West of Scotland Cancer Network

Urological Cancer
Managed Clinical Network

Audit Report

Bladder Cancer
Quality Performance Indicators

Clinical Audit Data: 1 April 2024 to 31 March 2025

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Bladder Cancer Quality Performance Indicators: Data Overview

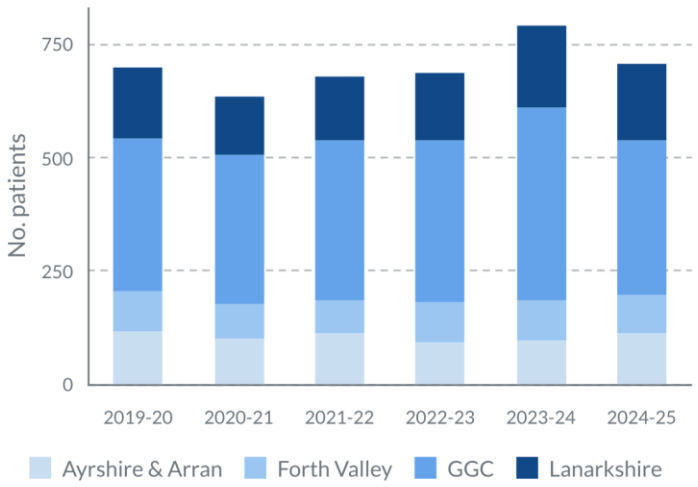
Patients diagnosed April 2024 - March 2025

Number of patients diagnosed	708
Non-muscle invasive bladder cancer	507
Muscle invasive bladder cancer	201

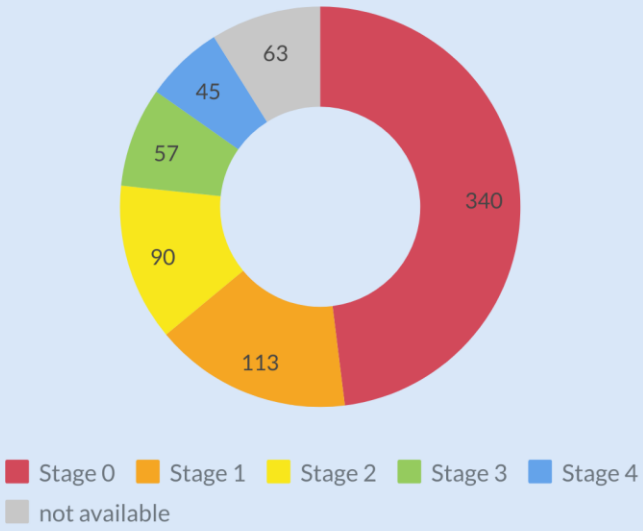
Muscle Invasive Bladder Cancer Survival	
1 Year age standardised net survival	70%
5 Year age standardised net survival	48%

* patients diagnosed 2018-22
www.publichealthscotland.scot/publications/cancer-survival-statistics/

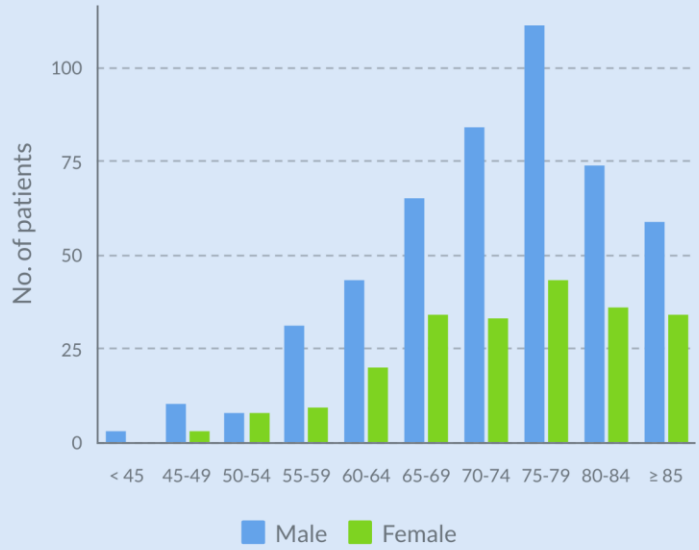
Where are patients diagnosed



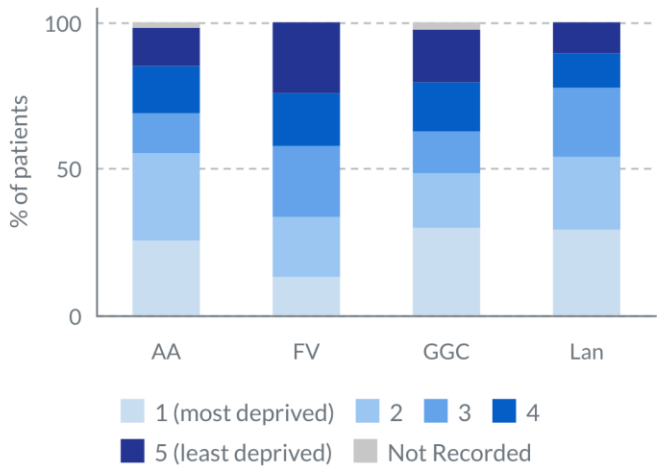
Stage at Presentation (TNM8)



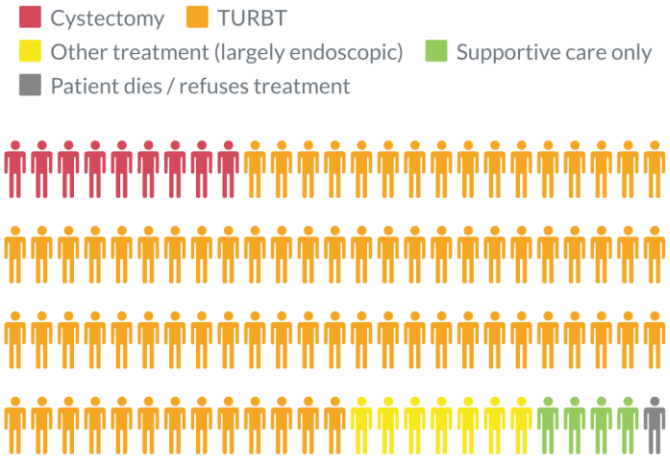
Age of Patients



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 2024 and 31 March 2025.

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 highlight improvements in performance in some key areas including the use of mitomycin C (QPI 3), lymph node yield (QPI 6) and the use of concomitant radiosensitiser (QPI 10). In addition, 90 day post treatment mortality was zero for both surgical patients and those having radiotherapy.

However, performance against the Bladder Cancer QPIs also illustrates that some of the QPI targets remain challenging, with room for further service improvement. Performance against the Bladder Cancer QPIs highlights a number of recurring themes:

Systemic resource pressures on Urology Services and capacity issues across the region present challenges for patients going through the bladder cancer diagnostic pathway, most notably delays to pathology reporting and theatre capacity, with additional capacity pressures on the oncology service. These all adversely affect time to treatment (QPIs 4 and 7) and may ultimately have a negative impact on patient outcomes.

A further area of scrutiny is quality of TURBT which is important for treatment decision making and also impacts on patient outcomes (QPIs 2, 3, 4 and 13).

A recent initiative has been commissioned by the National Cancer Quality Improvement Board (NCQIB) to undertake a ‘deep dive’ into bladder cancer services across Scotland which aims to identify the most significant challenges facing patients going through the bladder cancer pathway and how these can be addressed. It is anticipated that this will have a positive effect on performance against a number of the QPIs.

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 highlight to RCOG that systemic resourcing issues within Urology Services are impacting on the quality of services provided for bladder cancer patients, notably timely re-resection in patients with an incomplete initial TURBT. This risk should be escalated to the Senior Management Teams within individual Boards. This has also been highlighted at NCQIB discussions.**

- **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 highlight to RCOG that systemic resourcing issues within Urology Services are impacting on the quality of services provided for bladder cancer patients, notably timely treatment of patients with MIBC. This risk should be escalated to the Senior Management Teams within individual Boards. This has been highlighted in NCQIB discussions.**

- **All NHS Boards to ensure that all surgeons undertaking cystectomy perform a minimum of 10 cystectomies per year.**

- **MCN to encourage national discussion on the definitions and targets for QPI 13 and to submit suggested amendments to the next Formal Review of Bladder Cancer QPIs.**

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	A&A	FV	GGC	LAN	WoSCAN
QPI 2: Quality of Transurethral Resection of Bladder Tumour: Proportion of patients with bladder cancer who undergo good quality TURBT* (i) *Use of a bladder diagram / detailed description with documentation of tumour location, size, number and appearance at initial resection*	**95%**	2024 - 25	77% (67/87)	97% (61/63)	94% (275/292)	93% (131/141)	92% (534/583)
		2023 - 24	70%	97%	96%	99%	94%
		2022 - 23	81%	96%	95%	95%	93%
(ii) *Whether the resection is complete or not at initial resection*	**95%**	2024 - 25	100% (81/81)	100% (58/58)	96% (256/267)	100% (133/133)	98% (528/539)
		2023 - 24	99%	98%	99%	100%	99%
		2022 - 23	96%	99%	99%	99%	98%
(iii) *Whether detrusor muscle included in the specimen at initial resection*	**90%**	2024 - 25	74% (26/35)	97% (28/29)	70% (73/104)	78% (35/45)	76% (162/213)
		2023 - 24	43%	91%	62%	71%	65%
		2022 - 23	78%	97%	73%	86%	80%
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%**	2024 - 25	71% (20/28)	63% (12/19)	80% (96/120)	73% (38/52)	76% (166/219)
		2023 - 24	56%	76%	73%	68%	70%
		2022 - 23	68%	73%	72%	61%	69%
QPI 4: Early Re-Transurethral Resection of Bladder Tumour: *(i) Proportion of patients with T1 (all grades) NMIBC where initial resection is complete who have a second TURBT or early cystoscopy (± biopsy) within 3 months (90 days) of initial resection**	**80%**	2024 - 25	69% (9/13)	90% (9/10)	90% (44/49)	67% (10/15)	83% (72/87)
		2023 - 24					
		2022 - 23					

QPI	Target	Year	A&A	FV	GGC	LAN	WoSCAN
*(iii) Proportion 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**	**80%**	2024 - 25	17% (1/6)	-	14% (4/28)	8% (1/13)	13% (6/48)
		2023 - 24	17%	-	25%	38%	28%
		2022 - 23	0%	-	19%	20%	14%
QPI 6: Lymph Node Yield (v4): 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%**	2024 - 25	72% (13/18)	-	92% (23/25)	100% (19/19)	89% (55/62)
		2023 - 24	56%	-	81%	94%	81%
		2022 - 23	20%	-	91%	91%	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) Radical treatment (cystectomy or radiotherapy) without neoadjuvant chemotherapy*	**90%**	2024 - 25	0% (0/6)	0% (0/7)	26% (5/19)	0% (0/5)	14% (5/37)
		2023 - 24	0%	0%	16%	8%	11%
		2022 - 23	0%	0%	35%	33%	24%
(ii) Neoadjuvant chemotherapy prior to radical treatment	**90%**	2024 - 25	-	-	70% (7/10)	40% (4/10)	59% (16/27)
		2023 - 24	-	-	38%	87%	68%
		2022 - 23	-	-	18%	75%	61%
QPI 8: Volume of Cases per Surgeon: Number of radical cystectomy procedures performed by a surgeon over a 1 year period (SMR01 data)* *By Surgeon*	**Min 10 per year**	2024 - 25	1 met	-	1 met 4 not met	1 met 3 not met	3 met 7 not met
		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
By Surgical Centre	**Min 20 per year**	2024 - 25	17	-	37	23	2 met 1 not met
		2023 - 24	6	-	47	31	2 met 1 not met
		2022 - 23	16	-	52	21	2 met 1 not met

QPI	Target	Year	A&A	FV	GGC	LAN	WoSCAN
QPI 9: Oncological Discussion (v4): Proportion of patients with muscle invasive bladder cancer who had radical surgery who met with an oncologist prior to radical cystectomy	**60%**	2024 - 25	43% (3/7)	86% (6/7)	79% (11/14)	91% (10/11)	77% (30/39)
		2023 - 24	60%	-	71%	100%	77%
		2022 - 23	29%	-	48%	67%	52%
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%**	2024 - 25	-	-	27% (4/15)	17% (1/6)	35% (9/26)
		2023 - 24	-	22%	23%	0%	14%
		2022 - 23	-	11%	0%	0%	6%
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) *30 Day Mortality - Surgery**	**<3%**	2024 - 25	0% (0/18)	-	0% (0/25)	0% (0/21)	0% (0/64)
		2023 - 24	10%	-	0%	0%	2%
		2022 - 23	10%	-	3%	0%	3%
(i) 30 Day Mortality - Radiotherapy	**<3%**	2024 - 25	-	-	0% (0/16)	0% (0/7)	0% (0/29)
		2023 - 24	-	0%	4%	6%	6%
		2022 - 23	0%	0%	0%	0%	0%
*(ii) 90 Day Mortality - Surgery**	**<5%**	2024 - 25	0% (0/18)	-	4% (1/25)	0% (0/21)	2% (1/64)
		2023 - 24	10%	-	0%	6%	4%
		2022 - 23	10%	-	6%	4%	6%
(ii) QPI 11 – 90 Day Mortality - Radiotherapy	**<5%**	2024 - 25	-	-	0% (0/16)	0% (0/7)	0% (0/29)
		2023 - 24	-	0%	14%	6%	10%
		2022 - 23	0%	0%	6%	22%	7%

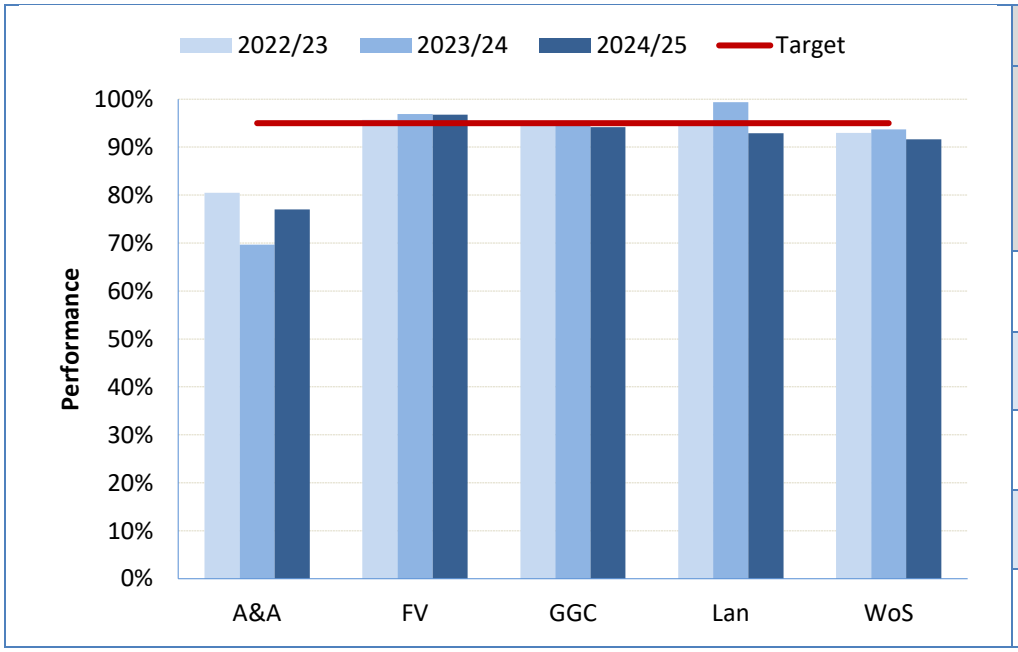
QPI	Target	Year	A&A	FV	GGC	LAN	WoSCAN
QPI 13: Early Recurrence in Patients (NMIBC): Proportion of patients who have undergone TURBT with low grade pTa cancer where recurrence is found at first follow up cystoscopy, or with pT1 who have residual cancer or pathological MIBC (pT2) at reTURBT. *(i) Radical treatment (cystectomy or radiotherapy)*	**<10%**	2024 - 25	0% (0/27)	11% (2/19)	9% (11/117)	16% (8/50)	10% (21/213)
		2023 - 24	6%	0%	8%	13%	8%
		2022 - 23	20%	0%	8%	9%	9%
(ii) Residual cancer at re-TURBT in patients with pT1	**<20%**	2024 - 25	56% (5/9)	25% (2/8)	40% (18/45)	50% (5/10)	42% (30/72)
		2023 - 24	-	-	27%	20%	29%
		2022 - 23	-	33%	19%	43%	24%
(iii) Pathological MIBC (pT2) at re-TURBT in patients with pT1	**<1%**	2024 - 25	10% (1/10)	18% (2/11)	2% (1/50)	8% (1/12)	6% (5/83)
		2023 - 24	-	0%	6%	0%	4%
		2022 - 23	-	11%	0%	11%	3%

** 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%**



2024-25			
Board / Area	**Performance (%)**	**Numerator**	**Denominator**
A&A	77.0%	67	87
FV	96.8%	61	63
GGC	94.2%	275	292
Lan	92.9%	131	141
WoS	**91.6%**	**534**	**583**

Within NHS Ayrshire & Arran, operation notes were hand written, and did not contain the full suite of information required, in all 20 instances where the QPI was not met. NHS Ayrshire & Arran held an MDT education event in April 2025 where the use of TURBT proforma for all patients was discussed and agreed; there is a need for the Board to ensure that this is implemented. If the expected improvements in recording for the 2025-26 audit period are not realised, this issue will be escalated to the RCOG.

Within NHS Lanarkshire, review of patients not meeting the QPI highlighted that, on occasion, a TURBT proforma had not been used and there was no bladder diagram; all staff performing TURBT have been reminded to use a proforma.

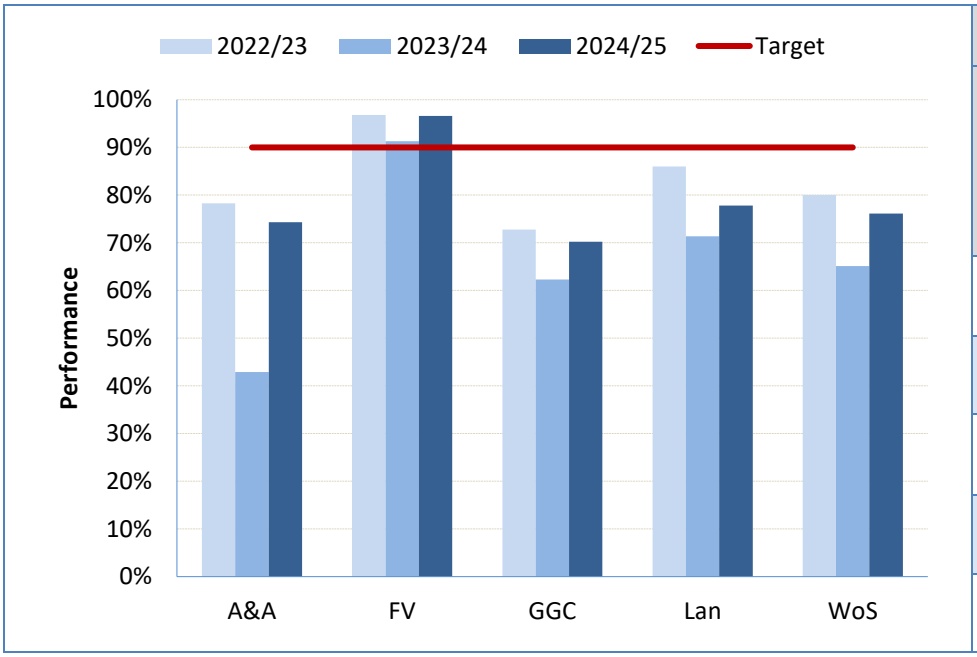
Action Required:

- **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:	• Patients undergoing palliative resection • Patients with very small tumours (≤5mm) • Patients with bladder diverticular tumours
Target:	**90%**

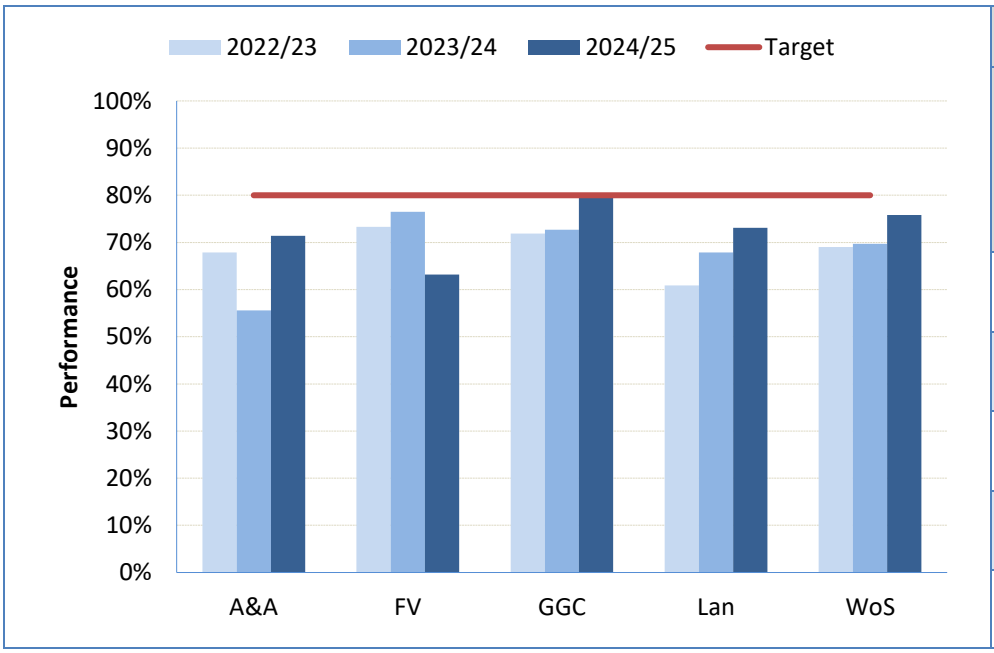


2024-5			
Board / Area	**Performance (%)**	**Numerator**	**Denominator**
A&A	74.3%	26	35
FV	96.6%	28	29
GGC	70.2%	73	104
Lan	77.8%	35	45
WoS	**76.1%**	**162**	**213**

Aggressive resection is not always clinically appropriate; review of cases where the QPI was not met identified that there were appropriate clinical reasons for many patients not having detrusor muscle sampled, including patients who were frail or had thin walled bladders. Nevertheless, attempts to sample detrusor muscle at initial resection should be undertaken where clinically appropriate. Performance has improved over the last year and is similar to that in other regions, suggesting that national discussion on whether the current target is clinically appropriate may be beneficial. A NCQIB deep dive into bladder cancer services across Scotland is currently underway and will include discussion on the role of detrusor muscle sampling in this group of patients. There is some evidence that the 90% target is too high.

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%**



2024-25			
Board / Area	**Performance (%)**	**Numerator**	**Denominator**
A&A	71.4%	20	28
FV	63.2%	12	19
GGC	80.0%	96	120
Lan	73.1%	38	52
WoS	**75.8%**	**166**	**219**

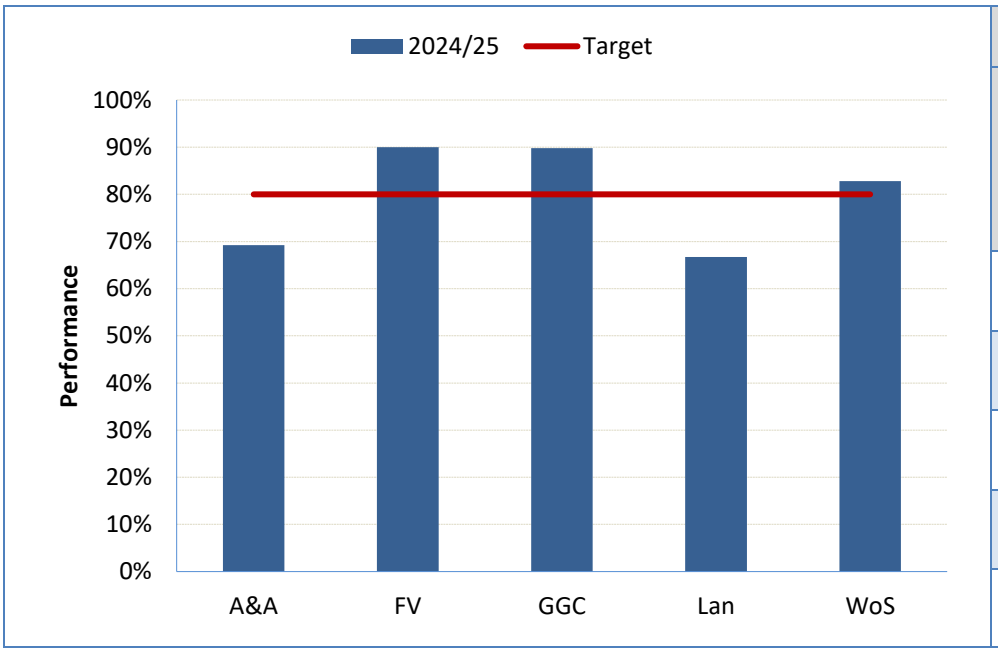
Performance against this measure improved in the last year. Review of patients not having mitomycin C highlighted that many patients had thin-walled bladder, fat was visible or patients had a deep resection. In such cases it was considered to be inappropriate for patients to have mitomycin C due to the risk of extravasation (chemotherapy agent leaking to surrounding tissue). In addition, in small numbers of patients there were concerns that the tumour was MIBC and therefore the patient did not receive mitomycin C.

Following review of performance against this measure NHS Ayrshire & Arran, NHS Forth Valley and NHS Lanarkshire considered that it was clinically appropriate to withhold mitomycin C for the majority of patients who did not receive it; as such no action is required.

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

(i) T1 (all grades) NMIBC where initial resection is complete

QPI 4 Title:	A second resection or early cystoscopy (± biopsy) should be carried out in patients with high grade and/ or T1 non muscle invasive bladder cancer (NMIB) where clinically appropriate
Specification (i):	All patients with T1 (all grades) NMIBC where initial resection is complete who have a second TURBT or early cystoscopy (± biopsy) within 3 months (90 days) of initial resection
Numerator (i):	Number of patients with T1 (all grades) NMIBC who have undergone TURBT where initial resection is complete who have a second TURBT or early cystoscopy (± biopsy) within 3 months (90 days) of initial resection
Denominator (i):	All patients with T1 (all grades) NMIBC who have undergone TURBT where initial resection is complete
Exclusions:	• Patients where TURBT has been carried out for palliation • Patients who have undergone early cystectomy • Patients with confirmed metastatic disease
Target:	**80%**



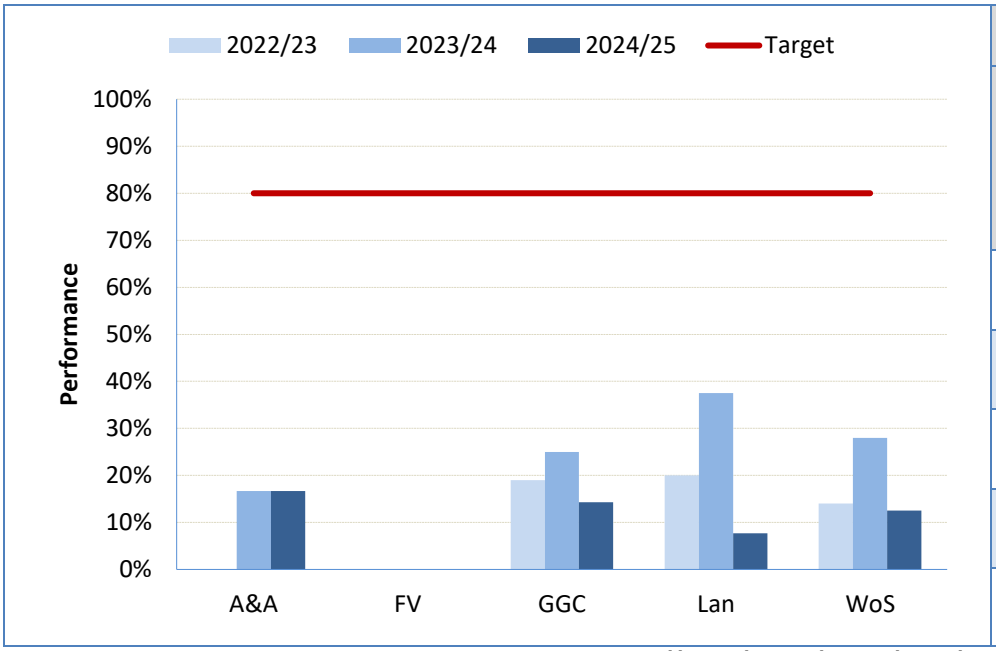
2024-25			
Board / Area	**Performance (%)**	**Numerator**	**Denominator**
A&A	69.2%	9	13
FV	90.0%	9	10
GGC	89.8%	44	49
Lan	66.7%	10	15
WoS	**82.8%**	**72**	**87**

The definition for this QPI was amended at the recent Formal Review of Bladder Cancer QPIs; as such there is no historic data against which to compare the 2024-25 results. This revised measure was met at a regional level.

Further analysis of results indicates that in some instances where the QPI was not met, the patient had re-TURBT or early cystoscopy outwith the 3 month timescale (8 patients) while others did not have a repeat procedure because it was not clinically appropriate (7 patients). Differences in performance against this measure between NHS Boards reflect differences in the proportion of patients having a re-TURBT, although numbers are small so further years of data are required to assess whether there is any variation in performance between NHS Boards. No action required at this time.

(iii) NMIBC where initial resection is incomplete

QPI 4 Title:	A second resection or early cystoscopy (± biopsy) should be carried out in patients with high grade and/ or T1 non muscle invasive bladder cancer (NMIB) where clinically appropriate
Specification (iii):	All patients with NMIBC where initial resection is incomplete who have a second TURBT or early cystoscopy (± biopsy) within 6 weeks (42 days) of initial resection
Numerator (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
Denominator (iii):	All patients with NMIBC who have undergone TURBT where initial resection is incomplete.
Exclusions:	• Patients where TURBT has been carried out for palliation • Patients who have undergone early cystectomy • Patients with confirmed metastatic disease
Target:	**80%**



	2024-25		
Board / Area	**Performance (%)**	**Numerator**	**Denominator**
A&A	16.7%	1	6
FV	-	-	-
GGC	14.3%	4	28
Lan	7.7%	1	13
WoS	**12.5%**	**6**	**48**

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

Performance against this specification is considerably below the 80% target. 81% of patients did have re-TURBT or early cystoscopy at some point, 48% within 12 weeks of initial resection.

Nine 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 fitness.

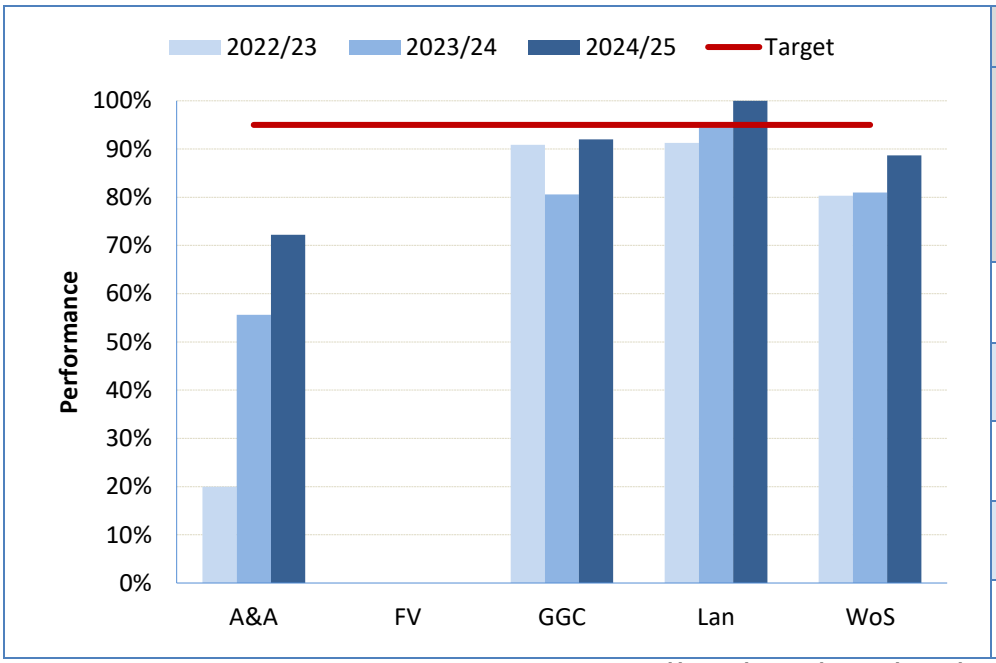
A further 33 patients had re-TURBT or cystoscopy more than 6 weeks after their initial resection, largely due to resourcing issues within Urology Services. Delays were multifactorial although a major cause of delay was theatre capacity issues, exacerbated by delays in pathology reporting. It was noted that pressure to undertake timely re-TURBT in patients with an incomplete resection would be reduced if a higher proportion of patients had complete resection at initial TURBT. In NHS Ayrshire & Arran yellow stickers are now being used on pathology forms for samples categorised as 'Urgent Suspected Cancer' with an aim of 7 day turn around in pathology reporting for these patients, which will reduce the timelines to re-TURBT.

Action Required:

- **MCN to highlight to RCOG that systemic resourcing issues within Urology Services are impacting on the quality of services provided for bladder cancer patients, notably timely re-resection in patients with an incomplete initial TURBT. This risk should be escalated to the Senior Management Teams within individual Boards. This has also been highlighted at NCQIB discussions.**

QPI 6: Lymph Node Yield (v4)

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:	Patients undergoing salvage cystectomy
Target:	**95%**



2024-25			
Board / Area	**Performance (%)**	**Numerator**	**Denominator**
A&A	72.2%	13	18
FV	*	0	0
GGC	92.0%	23	25
Lan	100%	19	19
WoS	**88.7%**	**55**	**62**

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

Seven patients had less than 10 lymph nodes examined following cystectomy. There are instances where a pelvic lymph node dissection is not appropriate, for example one patient had extensive pelvic scarring. In addition, for one case pathology was outsourced and the number of lymph nodes was not recorded. NHS Ayrshire & Arran have had lower performance against this measure over a number of years however staffing changes have resulted in improvement in performance against this measure which is anticipated to continue in future.

Actions Required:

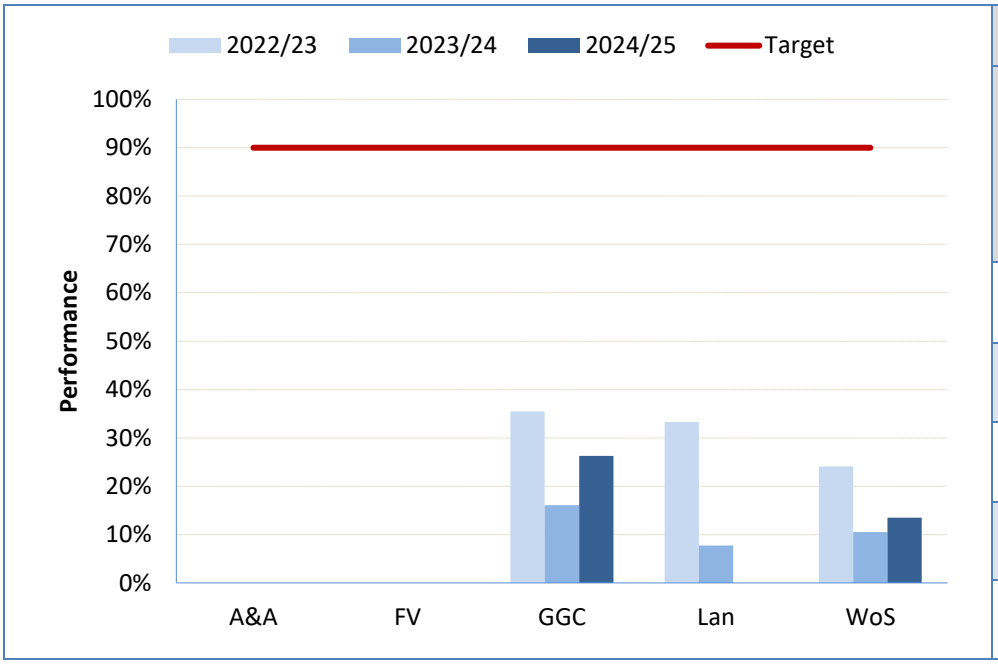
- **MCN to monitor improvements to lymph node yield within NHS Ayrshire & Arran until performance aligns with other NHS Boards.**

- **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%**



2024-25			
Board / Area	**Performance (%)**	**Numerator**	**Denominator**
A&A	0%	0	6
FV	0%	0	7
GGC	26.3%	5	19
Lan	0%	0	5
WoS	**13.5%**	**5**	**37**

Fifteen patients included within this QPI had cystectomy. Of these three (20%) had treatment within 6 weeks of diagnosis with MIBC and 11 (73%) within 12 weeks. For some patients surgery was delayed to undertake further investigations or fitness optimisation.

Twenty two patients had radiotherapy. Performance in this group of patients was similarly low; two patients (9%) had treatment within 6 weeks of diagnosis of MIBC and 16 (73%) 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.

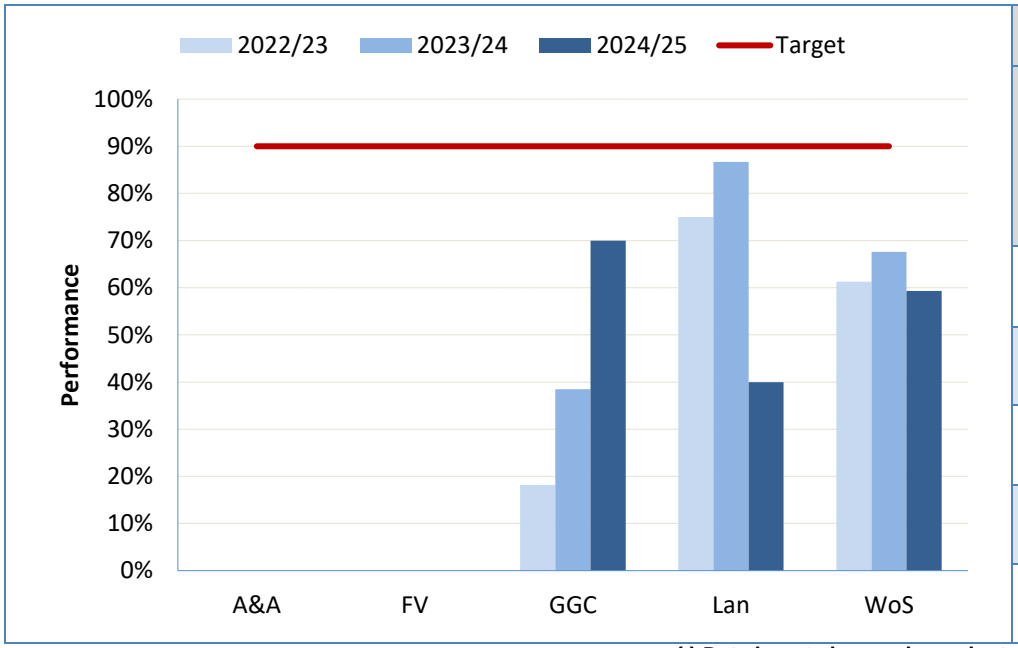
NHS Ayrshire & Arran noted that a new bladder cancer pathway has now been put in place, changes have been made in pathology services and the Board have an additional surgeon undertaking cystectomies. All these measures are anticipated to result in improvement in performance in future years.

Overall, results highlight concerning capacity issues throughout the patient pathway, including diagnostics, surgery and radiotherapy services, with delays while patients wait for outpatient

appointments for both the surgical team and oncologists. NHSGGC team are working with oncology services to introduce joint surgical and oncological clinics to streamline the pathway for these patients. In NHS Lanarkshire discussions are ongoing with oncology services to increase consultant provision within the Board with the aim of reducing the wait for oncology outpatient appointments.

(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%**



2024-25			
Board / Area	**Performance (%)**	**Numerator**	**Denominator**
A&A	-	-	-
FV	-	-	-
GGC	70.0%	7	10
Lan	40.0%	4	10
WoS	**59.3%**	**16**	**27**

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

Twenty two patients included within this QPI had cystectomy. Of these 11 (50%) had treatment within 8 weeks of chemotherapy and 21 (82%) within 12 weeks. Five patients had radiotherapy; all (100%) had radiotherapy within 8 weeks of chemotherapy. Some delays to treatment were the result of the need for additional investigations or the need to optimise patient fitness prior to surgery.

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 are impacting on performance against this measure as seen in specification (i). Within NHSGGC the addition of a surgical list has increased the capacity for cystectomies since the period reported.

Action required:

- **MCN to highlight to RCOG that systemic resourcing issues within Urology Services are impacting on the quality of services provided for bladder cancer patients, notably timely treatment of patients with MIBC. This risk should be escalated to the Senior Management Teams within individual Boards. This has been highlighted in NCQIB discussions.**

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
A&A	1	17	1
FV	0	0	-
GGC	5	37	1
Lan	4	23	1
WoS	**10**	**77**	**3**

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. One of the surgeons not meeting the QPI in NHS Lanarkshire was only in post for part of the audit period while another was unavailable for a large part of the audit year.

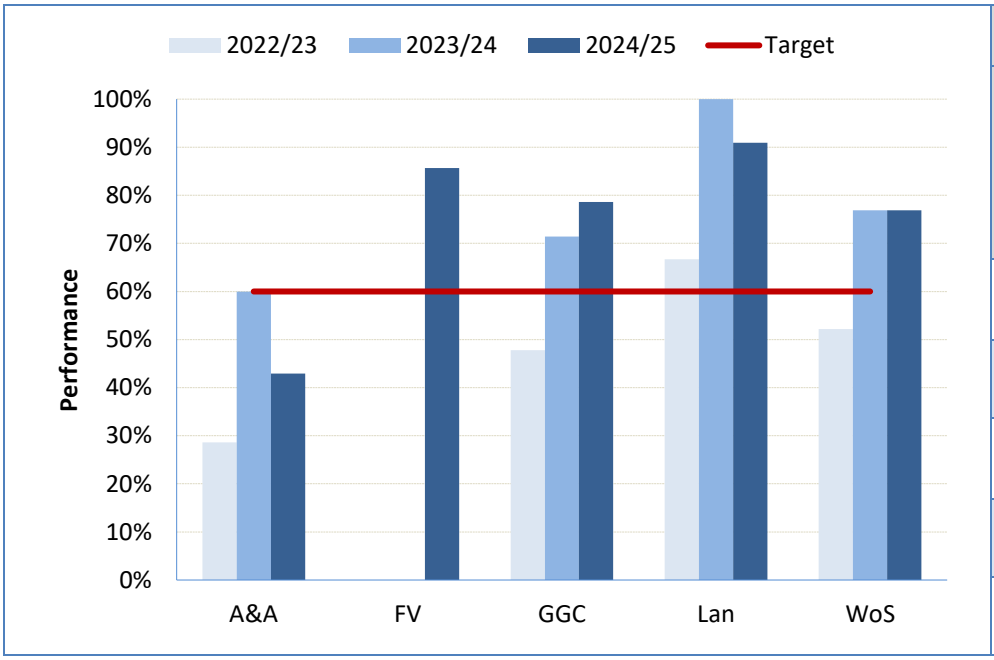
Currently, there are two surgeons undertaking cystectomies in NHS Ayrshire & Arran, two in NHS Lanarkshire and six in NHSGGC. In light of the numbers of cystectomies undertaken within individual NHS Boards, it would appear to be challenging for all surgeons to perform at least 10 surgeries per year going forward. Surgical volumes are currently under discussion with the NCQIB.

Action Required:

- **All NHS Boards to ensure that all surgeons undertaking cystectomy perform a minimum of 10 cystectomies per year.**

QPI 9: Oncology Discussion (v4)

QPI 9 Title:	Patients with muscle invasive bladder cancer (MIBC) should have all treatment options discussed with them prior to radical cystectomy.
Numerator:	Number of patients with MIBC who undergo cystectomy who met with an oncologist prior to radical cystectomy.
Denominator:	All patients with MIBC who undergo radical cystectomy.
Exclusions:	No exclusions.
Target:	**60%**

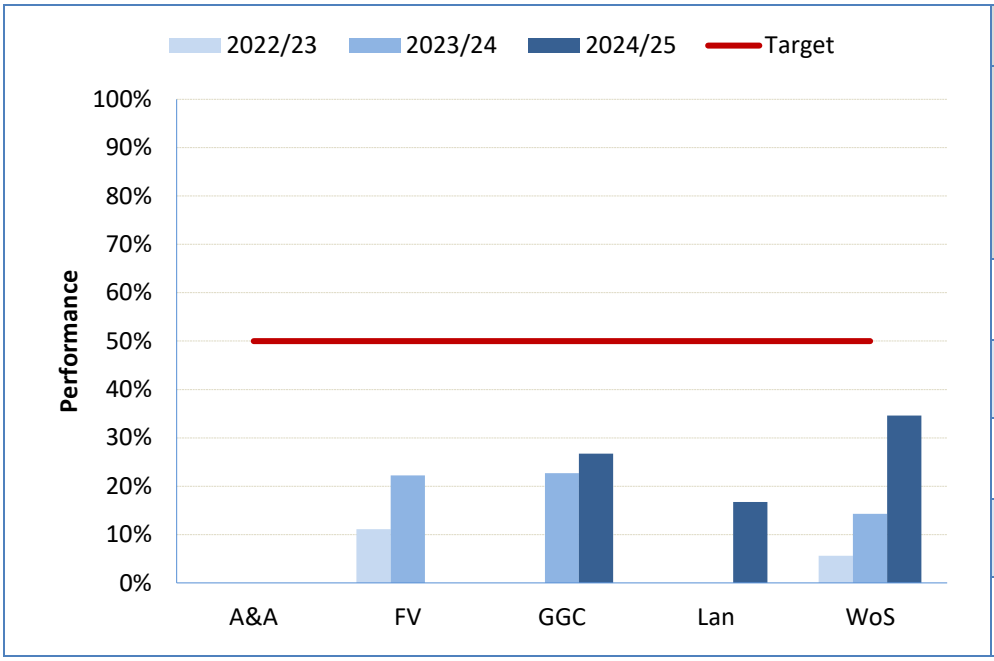


2024-25			
Board / Area	**Performance (%)**	**Numerator**	**Denominator**
A&A	42.9%	3	7
FV	85.7%	6	7
GGC	78.6%	11	14
Lan	90.9%	10	11
WoS	**76.9%**	**30**	**39**

This QPI was not met in NHS Ayrshire & Arran in 2024-25. Review of the four cases where the QPI was not met indicated that three patients proceeded straight to cystectomy for valid clinical reasons.

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%**



Board / Area	2024-25 Performance (%)	Numerator	Denominator
A&A	-	-	-
FV	-	-	-
GGC	26.7%	4	15
Lan	16.7%	1	6
WoS	**34.6%**	**9**	**26**

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

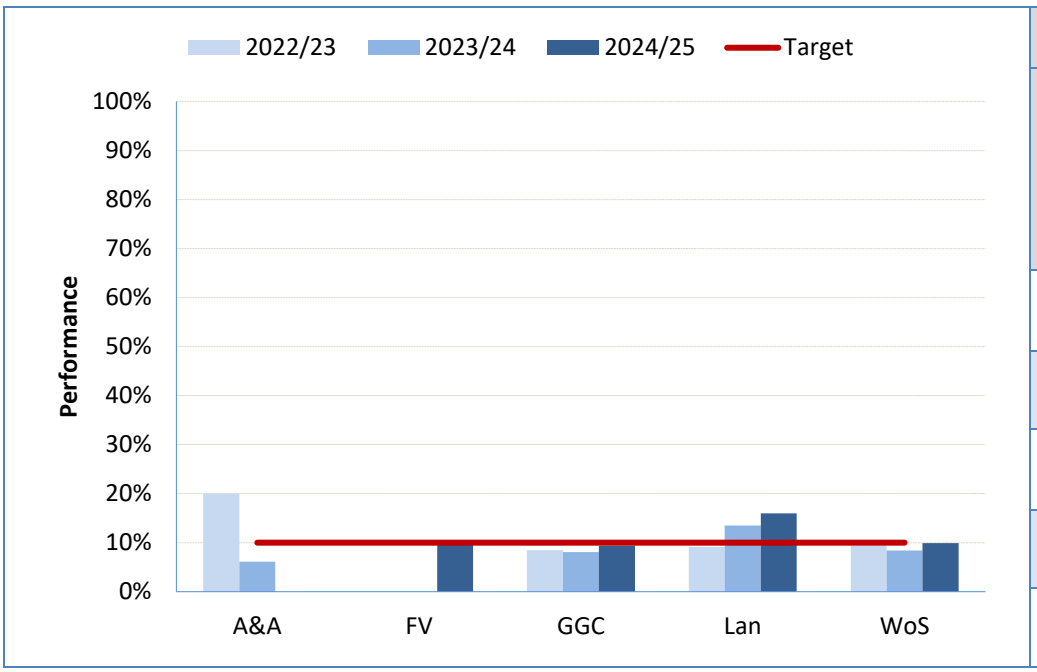
Review of cases where this measure was not met indicated that the majority of patients had co-morbidities or were not fit for SACT.

Bladder carbogen and nicotinamide (BCON) is a less toxic radiosensitiser that was introduced across the West of Scotland towards the end of the audit period. These treatments were incorporated into the Clinical Management Guideline in early 2025 and are administered to patients at the Beatson West of Scotland Cancer Centre. This has resulted in increased performance against this measure for 2024-25 and will result in further improvements in the next audit period.

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%**

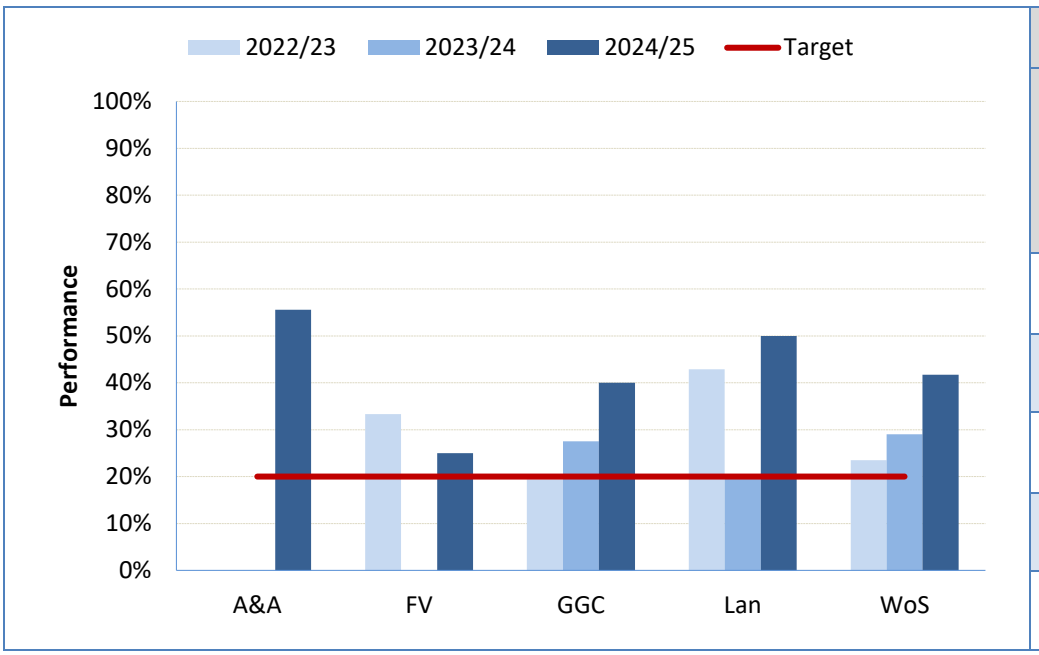


2024-25			
Board / Area	Performance (%)	Numerator	Denominator
A&A	0%	0	27
FV	10.5%	2	19
GGC	9.4%	11	117
Lan	16.0%	8	50
WoS	**9.9%**	**21**	**213**

The target was not met by NHS Forth Valley and NHS Lanarkshire. 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; quarter 1 of 2025-26 shows no instances of recurrence.

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 (± biopsy)
Exclusions:	• Patients in whom concomitant cis is present in the tumour specimen. • Patients with incomplete resection at initial TURBT
Target:	**< 20%**

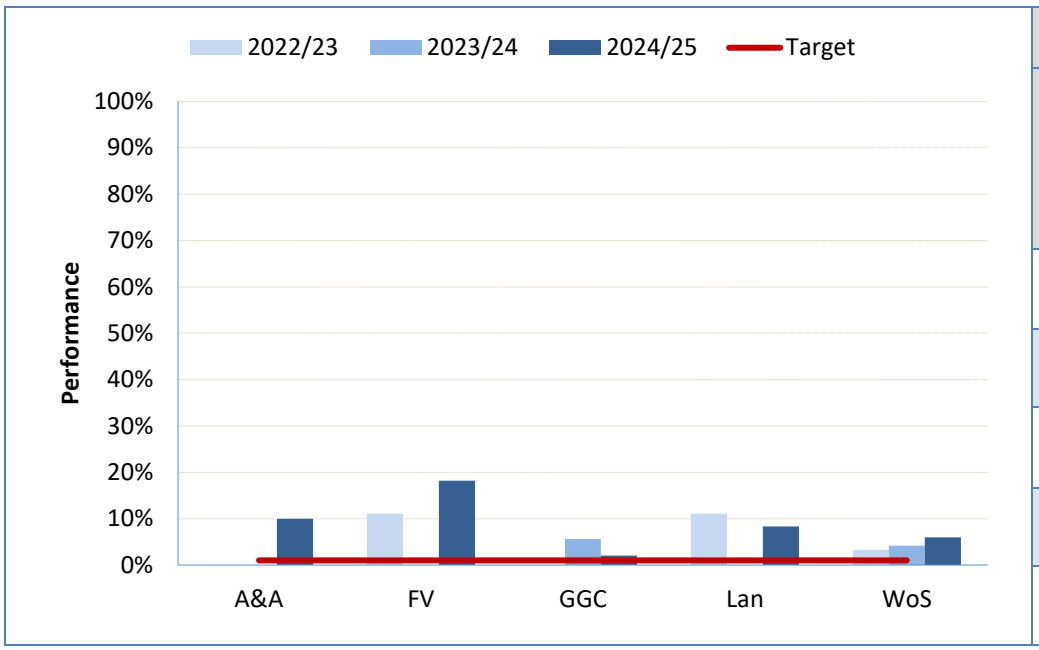


2024-25			
Board / Area	Performance (%)	Numerator	Denominator
A&A	55.6%	5	9
FV	25.0%	2	8
GGC	40.0%	18	45
Lan	50.0%	5	10
WoS	**41.7%**	**30**	**72**

The target of less than 20% was not met at a regional level for this specification in the first three years of reporting but it is noted that there was no outlier among the WoSCAN health boards. The MCN will continue to monitor performance against this measure and plan to discuss clinically appropriate levels of recurrence at a national level a part of the NCQIB deep dive process currently underway.

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 (± 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 (± biopsy)
Exclusions:	Patients with incomplete resection at initial TURBT
Target:	**< 1%**



	2024-25		
Board / Area	Performance (%)	Numerator	Denominator
A&A	10.0%	1	10
FV	18.2%	2	11
GGC	2.0%	1	50
Lan	8.3%	1	12
WoS	**6.0%**	**5**	**83**

Results show that the target of less than 1% was missed at a regional level for the third year with five patients having MIBC at re-TURBT. Given the relatively small numbers of patients within this QPI a 1% target is all but unachievable.

Overall, results for QPI 13 broadly reflect those in other regions. National discussion would be useful to better understand how recurrence rates should be clinically interpreted, whether the targets set are appropriate and whether results highlight the need to optimise the quality of the initial TURBT. The MCN clinical lead will raise this measure at the NCQIB deep dive exercise currently underway. In addition, WoSCAN will highlight that the definitions and targets for QPI 13 should be reviewed at the next Formal Review of Bladder Cancer QPIs; providing feedback on the clinical conclusions reached in national and regional discussions (e.g. as part of the NCQIB deep dive) .

Action Required:

- **MCN to encourage national discussion on the definitions and targets for QPI 13 and to submit suggested amendments to the next Formal Review of Bladder Cancer QPIs.**

Appendix 1: Meta Data

<table>
<tr><td>Report Title</td><td>Cancer Audit Report: Bladder Cancer Quality Performance Indicators</td></tr>
<tr><td>Time Period</td><td>Patients diagnosed between 1st April 2024 and 31st March 2025</td></tr>
<tr><td>QPI Version</td><td>Bladder Cancer QPIs v5.0 (November 2024) except for QPI 6 & 9 which are reported using v4 definitions for this year.</td></tr>
<tr><td>Data extraction date</td><td>26 January 2026. Cancer audit is a dynamic process with patient data continually being revised and updated as more information becomes available. This means that apparently comparable reports for the same time period and cancer site may produce different figures if extracted at different times.</td></tr>
<tr><td>Data Quality</td><td>
<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>114</td><td>83</td><td>342</td><td>169</td><td>708</td></tr>
<tr><td>Cancer Registry (2019-2023)</td><td>122</td><td>90</td><td>401</td><td>172</td><td>785</td></tr>
<tr><td>Case ascertainment</td><td>93.4%</td><td>92.2%</td><td>85.3%</td><td>98.3%</td><td>90.2%</td></tr>
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