WEST MIDLANDS CANCER ALLIANCE

Bladder Standards of Care

November 2025

West Midlands Cancer Alliance

EAG name	Urology EAG	
Document Title	Bladder Standards of Care	
Published date	November 2025	
Document Purpose	The aim of this document is to provide recommendations for streamlining the bladder cancer MDT and does not represent clinical guidelines.	
Authors	Mr David Mak, Consultant Urologist Mr Altan Omer, Consultant Urologist, WMCA Clinical Pathway Lead and EAG Chair Mr David Mathews, Consultant Urologist and EAG Deputy Chair The West Midlands Cancer Alliance Urology EAG membership	
Review Date (must be within three years)	November 2028	
Approval Signatures	**Urology EAG Chair** **Mr Altan Omer**  Date: 22.10.2025	**WMCA Clinical Director** **Dr Lydia Fresco**  Date: 14.11.2025

Version Control

Version	Date	Amendments
0.1	June 2025	Created by The Royal Wolverhampton NHS Trust (RWT) led by Mr David Mak.
0.2	August 2025	Encompasses comments from the Urology EAG on the 3rd of June 2025.
0.3	September 2025	Encompasses comments from the Urology EAG on the 10th September 2025.
1.0	November 2025	Ratified by the WMCA Urology EAG and WMCA Clinical Cabinet

Contents

1. INTRODUCTION 5
2. LISTING FOR CASES FOR MDT 6
3. BLADDER CANCER 8
3.1 RISK STRATIFICATION OF BLADDER CANCER PATIENTS FOR MDT DISCUSSION 8
3.2 RISK STRATIFICATION OF BLADDER PATIENTS UNDER SURVEILLANCE/MAINTENANCE TREATMENT FOR MDT DISCUSSION 10
3.3 RADICAL CYSTECTOMY BLADDER PATIENTS 11
3.4 MINIMUM CLINICAL DATASET FOR BLADDER PATIENTS DISCUSSED AT MDT 11

1.Introduction

The multi-disciplinary team (MDT) has been the cornerstone of cancer care delivery since the Calman-Hine report in 1995 and National Cancer Plan in 2000. Although it was originally mandated that all patients with cancer would be discussed by an MDT, the cancer landscape has changed with the demand for more personalised treatments to a higher volume of patients with more case complexity.

With the ever-increasing burden and workload on MDTs, there is a need to optimise case discussions to derive the full benefit of MDT meetings and provide input where it is needed. In line with guidance published from NHS England and NHS Improvement on streamlining MDT meetings, Standards of Care (SoC) have been introduced in various institutions to good effect with up to 25% of pelvic uro-oncology cases being streamlined and MDT discussion avoided.

There is a requirement for SoCs to be introduced as a routine part of the Urology MDT meetings to stratify patients into those that require full multidisciplinary discussion and those that can be listed but not discussed in the MDT meeting when the patient needs are met by a SoC.

Implementation of SoCs will require more work outside of the MDT meeting, including after the MDT for audit purposes, as well as support from and increased responsibility and input of all clinicians (benign or malignant) whether involved in MDT meeting discussions or not.

A regional SoC is required to decrease the variability in patient management. The West Midlands Cancer Alliance (WMCA) Urology Expert Advisory Group (EAG) had the task to review and agree the proposed SoC document. This was based on the MDT streamlining document by Mr David Mak, Consultant Urologist at RWT based on multiple sources, which are referenced below. A summary of the recommendations made during the EAG is included in the post-EAG meeting minutes document, which can be obtained on request from the WMCA.

This document outlines the various processes around the Urology MDT to facilitate streamlining with the objective of maximising MDT management discussion for patients with complex urological cancer disease that requires a full multidisciplinary approach while protocolising the management of patients with less complex disease for which national guidance (EAU and NICE) is sufficient for decision making.

2. Listing for Cases for MDT

The primary responsibility of listing of patients for formal discussion at MDT lies with the responsible clinician.

Requests for formal discussion at MDT must include a valid clinical question. The role of the MDT is to provide recommendations for treatment, in addition to oversight of clinical governance of cancer patient management. The responsibility of the final treatment choice lies with both the patient and responsible clinician.

When cases are listed for MDT, it must be indicated whether histology review, radiology review or both are required.

As outlined in this document, each of the organ site specific standards of care should be adhered to and guides whether patients are to be formally discussed at MDT or protocoled.

New diagnoses of urological malignancy will be listed on MDT, but not all will be formally discussed in line with the standards of care. Those cases that conform to a SoC will be protocoled.

Patients with benign histopathology will not be formally discussed at MDT unless the responsible clinician detects discrepancies. The responsible clinician must review these results and request MDT discussion if warranted. Benign histology includes – benign prostate biopsies, benign bladder biopsies/TURBT specimens and benign renal biopsies.

All tertiary referrals will be formally discussed at MDT. It is essential that all investigations have been received at the tertiary centre before listing and review. The referring clinical team must ensure all relevant information is provided and indicate the investigations that require review. If tertiary referrals are incomplete and further information is required, the case will not be listed at MDT and sent back to the referring clinical team.

Surveillance scans and investigations will not be routinely discussed at MDT. The responsible clinician must review the result of investigations of those patients following a surveillance protocol to determine if formal MDT discussion is required.

All patients who may be eligible for a clinical trial will be listed and discussed at the MDT.

Re-discussion of patients who are already being managed under an agreed MDT plan can be warranted if they are complex or if new pertinent information arises that requires discussion by more than one discipline. Patients that require discussion only by one discipline should not be discussed at MDT, but within their own directorate.

Clinicians could request formal discussion of cases if the criteria outlined in the SoC guidance are not fulfilled and if formal MDT discussion is warranted.

When patients are listed for formal MDT discussion, the relevant minimum datasets must be provided by the referring clinician as outlined in the specific organ site guidance detailed below. This will facilitate detailed and accurate discussion of cases. If minimum datasets are not complete, the responsible clinician will be requested to provide the necessary information before listing on MDT.

Whenever possible, all relevant investigations (particularly radiological investigations) should be completed before listing at the MDT, unless a particular initial investigation may alter management or latter investigations would not change a potential MDT outcome.

Note that for review of imported radiological investigations from other Trusts, the image reports must be available for MDT discussion. Cases from other Trusts will not be listed when the image reports are not available.

Table 1 – Summary of criteria for listing at MDT

New diagnosis of urological malignancy	Listed for MDT • Protocoled if standard of care can be applied, • Formally discussed as per SoC guidance,
Tertiary referrals	All cases listed and formally discussed at MDT
Benign histology	Not listed for MDT Responsible clinician to request MDT discussion if warranted after clinical review.
Surveillance investigations	Not listed for MDT Responsible clinician to request MDT discussion if warranted after clinical review.
Eligible for clinical trial	All cases to be listed and formally discussed at MDT

3. Bladder Cancer

3.1 Risk stratification of bladder cancer patients for MDT discussion

Bladder cancer patients will be risk stratified according to their tumour histological subtype and grade, size, focality and history of previous bladder or upper tract disease, in alignment with European Association of Urology Guidelines.

Patients will be further characterised according to life expectancy, co-morbidities and performance status.

All patients considered for clinical trials should be discussed in the MDT.

Criteria for discussion at MDT are:

- all intermediate and high-risk bladder cancer cases and new diagnosis of metastatic bladder cancer cases must be discussed at MDT.
- low risk disease will be protocoled according to their potential follow-up options and not formally discussed at the MDM/SMDM-rather the MDM chair will ratify the standard.

Patients that do not fit the criteria in Table 2 can be discussed in full at the MDT following clinician request.

Table 2. Standards of care for bladder cancer patients

Risk Group	Standard of Care Guidelines
High risk bladder cancer cases • Non-urothelial histological subtypes: • Squamous cell carcinoma • Adenocarcinoma • Small cell carcinoma • Unusual histological subtypes (lymphoma, etc) High grade urothelial carcinoma: • pTaG3 / High grade • pT1G2 / High grade • pT1G3 / High grade	Discuss all cases at MDT Consider discussion of suspected muscle invasive bladder cancer patients with radiological investigations and urine cytology prior to transurethral resection of bladder tumour where TURBT may not be essential in determining treatment decisions. If there is unequivocal radiological evidence of muscle invasive disease and histological confirmation of urothelial malignancy (i.e. on urine cytology or T1 disease from TURBT histology), the bladder malignancy should be treated as muscle invasive

• pTis (Cis) Aggressive variants of urothelial carcinoma (e.g. micropapillary or nested variants)	disease despite not having been evidenced as T2 histologically.
Muscle invasive pT2 and above Non-muscle invasive cancers who fail BCG treatment / hyperthermic mitomycin C	
Intermediate risk bladder cancer cases (urothelial) • 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) • Any pTaG2 (grade not further specified) • Any low-risk non-muscle-invasive bladder cancer recurring within 12 months of last tumour occurrence	Standard of care For intravesical mitomycin C treatment in accordance with local policy. OR Symptomatic Control - if marked co-morbidity or poor performance status This can also be considered if patient rejects cystoscopic surveillance or if patient life expectancy <5 years although benefits of surveillance may be in favour of younger men. [Follow up – F2F / Telephone OP with responsible/operating clinician/CNS team where appropriate – Priority 2]
Intermediate to high-risk bladder cancer cases • Urothelial: Recurrent pTaG2 (high grade)	Discuss all cases at MDT Recommend BCG
Low risk bladder cancer cases • Solitary pTaG1 with a diameter of less than 3 cm • Solitary pTaG2 (low grade) with a diameter of less than 3 cm.	Standard of care Recommend surveillance cystoscopy as first choice, in line with BAUS / NICE guidelines, with initial cystoscopy surveillance in 3 months and subsequent 12-month cystoscopy with a view to discharge if no recurrence. Symptomatic Control - if marked co-morbidity or poor performance status.

• Any papillary urothelial neoplasm of low malignant potential	[Follow up – F2F / Telephone OP with responsible/operating clinician/CNS team where appropriate – Priority 2]
Patients after radical cystectomy	Discuss all cases at MDT Consider referral to oncology and adjuvant therapy where appropriate. Consider PDL1 testing.
Metastatic bladder cancer cases Definition of metastatic disease: • Pelvic or Non-Pelvic Lymph Node • Bone • Soft tissue harbouring bladder cancer in addition to local bladder cancer on imaging	Discuss all cases at MDT Consider PDL1 testing.
Metastatic bladder cancer with marked comorbidity making unsuitable for chemotherapy or immunotherapy	Standard of care Symptomatic Control Only. Consider referral to oncology if for palliative treatment. Referral to community palliative care team. [Follow up – F2F Outpatient appointment with Any – Priority 2]

3.2 Risk stratification of bladder patients under surveillance/maintenance treatment for MDT discussion

Patients who are undergoing BCG treatment for high grade non-muscle invasive bladder cancer, will not be formally discussed at the MDT unless requested by the responsible clinician. Surveillance bladder biopsies and radiological imaging will be assessed by the responsible clinician. If surveillance investigations suggest a need for change in treatment strategy and MDT discussion is warranted, it is the responsibility of the responsible clinician to request formal discussion at MDT.

Bladder cancer patients who have previously undergone radical cystectomy and are under surveillance, will not formally be discussed at MDT meetings. If surveillance investigations

indicate a need for change in treatment strategy, the responsible clinician will request formal discussion at MDT.

3.3 Radical cystectomy bladder patients

All patients who have undergone a radical cystectomy for bladder cancer, will be formally discussed at the MDT to review post operative histology, need for adjuvant treatment and eligibility for clinical trials.

3.4 Minimum clinical dataset for bladder patients discussed at MDT

When a patient is added to the MDT irrespective of whether the patient's case is protocoled or formally discussed, the data items outlined in Table 3 (the minimum clinical dataset) must be provided.

Table 3 - Minimum clinical dataset for bladder patients discussed at MDT

Required minimum clinical dataset
Patient age
Is patient aware of diagnosis
Co-morbidity – listed in words
Smoking history
ASA grade
Performance status (WHO)
Bladder tumour characteristics – size of tumour, number of lesions, appearance (solid/papillary), macroscopic clearance
TNM staging
Histological findings – Grade, stage and presence of detrusor muscle
Any previous history of bladder cancer and treatment received to date
Imaging performed to date [MRI, Bone Scan, CT, PET Scan]
Renal function – eGFR
Is patient eligible for a clinical trial
Family history
Symptoms – e.g. haematuria
Type of MDT Discussion held – Standard of Care or Full MDT Discussion