# Audit of the patient pathway in bladder cancer

## Descriptor

Bladder cancer is the 7th most common cancer in the UK. Most are transitional cell carcinomas (TCCs). Muscle invasive bladder cancer can be treated by surgery or radiotherapy (RT), with 30-40% 5-year overall survival. Following a diagnosis of bladder TCC the patient pathway can be complex, with staging investigations, surgical/ anaesthetic assessment, and consideration of chemotherapy and RT. Care needs to be co-ordinated between Urology and Oncology teams and may involve more than one hospital. These factors can lead to delays in the treatment pathway, which can be audited.

## Background

NICE Guidelines for the treatment of bladder cancer, and [RCR Consensus Statements](https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/bladder-cancer-rcr-consensus-statements/), emphasise the importance of a streamlined pathway to improve outcomes. The RCR National Bladder Cancer Audit reported delays in the patient pathway.

## The Cycle

#### The standard:

Two points in the pathway are particularly relevant to a radiotherapy department, the time between diagnosis at TURBT (trans urethral resection of bladder tumour) and referral to Oncology, and the time between decision to proceed with radiotherapy treatment and the RT start date.

1. Time between initial diagnosis and Oncology review should be <31 days where treatment intent is radical
2. Time between decision date for radiotherapy and treatment start date should be <31 days, for both radical and palliative treatments

Standard 1 has no evidence base for using <31 days, so a local standard should be agreed and adopted. This figure was not felt to be unreasonable in our department. Standard 2 is based on cancer waiting times targets.

#### Target:

* Diagnosis to oncology review should be <31 days in 95% (if treatment intent is radical)
* Decision to treat to radiotherapy start should be <31 days in 100%

## Assess local practice

#### Indicators

* Time in days between initial bladder cancer diagnosis (taken as date of TURBT or bladder biopsy with histological confirmation) and initial Oncology clinic review
* Time in days between decision to proceed with radiotherapy, to receiving the first planned fraction
* The decision may be made at the first oncology appointment, or may be delayed until after neo-adjuvant chemotherapy, or delayed to allow more time to consider surgical options

#### Data items to be collected

* Date ofTURBT or initial bladder biopsy
* Date of first oncology clinic review
* Date of decision to proceed with radiotherapy treatment
* Date of first delivered radiotherapy fraction
* Treatment intent (radical or palliative)
* In the majority of centres all these items can be collected using electronic patient management systems, avoiding the need to assess patient notes

#### Suggested number

Different oncology departments see varying numbers of bladder cancer patients. To assess the pathway locally we would suggest auditing all patients receiving bladder cancer radiotherapy over a specified time period - for example, a year for smaller departments and 3-6 months in a larger centre. Clearly with small numbers, even one patient failing to meet the targets will have a significant effect on the results. In this instance looking at average waits in days and the range of waiting times, can give valuable additional information to help assess the performance of a department.

## Suggestions for change if target not met

* Firstly the data needs to be analysed to identify the delays in the pathway
* Significant delays due to capacity issues - for example, not enough Clinical Oncologists or radiotherapy treatment capabilities, this need to be addressed at a senior management level
* Each department should have a guideline outlining the treatment of bladder cancer that is endorsed by the local MDT. If areas are identified that are causing delays, changes can be made within this structure to improve the pathway. Examples include:
- Changing the referral timing to allow simultaneous assessment by surgeons and oncologists after diagnosis, and direct booking into outpatient clinic slots from the MDT. Often these changes involve additional administrative support
* Once changes have been made, re-audit should be carried out to assess if improvements have been made. If standards have been achieved, it is important to continue to re-audit to show that standards have been maintained

## References

1. NICE guidelines - Improving Outcomes in Urological Cancers, ISBN: 1-84257- 210-5, 2002
2. Office for National Statistics (ONS) Cancer Survival in England: Patients diagnosed 2005-2009 and followed up to 2010. London: ONS;2011
3. [Radiotherapy Management of Muscle Invasive Bladder Cancer: Evaluation of a National Cohort.](https://doi.org/10.1016/j.clon.2019.04.009) Varughes M., Treece S. Drinkwater K.J. Clinical Oncology, May 2019. DOI:https://doi.org/10.10l6Lj.clon.2019.04.009
4. [Bladder Cancer - RCR Consensus Statements 2023](https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/bladder-cancer-rcr-consensus-statements/)

## Submitted by

Dr Sarah Treece

#### Co-authors

Dr Martin Cooling

Dr Abigail Hollingdale