

Bladder cancer

NICE quality standard

Draft for consultation

July 2015

Introduction

This quality standard covers diagnosis and management of bladder cancer in adults (18 years and older) referred from primary care. It includes suspected, newly diagnosed and recurrent bladder cancers (urothelial carcinoma, adenocarcinoma, squamous cell carcinoma or small-cell carcinoma) and urethral cancers. For more information see the [bladder cancer topic overview](#).

Why this quality standard is needed

Bladder cancer is defined by the development of a tumour in the lining of the bladder. In the case of non-muscle-invasive bladder cancer, cancerous cells are contained inside the lining of the bladder. Muscle-invasive bladder cancer occurs if cancerous cells spread to the surrounding muscle.

The main risk factor for bladder cancer is increasing age, but smoking and exposure to some industrial chemicals also increase risk.

Bladder cancer is usually identified on the basis of visible blood in the urine or blood found on urine testing, but it can commonly present for the first time as an emergency admission, which is often associated with a poor prognosis.

Bladder cancer is the seventh most common cancer in the UK, with just over 10,000 cases diagnosed each year¹. It is also the seventh most common cause of cancer death in the UK, with around 5000 deaths each year². Bladder cancer is 3–4 times more common in men than in women, and the majority of cases occur in people aged over 60. The involvement of the urogenital tract and the nature of the

¹ Cancer Research UK (2013) [Bladder cancer incidence statistics](#)

² Cancer Research UK (2013) [Bladder cancer mortality statistics](#)

treatments give this cancer a strong psychological impact, in addition to the physical impact of the disease and its treatments, which is often profound.

Most bladder cancers (75–80%) do not involve the muscle wall of the bladder and are usually treated with telescopic removal of the cancer (transurethral resection of bladder tumour [TURBT]). This may be followed by instillation of chemotherapy or vaccine-based therapy into the bladder, with prolonged telescopic checking of the bladder (cystoscopy) as follow-up. Some people in this group who are at higher risk of poor prognosis are treated with major surgery to remove the bladder (cystectomy). Adults with cancer in or through the bladder muscle wall may be treated with intent to cure using chemotherapy, cystectomy or radiotherapy, and those who have cancer too advanced to cure may have radiotherapy and chemotherapy.

The quality standard is expected to contribute to improvements in the following outcomes:

- premature mortality
- experience of care: hospital and outpatient services
- experience of carers: palliative care
- quality of life for adults with bladder cancer.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2015–16](#)
- [Public Health Outcomes Framework 2013–2016](#).

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [NHS Outcomes Framework 2015–16](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p>Overarching indicators</p> <p>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare:</p> <p>i Adults</p> <p>1b Life expectancy at 75</p> <p>i Males ii Females</p> <p>Improvement areas</p> <p>Reducing premature mortality from the major causes of death</p> <p>1.4 Under 75 mortality rate from cancer* (PHOF 4.5)</p> <p>i One- and ii Five-year survival from all cancers</p> <p>v <i>One-</i> and vi <i>Five-year survival from cancers diagnosed at stage 1&2</i>** (PHOF 2.19)</p>
4 Ensuring that people have a positive experience of care	<p>Overarching indicator</p> <p>4b Patient experience of hospital care</p> <p>4d <i>Patient experience characterised as poor or worse</i></p> <p>ii. <i>Hospital care</i></p> <p>Improvement areas</p> <p>Improving people’s experience of outpatient care</p> <p>4.1 Patient experience of outpatient services</p> <p>Improving hospitals’ responsiveness to personal needs</p> <p>4.2 Responsiveness to in-patients’ personal needs</p> <p>Improving people’s experience of accident and emergency services</p> <p>4.3 Patient experience of A&E services</p> <p>Improving the experience of care for people at the end of their lives</p> <p>4.6 Bereaved carers’ views on the quality of care in the last 3 months of life</p>
<p>Alignment across the health and social care system</p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p>	

Table 2 [Public health outcomes framework for England, 2013–2016](#)

Domain	Objectives and indicators
2 Health improvement	<p>Objective</p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities.</p> <p>Indicators</p> <p>2.19 Cancer diagnosed at stage 1 and 2** (NHSOF 1.4)</p>
4 Healthcare public health and preventing premature mortality	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities.</p> <p>Indicators</p> <p>4.3 Mortality rate from causes considered preventable** (NHSOF 1a)</p> <p>4.5 Under 75 mortality rate from cancer* (NHSOF 1.4)</p>
<p>Alignment across the health and social care system</p> <p>* Indicator shared with the NHS Outcomes Framework</p> <p>** Complementary indicators in the NHS Outcomes Framework</p>	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to bladder cancer.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and are supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for bladder cancer specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole bladder cancer care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults with bladder cancer.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality.

Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality bladder cancer service are listed in Related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health, public health and social care practitioners involved in assessing, caring for and treating adults with bladder cancer should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting adults with bladder cancer. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

[Statement 1](#). Adults who are having transurethral resection of bladder tumour (TURBT) have detrusor muscle obtained during the procedure.

[Statement 2](#). Adults with suspected bladder cancer are offered a single dose of intravesical mitomycin C, given at the same time as the first transurethral resection of bladder tumour (TURBT).

[Statement 3](#). Adults with bladder cancer have a designated clinical nurse specialist.

[Statement 4](#). Adults with newly diagnosed non-muscle-invasive bladder cancer have prognostic information recorded and have a risk classification of their cancer completed.

[Statement 5](#). Adults with high-risk non-muscle-invasive bladder cancer have a discussion about intravesical Bacille Calmette-Guérin (BCG) and radical cystectomy as treatment options.

[Statement 6](#). Adults with muscle-invasive urothelial bladder cancer have a discussion about neoadjuvant chemotherapy, radical cystectomy and radiotherapy with a radiosensitiser as treatment options.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 For each quality statement what do you think could be done to support improvement and help overcome barriers?

Question 4 Should a statement be included that focuses on discharge to primary care for adults with low-risk non-muscle-invasive bladder cancer if they have no recurrence of the bladder cancer within 12 months?

Quality statement 1: Obtaining detrusor muscle during transurethral resection of bladder tumour

Quality statement

Adults who are having transurethral resection of bladder tumour (TURBT) have detrusor muscle obtained during the procedure.

Rationale

Obtaining detrusor muscle at TURBT is important for assessing the stage and type of bladder cancer, which can help to identify the most effective treatment.

Quality measures

Structure

Evidence of local arrangements to ensure that adults having TURBT have detrusor muscle obtained during the procedure.

Data source: Local data collection.

Process

Proportion of TURBT procedures during which detrusor muscle was obtained.

Numerator – the number in the denominator where a sample of detrusor muscle was taken at the time of performing the TURBT.

Denominator – the number of TURBT procedures performed.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for example secondary care services) ensure that systems are in place for adults who are having TURBT to have detrusor muscle obtained during the procedure.

Healthcare professionals ensure that adults who are having TURBT have detrusor muscle obtained during the procedure.

Commissioners (for example clinical commissioning groups) ensure that they commission services that obtain detrusor muscle during TURBT.

What the quality statement means for patients and carers

Adults who are having transurethral resection of bladder tumour (a type of biopsy procedure to take tissue samples for testing), have tissue from the muscle wall of their bladder included in the samples taken. This is to check whether there is bladder cancer that has grown into the muscle wall so that the correct treatment can be offered.

Source guidance

- [Bladder cancer: diagnosis and management](#) (2015) NICE guideline NG2, recommendation 1.2.4

Quality statement 2: Chemotherapy during transurethral resection of bladder tumour

Quality statement

Adults with suspected bladder cancer are offered a single dose of intravesical mitomycin C, given at the same time as the first transurethral resection of bladder tumour (TURBT).

Rationale

A single dose of intravesical mitomycin C given at the same time as the first TURBT has been found to reduce recurrence rates and slow progression of bladder cancer.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with suspected bladder cancer who are having a first TURBT are offered a single dose of intravesical mitomycin C, at the same time as the TURBT.

Data source: Local data collection.

Process

Proportion of first TURBT procedures in which adults with suspected bladder cancer are given a single dose of intravesical mitomycin C.

Numerator – the number in the denominator in which a single dose of intravesical mitomycin C is given.

Denominator – the number of first TURBTs performed for adults with suspected bladder cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for example secondary care services) ensure that systems are in place for adults with suspected bladder cancer who are having a first TURBT to be offered a single dose of intravesical mitomycin C given at the same time as the TURBT.

Healthcare professionals offer adults with suspected bladder cancer who are having their first TURBT a single dose of intravesical mitomycin C given at the same time as the TURBT.

Commissioners (for example clinical commissioning groups) ensure that they commission services that offer adults with suspected bladder cancer who are having their first TURBT a single dose of intravesical mitomycin C given at the same time as the TURBT.

What the quality statement means for patients and carers

Adults who are having transurethral resection of bladder tumour for the first time (a type of biopsy procedure to take tissue samples for testing) are offered one dose of an anticancer drug called mitomycin C, which is given when they have the operation. If cancer is found in their bladder, mitomycin C can slow its growth and reduce the chance of it coming back again in the future.

Source guidance

- [Bladder cancer: diagnosis and management](#) (2015) NICE guideline NG2, recommendation 1.2.7

Quality statement 3: Support from a clinical nurse specialist

Quality statement

Adults with bladder cancer have a designated clinical nurse specialist.

Rationale

Symptoms, investigations and treatments for bladder cancer affect the urogenital organs and may be distressing and intrusive. It has been shown that adults with bladder cancer who are supported by a clinical nurse specialist have a better experience of bladder cancer services. The clinical nurse specialist can be involved in discussions about treatment options and act as the person's key worker to address their information and care needs, including psychosocial support and palliative care if needed. They can also discuss the impact of treatment on the person's body image and sexual health, and help them find relevant information.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with bladder cancer have a designated clinical nurse specialist.

Data source: Local data collection.

Process

Proportion of adults with bladder cancer who have a designated clinical nurse specialist.

Numerator – the number in the denominator who have a designated clinical nurse specialist.

Denominator – the number of adults with bladder cancer.

Data source: Local data collection.

Outcome

Satisfaction with support received from a clinical nurse specialist, reported by adults with bladder cancer.

Data source: Local data collection. The [National cancer patient experience survey](#) collects data on support from a clinical nurse specialist for adults with urological cancers.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for example secondary care services) ensure that systems are in place for adults with bladder cancer to have a designated clinical nurse specialist.

Healthcare professionals offer adults with bladder cancer support from a designated clinical nurse specialist.

Commissioners (for example clinical commissioning groups) ensure that they commission services that offer adults with bladder cancer support from a designated clinical nurse specialist.

What the quality statement means for patients and carers

Adults with bladder cancer are offered support from a designated clinical nurse specialist who has experience in caring for people with bladder cancer. The clinical nurse specialist can provide information about bladder cancer and the treatment options, and help them find information and other support they might need.

Source guidance

- [Bladder cancer: diagnosis and management](#) (2015) NICE guideline NG2, recommendations 1.1.2, 1.1.3

Quality statement 4: Prognostic information and risk classification

Quality statement

Adults with newly diagnosed non-muscle-invasive bladder cancer have prognostic information recorded and have a risk classification of their cancer completed.

Rationale

Prognostic information and risk classification of non-muscle-invasive bladder cancer informs discussions about risk and supports treatment planning. It is used in multidisciplinary team discussions and in discussion with the person with bladder cancer to help decide treatment options.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with newly diagnosed non-muscle-invasive bladder cancer have prognostic information recorded and have a risk classification of their cancer completed.

Data source: Local data collection.

Process

Proportion of adults with newly diagnosed non-muscle-invasive bladder cancer who have prognostic information recorded and have a risk classification of their cancer completed.

Numerator – the number in the denominator who have prognostic information recorded and have a risk classification of their cancer completed.

Denominator – the number of adults with a new diagnosis of non-muscle-invasive bladder cancer in the last 12 months.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for example secondary care services) ensure that systems are in place for adults with newly diagnosed non-muscle-invasive bladder cancer to have prognostic information recorded and have a risk classification completed.

Healthcare professionals record prognostic information and complete a risk classification for adults with newly diagnosed non-muscle-invasive bladder cancer.

Commissioners (for example clinical commissioning groups) ensure that they commission services that record prognostic information and complete a risk classification for adults with newly diagnosed non-muscle-invasive bladder cancer.

What the quality statement means for patients, service users and carers

Adults with bladder cancer that has not grown into the muscle wall of the bladder have information about the likely future risk from their cancer, including the risk of it growing into the muscle wall, recorded in their notes when their cancer is first diagnosed. This information helps them and their doctors to decide the best treatment options.

Source guidance

- [Bladder cancer: diagnosis and management](#) (2015) NICE guideline NG2, recommendation 1.3.1

Definitions of terms used in this quality statement

Prognostic information

For adults with non-muscle-invasive bladder cancer, all of the following should be recorded and used to guide discussions, both within multidisciplinary team meetings and with the person, about prognosis and treatment options:

- recurrence history
- size and number of cancers

- histological type, grade, stage and presence (or absence) of flat urothelium, detrusor muscle (muscularis propria), and carcinoma in situ
- the risk category of the person's cancer
- predicted risk of recurrence and progression, estimated using a risk prediction tool.

[[Bladder cancer: diagnosis and management](#) (NICE guideline NG2) recommendation 1.3.1]

Risk classification of non-muscle-invasive bladder cancer

Low-risk

Urothelial cancer with any of:

- solitary pTaG1 with a diameter of less than 3 cm
- solitary pTaG2 (low grade) with a diameter of less than 3 cm
- any papillary urothelial neoplasm of low malignant potential.

Intermediate risk

Urothelial cancer that is not low risk or high risk, including:

- solitary pTaG1 with a diameter of more than 3 cm
- multifocal pTaG1
- solitary pTaG2 (low grade) with a diameter of more than 3 cm
- multifocal pTaG2 (low grade)
- pTaG2 (high grade)
- any pTaG2 (grade not further specified)
- any low-risk non-muscle-invasive bladder cancer recurring within 12 months of last tumour occurrence.

High risk

Urothelial cancer with any of:

- pTaG3
- pT1G2
- pT1G3

- pTis (Cis)
aggressive variants of urothelial carcinoma, for example micropapillary or nested variants

[\[Bladder cancer: diagnosis and management\]](#) (NICE guideline NG2) section 1.3].

Quality statement 5: Discussing treatment options for high-risk non-muscle-invasive bladder cancer

Quality statement

Adults with high-risk non-muscle-invasive bladder cancer have a discussion about intravesical Bacille Calmette-Guérin (BCG) and radical cystectomy as treatment options.

Rationale

Discussing the benefits and risks of BCG therapy and radical cystectomy helps adults to make an informed choice of treatment. It ensures that they are aware of the possible outcomes and implications of both treatments, including likely effects on their quality of life, body image, and sexual and urinary function.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with high-risk non-muscle-invasive bladder cancer have a discussion about intravesical BCG and radical cystectomy before a treatment option is agreed.

Data source: Local data collection.

Process

The proportion of adults with high-risk non-muscle-invasive bladder cancer who have a discussion about intravesical BCG and radical cystectomy as treatment options.

Numerator – the number in the denominator who had a discussion about intravesical BCG and radical cystectomy.

Denominator – the number of adults with high-risk non-muscle-invasive bladder cancer.

Data source: Local data collection.

Outcome

a) Reported understanding of the treatment options available by adults with high-risk non-muscle-invasive bladder cancer.

Data source: Local data collection.

b) Ratio of intravesical BCG to radical cystectomy procedures for the treatment of high-risk non-muscle-invasive bladder cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for example secondary care services) ensure that systems are in place for adults with high-risk non-muscle-invasive bladder cancer to have a discussion about intravesical BCG and radical cystectomy before agreeing a treatment option.

Healthcare professionals (clinical nurse specialists, urologists who perform both intravesical BCG and radical cystectomy) discuss intravesical BCG and radical cystectomy with adults with high-risk non-muscle-invasive bladder cancer before agreeing a treatment option.

Commissioners (for example clinical commissioning groups) ensure that they commission services that discuss intravesical BCG and radical cystectomy with adults who have high-risk non-muscle-invasive bladder cancer before agreeing a treatment option.

What the quality statement means for patients and carers

Adults with bladder cancer that has not grown into the muscle wall of the bladder, but has a high risk of growing have a discussion with a clinical nurse specialist and a specialist bladder cancer doctor about having treatment either with a vaccine called BCG, which can stop the cancer growing, or by having their bladder removed (cystectomy). Knowing the benefits and risks of these treatment options, including the effects on their future quality of life, will help them to choose the option that is best for them.

Source guidance

- [Bladder cancer: diagnosis and management](#) (2015) NICE guideline NG2, recommendation 1.3.6

Definitions of terms used in this quality statement

Discussion

Adults with high-risk non-muscle-invasive bladder cancer should be offered a choice of intravesical BCG or radical cystectomy, based on a full discussion with the person, the clinical nurse specialist and a urologist who performs both intravesical BCG and radical cystectomy. The discussion includes:

- the type, stage and grade of the cancer, the presence of carcinoma in situ, the presence of variant pathology, prostatic urethral or bladder neck status and the number of tumours
- risk of progression to muscle invasion, metastases and death
- risk of understaging
- benefits of both treatments, including survival rates and the likelihood of further treatment
- risks of both treatments
- factors that affect outcomes (for example, comorbidities and life expectancy)
- impact on quality of life, body image, and sexual and urinary function.

[[Bladder cancer: diagnosis and management](#) (NICE guideline NG2) recommendation 1.3.6].

Equality and diversity considerations

Radical cystectomy may not be suitable for people who have problems with manual dexterity or cognitive function, or people who have visual impairment.

Quality statement 6: Discussing treatment options for muscle-invasive urothelial bladder cancer

Quality statement

Adults with muscle-invasive urothelial bladder cancer have a discussion about neoadjuvant chemotherapy, radical cystectomy and radiotherapy with a radiosensitiser as treatment options.

Rationale

Discussing the benefits and risks of neoadjuvant chemotherapy and cystectomy helps adults to make an informed choice of treatment. It ensures that they are aware of the possible outcomes and implications of both treatments, including likely effects on their quality of life, body image, and sexual and urinary function.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with muscle-invasive urothelial bladder cancer have a discussion about neoadjuvant chemotherapy, radical cystectomy and radiotherapy with a radiosensitiser before a treatment option is agreed.

Data source: Local data collection.

Process

The proportion of adults with muscle-invasive urothelial bladder cancer who have a discussion about neoadjuvant chemotherapy, radical cystectomy and radiotherapy with a radiosensitiser before agreeing a treatment option.

Numerator – the number in the denominator who had a discussion about neoadjuvant chemotherapy, radical cystectomy and radiotherapy with a radiosensitiser .

Denominator – the number of adults with muscle-invasive urothelial bladder cancer.

Data source: Local data collection.

Outcome

Reported understanding of the treatment options available by adults with muscle-invasive urothelial bladder cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for example secondary care services) ensure that systems are in place for adults with muscle-invasive urothelial bladder cancer to have a discussion about neoadjuvant chemotherapy, radical cystectomy and radiotherapy with a radiosensitiser before agreeing a treatment option.

Healthcare professionals (urologists who perform radical cystectomy, oncologists who treat bladder cancer, clinical oncologists and clinical nurse specialists) discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy with a radiosensitiser with adults who have muscle-invasive urothelial bladder cancer before agreeing a treatment option.

Commissioners (for example clinical commissioning groups) ensure that they commission services that discuss neoadjuvant chemotherapy, radical cystectomy and radiotherapy with a radiosensitiser with adults who have muscle-invasive urothelial bladder cancer before agreeing a treatment option.

What the quality statement means for patients, service users and carers

Adults with bladder cancer that has grown into the muscle wall of the bladder have a discussion with a clinical nurse specialist and specialist bladder cancer doctors about either having their bladder removed (cystectomy) or having radiotherapy (high-energy rays that destroy cancer cells). They also discuss having chemotherapy (treatment with anticancer drugs) before having their bladder removed or having radiotherapy. Knowing the benefits and risks of these treatment options, including the effects on their future quality of life, will help them to choose the option that is best for them.

Source guidance

- [Bladder cancer: diagnosis and management](#) (2015) NICE guideline NG2, recommendations 1.5.2 and 1.5.3

Definitions of terms used in this quality statement

Discussion

Adults with newly diagnosed muscle-invasive urothelial bladder cancer for whom cisplatin-based chemotherapy is suitable should be offered neoadjuvant chemotherapy using a cisplatin combination regimen before radical cystectomy or radical radiotherapy. They should have an opportunity to discuss the risks and benefits with an oncologist who treats bladder cancer.

[[Bladder cancer: diagnosis and management](#) (NICE guideline NG2) recommendation 1.5.2].

Adults with muscle-invasive urothelial bladder cancer for whom radical therapy is suitable should be offered a choice of radical cystectomy or radiotherapy with a radiosensitiser, and have their choice of treatment based on a discussion with a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist.

The discussion includes:

- the prognosis with or without treatment
- the limited evidence about whether surgery or radiotherapy with a radiosensitiser is the most effective cancer treatment
- the benefits and risks of surgery and radiotherapy with a radiosensitiser, including the impact on sexual and bowel function and the risk of death as a result of the treatment.

[[Bladder cancer: diagnosis and management](#) (NICE guideline NG2) recommendation 1.5.3].

Equality and diversity considerations

Radical cystectomy may not be suitable for people who have problems with manual dexterity or cognitive function, or people who have visual impairment.

Status of this quality standard

This is the draft quality standard released for consultation from 23 July to 18 August. It is not NICE's final quality standard on bladder cancer. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 18 August. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the [NICE website](#) from December 2015.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its [Indicators for Quality Improvement Programme](#). If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's [What makes up a NICE quality standard?](#) for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources, NICE's cancer service guidance on [improving outcomes in urological cancers](#) and the National Cancer Peer Review Programme's [Manual for cancer services: urology](#).

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between healthcare professionals and adults with bladder cancer is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with bladder cancer should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards [Process guide](#).

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Bladder cancer: diagnosis and management](#) (2015) NICE guideline NG2

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- National Audit Office (2015) [Progress in improving cancer services and outcomes in England](#)
- Department of Health (2014) [National cancer patient experience survey](#)
- Department of Health (2014) [The national cancer strategy: 4th annual report](#)
- Map of Medicine (2014) [Bladder cancer – suspected \(A–Z, Athens login required\)](#)
- NHS England (2014) [Manual for cancer services – urology measures](#)
- [Solutions for Public Health \(2014\)](#)
- National Cancer Intelligence Network (2013) [Bladder cancer incidence, mortality and survival rates in the United Kingdom](#)
- Department of Health (2012) [Improving older people's access to cancer treatment services](#)
- Department of Health (2011) [Commissioning cancer services](#)
- National Cancer Intelligence Network (2011) [Survival in patients treated by cystectomy for bladder cancer](#)
- Royal College of General Practitioners (2011) [National audit of cancer diagnosis in primary care](#)

Definitions and data sources for the quality measures

- Quality Health (2011) [National cancer patient experience survey](#)

Related NICE quality standards

Published

- [Prostate cancer](#) (2015) NICE quality standard 91
- [Children and young people with cancer](#) (2014) NICE quality standard 55
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Referral for suspected cancer

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

Ms Deryn Bishop

Public Health Behaviour Change Specialist, Solihull Public Health Department

Dr Alastair Bradley

General Medical Practitioner, Tramways Medical Centre/Academic Unit of Primary Medical Care, University of Sheffield

Jan Dawson

Registered Dietitian

Dr Matthew Fay

GP, Westcliffe Medical Practice, Shipley, West Yorkshire

Dr Malcolm Fisk

Co-Director, Ageing Society Grand Challenge Initiative, Coventry University

Ms Margaret Goose

Lay member

Dr Madhavan Krishnaswamy

Consultant Clinical Oncologist, Southend University Hospital NHS Trust

Mrs Geeta Kumar

Clinical Director, Women's Services (East) Betsi Cadwaladr University Health Board

Mrs Rhian Last

Clinical Lead, Education For Health

Dr Hugh McIntyre (Chair)

Consultant Physician, East Sussex Healthcare Trust

Ms Ann Nevinson

Lay member

Dr Jane O'Grady

Director of Public Health, Buckinghamshire County Council

Mrs Jane Orr-Campbell

Director, Orr-Campbell Consultancy, Bedfordshire

Professor Gillian Parker

Professor of Social Policy Research and Director, Social Policy Research Unit,
University of York

Mr David Pugh

Independent Consultant, Gloucestershire County Council

Dr Eve Scott

Head of Safety and Risk, The Christie NHS Foundation Trust, Manchester

Dr Jim Stephenson

Consultant Medical Microbiologist, Epsom and St Helier NHS Trust

Mr Darryl Thompson

Registered Nurse (Mental Health), South West Yorkshire Partnership NHS
Foundation Trust

Mrs Julia Thompson

Health Improvement Principal, Sheffield City Council

Mrs Sarah Williamson

Clinical Quality Assurance and Performance Manager, NHS Stockport Clinical
Commissioning Group

The following specialist members joined the committee to develop this quality
standard:

Dr Ananya Choudhury

Consultant and Honorary Senior Clinical Lecturer, Clinical Oncology, The Christie
NHS Foundation Trust

Dr Ben Taylor

Consultant Radiologist, The Christie NHS Foundation Trust

Mrs Susan Thompson

Clinical Nurse Specialist

Mr William Turner

Consultant Urologist, Cambridge University Hospitals NHS Foundation Trust

Mr Andrew Winterbottom

Lay member

NICE project team

Mark Minchin

Associate Director

Karen Slade

Consultant Clinical Adviser

Michelle Gilberthorpe

Lead Technical Analyst

Rachel Neary-Jones

Programme Manager

Esther Clifford

Project Manager

Liane Marsh

Coordinator

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathway on [bladder cancer](#).

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