduit
1690	126	Bradford Royal Infirmary	7	107		6	384		F	75	Muscle invasive TCC	Ileal Conduit
1691	126	Bradford Royal Infirmary	7	107		6	384		M	74	Muscle invasive TCC	Ileal Conduit
1692	126	Bradford Royal Infirmary	7	107		6	384		F	54	Muscle invasive TCC	Ileal Conduit
1693	126	Bradford Royal Infirmary	7	107		6	384		M	60	Muscle invasive TCC	Ileal Conduit
1694	126	Bradford Royal Infirmary	7	107		6	384		M	70	Muscle invasive TCC	Ileal Conduit
1695	126	Bradford Royal Infirmary	7	107		6	384		M	65	Primary CIS	Ileal Conduit
1696	126	Bradford Royal Infirmary	7	107		6	384		M	73	Muscle invasive TCC	Ileal Conduit
1697	126	Bradford Royal Infirmary	7	107		6	384		F	70	Muscle invasive TCC	Ileal Conduit
1698	126	Bradford Royal Infirmary	7	107		6	384		F	74	Muscle invasive TCC	Ileal Conduit
1699	126	Bradford Royal Infirmary	7	107		6	384		F	76	Muscle invasive TCC	Ileal Conduit
1700	126	Bradford Royal Infirmary	7	107		6	384		M	72	Muscle invasive TCC	Ileal Conduit
1701	126	Bradford Royal Infirmary	7	107		6	384		M	67	Muscle invasive TCC	Ileal Conduit
1702	126	Bradford Royal Infirmary	7	107		6	384		M	38	Primary adenocarcinoma	Orthotopic
1703	126	Bradford Royal Infirmary	7	107		6	384		M	68	Muscle invasive TCC	Ileal Conduit
1704	126	Bradford Royal Infirmary	7	107		6	384		M	75	Muscle invasive TCC	Ileal Conduit
1705	126	Bradford Royal Infirmary	7	107		6	384		M	61	Primary CIS	Orthotopic
1706	126	Bradford Royal Infirmary	7	107		6	384		M	54	Muscle invasive TCC	Ileal Conduit
1707	126	Bradford Royal Infirmary	7	107		6	384		M	61	Muscle invasive TCC	Ileal Conduit
1708	126	Bradford Royal Infirmary	7	107		6	384		M	85	Salvage after radiotherapy	Ileal Conduit
1709	126	Bradford Royal Infirmary	7	107		6	384		M	65	Other	Ileal Conduit

1710	126	Bradford Royal Infirmary	7	107		6	384		M	31	Muscle invasive TCC	Ileal Conduit
1711	126	Bradford Royal Infirmary	7	107		6	384		F	73	Muscle invasive TCC	Ileal Conduit
1712	126	Bradford Royal Infirmary	7	107		6	384		M	61	Muscle invasive TCC	Ileal Conduit
1713	126	Bradford Royal Infirmary	7	107		6	384		M	62	Muscle invasive TCC	Ileal Conduit
1714	126	Bradford Royal Infirmary	7	107		6	384		F	48	Squamous cell Ca	Ileal Conduit
1715	126	Bradford Royal Infirmary	7	107		6	384		M	65	Muscle invasive TCC	Ileal Conduit
1716	126	Bradford Royal Infirmary	7	107		6	384		M	71	Muscle invasive TCC	Ileal Conduit
1717	126	Bradford Royal Infirmary	7	107		6	384		M	77	Muscle invasive TCC	Ileal Conduit
1718	126	Bradford Royal Infirmary	7	107		6	384		M	62	Muscle invasive TCC	Ileal Conduit
1719	126	Bradford Royal Infirmary	7	107		6	384		M	58	Muscle invasive TCC	Orthotopic
1720	126	Bradford Royal Infirmary	7	107		6	384		M	80	Muscle invasive TCC	Ileal Conduit
1721	126	Bradford Royal Infirmary	7	107		6	384		F	65	Muscle invasive TCC	Ileal Conduit
1722	126	Bradford Royal Infirmary	7	107		6	384		M	76	Squamous cell Ca	Ileal Conduit
1723	126	Bradford Royal Infirmary	7	107		6	384		M	53	Muscle invasive TCC	Orthotopic
1724	126	Bradford Royal Infirmary	7	107		6	384		M	999	Muscle invasive TCC	Orthotopic
1725	126	Bradford Royal Infirmary	7	107		6	384		F	80	Muscle invasive TCC	Ileal Conduit
1726	126	Bradford Royal Infirmary	7	107		6	384		M	77	Other	Ileal Conduit
1727	126	Huddersfield Royal Infirmary	28	10		6	384		M	67	Muscle invasive TCC	Ileal Conduit
1728	127	University College Hospital London	72	38		22	118		M	68	Muscle invasive TCC	Ileal Conduit
1729	127	University College Hospital London	72	38		22	118		M	39	Squamous cell Ca	Ileal Conduit
1730	128	Walsgrave Hospital	76	9		12	22		F	79	Muscle invasive TCC	Ileal Conduit
1731	128	Walsgrave Hospital	76	9		12	22		F	67	Muscle invasive TCC	Ileal Conduit
1732	128	Walsgrave Hospital	76	9		12	22		M	81	Muscle invasive TCC	Ileal Conduit
1733	129	Chesterfield & North Derbyshire	12	6		8	261		M	51	Squamous cell Ca	Ileal Conduit
1734	129	Chesterfield & North Derbyshire	12	6		8	261		F	70	Muscle invasive TCC	Ileal Conduit
1735	129	Chesterfield & North Derbyshire	12	6		8	261		F	69	Muscle invasive TCC	Ileal Conduit
1736	129	Chesterfield & North Derbyshire	12	6		8	261		M	75	Primary CIS	Ileal Conduit
1737	129	Chesterfield & North Derbyshire	12	6		8	261		M	71	Muscle invasive TCC	Ileal Conduit
1738	129	Chesterfield & North Derbyshire	12	6		8	261		M	79	Uncontrolled superficial disease	Ileal Conduit
1739	129	Chesterfield & North Derbyshire	12	6		8	261		M	66	Uncontrolled superficial disease	Ileal Conduit
1740	129	Chesterfield & North Derbyshire	12	6		8	261		M	73	Muscle invasive TCC	Ileal Conduit
1741	129	Chesterfield & North Derbyshire	12	6		8	261		M	67	Salvage after radiotherapy	Ileal Conduit
1742	129	Chesterfield & North Derbyshire	12	6		8	261		M	65	Muscle invasive TCC	Ileal Conduit
1743	129	Chesterfield & North Derbyshire	12	6		8	261		F	65	Muscle invasive TCC	Ileal Conduit
1744	129	Chesterfield & North Derbyshire	12	6		8	261		F	76	Uncontrolled superficial disease	Ileal Conduit
1745	129	Chesterfield & North Derbyshire	12	6		8	261		M	74	Uncontrolled superficial disease	Ileal Conduit
1746	129	Chesterfield & North Derbyshire	12	6		8	261		M	68	Muscle invasive TCC	Ileal Conduit
1747	129	Chesterfield & North Derbyshire	12	6		8	261		F	58	Muscle invasive TCC	Ileal Conduit
1748	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	52	Uncontrolled superficial disease	Ileal Conduit
1749	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	44	Muscle invasive TCC	Ileal Conduit

1750	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	70	Muscle invasive TCC	Ileal Conduit
1751	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	76	Uncontrolled superficial disease	Ileal Conduit
1752	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	69	Muscle invasive TCC	Ileal Conduit
1753	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	80	Muscle invasive TCC	Ileal Conduit
1754	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	80	Squamous cell Ca	Ileal Conduit
1755	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	42	Gynaecological Ca	Ileal Conduit
1756	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	69	Muscle invasive TCC	Ileal Conduit
1757	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	65	Muscle invasive TCC	Ileal Conduit
1758	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	77	Primary CIS	Ileal Conduit
1759	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	999	Muscle invasive TCC	Ileal Conduit
1760	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	68	Muscle invasive TCC	Ileal Conduit
1761	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	59	Salvage after radiotherapy	Ileal Conduit
1762	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	59	Muscle invasive TCC	Orthotopic
1763	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	64	Uncontrolled superficial disease	Ileal Conduit
1764	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	71	Squamous cell Ca	Ileal Conduit
1765	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	70	Muscle invasive TCC	Ileal Conduit
1766	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	55	Salvage after radiotherapy	Ileal Conduit
1767	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	56	Uncontrolled superficial disease	Ileal Conduit
1768	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	75	Muscle invasive TCC	Ileal Conduit
1769	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	67	Muscle invasive TCC	Ileal Conduit
1770	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		999	999	Secondary adenocarcinoma	Ileal Conduit
1771	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	60	Uncontrolled superficial disease	Ileal Conduit
1772	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	70	Muscle invasive TCC	Ileal Conduit
1773	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	70	Muscle invasive TCC	Ileal Conduit
1774	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	74	Uncontrolled superficial disease	Ileal Conduit
1775	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	68	Other	Ileal Conduit
1776	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	62	Gynaecological Ca	Ileal Conduit
1777	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	61	Uncontrolled superficial disease	Ileal Conduit
1778	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	64	Muscle invasive TCC	Ileal Conduit
1779	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	78	Muscle invasive TCC	Ileal Conduit
1780	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	82	Muscle invasive TCC	Ileal Conduit
1781	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	63	Muscle invasive TCC	Ileal Conduit
1782	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	61	Muscle invasive TCC	Ileal Conduit
1783	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	999	Gynaecological Ca	Ileal Conduit
1784	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	78	Muscle invasive TCC	Ileal Conduit
1785	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	55	Uncontrolled superficial disease	Ileal Conduit
1786	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	76	Muscle invasive TCC	Ileal Conduit
1787	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	73	Muscle invasive TCC	Ileal Conduit
1788	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	63	Muscle invasive TCC	Ileal Conduit
1789	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	69	Muscle invasive TCC	Ileal Conduit
1790	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	82	Muscle invasive TCC	Ileal Conduit
1791	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	73	Muscle invasive TCC	Ileal Conduit
1792	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	72	Uncontrolled superficial disease	Ileal Conduit
1793	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	999	Muscle invasive TCC	Ileal Conduit
1794	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	63	Muscle invasive TCC	Ileal Conduit
1795	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	66	Uncontrolled superficial disease	Ileal Conduit
1796	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	70	Uncontrolled superficial disease	Ileal Conduit
1797	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	62	Uncontrolled superficial disease	Ileal Conduit
1798	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	61	Uncontrolled superficial disease	Ileal Conduit
1799	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	63	Muscle invasive TCC	Ileal Conduit

1800	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	79	Uncontrolled superficial disease	Ileal Conduit
1801	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	73	Muscle invasive TCC	Ileal Conduit
1802	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	70	Uncontrolled superficial disease	Ileal Conduit
1803	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	66	Muscle invasive TCC	Ileal Conduit
1804	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	71	Muscle invasive TCC	Ileal Conduit
1805	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	77	Muscle invasive TCC	Ileal Conduit
1806	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	59	Uncontrolled superficial disease	Ileal Conduit
1807	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	59	Other	Ileal Conduit
1808	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	61	Squamous cell Ca	Ileal Conduit
1809	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	66	Primary CIS	Ileal Conduit
1810	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	58	Muscle invasive TCC	Ileal Conduit
1811	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	62	Muscle invasive TCC	Ileal Conduit
1812	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	68	Muscle invasive TCC	Ileal Conduit
1813	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	70	Gynaecological Ca	Ileal Conduit
1814	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	63	Muscle invasive TCC	Ileal Conduit
1815	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	67	Muscle invasive TCC	Ileal Conduit
1816	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	68	Muscle invasive TCC	Ileal Conduit
1817	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	74	Uncontrolled superficial disease	Ileal Conduit
1818	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	73	Muscle invasive TCC	Ileal Conduit
1819	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	83	Uncontrolled superficial disease	Ileal Conduit
1820	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	60	Other	Ileal Conduit
1821	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	49	Muscle invasive TCC	Orthotopic
1822	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	70	Muscle invasive TCC	Ileal Conduit
1823	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	75	Muscle invasive TCC	Ileal Conduit
1824	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	74	Muscle invasive TCC	Ileal Conduit
1825	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	47	Muscle invasive TCC	Ileal Conduit
1826	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	69	Uncontrolled superficial disease	Ileal Conduit
1827	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	73	Uncontrolled superficial disease	Ileal Conduit
1828	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	56	Muscle invasive TCC	Orthotopic
1829	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	57	Uncontrolled superficial disease	Ileal Conduit
1830	129	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	71	Squamous cell Ca	Ileal Conduit
1831	129	Queen's Hospital Burton	46	13		39	345		M	79	Salvage after radiotherapy	Ileal Conduit
1832	129	Queen's Hospital Burton	46	13		39	345		M	71	Uncontrolled superficial disease	Ileal Conduit
1833	129	Queen's Hospital Burton	46	13		39	345		M	62	Muscle invasive TCC	Ileal Conduit
1834	129	Queen's Hospital Burton	46	13		39	345		F	74	Muscle invasive TCC	Ileal Conduit
1835	129	Queen's Hospital Burton	46	13		39	345		M	61	Muscle invasive TCC	Ileal Conduit
1836	129	Queen's Hospital Burton	46	13		39	345		M	71	Muscle invasive TCC	Ileal Conduit
1837	129	Queen's Hospital Burton	46	13		39	345		M	63	Muscle invasive TCC	Ileal Conduit
1838	129	Queen's Hospital Burton	46	13		39	345		M	55	Muscle invasive TCC	Ileal Conduit
1839	129	Queen's Hospital Burton	46	13		39	345		M	70	Uncontrolled superficial disease	Ileal Conduit
1840	129	Queen's Hospital Burton	46	13		39	345		F	68	Muscle invasive TCC	Ileal Conduit
1841	129	Queen's Hospital Burton	46	13		39	345		M	67	Uncontrolled superficial disease	Orthotopic
1842	129	Queen's Hospital Burton	46	13		39	345		F	73	Uncontrolled superficial disease	Ileal Conduit
1843	129	Queen's Hospital Burton	46	13		39	345		M	61	Uncontrolled superficial disease	Orthotopic
1844	129	Portsmouth Hospitals NHS Trust	43	150		31	307		F	83	Uncontrolled superficial disease	Ileal Conduit
1845	129	Portsmouth Hospitals NHS Trust	43	150		31	307		M	65	Muscle invasive TCC	Ileal Conduit
1846	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	61	Muscle invasive TCC	Ileal Conduit
1847	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	58	Muscle invasive TCC	Ileal Conduit
1848	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	56	Muscle invasive TCC	Orthotopic
1849	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	65	Uncontrolled superficial disease	Ileal Conduit

1850	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	62	Uncontrolled superficial disease	Ileal Conduit
1851	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	69	Gynaecological Ca	Ileal Conduit
1852	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	30	Gynaecological Ca	Ileal Conduit
1853	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	69	Muscle invasive TCC	Ileal Conduit
1854	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	68	Other	Ileal Conduit
1855	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	73	Other	Ileal Conduit
1856	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	72	Muscle invasive TCC	Ileal Conduit
1857	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	72	Muscle invasive TCC	Ileal Conduit
1858	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	76	Muscle invasive TCC	Ileal Conduit
1859	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	999	Muscle invasive TCC	Ileal Conduit
1860	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	61	Muscle invasive TCC	Ileal Conduit
1861	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	56	Muscle invasive TCC	Ileal Conduit
1862	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	64	Muscle invasive TCC	Ileal Conduit
1863	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	46	Muscle invasive TCC	Ileal Conduit
1864	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	46	Muscle invasive TCC	Ileal Conduit
1865	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	70	Muscle invasive TCC	Ileal Conduit
1866	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	74	Muscle invasive TCC	Ileal Conduit
1867	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	81	Muscle invasive TCC	Ileal Conduit
1868	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	69	Muscle invasive TCC	Ileal Conduit
1869	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	999	Muscle invasive TCC	Ileal Conduit
1870	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	39	Muscle invasive TCC	Ileal Conduit
1871	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	69	Other	Ileal Conduit
1872	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	68	Primary CIS	Ileal Conduit
1873	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	56	Muscle invasive TCC	Ileal Conduit
1874	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	45	Muscle invasive TCC	Orthotopic
1875	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	61	Muscle invasive TCC	Ileal Conduit
1876	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	68	Primary CIS	Ileal Conduit
1877	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	72	Muscle invasive TCC	Ileal Conduit
1878	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	999	Muscle invasive TCC	Ileal Conduit
1879	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	68	Muscle invasive TCC	Ileal Conduit
1880	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	79	Muscle invasive TCC	Ileal Conduit
1881	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	81	Muscle invasive TCC	Ileal Conduit
1882	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	70	Muscle invasive TCC	Ileal Conduit
1883	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	75	Muscle invasive TCC	Ileal Conduit
1884	130	Portsmouth Hospitals NHS Trust	43	150		31	307		F	68	Muscle invasive TCC	Ileal Conduit
1885	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	80	Muscle invasive TCC	Ileal Conduit
1886	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	46	Muscle invasive TCC	Ileal Conduit
1887	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	70	Muscle invasive TCC	Ileal Conduit
1888	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	63	Muscle invasive TCC	Ileal Conduit
1889	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	62	Muscle invasive TCC	Ileal Conduit
1890	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	76	Muscle invasive TCC	Ileal Conduit
1891	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	50	Muscle invasive TCC	Ileal Conduit
1892	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	57	Muscle invasive TCC	Ileal Conduit
1893	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	72	Muscle invasive TCC	Ileal Conduit
1894	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	65	Muscle invasive TCC	Ileal Conduit
1895	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	64	Squamous cell Ca	Ileal Conduit
1896	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	63	Muscle invasive TCC	Orthotopic
1897	130	Portsmouth Hospitals NHS Trust	43	150		31	307		M	79	Muscle invasive TCC	Ileal Conduit
1898	130	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	57	Muscle invasive TCC	Orthotopic
1899	130	Royal West Sussex NHS Trust, St Richard's Hospita	59	12		31	307		M	74	Muscle invasive TCC	Ileal Conduit

1900	130	Royal West Sussex NHS Trust, St Richard's Hospit	59	12		31	307		M	66	Muscle invasive TCC	Ileal Conduit
1901	131	Dorset County Hospital	21	3		27	60		M	65	Salvage after radiotherapy	Ileal Conduit
1902	131	Dorset County Hospital	21	3		27	60		M	59	Muscle invasive TCC	Ileal Conduit
1903	131	Royal Bournemouth Hospital	49	57		27	60		F	999	Muscle invasive TCC	Ileal Conduit
1904	132	North Devon District Hospital	38	6		26	205		M	65	Muscle invasive TCC	Ileal Conduit
1905	132	North Devon District Hospital	38	6		26	205		M	53	Muscle invasive TCC	Ileal Conduit
1906	132	North Devon District Hospital	38	6		26	205		F	62	Muscle invasive TCC	Ileal Conduit
1907	132	North Devon District Hospital	38	6		26	205		M	69	Other	Ileal Conduit
1908	132	North Devon District Hospital	38	6		26	205		M	68	999	Orthotopic
1909	133	Castle Hill Hospital	11	135		7	144		M	51	Muscle invasive TCC	Ileal Conduit
1910	133	Castle Hill Hospital	11	135		7	144		F	57	Muscle invasive TCC	Ileal Conduit
1911	133	Castle Hill Hospital	11	135		7	144		M	69	Muscle invasive TCC	Orthotopic
1912	134	King George Hospital	32	49		23	49		F	71	Muscle invasive TCC	Ileal Conduit
1913	135	St James's University Hospital	67	108		6	384		M	81	Squamous cell Ca	Ileal Conduit
1914	135	St James's University Hospital	67	108		6	384		M	34	Sarcoma	Ileal Conduit
1915	135	St James's University Hospital	67	108		6	384		M	70	Uncontrolled superficial disease	Ileal Conduit
1916	135	St James's University Hospital	67	108		6	384		F	69	Salvage after radiotherapy	Ileal Conduit
1917	135	St James's University Hospital	67	108		6	384		F	65	Muscle invasive TCC	Ileal Conduit
1918	136	New Cross Hospital	35	37		35	226		M	52	Muscle invasive TCC	Ileal Conduit
1919	137	Royal Preston Hospital	56	22		2	101.00		M	79	Muscle invasive TCC	Ileal Conduit
1920	137	Royal Preston Hospital	56	22		2	101.00		M	71	Muscle invasive TCC	Orthotopic
1921	137	Royal Preston Hospital	56	22		2	101.00		M	63	Muscle invasive TCC	Ileal Conduit
1922	137	Royal Preston Hospital	56	22		2	101.00		M	61	Muscle invasive TCC	Ileal Conduit
1923	137	Royal Preston Hospital	56	22		2	101.00		M	56	Other	Ileal Conduit
1924	138	Freeman Hospital	23	258		36	405		M	66	Muscle invasive TCC	Ileal Conduit
1925	138	Freeman Hospital	23	258		36	405		M	71	Muscle invasive TCC	Ileal Conduit
1926	138	Freeman Hospital	23	258		36	405		M	48	Muscle invasive TCC	Ileal Conduit
1927	139	Derby Hospitals NHS Foundation Trust	18	121		39	345		F	65	Muscle invasive TCC	Ileal Conduit
1928	139	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	63	Muscle invasive TCC	Ileal Conduit
1929	139	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	76	Muscle invasive TCC	Ileal Conduit
1930	139	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	74	Muscle invasive TCC	Ileal Conduit
1931	139	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	72	Muscle invasive TCC	Ileal Conduit
1932	139	Derby Hospitals NHS Foundation Trust	18	121		39	345		M	77	Muscle invasive TCC	Ileal Conduit
1933	140	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	75	Muscle invasive TCC	Ileal Conduit
1934	140	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	74	Muscle invasive TCC	Ileal Conduit
1935	140	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	71	Muscle invasive TCC	Ileal Conduit
1936	140	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	79	Other	Ileal Conduit
1937	140	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	68	Muscle invasive TCC	Ileal Conduit
1938	140	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		M	59	Primary CIS	Ileal Conduit
1939	140	City Hospitals Sunderland NHS Foundation Trust	15	136		36	405		F	73	Muscle invasive TCC	Ileal Conduit
1940	141	University College Hospital London	72	38		22	118		M	999	999	Orthotopic
1941	142	Royal Sussex County Hospital	58	34		33	129		M	60	999	Ileal Conduit
1942	143	Barnet & Chase Farm Hospital	5	64		22	118		M	57	Muscle invasive TCC	Ileal Conduit
1943	143	Barnet & Chase Farm Hospital	5	64		22	118		M	999	Salvage after radiotherapy	Ileal Conduit
1944	143	Barnet & Chase Farm Hospital	5	64		22	118		M	79	Salvage after radiotherapy	Ileal Conduit
1945	143	Barnet & Chase Farm Hospital	5	64		22	118		M	999	Muscle invasive TCC	Ileal Conduit
1946	143	Barnet & Chase Farm Hospital	5	64		22	118		M	72	Uncontrolled superficial disease	Ileal Conduit
1947	143	Barnet & Chase Farm Hospital	5	64		22	118		M	85	Primary adenocarcinoma	Ileal Conduit
1948	143	Barnet & Chase Farm Hospital	5	64		22	118		M	77	Other	Ileal Conduit
1949	143	Barnet & Chase Farm Hospital	5	64		22	118		F	72	Muscle invasive TCC	Ileal Conduit

1950	143	Barnet & Chase Farm Hospital	5	64		22	118		F	64	Muscle invasive TCC	Ileal Conduit
1951	143	Barnet & Chase Farm Hospital	5	64		22	118		M	68	Uncontrolled superficial disease	Ileal Conduit
1952	143	Barnet & Chase Farm Hospital	5	64		22	118		F	46	Muscle invasive TCC	Ileal Conduit
1953	143	Barnet & Chase Farm Hospital	5	64		22	118		M	999	Squamous cell Ca	Ileal Conduit
1954	143	Barnet & Chase Farm Hospital	5	64		22	118		M	41	Uncontrolled superficial disease	Ileal Conduit
1955	143	Barnet & Chase Farm Hospital	5	64		22	118		F	80	Muscle invasive TCC	Ileal Conduit
1956	143	Barnet & Chase Farm Hospital	5	64		22	118		M	999	999	Ileal Conduit
1957	143	Barnet & Chase Farm Hospital	5	64		22	118		M	78	Other	Ileal Conduit
1958	143	Barnet & Chase Farm Hospital	5	64		22	118		M	72	Muscle invasive TCC	Ileal Conduit
1959	143	Barnet & Chase Farm Hospital	5	64		22	118		M	77	Salvage after radiotherapy	Ileal Conduit
1960	143	Barnet & Chase Farm Hospital	5	64		22	118		M	79	Uncontrolled superficial disease	Ileal Conduit
1961	143	Barnet & Chase Farm Hospital	5	64		22	118		M	48	Other	Orthotopic
1962	143	North Middlesex Hospital	39	2		22	118		M	57	Muscle invasive TCC	Orthotopic
1963	144	Basildon Hospital	6	12		38	164		M	60	Muscle invasive TCC	Ileal Conduit
1964	144	Basildon Hospital	6	12		38	164		M	69	Salvage after radiotherapy	Ileal Conduit
1965	144	Basildon Hospital	6	12		38	164		M	76	Primary CIS	Ileal Conduit
1966	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	63	Muscle invasive TCC	Ileal Conduit
1967	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	69	Muscle invasive TCC	Ileal Conduit
1968	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	71	Muscle invasive TCC	Ileal Conduit
1969	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	50	Muscle invasive TCC	Ileal Conduit
1970	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	49	Muscle invasive TCC	Ileal Conduit
1971	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	54	Muscle invasive TCC	Ileal Conduit
1972	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	65	Muscle invasive TCC	Ileal Conduit
1973	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	70	Uncontrolled superficial disease	Ileal Conduit
1974	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	76	Muscle invasive TCC	Ileal Conduit
1975	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	60	Muscle invasive TCC	Ileal Conduit
1976	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	999	Muscle invasive TCC	Ileal Conduit
1977	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	68	Primary CIS	Ileal Conduit
1978	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	76	Squamous cell Ca	Ileal Conduit
1979	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	72	Muscle invasive TCC	Ileal Conduit
1980	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	73	Squamous cell Ca	Ileal Conduit
1981	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	61	Muscle invasive TCC	Ileal Conduit
1982	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	73	Muscle invasive TCC	Ileal Conduit
1983	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	66	Salvage after radiotherapy	Ileal Conduit
1984	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	69	Muscle invasive TCC	Ileal Conduit
1985	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	71	Muscle invasive TCC	Ileal Conduit
1986	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	73	Muscle invasive TCC	Ileal Conduit
1987	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	69	Muscle invasive TCC	Ileal Conduit
1988	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	55	Uncontrolled superficial disease	Ileal Conduit
1989	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	64	999	Ileal Conduit
1990	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	74	Muscle invasive TCC	Ileal Conduit
1991	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	75	Muscle invasive TCC	Ileal Conduit
1992	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	81	Uncontrolled superficial disease	Ileal Conduit
1993	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	63	Muscle invasive TCC	Ileal Conduit
1994	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	81	Muscle invasive TCC	Ileal Conduit
1995	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	38	Muscle invasive TCC	Ileal Conduit
1996	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	71	Primary CIS	Ileal Conduit
1997	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	73	Muscle invasive TCC	Ileal Conduit
1998	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	70	Squamous cell Ca	Ileal Conduit
1999	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	66	Muscle invasive TCC	Ileal Conduit

2000	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	70	Muscle invasive TCC	Ileal Conduit	
2001	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	72	Muscle invasive TCC	Ileal Conduit	
2002	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	62	Muscle invasive TCC	Ileal Conduit	
2003	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	56	Muscle invasive TCC	Ileal Conduit	
2004	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	77	Muscle invasive TCC	Ileal Conduit	
2005	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	72	Muscle invasive TCC	Ileal Conduit	
2006	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	48	Muscle invasive TCC	Ileal Conduit	
2007	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	63	Muscle invasive TCC	Ileal Conduit	
2008	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	75	Muscle invasive TCC	Ileal Conduit	
2009	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	60	Muscle invasive TCC	Ileal Conduit	
2010	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		M	72	Muscle invasive TCC	Ileal Conduit	
2011	144	Southend University Hospital NHS Foundation Tru	65	84		38	164		F	62	Muscle invasive TCC	Ileal Conduit	
2012	145	Bristol Oncology Centre; United Bristol Health Ca	8	7		28	351		F	81	Uncontrolled superficial disease	Ileal Conduit	

Appendix 17 – Patient Questionnaire Survey Raw Results

RemovalMonths	RemovalYears	AgeGroup	Gender	UrineDiversion	BothMethodsAvailable	UBenefits	URisks	URecovery	UPeerSupport	UDailyCare	UAppliances	UEmployment	ULeisure	UAppearance	USexual	SBBenefits	SBRisks	SBRecovery	SBPeerSupport	SBDailyCare	SBAppliances	SBEmployment	SBLeisure	SBAppearance	SBSexual	Information
3	6	4	1	2	1	1	2	3	666	1	2	3	2	2	3	1	2	3	666	1	2	3	2	2	3	2
0	12	4	1	2	1	1	1	999	1	1	2	999	2	2	3	1	2	2	2	1	2	2	2	1	3	
8	4	5	1	1	2	2	2	3	2	2	3	3	2	3	6	6	6	6	6	6	6	6	6	6	6	1
6	5	4	1	1	2																					
6	4	3	1	1	2																					
0	6	3	1	2	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1
1	4	5	1	1	2																					
	4	5	2	1	2																					
0	4	2	1	2	1	1	1	1	1	1	1	1	1	3	1	1	1	1	1	1	1	1	1	4	1	2
	4	4	1	1	2																					
10	3	4	1	1	1	1	1	1	1	1	1	1	1	1	4	1	1	1	1	1	999	1	1	1	5	2
9	4	4	1	1	2																					
11	15	4	1	2	1	999	999	999	999	999	999	999	999	999	999	2	2	2	3	2	3	3	3	3	2	2
	3	5	2	1	999			1	2	2	1		2	2												
2	3	5	1	1	2																					
8	3	3	1	1	999	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	1
0	3	4	2	1	1	2	2	2	2	2	2	999	2	2	2	2	2	2	3	3	2	2	2	2	2	2
	2	4	1	1	2																					
	3	5	2	999	2	1				1	2	1	3	2	6	6	1	1	1	1	1		6	3	6	
0	3	4	1	1	1	2	2	2	2	3	2	2	2	3	4	2	2	2	2	3	2	2	2	2	3	1
10	2	5	1	1	2	2	2	2	3	2	2	2	2	2	2											2
	3	4	1	1	2																					
8	2	3	1	1	2																					
7	2	5	1	1	2																					
	3	5	1	1	2																					
0	3	3	1	1	1	1	1	2	3	1	2	3	2	2	2	1	1	1	2	1	1	2	1	1	1	2
5	2	3	1	2	1	3	2	3	4	3	3	3	3	4	5	1	2	4	2	4	3	2	1	1	5	2
5	3	5	1	1	1	1	1	1	1	1	1	1	1	1	3	2	2	2	999	999	999	999	999	999	999	2
0	2	3	1	1	1	1	2	2	1	1	1	2	2	2	3	999	999	999	999	999	999	999	999	999	999	2
0	2	4	1	1	1	1	1	1	3	2	2	2	2	2	2	2	1	2	3	3	3	2	2	2	2	2
0	2	4	1	1	1	2	2	2	3	2	2	2	3	3	3	2	2	2	2	2	2	2	3	3	3	2
10	1	4	1	1	2																					
10	1	3	1	2	1	3	3	2	3	3	2	3	3	3	4	2	2	2	2	3	3	3	2	2	3	2
9	1	5	1	1	2																					
9	1	5	1	1	1	1	1	1	1	1	1	999	999	2	2	1	1	1	2	1	1	999	999	2	2	2
10	1	4	2	2	1	2	2	1	3	1	3	3	2	2	2	2	2	2	3	2	2	2	2	2	2	2
5	1	5	1	1	2	3	2	2	2	3	3	2	3	2	3	2	2	2	2	2	2	2	2	2	2	
6	1	4	1	1	1	1	1	1	2	1	1	1	1	2	1	1	1	1	1	999	999	999	999	999	999	2
6	1	4	1	2	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2

6	5	4	2	1	2																					
3	4	5	1	1	2																					
8	5	3	1	1	1	2	2	2	2	1	1	2	3	3	3	2	2	3	3	3	666	2	3	2	3	
999	999	2	1	2	1	999	999	999	999	999	999	999	999	999	999	2	1	2	1	1	1	1	2	2	2	
	5	4	1	1	2	2	2	2	2	2	2	2	2	2	6	3	3	3	3	3	3	3	3	3	6	
0	5	3	1	2	1	2	2	2	2	4	4	4	3	2	2	1	2	3	2	4	5	3	3	2	2	
	5	5	1	1	2																					
		5	2	1	2																					
4	4	3	2	1	2																					
9	3	4	1	1	1	1	2	1	2	3	2	3	2	666	666	1	1	1	666	666	666	666	666	666	666	
0	5	4	2	1	1	1	1	1	1	1	1	999	1	1	4	999	999	999	999	999	999	999	999	999	999	
	2	5	2	1	2																					
	3	4	2	1	2																					
6	2	3	1	2	1	3	2	2	2	2	2	3	3	4	4	3	2	2	3	2	3	3	3	4	4	
7	2	5	1	1	2																					
0	2	5	1	1	1	1	1	1	1	1	1	1	1	1	666	999	999	999	999	999	999	999	999	999	999	
	2	4	2	1	2																					
1	1	5	1	1	1	1	1	1	1	1	1	3	3	2	666	3	1	3	3	1	1	3	3	3	666	
7	1	5	2	1	2																					
6	1	4	2	2	1	1	2	1	2	3	2	2	2	2	2	1	2	2	666	666	3	2	2	2	2	
1	1	5	1	1	2																					
1	1	4	2	1	2																					
999	999	5	1	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
	1	5	2	1	2	1	1	1	1	3	1		3	1	3	6										
	5	5	1	1	2																					
0	5	5	1	1	1	2	2	1	1	1	1	2	2	1	3	2	2	666	666	666	666	666	666	666	666	
9	4	3	1	2	1	1	3	1	3	1	1	3	1	1	1	1	1	1	1	1	1	1	1	1	2	
2	3	5	1	1	2																					
8	4	4	1	2	1	1	1	1	1	1	2	2	2	2	3	1	1	1	1	1	2	2	2	2	4	
0	5	4	1	2	1	1	1	1	999	1	1	1	1	1	2	1	1	1	999	1	1	1	1	1	2	
0	4	2	1	1	1	3	3	2	2	2	2	1	3	3	5	3	3	3	3	3	3	2	2	3	3	
0	4	4	1	2	1	2	2	2	3	3	2	3	3	3	3	2	2	2	3	2	2	2	2	3	3	
10	3	3	1	2	2																					
8	3	4	1	2	1	999	999	999	999	999	999	999	999	999	999	666	999	999	999	999	1	999	999	1	666	
8	1	3	1	1	2																					
6	1	4	1	1	1	2	2	2	666	2	3	3	666	2	5	2	2	2	666	2	3	666	666	2	5	
9	4	5	1	1	2																					
8	4	4	1	1	2																					
7	4	5	1	1	2	2	1	1		1	1	6	6	6												
7	1	5	1	1	2	1	1	1		1	1	1	1	1												

6	1	4	1	1	2																						
		4	1	1	2																						
6	1	4	1	1	2																						
3	1	4	1	1	1	1	1	1	999	1	1	999	1	1	1	1	1	1	999	999	1	999	1	1	1	2	
4	1	4	2	1	1	2	1	2	1	2	1	999	2	4	666	2	2	2	1	2	2	999	2	4	666	1	
3	1	5	1	1	2																						
1	1	5	1	1	1	2	1	2	5	1	3	2	2	4	2	2	2	3	5	2	5	3	3	3	3	1	
9	5	4	1	2	1	2	2	666	666	666	2	666	2	2	666	2	1	1	2	2	2	666	2	666	666	2	
8	5	3	1	1	2																						
6	5	4	2	1	2																						
	4	4	1	2	2											1	1	1	1	1	1	1	1	1	3	2	
0	4	4	1	2	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	2	2	
9	3	2	2	1	1	1	2	1	666	2	4	666	666	666	666	666	3	666	666	666	666	666	666	2	666		
	3	5	2	1	2																						
0	3	3	1	2	1	1	2	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2	2	
7	3	5	1	1	2	1	1	1	1	1	1	1	1	1													
	3	4	1	1	2																						
1	3	5	1	1	2																						
2	2	4	1	2	1	999	999	999	999	999	999	999	999	999	999	2	2	2	1	2	2	2	2	2	2	1	
	2	5	1	1	2																						
8	1	4	1	1	2																						
8	1	999	2	1	1	1	1	2	1	1	2	999	2	1	999	999	999	999	999	999	999	999	999	999	999	2	
13		4	1	1	2	3	3	3	2	1	1	1	2	2	3											2	
		4	1	1	2																						
7	6	4	1	1	1	2	2	2	2	1	1	1	1	2	3	2	1	1	3	3	3	3	3	3	3	2	
		5	1	1	2	2	2	2	2	2	2	2	2	2	6												
		999	2	1	2																						
	5	999	1	1	2																						
0	3	5	1	1	1	2	2	2	3	2	2	3	3	3	999	3	3	2	3	2	3	3	3	3	999	1	
6	5	5	1	1	1	1	2	1	1	1	2	2	2	1	2	1	1	1	1	1	1	1	1	1	2	1	
10	5	4	1	2	1	2	2	2	2	2	2	2	3	2	3	1	2	2	1	1	2	2	3	2	3	2	
	6	5	1	1	2																						
	4	4	1	1	2																						
1	4	4	2	2	1	1	999	999	999	1	2	999	2	2	999	1	999	1	999	999	999	999	999	1	1	999	
0	5	4	2	1	1	2	2	2	999	2	2	999	2	2	2	2	999	666	999	3	999	3	3	3	3	1	
	6	4	1	1	2	5	5	5	5	5	5	5	5	5	5											1	
4	5	3	1	2	1	1	1	1	1	2	1	1	1	1	3	1	1	1	3	3	1	1	1	1	4	2	
3	5	3	2	2	1	1	1	1	1	1	1	2	2	1	2	1	1	1	1	1	1	2	2	1	2	2	
	5	5	1	1	2	2	2	2	2	1	2	1	2	2	6												
9	4	3	1	2	1	1	1	1	1	1	1	1	3	1	3	1	1	1	1	1	1	1	3	1	3	2	

9	4	4	1	2	1	2	2	1	1	1	2	1	1	1	2	1	1	1	1	1	1	1	1	1	2	2
8	4	4	1	2	1	1	2	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2	2
7	4	5	1	2	1	1	1	1	2	1	1	2	3	1	2	1	2	1	1	1	1	2	3	1	2	2
999	999	4	2	1	1	2	1	1	1	1	1	666	666	1	666	999	999	999	999	999	999	999	999	999	999	2
6	3	3	1	2	1	1	1	1	1	1	999	3	2	1	3	1	1	1	1	1	666	2	2	1	3	2
0	3	4	1	2	1	999	999	999	999	999	999	999	999	999	999	1	1	1	1	1	1	1	1	1	1	2
	3	5	2	1	2																					
0	3	4	1	2	1	3	3	999	2	2	5	999	3	2	666	2	2	2	999	1	999	3	2	2	666	
999	999	4	1	2	1	2	2	2	2	2	2	2	2	2	2	1	1	1	1	1	1	1	1	1	666	1
999	999	5	1	1	1	999	999	1	999	1	1	999	999	1	999	999	999	999	999	999	999	999	999	999	999	
9	2	3	1	2	1	2	2	2	2	2	2	2	2	2	2	1	1	1	1	1	1	1	1	1	1	2
	6	5	2	1	2																					
	6	5	2	1	2	2	2	2	2	2	2	2	2	2	2											
6	5	5	1	1	2	1	1	1	3	1	1	6	1	3	1											
	5	3	1	1	2																					
3	5	4	2	1	1	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	999	2
	5	5	1	1	2	2	2	2	3	3	2	3	3	2	3	6	6	6	6	6	6	6	6	6	6	2
		4	1	2	2	2	2	2	3	2	1	2	3	2	6	2										
	5	5	1	1	2																					
1	5	5	1	1	2	1	1	1	1	1	1	1	1	1												2

Appendix 18 – Clinician Questionnaire Raw Results (Surgeons)

Are you	Could y	What is	How ma	Over th	How ma	of the f	How oft
Respons	Open-En	Respons	Respons	Open-En	Ileal Con	Orthotopi	Technica
Male	56	Consultan	16 to 20 ye	10	8	0	Every time
Male	59	Consultan	999	999	999	999	
Male	44	Consultan	6 to 10 yea	40	26	10	Every time
Male	47	Consultan	11 to 15 ye	12	8	4	Every time
Male	41	Consultan	999	999	999	999	
Male	53	Consultan	16 to 20 ye	0	0	6	Every time
Male	53	Consultan	16 to 20 ye	18	15	3	Very often
Male	57	Consultan	999	999	999	999	
Male	47	Consultan	11 to 15 ye	0	0	0	Not discus
Male	39	Consultan	0 to 5 year	60	37	3	Not very o
Male	61	Consultan	over 20 ye	0	0	0	
Male	53	Consultan	16 to 20 ye	0	0	0	
Male	45	Consultan	6 to 10 yea	15	11	4	Every time
Male	46	Consultan	6 to 10 yea	0	0	0	
Male	45	Consultan	0 to 5 year	20	0	0	Every time
Male	63	Consultan	999	999	999	999	
Male	51	Consultan	6 to 10 yea	18	18	0	Every time
Male	54	Consultan	16 to 20 ye	30	25	5	Every time
Male	47	Consultan	6 to 10 yea	6	6	0	
Male	40	Consultan	0 to 5 year	0	0	0	Every time
Male	55	Consultan	16 to 20 ye	0	0	0	Not discus
Male	44	Consultan	0 to 5 year	4	0	0	
Male	62	Consultan	16 to 20 ye	12	6	2	Every time
Male	44	Consultan	6 to 10 yea	15	12	0	Very often
Male	56	Consultan	16 to 20 ye	2	2	999	Very often
Male	43	Consultan	6 to 10 yea	25	23	2	Every time
Male	44	Consultan	6 to 10 yea	17	14	3	Very often
Male	63	Consultan	over 20 ye	0	0	3	
Male	53	Consultan	16 to 20 ye	999	999	999	
Male	52	Consultan	11 to 15 ye	25	19	2	Every time
Male	38	Consultan	over 20 ye	40	20	2	
Male	50	Consultan	11 to 15 ye	20	14	6	Every time
Male	57	Consultan	999	999	999	999	
Male	40	Consultan	0 to 5 year	0	0	0	Not discus
Male	44	Consultan	6 to 10 yea	25	8	5	
Male	57	Consultan	11 to 15 ye	0	0	0	
Male	57	Consultan	over 20 ye	30	25	5	Sometime
Male	50	Consultan	16 to 20 ye	21	21	0	Every time
Male	49	Consultan	11 to 15 ye	10	0	0	Every time
Male	47	Consultan	6 to 10 yea	35	28	7	Sometime
Female	46	Consultan	6 to 10 yea	0	0	0	
Male	52	Consultan	11 to 15 ye	7	0	0	Every time
Male	53	Consultan	11 to 15 ye	0	0	0	Every time
Male	45	Consultan	0 to 5 year	5	3	2	Very often
Male	42	Consultan	0 to 5 year	12	11	1	Every time
Male	44	Consultan	6 to 10 yea	20	12	3	Every time
Male	45	Consultan	6 to 10 yea	6	4	999	Every time
Male	50	Consultan	999	999	999	999	
Male	54	Consultan	999	999	999	999	
Male	59	Consultan	11 to 15 ye	8	6	2	Every time
Male	40	Consultan	0 to 5 year	28	24	4	Every time
Male	54	Consultan	16 to 20 ye	5	0	0	Every time
Male	53	Consultan	16 to 20 ye	60	35	25	Every time
Male	61	Consultan	over 20 ye	15	10	2	
Male	61	Consultan	over 20 ye	10	7	3	Every time
Male	55	Consultan	16 to 20 ye	0	999	999	
Male	43	Consultan	6 to 10 yea	10	9	1	Every time
Male	43	Consultan	6 to 10 yea	0	0	0	Not discus
Male	41	Consultan	0 to 5 year	2	0	0	Every time
Male	55	Consultan	999	999	999	999	
Male	64	Consultan	over 20 ye	20	10	2	Every time
Male	42	Consultan	6 to 10 yea	30	20	3	Very often
Male	52	Consultan	11 to 15 ye	75	48	4	Every time
Male	46	Consultan	6 to 10 yea	6	6	999	Every time
Male	60	Consultan	over 20 ye	0	0	0	Every time
Female	47	Consultan	16 to 20 ye	0	0	0	Not discus
Male	43	Consultan	0 to 5 year	0	0	0	
Male	41	Consultan	0 to 5 year	15	15	0	Every time
Male	53	Consultan	11 to 15 ye	0	0	0	
Male	47	Consultan	11 to 15 ye	20	15	5	Every time
Male	39	Consultan	0 to 5 year	14	10	4	Every time
Female	48	Consultan	11 to 15 ye	15	15	999	Every time
Female	48	Consultan	6 to 10 yea	0	0	0	
Male	57	Consultan	over 20 ye	0	0	0	Not discus
Male	55	Consultan	999	999	999	999	
Male	37	Consultan	0 to 5 year	5	5	0	Every time
Male	42	Consultan	0 to 5 year	10	8	0	Every time
Female	48	Consultan	6 to 10 yea	0	0	0	
Male	60	Consultan	over 20 ye	6	6	0	Every time
Male	52	Consultan	11 to 15 ye	0	0	0	
Male	45	Consultan	6 to 10 yea	10	0	0	Every time
Male	46	Consultan	6 to 10 yea	0	0	0	Not discus
Male	62	Consultan	999	999	999	999	
Male	55	Consultan	16 to 20 ye	0	0	0	Not discus
Male	52	Consultan	16 to 20 ye	30	26	4	Every time
Male	41	Consultan	0 to 5 year	5	1	4	Every time
Male	41	Consultan	6 to 10 yea	2	0	0	
Male	38	Consultan	0 to 5 year	0	0	0	
Male	47	Consultan	6 to 10 yea	21	18	3	Every time
Female	44	Consultan	6 to 10 yea	0	0	0	
Male	42	Consultan	0 to 5 year	20	15	0	Every time
Male	57	Consultan	6 to 10 yea	4	0	0	Every time
Male	50	Consultan	16 to 20 ye	18	15	3	Every time
Male	40	Consultan	0 to 5 year	10	9	1	Every time
Male	61	Consultan	over 20 ye	20	14	2	
Male	49	Consultan	11 to 15 ye	10	8	2	Every time
Male	41	Consultan	999	999	999	999	
Male	44	Consultan	6 to 10 yea	8	4	0	Not very o
Male	57	Consultan	over 20 ye	55	31	9	Very often
Female	43	Consultan	6 to 10 yea	0	0	0	
Female	42	Consultan	0 to 5 year	0	0	0	Not discus
Male	51	Consultan	16 to 20 ye	8	8	0	Every time
Male	38	Consultan	0 to 5 year	40	25	10	Every time
Male	48	Consultan	11 to 15 ye	15	13	2	Every time
Male	45	Consultan	6 to 10 yea	0	0	0	
Male	49	Consultan	6 to 10 yea	5	0	0	
Male	44	Consultan	6 to 10 yea	20	10	5	Very often
Male	37	Consultan	0 to 5 year	30	25	0	Every time
Male	45	Consultan	6 to 10 yea	30	8	2	Every time
Male	55	Consultan	11 to 15 ye	10	9	1	Every time
Male	48	Consultan	11 to 15 ye	6	5	1	Every time
Male	40	Consultan	0 to 5 year	30	28	2	Every time
Female	40	Consultan	0 to 5 year	10	8	0	Very often
Male	55	Consultan	16 to 20 ye	5	0	0	
Male	43	Consultan	0 to 5 year	20	15	0	Sometime
Male	56	Consultan	16 to 20 ye	0	0	0	
Male	55	Consultan	16 to 20 ye	10	8	2	Very often
Male	38	Consultan	0 to 5 year	15	5	0	Every time
Male	45	Consultan	0 to 5 year	10	4	6	Every time
Male	51	Consultan	11 to 15 ye	30	24	6	Very often
Male	57	Consultan	16 to 20 ye	5	0	0	
Male	37	Consultan	0 to 5 year	0	0	1	Very often
Male	49	Consultan	11 to 15 ye	5	3	2	Very often

Dup

Non-rep

Appendix 18 – Clinician Questionnaire Survey Raw Results (Nurses)