

West of Scotland Cancer Network

**Urological Cancer
Managed Clinical Network**



Audit Report

Bladder Cancer Quality Performance Indicators

Clinical Audit Data: 01 April 2023 to 31 March 2024

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Bladder Cancer Quality Performance Indicators: Data Overview

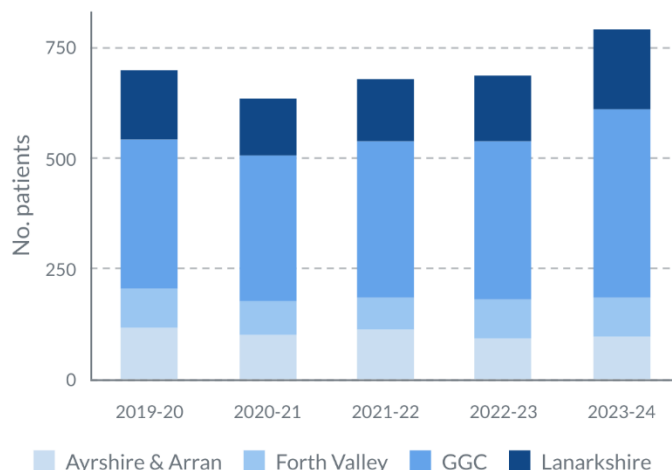
Patients diagnosed April 2023 - March 2024

Number of patients diagnosed **792**
 Non-muscle invasive bladder cancer **545**
 Muscle invasive bladder cancer **247**

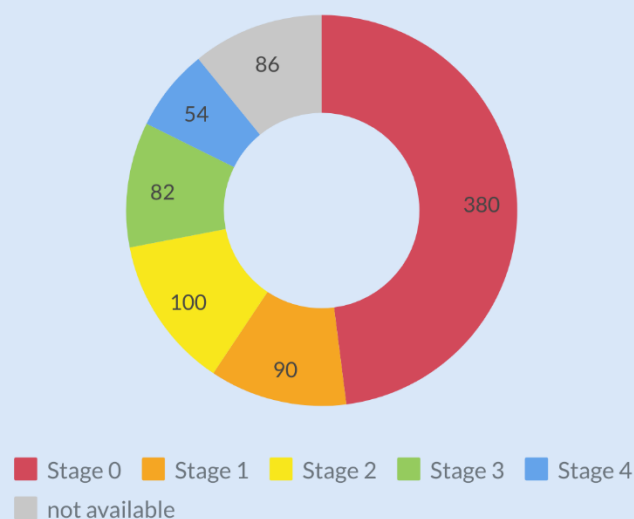
Muscle Invasive Bladder Cancer Survival
 1 Year age standardised net survival **70%**
 5 Year age standardised net survival **48%**

* patients diagnosed 2015-2019
www.publichealthscotland.scot/publications/cancer-survival-statistics/

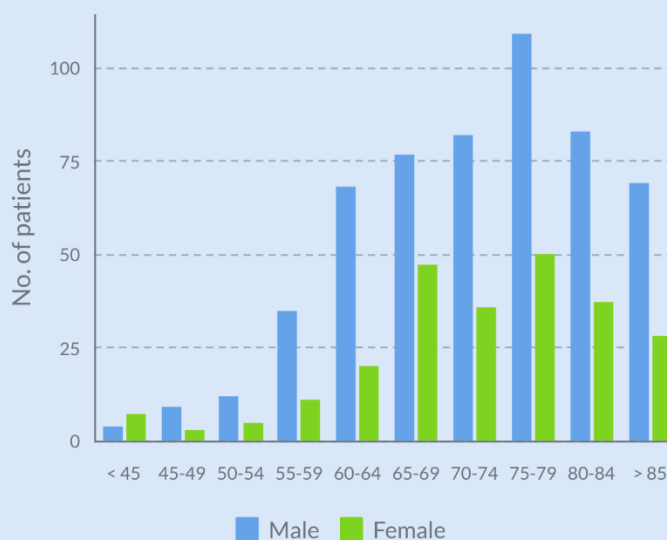
Where are patients diagnosed



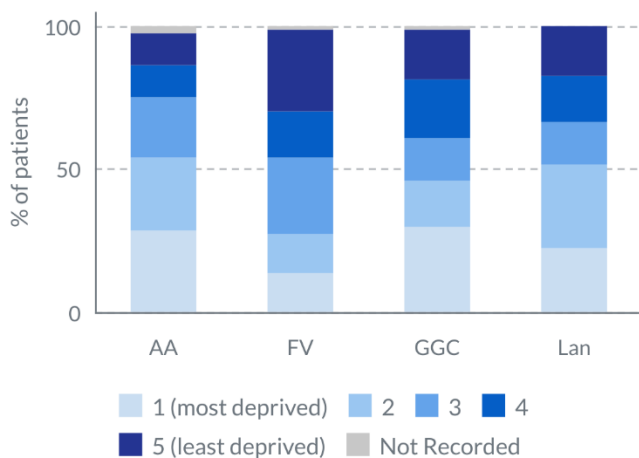
Stage at Presentation



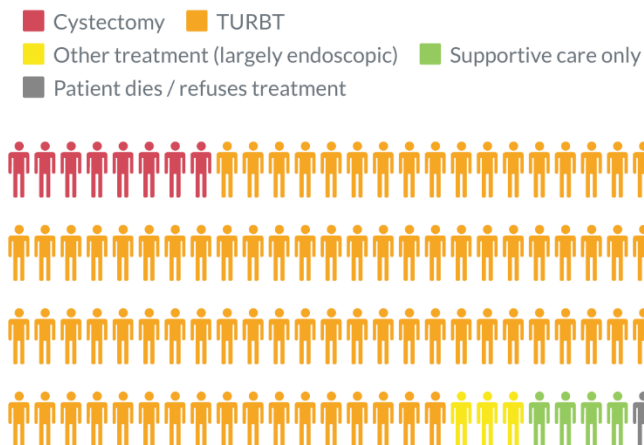
Age of patients



Deprivation Index of Patients



Treatment



Executive Summary

This report contains an assessment of the performance of West of Scotland (WoS) urological cancer services using clinical audit data relating to patients diagnosed with bladder cancer in the twelve months between 01 April 2023 and 31 March 2024.

Cancer audit has underpinned much of the regional development and service improvement work of the MCN and the regular reporting of activity and performance have been fundamental in assuring the quality of care delivered across the region. With the development of QPIs, this has now become a national programme to drive continuous improvement and ensure equity of care for patients across Scotland. Note that QPI measures that have been met by all NHS Boards are included in the summary results table but not within the body of the report.

The results presented within this report illustrate that some of the QPI targets remain challenging, with room for further service improvement which is evidenced in the actions below. The main challenge is ensuring timely treatment in the face of pressures on theatre capacity and oncology resource; these pressures will be escalated via existing QPI governance processes. It is encouraging that targets relating to discussion at MDT (QPI 1) were consistently met by all Boards in this reporting period. In addition, this second year of reporting of the revised QPI 10 will act as a benchmark for measuring the introduction of the new radiosensitiser service at the Beatson West of Scotland Cancer Centre.

There are a number of actions required as a consequence of this assessment of performance against the agreed criteria.

Actions required:

- **NHS Ayrshire & Arran Cancer Service Manager to work with Urology Services to ensure that a TURBT proforma is fully completed for all TURBT patients.**
- **MCN to lead an audit into the quality of TURBT procedures undertaken within WoSCAN with the aim of identifying any surgical training required or other areas for improvement and agree specific actions to improve performance.**
- **MCN to continue to review performance against QPI 3 regionally and nationally and take action if there is no improvement in the next reporting period.**
- **MCN to monitor improvements to lymph node yield within NHS Ayrshire & Arran until performance aligns with other NHS Boards.**
- **NHS Boards to provide patient level review for all patients having less than 10 nodes resected and pathologically examined in future years of reporting.**
- **MCN to escalate increasing resourcing constraints in cystectomy and radiotherapy services, delays to treatment and variations in treatment modality to the Regional Cancer Oversight Group (RCOG).**
- **MCN to highlight the low volumes of cystectomies undertaken by some surgeons / centres to RCOG.**

A summary of actions has been included within the Action Plan Report accompanying this report and templates have been provided to Boards. **Completed Action Plans should be returned to WoSCAN in a timely manner to facilitate further scrutiny at a regional level and to allow co-ordinated regional action where appropriate.**

Summary of Bladder QPI results

Key	
	Target met
	Target not met
-	< 5 patients in denominator
	No comparable data for previous years

QPI	Target	Year	AA	FV	GGC	LAN	WoSCAN
QPI 1: Multi-Disciplinary Team Meeting Discussion: Proportion of patients with bladder cancer who are discussed at MDT meeting before definitive treatment <i>(i) MIBC</i>	95%	2023 - 24	97% (29/30)	100% (36/36)	99% (121/122)	100% (59/59)	99% (245/247)
		2022 - 23	97%	100%	98%	100%	99%
		2021 - 22	100%	100%	96%	100%	98%
<i>(ii) NMIBC</i>	95%	2023 - 24	98% (62/63)	98% (42/43)	100% (289/290)	99% (113/114)	99% (506/510)
		2022 - 23	100%	100%	99%	100%	100%
		2021 - 22	100%	97%	99%	100%	99%
QPI 2: Quality of Transurethral Resection of Bladder Tumour: Proportion of patients with bladder cancer who undergo good quality TURBT* <i>(i) Use of a bladder diagram / detailed description with documentation of tumour location, size, number and appearance at initial resection</i>	95%	2023 - 24	70% (53/76)	97% (62/64)	96% (343/359)	99% (164/165)	94% (622/664)
		2022 - 23	81%	96%	95%	95%	93%
		2021 - 22	96%	92%	92%	95%	93%
<i>(ii) Whether the resection is complete or not at initial resection</i>	95%	2023 - 24	99% (70/71)	98% (60/61)	99% (329/333)	100% (158/158)	99% (617/623)
		2022 - 23	96%	99%	99%	99%	98%
		2021 - 22	99%	98%	98%	97%	98%
<i>(iii) Whether detrusor muscle included in the specimen at initial resection</i>	90%	2023 - 24	43% (12/28)	91% (21/23)	62% (76/122)	71% (40/56)	65% (149/229)
		2022 - 23	78%	97%	73%	86%	80%
		2021 - 22	73%	91%	70%	76%	74%

QPI	Target	Year	AA	FV	GGC	LAN	WoSCAN
QPI 3: Mitomycin C Following Transurethral Resection of Bladder Tumour: Proportion of patients with low grade Ta NMIBC who undergo TURBT who receive a single instillation of mitomycin C (or other alternative chemotherapy agent) within 24 hours of resection*	80%	2023 - 24	56% (20/36)	76% (13/17)	73% (120/165)	68% (38/56)	70% (191/274)
		2022 - 23	68%	73%	72%	61%	69%
		2021 - 22					
QPI 4: Early Re-Transurethral Resection of Bladder Tumour: <i>(i) Proportion of patients with T1 (all grades) or select high grade Ta NMIBC who have undergone TURBT who have a second TURBT or early cystoscopy (± biopsy) within 6 weeks (42 days) of initial resection*</i>	80%	2023 - 24	11% (2/18)	11% (2/19)	32% (35/111)	25% (12/48)	26% (51/196)
		2022 - 23	6%	17%	35%	26%	27%
		2021 - 22	5%	29%	44%	13%	32%
<i>(ii) Proportion of patients with high grade NMIBC who have undergone TURBT where detrusor muscle is absent from specimen who have a second TURBT or early cystoscopy (± biopsy) within 6 weeks (42 days) of initial resection*</i>	80%	2023 - 24	7% (1/14)	-	33% (15/46)	11% (2/18)	24% (19/80)
		2022 - 23	-	-	40%	33%	35%
		2021 - 22	11%	67%	34%	44%	34%
<i>(iii) Number of patients with NMIBC who have undergone TURBT where initial resection is incomplete who have a second TURBT or early cystoscopy (± biopsy) within 6 weeks (42 days) of initial resection*</i>	80%	2023 - 24	17% (1/6)	-	25% (7/28)	38% (6/16)	28% (14/50)
		2022 - 23	0%	-	19%	20%	14%
		2021 - 22	0%	-	42%	30%	35%
QPI 6: Lymph Node Yield: Proportion of patients with bladder cancer who undergo primary radical cystectomy where ≥ 10 lymph nodes are resected and pathologically examined, and at least level 2 pelvic lymph node dissection (to the middle of the common iliac artery or level of the crossing of the ureter) has been undertaken*	95%	2023 - 24	56% (5/9)	-	81% (25/31)	94% (17/18)	81% (47/58)
		2022 - 23	20%	-	91%	91%	80%
		2021 - 22	47%	-	89%	100%	80%
QPI 7: Time To Treatment: Proportion of patients with MIBC who commence radical treatment within 6 weeks of their diagnosis of MIBC, or within 8 weeks of completing treatment where patients are undergoing neoadjuvant chemotherapy <i>(i) Radical treatment (cystectomy or radiotherapy)</i>	90%	2023 - 24	0% (0/5)	0% (0/8)	16% (5/31)	8% (1/13)	11% (6/57)
		2022 - 23	0%	0%	35%	33%	24%
		2021 - 22					

QPI	Target	Year	AA	FV	GGC	LAN	WoSCAN
<i>(ii) Neoadjuvant chemotherapy</i>	90%	2023 - 24	-	-	38% (5/13)	87% (13/15)	68% (23/34)
		2022 - 23	-	-	18%	75%	61%
		2021 - 22					
QPI 8: Volume of Cases per Surgeon: Number of radical cystectomy procedures performed by a surgeon over a 1 year period (SMR01 data)* <i>By Surgeon</i>	Min 10 per year	2023 - 24	2 not met	-	1 met 6 not met	2 met 2 not met	3 met 10 not met
		2022 - 23	1 met 1 not met	-	2 met 5 not met	1 met 2 not met	4 met 8 not met
		2021 - 22	1 met 1 not met	-	2 met 3 not met	3 met	6 met 4 not met
<i>By Surgical Centre</i>	Min 20 per year	2023 - 24	5	-	47	31	2 met 2 not met
		2022 - 23	16	-	52	21	2 met 1 not met
		2021 - 22					
QPI 9: Oncological Discussion: Proportion of patients with muscle invasive bladder cancer who had radical surgery who met with an oncologist prior to radical cystectomy	60%	2023 - 24	60% (3/5)	-	71% (15/21)	100% (10/10)	77% (30/39)
		2022 - 23	29%	-	48%	67%	52%
		2021 - 22	33%	-	87%	56%	71%
QPI 10: Radical Radiotherapy Treatment with a Concomitant Radiosensitiser: Proportion of patients with transitional cell carcinoma of the bladder (T2-T4) undergoing radical radiotherapy receiving a concomitant radiosensitiser.	50%	2023 - 24	-	22% (2/9)	23% (5/22)	0% (0/16)	14% (7/49)
		2022 - 23	-	11%	0%	0%	6%
		2021 - 22					
QPI 11: 30/90 Day Mortality after Treatment for Bladder Cancer: Proportion of patients with bladder cancer who die within 30 days of treatment with curative intent (radical cystectomy or radiotherapy) for bladder cancer <i>(i) 30 Day Mortality - Surgery*</i>	<3%	2023 - 24	10% (1/10)	-	0% (0/31)	0% (0/18)	2% (1/59)
		2022 - 23	10%	-	3%	0%	3%
		2021 - 22	0%	-	4%	0%	2%

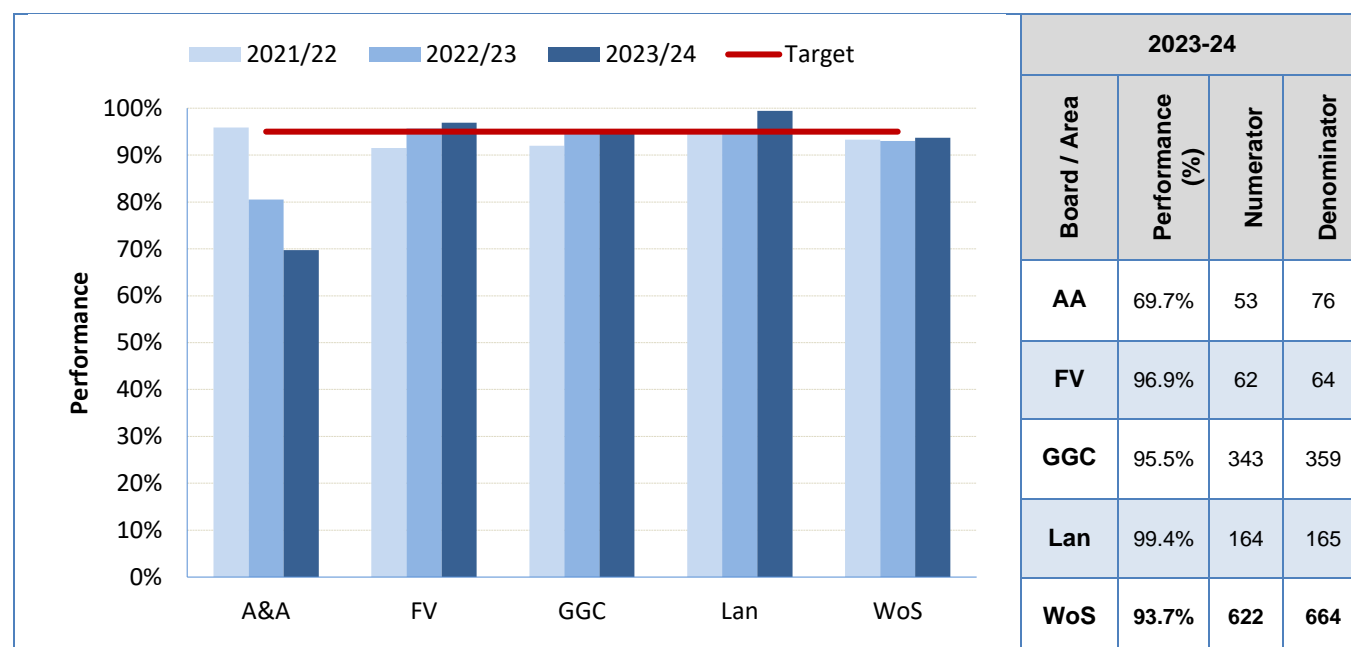
QPI	Target	Year	AA	FV	GGC	LAN	WoSCAN
<i>(i) 30 Day Mortality - Radiotherapy</i>	<3%	2023 - 24	-	0% (0/9)	4% (1/23)	6% (1/18)	6% (3/52)
		2022 - 23	-	0%	0%	0%	0%
		2021 - 22	0%	0%	0%	0%	0%
<i>(ii) 90 Day Mortality - Surgery*</i>	<5%	2023 - 24	10% (1/10)	-	0% (0/28)	6% (1/18)	4% (2/56)
		2022 - 23	10%	-	6%	4%	6%
		2021 - 22	7%	-	8%	0%	6%
<i>(iii) QPI 11 – 90 Day Mortality - Radiotherapy</i>	<5%	2023 - 24	-	0% (0/9)	14% (3/22)	6% (1/18)	10% (5/51)
		2022 - 23	-	0%	6%	22%	7%
		2021 - 22	0%	0%	0%	0%	0%
QPI 13: Early Recurrence in Patients (NMIBC): Proportion of patients who have undergone TURBT with low grade pTa cancer where recurrence is found at first follow up cystoscopy, or with pT1 who have residual cancer or pathological MIBC (pT2) at reTURBT. <i>(i) Radical treatment (cystectomy or radiotherapy)</i>	<10%	2023 - 24	6% (2/33)	0% (0/17)	8% (12/149)	13% (7/52)	8% (21/251)
		2022 - 23	20%	0%	8%	9%	9%
		2021 - 22					
<i>(ii) Residual cancer at re-TURBT in patients with pT1</i>	<20%	2023 - 24	-	-	27% (14/51)	20% (1/5)	29% (18/62)
		2022 - 23	-	33%	19%	43%	24%
		2021 - 22					
<i>(iii) Pathological MIBC (pT2) at re-TURBT in patients with pT1</i>	<1%	2023 - 24	-	0% (0/7)	6% (3/54)	0% (0/6)	4% (3/71)
		2022 - 23	-	11%	0%	11%	3%
		2021 - 22					

* QPIs analysed by NHS Board of Surgery

QPI 2: Quality of Transurethral Resection of Bladder Tumour Recording

(i) Use of a bladder diagram with documentation of tumour location, size, number and appearance

QPI 2 Title:	Transurethral resection of bladder tumour (TURBT) procedures undertaken should be of good quality
Specification (i):	Use of a bladder diagram / detailed description with documentation of tumour location, size, number and appearance
Numerator (i):	Number of patients with bladder cancer who undergo TURBT where a bladder diagram / detailed description with documentation of tumour location, size, number and appearance has been used at initial resection
Denominator (i):	All patients with bladder cancer who undergo TURBT
Exclusions:	Patients undergoing palliative resection
Target:	95%



Within NHS Ayrshire & Arran the 22 patients that did not meet this QPI had hand written operation notes which did not contain the full suite of information required. In 2024, the Board agreed that a TURBT proforma would be routinely used for all TURBT patients to ensure complete recording of the procedure; there is a need for the Board to ensure that this is implemented.

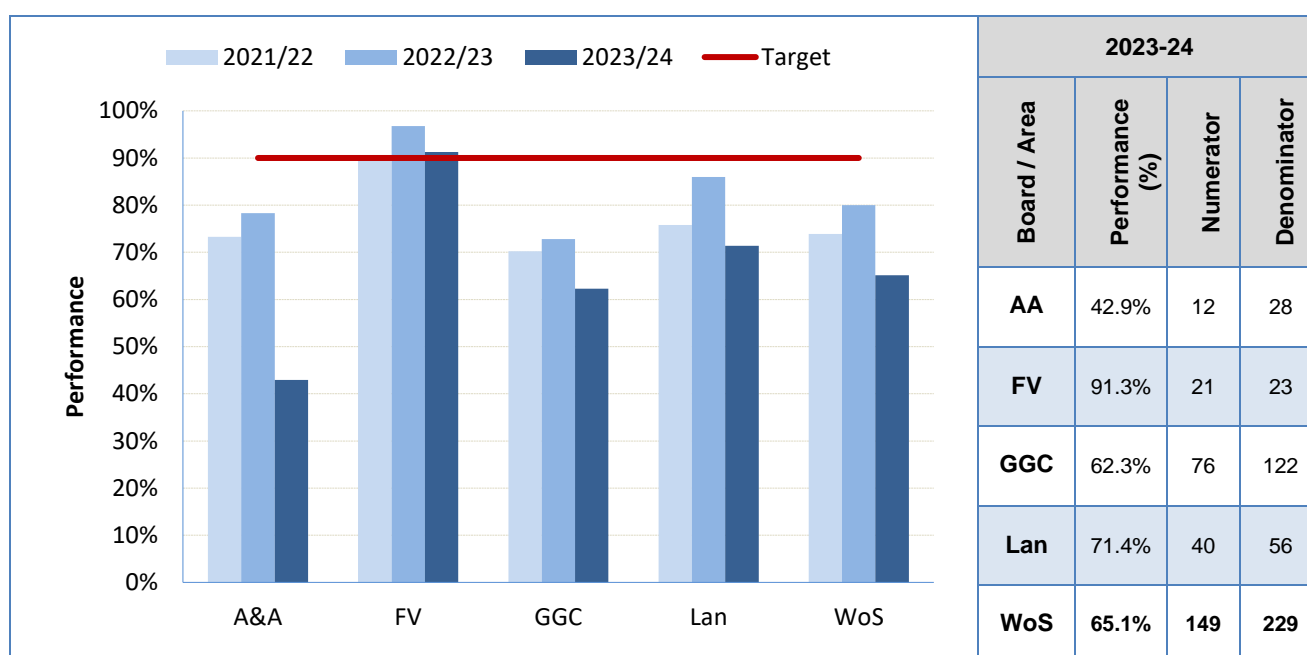
Action Required:

- NHS Ayrshire & Arran Cancer Service Manager to work with Urology Services to ensure that a TURBT proforma is fully completed for all TURBT patients.

(ii) Documented whether complete resection or not –specification met by all NHS Boards

(iii) Detrusor muscle included in the specimen at initial resection

QPI 2 Title:	Transurethral resection of bladder tumour (TURBT) procedures undertaken should be of good quality
Specification (iii):	Whether detrusor muscle included in the specimen
Numerator (iii):	Number of patients with high grade NMIBC who undergo TURBT where detrusor muscle is included in the specimen at initial resection
Denominator (iii):	All patients with high grade NMIBC who undergo TURBT
Exclusions:	<ul style="list-style-type: none"> • Patients undergoing palliative resection • Patients with very small tumours ($\leq 5\text{mm}$) • Patients with bladder diverticular tumours
Target:	90%



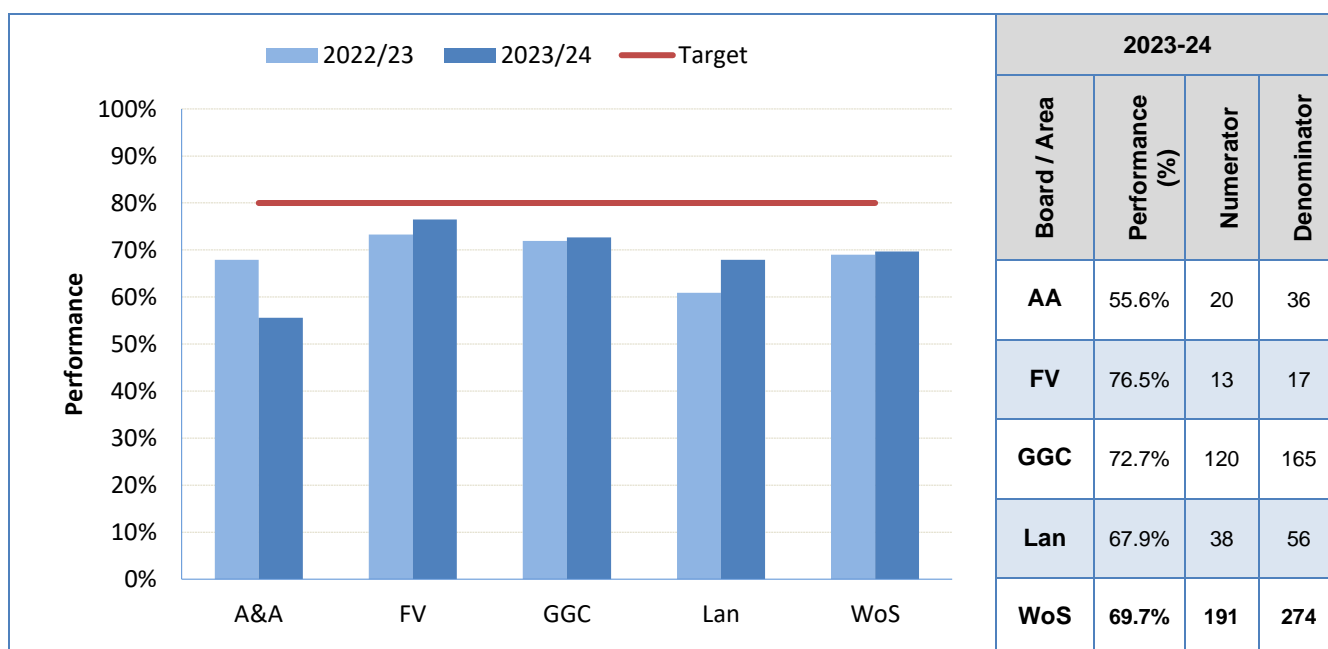
This is a challenging QPI. While aggressive resection is not always clinically appropriate for this cohort of patients, attempts to sample detrusor muscle at initial resection are important. The QPI target has been met by NHS Forth Valley over a number of years suggesting that the target is achievable.

Action Required:

- **MCN to lead an audit into the quality of TURBT procedures undertaken within WoSCAN with the aim of identifying any surgical training required or other areas for improvement and agree specific actions to improve performance.**

QPI 3: Mitomycin C Following Transurethral Resection of Bladder Tumour (TURBT)

QPI 3 Title:	Patients with low grade Ta non muscle invasive bladder cancer (NMIBC) who undergo TURBT should receive a single instillation of mitomycin C (or other alternative chemotherapy agent) within 24 hours of resection, unless contraindicated
Numerator:	Number of patients with low grade Ta NMIBC who undergo TURBT who receive a single instillation of mitomycin C (or other alternative chemotherapy agent) within 1 day of initial TURBT
Denominator:	All patients with low grade Ta NMIBC who undergo initial TURBT
Exclusions:	No exclusions
Target:	80%



All NHS Boards noted that the majority of patients not meeting the QPI did not have mitomycin C due to having a perforation or thin-walled bladder. In such cases it was considered to be inappropriate for patients to have mitomycin C due to the risk of extravasation (chemotherapy agent leaking to surrounding tissue). In addition small numbers of patients were not thought to have NMIBC and therefore did not receive mitomycin C; these patients were either clinically assessed as having MIBC or bladder cancer was not suspected.

Following review of performance against this measure NHS Forth Valley, NHSGGC and NHS Lanarkshire considered that it was clinically appropriate to withhold mitomycin C for the majority of patients not meeting this QPI; as such no action was required. In March 2025 clinicians in NHS Ayrshire & Arran agreed that mitomycin would be used for all cases of NMIBC going forwards.

Action Required:

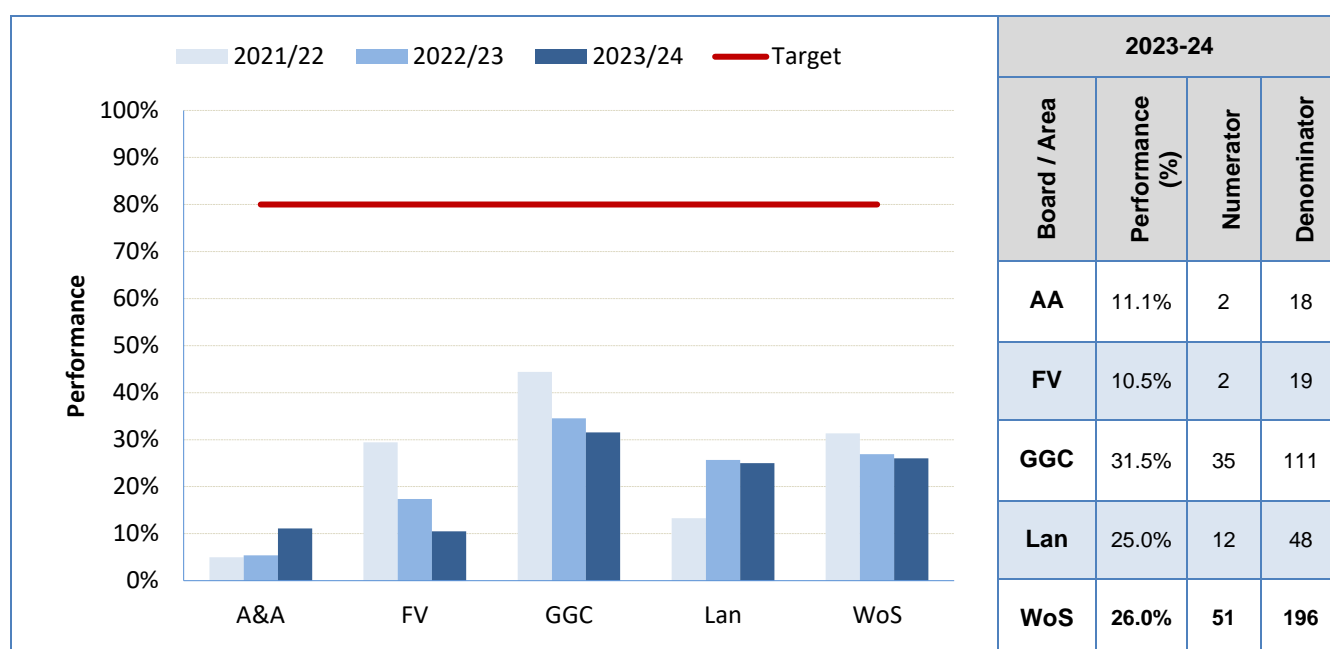
- **MCN to continue to review performance against QPI 3 regionally and nationally and take action if there is no improvement in the next reporting period.**

QPI 4: Early Re-Transurethral Resection of Bladder Tumour (TURBT)

(i) T1 (all grades) or select high grade Ta* NMIBC

QPI 4 Title:	A second resection or early cystoscopy (\pm biopsy) should be carried out within 6 weeks of initial TURBT in patients with high grade and/ or T1 non muscle invasive bladder cancer (NMIBC), when detrusor muscle is absent or when initial resection is incomplete
Specification (i):	T1 (all grades) or select high grade Ta* NMIBC
Numerator (i):	Number of patients with T1 (all grades) or select high grade Ta NMIBC who have undergone TURBT who have a second TURBT or early cystoscopy (\pm biopsy) within 6 weeks (42 days) of initial resection
Denominator (i):	All patients with T1 (all grades) or select high grade Ta NMIBC who have undergone TURBT
Exclusions:	<ul style="list-style-type: none"> Patients where TURBT has been carried out for palliation Patients who have undergone early cystectomy Patients with confirmed metastatic disease
Target:	80%

*High grade Ta which are multifocal (more than 1) or large (>3cm)



Further analysis of results indicates that the vast majority of patients not meeting this measure did have a re-TURBT or early cystoscopy but this was outwith the 6 week timescale. Some patients did not have a repeat procedure because it was not clinically appropriate.

Theatre capacity issues were identified as the main reason for the delay. In addition, some intermediate risk patients had a course of intravesical therapy prior to early cystoscopy, delaying the repeat procedure.

The recent Formal Review of Bladder Cancer QPIs has resulted in amendment to the definition of this specification from the next reporting cycle. The measure will be amended to include patients with pT1 disease who had a complete TURBT only. In addition, the timescale for repeat TURBT or early cystoscopy has been extended from 6 weeks to 3 months to take into account the use of intravesical therapy.

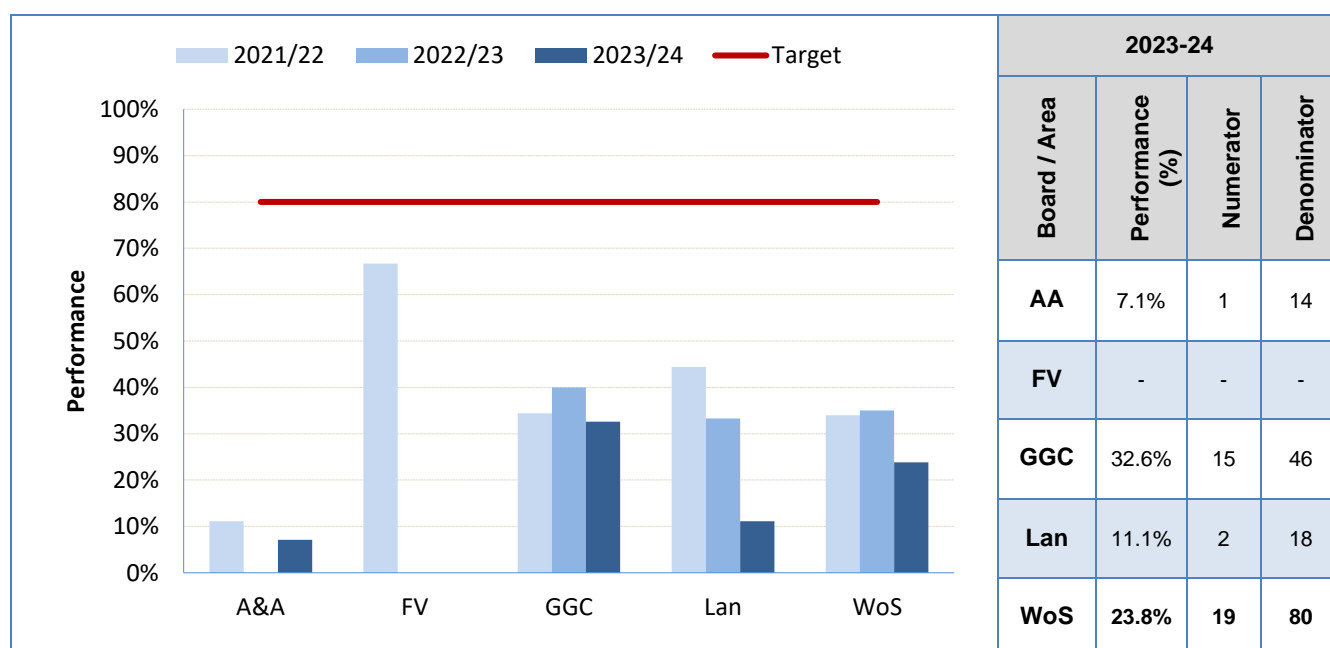
Improvement actions already identified within individual NHS Boards are as follows:

- NHSGGC have recently implemented a board wide pooled theatre list for all TURBT patients for both initial and re-resection. This is expected to result in an improvement in performance against this measure in future years.
- Within NHS Lanarkshire changes to the scheduling of re-TURBT were implemented during 2022-2023; patients requiring re-resection are now highlighted to the MDT, the 6-week target date calculated and given to the theatre scheduling team to ensure timely booking of re-TURBT.
- In NHS Ayrshire & Arran delays in pathology reporting had made the 6 week target challenging, but following new appointments this is anticipated to improve.

Performance against this measure will be reviewed against the revised QPI specification in the next reporting cycle, which should help to identify where further work on pathways to repeat TURBT and early cystoscopy would be beneficial.

(ii) High grade NMIBC where detrusor muscle absent from specimen

QPI 4 Title:	A second resection or early cystoscopy (\pm biopsy) should be carried out within 6 weeks of initial TURBT in patients with high grade and/ or T1 non muscle invasive bladder cancer (NMIBC), when detrusor muscle is absent or when initial resection is incomplete
Specification (ii):	High grade NMIBC where detrusor muscle is absent from specimen
Numerator (ii):	Number of patients with high grade NMIBC who have undergone TURBT where detrusor muscle is absent from specimen who have a second TURBT or early cystoscopy (\pm biopsy) within 6 weeks (42 days) of initial resection
Denominator (ii):	All patients with high grade NMIBC who have undergone TURBT where detrusor muscle is absent from specimen
Exclusions:	<ul style="list-style-type: none"> • Patients where TURBT has been carried out for palliation • Patients who have undergone early cystectomy • Patients with confirmed metastatic disease
Target:	80%



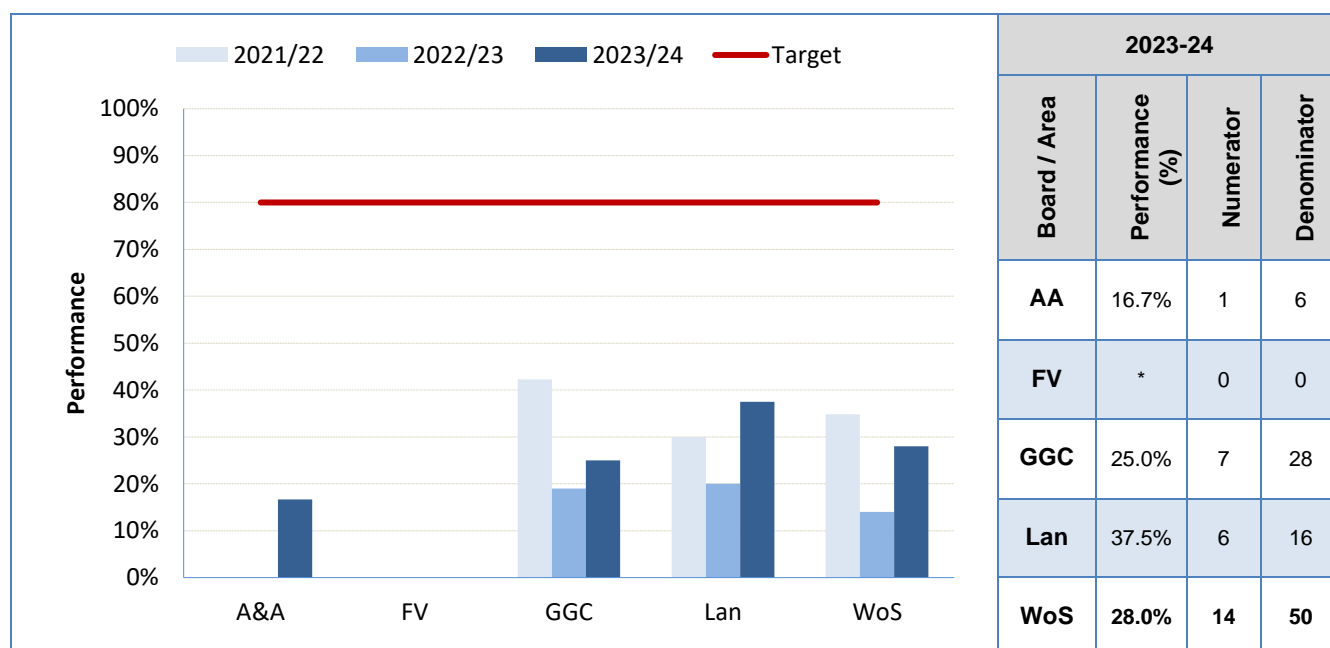
(-) Data is not shown; denominator less than 5. (*) denotes a zero.

As for specification (i), the majority of patients not meeting this measure did have re-TURBT or early cystoscopy; but outwith the 6 week timescale.

This specification has been archived at the recent Formal Review of Bladder Cancer QPIs and will not be reported in future years. Patients with high grade T1 NMIBC will undergo a re-TURBT irrespective of whether detrusor muscle is present in the specimen; these patients are included within specification (i).

(iii) NMIBC where initial resection is incomplete

QPI 4 Title:	A second resection or early cystoscopy (\pm biopsy) should be carried out within 6 weeks of initial TURBT in patients with high grade and/ or T1 non muscle invasive bladder cancer (NMIBC), when detrusor muscle is absent or when initial resection is incomplete
Specification (iii):	NMIBC where initial resection is incomplete
Numerator (iii):	Number of patients with NMIBC who have undergone TURBT where initial resection is incomplete who have a second TURBT or early cystoscopy (\pm biopsy) within 6 weeks (42 days) of initial resection
Denominator (iii):	All patients with NMIBC who have undergone TURBT where initial resection is incomplete.
Exclusions:	<ul style="list-style-type: none"> • Patients where TURBT has been carried out for palliation • Patients who have undergone early cystectomy • Patients with confirmed metastatic disease
Target:	80%



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

Performance against this specification is considerably below the 80% target, however 90% of patients did have re-TURBT or early cystoscopy at some point, 60% within 12 weeks of initial resection.

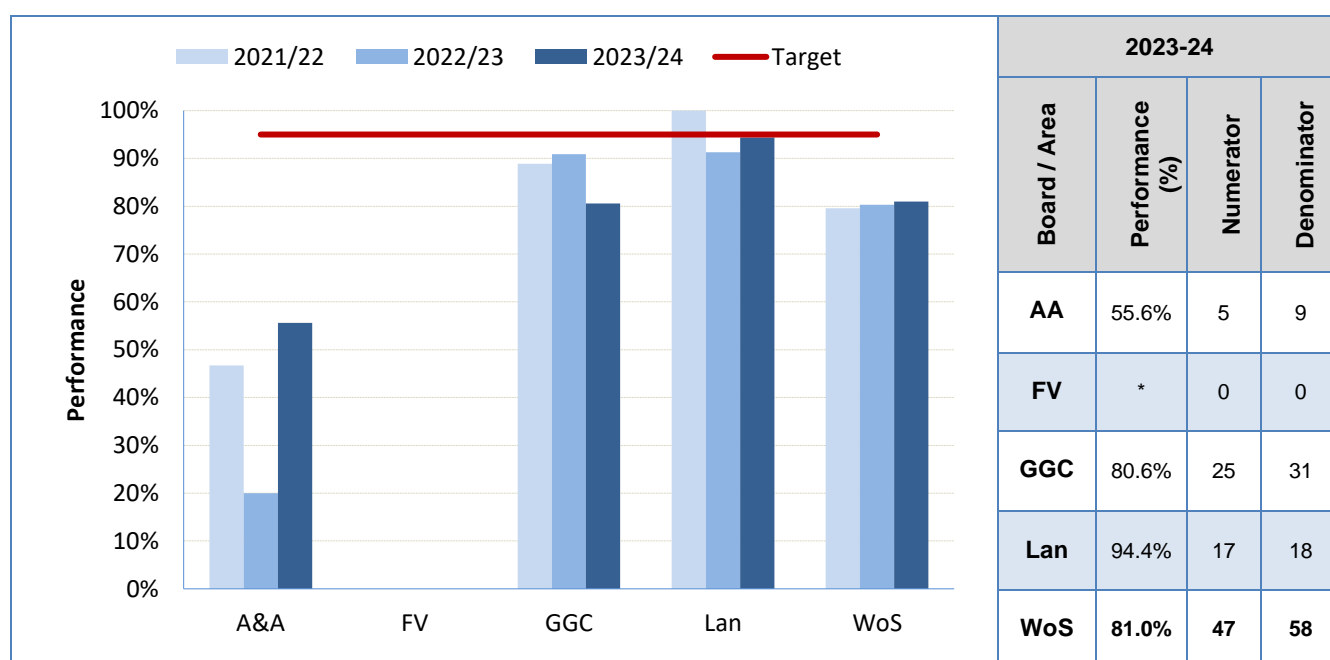
Five patients did not have re-TURBT or early cystoscopy. Review of these cases showed that it was not clinically appropriate for patients to have a second procedure in view of their co-morbidities or disease progression.

A further 31 patients had re-TURBT or cystoscopy more than 6 weeks after their initial resection, the reasons outlined for delays were the same as those outlined in Specification (i) above.

This specification was not changed at the Formal Review and therefore challenges meeting the tight timelines required are likely to be an ongoing issue. Actions to address more timely re-TURBT and early cystoscopy being undertaken by NHS Boards are outlined under specification (i). This cohort of patients may need to be prioritised for repeat procedures going forward.

QPI 6: Lymph Node Yield

QPI 6 Title:	For patients undergoing primary radical cystectomy for bladder cancer the number and extent of lymph nodes examined should be maximised
Numerator:	Number of patients with bladder cancer who undergo primary radical cystectomy where ≥ 10 lymph nodes are resected and pathologically examined, and at least level 2 pelvic lymph node dissection (i.e. to the middle of the common iliac artery or level of the crossing of the ureter) has been undertaken
Denominator:	All patients with bladder cancer who undergo primary radical cystectomy
Exclusions:	<ul style="list-style-type: none"> Patients undergoing salvage cystectomy
Target:	95%



Eleven patients had less than 10 lymph nodes examined following cystectomy; many of these missed the target by one or two nodes. The anatomy of some patients means that it is not always possible to remove 10 or more nodes; for example one patient had previously had pelvic lymph node dissection. In addition, for one patient not meeting the QPI there were concerns about their stability under anaesthetic. NHS Ayrshire & Arran have had lower performance against this measure over a number of years however staffing changes are anticipated to result in improvement in performance against this measure in future.

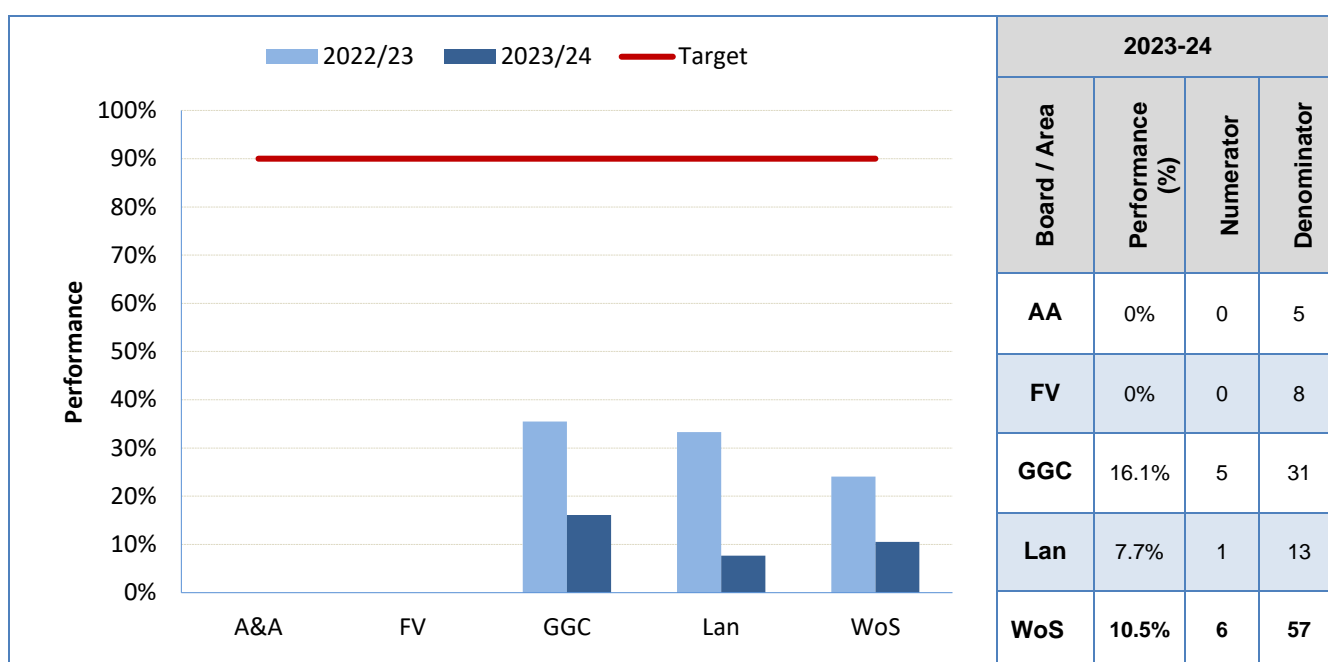
Action Required:

- MCN to monitor improvements to lymph node yield within NHS Ayrshire & Arran until performance aligns with other NHS Boards.
- NHS Boards to provide patient level review for all patients having less than 10 nodes resected and pathologically examined in future years of reporting.

QPI 7: Time to Treatment

(i) Radical treatment (cystectomy or radiotherapy)

QPI 7 Title:	Patients with muscle invasive bladder cancer (MIBC) undergoing treatment with radical intent should commence treatment as soon as possible
Specification (i):	Radical treatment (cystectomy or radiotherapy)
Numerator (i):	Number of patients with MIBC who undergo radical cystectomy or radiotherapy only within 6 weeks of diagnosis of MIBC
Denominator (i):	All patients with MIBC undergoing radical cystectomy or radiotherapy only
Exclusions:	No exclusions
Target:	90%



The timescale within which treatment is required for this QPI measure was decreased from 3 months to 6 weeks for patients diagnosed from 2022 and results highlight the challenges that NHS Boards in the West of Scotland have had with this more ambitious measure.

Seventeen patients included within this QPI had cystectomy. Of these 4 (24%) had treatment within 6 weeks of diagnosis with MIBC and 9 (76%) within 12 weeks. For some patients surgery was delayed to undertake further investigations or anaesthetic review.

Forty patients had radiotherapy. Performance in this group of patients was lower; only 2 patients (5%) had treatment within 6 weeks of diagnosis of MIBC and 22 (70%) within 12 weeks. NHS Lanarkshire reported that the main delays were between referral to oncology services and being seen by an oncologist, which is directly linked to a shortage in oncology resource within the Board.

NHS Ayrshire & Arran noted that a new pathway from referral to definitive treatment is being considered, although it has yet to be implemented.

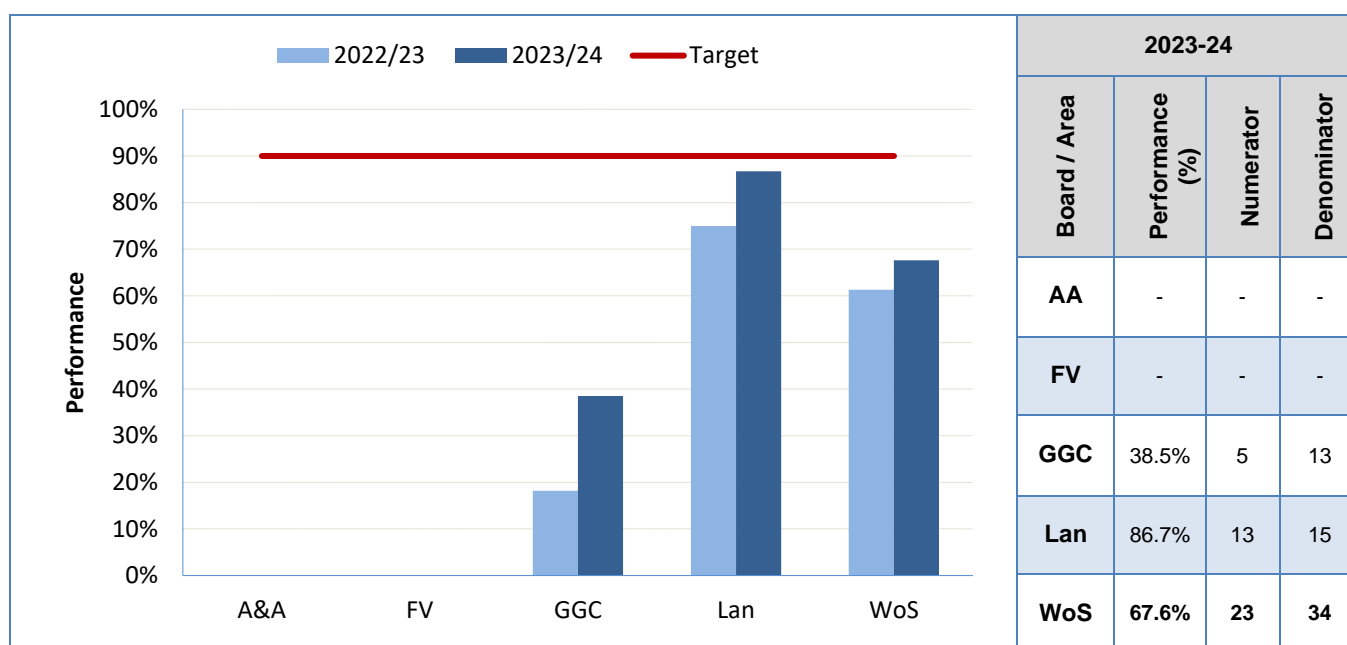
Results for 2023-24 were poorer than in 2022-23 and highlight concerning capacity issues in both surgery and radiotherapy services. In addition, there was some variation in the proportion of patients included in this specification having cystectomy and radiotherapy between NHS Boards, with a higher proportion of patients in NHS Ayrshire & Arran having cystectomy and higher proportions in NHS Forth Valley and NHS Lanarkshire having radiotherapy. While numbers of patients included in the QPI were small, these trends were maintained when data was combined over multiple years.

Action required:

- MCN to escalate increasing resourcing constraints in cystectomy and radiotherapy services, delays to treatment and variations in treatment modality to RCOG.

(ii) Neoadjuvant chemotherapy

QPI 7 Title:	Patients with muscle invasive bladder cancer (MIBC) undergoing treatment with radical intent should commence treatment as soon as possible
Specification (ii):	Neoadjuvant chemotherapy
Numerator (ii):	Number of patients with MIBC who have neoadjuvant chemotherapy who undergo cystectomy or radiotherapy within 8 weeks of completing treatment
Denominator (ii):	All patients with MIBC undergoing neo-adjuvant chemotherapy
Exclusions:	No exclusions
Target:	90%



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

Twenty two patients included within this QPI had cystectomy. Of these 16 (73%) had treatment within 8 weeks of chemotherapy and 21 (95%) within 12 weeks. All patients not meeting the measure were from NHSGGC. Twelve patients had radiotherapy; 7 (58%) had radiotherapy within 8 weeks of chemotherapy and 83% within 12 weeks. Some delays to treatment were the result of patient choice, while others were due to clinical factors.

While performance for patients having neo-adjuvant therapy was better than it was for those proceeding directly with radiotherapy or surgical treatment, resourcing pressures in both surgical and radiotherapy services will be impacting on performance against this measure as for specification (i).

QPI 8: Volume of Cases per Surgeon/Centre

QPI 8 Title:	Radical cystectomy should be performed by surgeons who perform the procedure routinely in hospitals where there is an appropriate volume of such cases.
Description:	Number of radical cystectomy procedures performed by a specialist centre, and surgeon over a one year period.
Exclusions:	No exclusions.
Target:	Minimum 20 procedures per centre, with a minimum of 10 procedures per surgeon in a 1 year period.

	No. of Operating Surgeons	No. of Procedures	No. of Surgeons Meeting Target
AA	2	5	0
FV*	0	0	0
GGC*	7	47	1
Lan*	4	31	2
WoS	13	83	3

**Board adjusted results*

Data from this QPI were extracted from SMR01; NHS Boards have checked these data against local records and made corrections where there are inaccuracies, for example in the surgeon or the operation code recorded.

All NHS Boards met the target of 20 surgeries per centre with the exception of NHS Ayrshire & Arran; however the target for 10 surgeries per individual surgeon was more challenging.

Within NHS Ayrshire & Arran one surgeon retired part way through the audit period and there is now just one lead surgeon undertaking cystectomies within the Board. Similarly, one of the surgeons not meeting the QPI in NHS Lanarkshire was only in post for a small part of the audit period and two of the NHSGGC surgeons only undertook simple cystectomies, an operation for benign disease that will be excluded from this measure in future years.

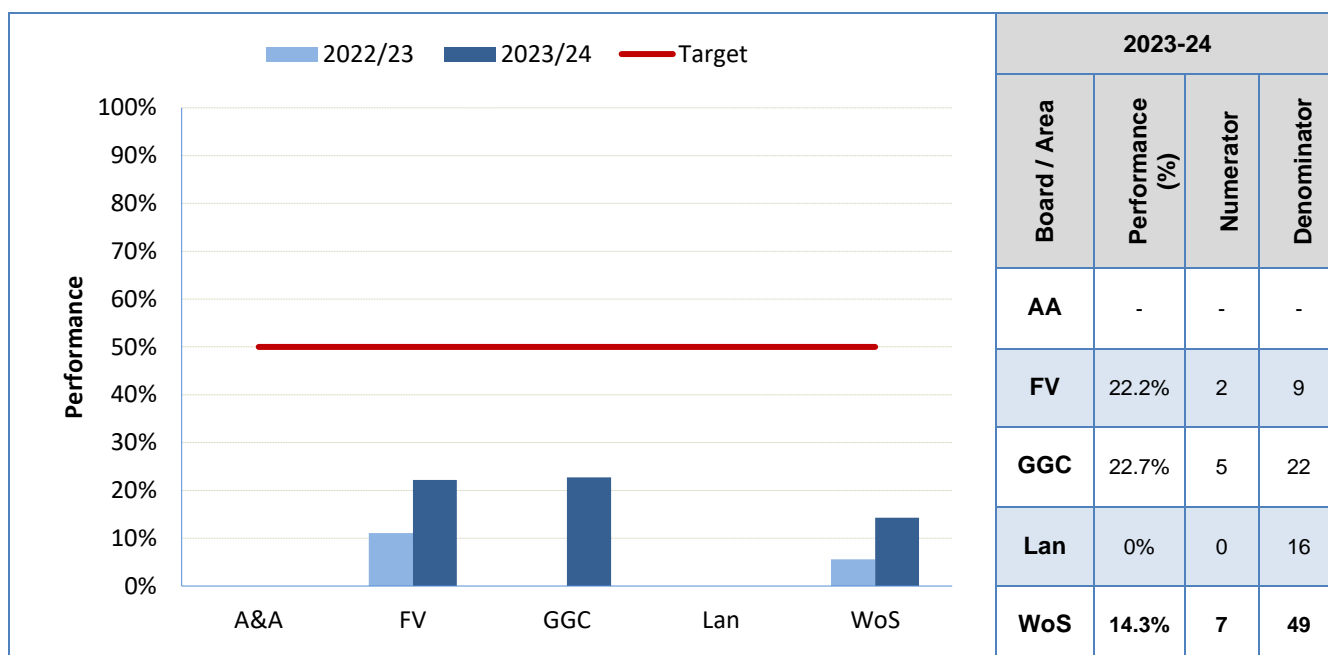
Nevertheless there is ongoing concern about low surgeon and centre volumes for cystectomy and a need to review cystectomy services in the WoS. There is ongoing Regional Planning work to rationalise the cystectomy service and the number of surgeons performing cystectomy as part of wider work on the delivery of robotic services in the region.

Action Required:

- **MCN to highlight the low volumes of cystectomies undertaken by some surgeons / centres to RCOG.**

QPI 10: Radical Radiotherapy Treatment with a Concomitant Radiosensitiser

QPI 10 Title:	Patients undergoing radical radiotherapy for transitional cell carcinoma of bladder should be considered for treatment with a concomitant radiosensitiser.
Numerator:	Number of patients with transitional cell carcinoma of the bladder (T2-T4) receiving radical radiotherapy treated with a concomitant radiosensitiser.
Denominator:	All patients with transitional cell carcinoma of the bladder (T2-T4) receiving radical radiotherapy.
Exclusions:	Patients enrolled in a clinical trial.
Target:	50%



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

Only seven of the 49 patients with transitional cell carcinoma receiving radical radiotherapy had concomitant radiosensitiser. Review of patients not meeting this measure indicated that the majority had co-morbidities or were not fit for SACT. In addition a small number of patients declined SACT. Performance is anticipated to improve with the recent introduction of less toxic radiosensitisers; these treatments were incorporated into the CMG in early 2025 and are now being administered to patients at the Beatson West of Scotland Cancer Centre. These first two years of reporting of the updated QPI definition will act as a benchmark against which the development of this service can be assessed.

QPI 11: 30/90-Day Mortality after Treatment for Bladder Cancer

QPI 11 Title:	30/90 day mortality following treatment with curative intent for bladder cancer. i) 30/90-day mortality - Surgery (Radical Cystectomy) ii) 30/90-day mortality - Radiotherapy
Numerator:	Number of patients with bladder cancer who receive treatment with curative intent (radical cystectomy or radiotherapy) that die within 30/90 days of treatment
Denominator:	All patients with bladder cancer who receive treatment with curative intent (radical cystectomy or radiotherapy)
Exclusions:	No exclusions
Target:	<3% - 30 day and <5% - 90 day

(i) **30/90-Day Mortality – Surgery (Radical Cystectomy)**

Board / Area	30 Day mortality			90 Day mortality		
	Performance (%)	Numerator	Denominator	Performance (%)	Numerator	Denominator
AA	10.0%	1	10	10.0%	1	10
FV	*	0	0	*	0	0
GGC	0%	0	31	0%	0	28
Lan	0%	0	18	5.6%	1	18
WoS	1.7%	1	59	3.6%	2	56

Clinical review of patients that died within 90 days of surgery did not highlight any issues of concern or areas for improvement. It should be noted that this measure reports patients that died regardless of the cause.

(i) **30/90-Day Mortality – Radiotherapy**

Board / Area	30 Day mortality			90 Day mortality		
	Performance (%)	Numerator	Denominator	Performance (%)	Numerator	Denominator
AA	-	-	-	-	-	-
FV	0%	0	9	0%	0	9
GGC	4.3%	1	23	13.6%	3	22
Lan	5.6%	1	18	5.6%	1	18
WoS	5.8%	3	52	9.8%	5	51

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

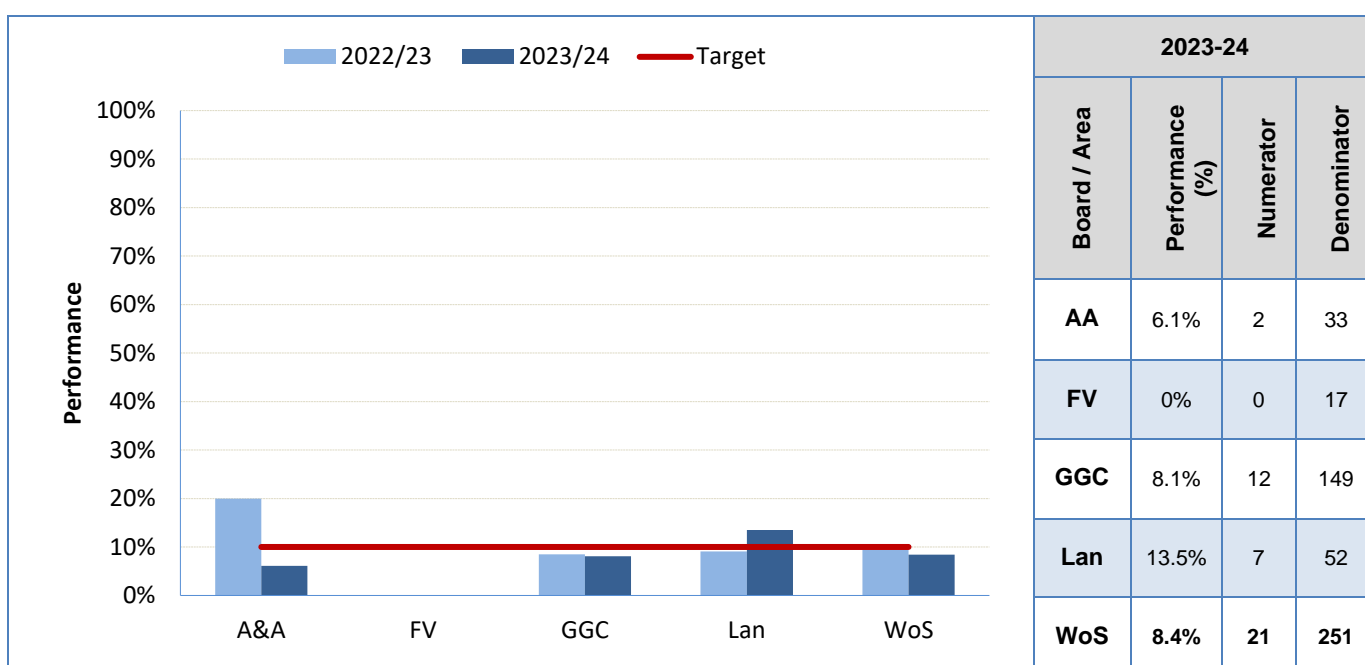
Review of the five patients that died within 90 days of radiotherapy indicated that three of these patients died of rapid disease progression while two died of pneumonia. These deaths were considered to be attributed to disease progression or complications of bladder cancer and not related to the radiotherapy treatment given.

Patients that die within 90 days of treatment will continue to be reviewed on a case-by-case basis. On review of these data no areas of concern were noted, however clinicians will ensure that review of practice is undertaken if any potential issues are raised when reviewing patient outcomes.

QPI 13: Early Recurrence in Patients with Non-Muscle Invasive Bladder Cancer (NMIBC)

i) Recurrence at first follow-up cystoscopy (RRFFC) in patients with low grade pTa cancer

QPI 13 Title:	The risk of early recurrence in patients with non-muscle invasive bladder cancer (NMIBC) should be minimised
Specification (i):	Recurrence at first follow-up cystoscopy (RRFFC) in patients with low grade pTa cancer
Numerator (i):	Number of patients with low grade pTa NMIBC who have undergone initial TURBT where recurrence is found at first follow up cystoscopy
Denominator (i):	All patients with low grade pTa NMIBC who have undergone initial TURBT
Exclusions:	Patients with incomplete resection at initial TURBT
Target:	< 10%

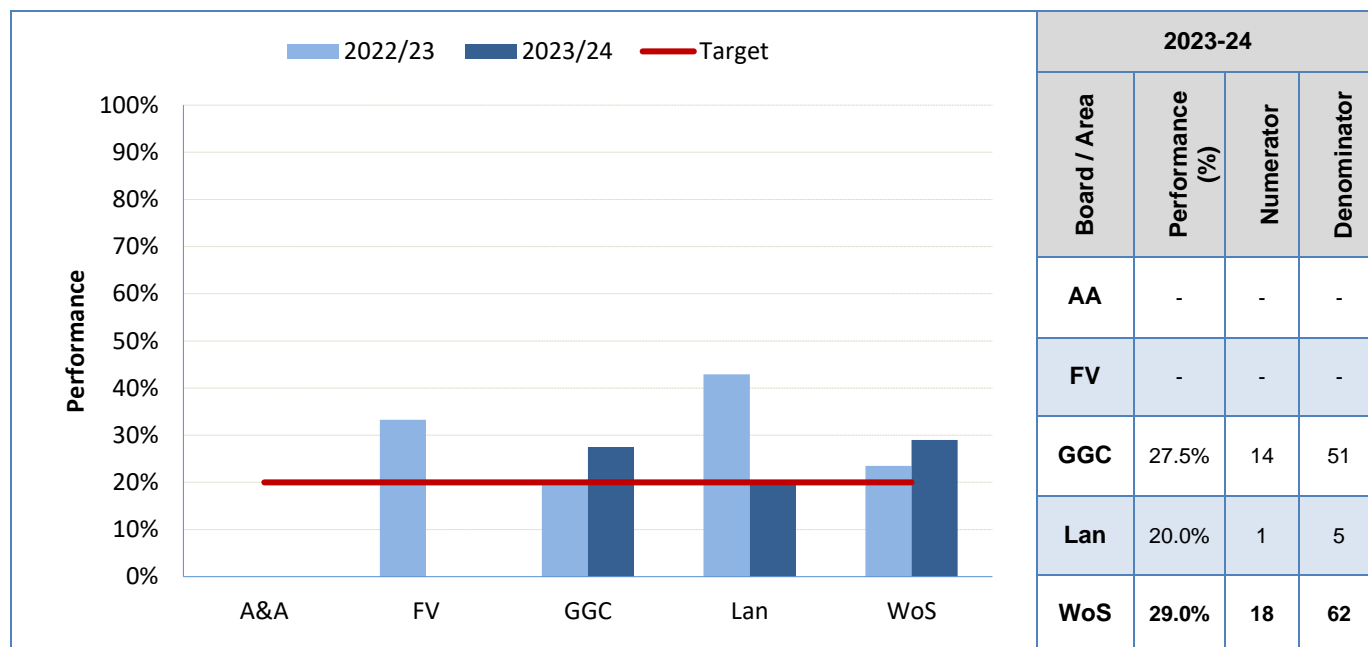


The target was not met by NHS Lanarkshire, where 6 patients had residual pTa disease and one had a check cystoscopy that showed recurrence. Due to the small numbers of patients with recurrence, further years of data are required to establish whether there is any variation in performance against this measure within WoSCAN. NHS Lanarkshire will monitor future performance against this measure through early local reporting of QPI results.

ii) Residual cancer at re-TURBT in patients with pT1

QPI 13 Title:	The risk of early recurrence in patients with non-muscle invasive bladder cancer (NMIBC) should be minimised
Specification (ii):	Residual cancer at re-TURBT in patients with pT1
Numerator (ii):	Number of patients with pT1 NMIBC who have undergone a second TURBT or early cystoscopy (± biopsy) and have residual cancer at re-TURBT

Denominator (ii):	All patients with pT1 NMIBC who have undergone a second TURBT or early cystoscopy (\pm biopsy)
Exclusions:	<ul style="list-style-type: none"> Patients in whom concomitant cis is present in the tumour specimen. Patients with incomplete resection at initial TURBT
Target:	< 20%

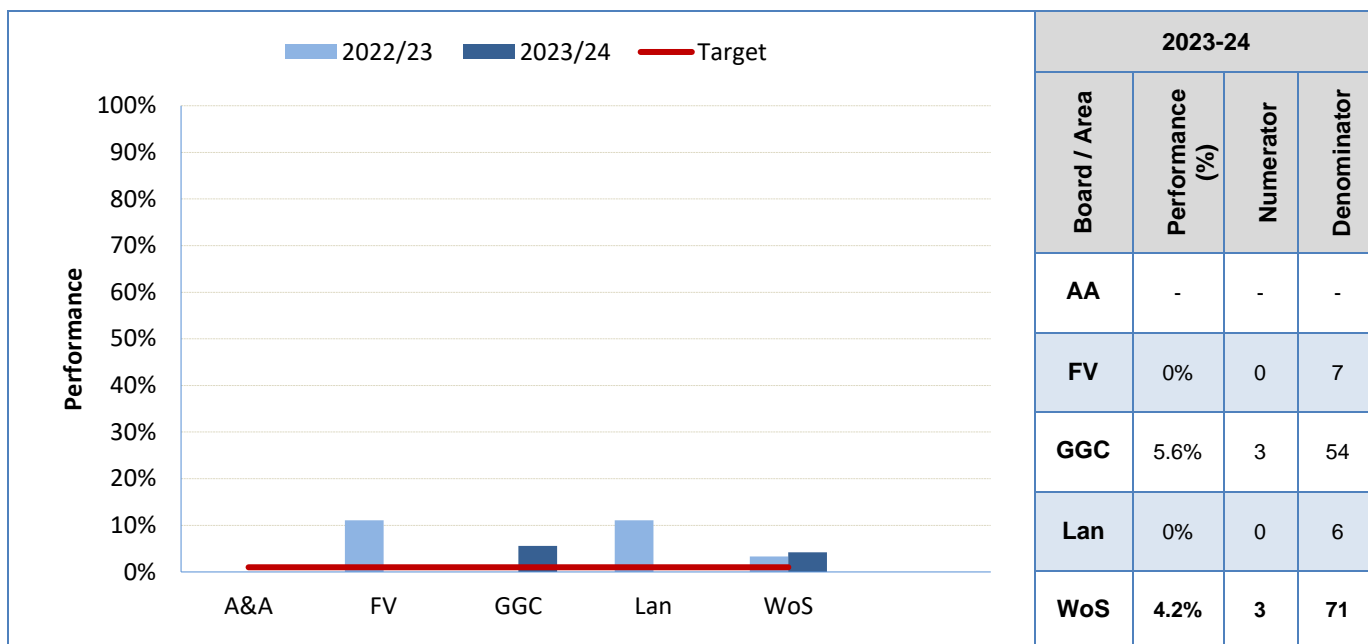


(-) Data is not shown; denominator less than 5. (*) denotes a zero.

The target of less than 20% was not met at a regional level for this specification in either of the first two years of reporting but it is noted that there was no outlier among the WoSCAN health boards. We will continue to monitor performance against this measure.

iii) Pathological MIBC (pT2) at re-TURBT in patients with pT1

QPI 13 Title:	The risk of early recurrence in patients with non-muscle invasive bladder cancer (NMIBC) should be minimised
Specification (iii):	Pathological MIBC (pT2) at re-TURBT in patients with pT1
Numerator (iii):	Number of patients with pT1 NMIBC who have undergone a second TURBT or early cystoscopy (\pm biopsy) and have Pathological MIBC (pT2) at re-TURBT
Denominator (iii):	All patients with pT1 NMIBC who have undergone a second TURBT or early cystoscopy (\pm biopsy)
Exclusions:	Patients with incomplete resection at initial TURBT
Target:	< 1%



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

Results show that the target of less than 1% was missed at a regional level for the second year with three patients having MIBC at re-TURBT; none of these patients had muscle sampled at initial TURBT.

While this measure is based on small numbers of patients, results highlight the importance of optimising the quality of the initial TURBT. We anticipate that improvements in the quality of TURBT and rates of mitomycin use will lead to improvements in this QPI.

Appendix 1: Meta Data

Report Title	Cancer Audit Report: Bladder Cancer Quality Performance Indicators																												
Time Period	Patients diagnosed between 1st April 2023 and 31st March 2024																												
QPI Version	Bladder Cancer QPIs V4.0 (April 22) Cancer Quality Performance Indicators (QPIs) (healthcareimprovementscotland.org)																												
Data extraction date	0800 hrs on 21 st January 2025																												
Data Quality	<table> <tr> <th></th><th>Ayrshire & Arran</th><th>Forth Valley</th><th>GGC</th><th>Lanarkshire</th><th>WoS</th></tr> <tr> <td>Cases from audit</td><td>98</td><td>87</td><td>424</td><td>183</td><td>792</td></tr> <tr> <td>Cancer Registry (2018-2022)</td><td>130</td><td>86</td><td>381</td><td>165</td><td>762</td></tr> <tr> <td>Case ascertainment</td><td>75.4%</td><td>101.2%</td><td>111.3%</td><td>110.9%</td><td>103.9%</td></tr> </table>						Ayrshire & Arran	Forth Valley	GGC	Lanarkshire	WoS	Cases from audit	98	87	424	183	792	Cancer Registry (2018-2022)	130	86	381	165	762	Case ascertainment	75.4%	101.2%	111.3%	110.9%	103.9%
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