

B14/S/b

**2013/14 NHS STANDARD CONTRACT
FOR PENILE CANCER**

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	B14/S/b
Service	Penile cancer
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National context

Penile cancer treatment is delivered under specialist urological cancer services. Cancer of the penis is rare in England and is most often diagnosed in men aged 50 and over, although it does also occur in younger men. There are just over 400 cases of penile cancer diagnosed in England each year, with a crude incidence rate of 1.3 per 100,000 male population.

The most common treatment for the primary lesion is surgery although radiotherapy is occasionally used. Topical chemotherapy (5-FU or imiquimod), surgery or laser treatment can be used for pre-malignant lesions of the penis (carcinoma in situ). Radiotherapy or systemic chemotherapy is also used for metastatic disease.

Local context

There are different levels of care for penile cancer: local care, specialist care and supranetwork care. This specification focuses on specialist and supranetwork care services.

The national model requires penile cancer services to be managed at a supranetwork level with appropriate commissioner, clinical and user representation. The supranetwork primarily receives referrals from: local urology teams within the cancer network in addition to cross referrals from related specialties such as dermatology, GUM, and GPs. Representatives from the supranetwork penile service work with members of the specialist urological cancer teams to develop treatment and referral protocols and ensure that the service works in a co-ordinated way.

Evidence Base

This specification draws its evidence and rationale from a range of documents and reviews as listed below:

Department of Health

- Improving Outcomes; a Strategy for Cancer – Department of Health (2011)
- Cancer Commissioning Guidance - Department of Health (2011)
- Five year forward view - Department of Health (2014)
- Report of the Independent Cancer Taskforce - 'Achieving World-Class Cancer Outcomes: A Strategy for the NHS 2015-2020'

NICE

- Improving Outcomes Guidance: Urological Cancer – NICE (2002)
- Improving Supportive and Palliative Care for Adults with Cancer – NICE (2004)
- Quality standard for end of life care for adults – NICE (2011)
- Quality standard for patient experience in adult NHS services – NICE (2012)

National Cancer Peer Review

- National Cancer Peer Review Handbook – NCPR, National Cancer Action Team (2011)
- Manual for Cancer Services: Urological Measures, Version 2.0 – NCPR, National Cancer Action Team (2011)
- Manual for Cancer Services Acute Oncology Measures NCPR National Cancer Action Team (April 2011)
- Manual for Cancer Services Acute Oncology Measures NCPR National Cancer Action Team (June 2011)

Other

- Chemotherapy Services in England. National Chemotherapy Advisory Group (2009) Summary of Review of Specialised Commissioning Documents – Pathology (2014)
- Summary of Review of Specialised Commissioning Documents – Pathology (2014)
- European Association of Urology Clinical Guidelines

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

Quality and Performance and Quality Dashboard measures are outlined in Section 4 and 6.

Key service outcomes

- 100% of cases should be discussed at Multidisciplinary Team meeting and this should include central pathology review (Domains 1 and 5).
- 100% compliance with population and specialist surgical configurations as outlined in this document (Domains 1, 2, 3, 4 & 5).
- Attendance at MDT, of an individual member or their agreed cover should be at least 67% (Domains 1, 2, 3, 4 and 5).
- 100% compliance with tumour site measures as set out in IOG and this specification (Domains 1, 2, 3, 4 & 5).
- 93%, 96% and 86% compliance with National 14, 31 and 62 day waiting time measures, respectively (Domains 1, 2, 3, 4 & 5).
- All centres should participate in 100% of national audits (Domains 1, 2, 3, 4 & 5).
- All Centres should participate in the National Patient Experience Survey and of responses received 75% should express overall satisfaction with the service (Domains 1, 2, 3, 4 and 5).
- 100% of patients should receive information on their condition (Domains 1, 2, 3, 4 & 5).
- 100% of Patients should have a named Key Worker who should be a Uro-oncology trained Clinical Nurse Specialist (Domains 1, 2, 3, 4 & 5).
- 90% of Patients should be assessed for trial entry (Domain 1 and 2).

- Centres should ensure complete registry dataset in 90% of patients (COSD and BAUS)

The thresholds and methods of collection for each indicator are detailed in Section 4 and 6.

3. Scope

3.1 Aims and objectives of service

The aim of the supranetwork penile cancer service is to deliver high-quality multidisciplinary holistic care aimed at increasing survival while maintaining sexual and urinary function, and quality of life. It also ensures ready and timely access to appropriate supportive care for patients, their relatives and carers.

The service will be delivered through a supra-network penile multidisciplinary team, with some elements, (e.g. radiotherapy/chemotherapy) delivered at a local level depending upon the needs of the patient.

All patients with penile cancer, both new and existing, should be managed by specialist multidisciplinary urological cancer teams. These teams should be established in large hospitals or cancer centres.

All operations carried out by the penile cancer team should be carried out in a single hospital, which should also provide post-operative care and host the supranetwork multidisciplinary team (MDT) meetings.

Documented clinical policies for referral and treatment should be agreed between cancer leads in primary care and lead clinicians representing urological, oncology and palliative care services throughout the network, and signed off by the lead clinician for the network.

Effective systems will be required to ensure rapid communication and efficient co-

ordination between teams.

Supranetwork specialist teams

Patients with penile cancer should be managed by specialist penile cancer teams working at the supranetwork level. Such teams should serve up to four networks, with a combined population base of at least four million. These teams should liaise closely and regularly with local urological cancer teams, who themselves will be responsible for some aspects of the diagnosis and treatment of these cancers.

The service is required to agree the following areas with their local cancer networks:

- Service configuration and population coverage
- Referral criteria, clinical protocols (including referral and management of post-operative patients, emergency protocols, and pathways that enable rapid access for treatment), network policies (including local surgical policies) and treatment pathways.
- Engagement with the local network groups and National Cancer Peer Review for penile cancers under urological tumours.

The overall objectives of the services are:

- To provide care with a patient- and family-centred focus to deliver the best possible patient experience, contributing to and learning from patient experience and outcome measures.
- To provide an exemplary and comprehensive service for all referred patients.
- To ensure that radiological, pathological and diagnostic facilities are available and to use the most up-to-date validated diagnostic tools and knowledge in order to effectively review, diagnose, classify and stage the cancer prior to planning treatment.
- To provide expert diagnosis.
- To advise and undertake investigations and to proceed to treatment options if

clinically indicated, including high-quality and modern surgical treatment for patients.

- To conduct monitoring of patients to ensure that the treatment is safe and effective.
- To provide care that promotes optimal functioning and quality of life for each individual cancer patient.
- To provide appropriate follow-up and surveillance after definitive treatment.
- To ensure that all aspects of the service are delivered as safely as possible, conform to national standards and published clinical guidelines, and that they are monitored by regular objective audits.
- To support local healthcare providers to manage patients with penile cancer whenever it is safe to do so and clinically appropriate within the framework of the Improving Outcomes Guidance.
- To provide high-quality and up-to-date information for patients, families and carers in appropriate and accessible formats and media.
- To ensure that the patient's General Practitioner receives accurate and timely information within 24 hours of the diagnosis.
- To ensure the active involvement of service users and carers in service development and review.
- To ensure there is a commitment to continual service improvement.
- To ensure compliance with Peer Review Cancer Measures.
- To ensure compliance with Care Quality Commission regulations.

3.2 Service description

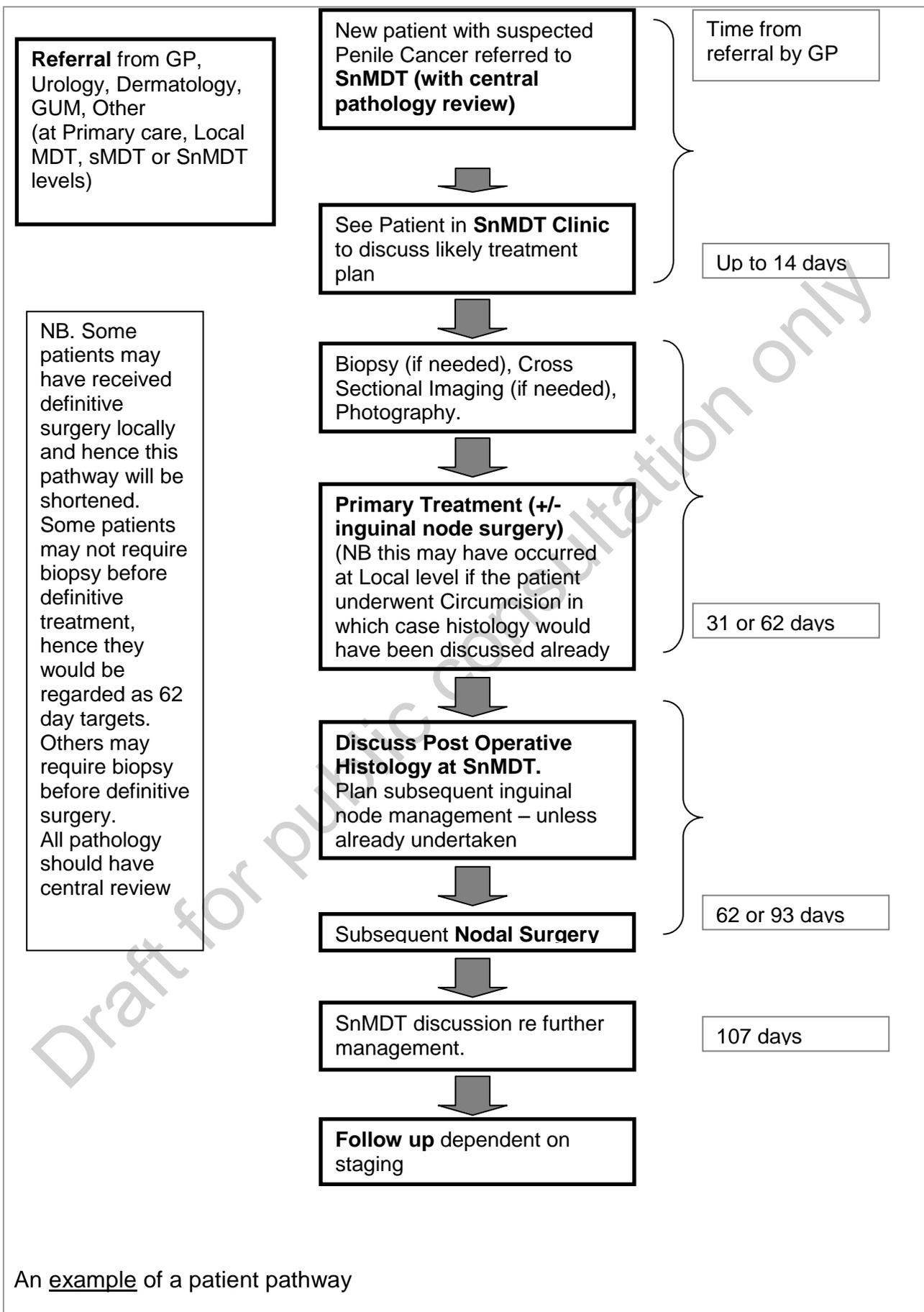
Because penile cancer is uncommon, its management should be formalised, with a degree of specialisation similar to that for testicular cancer. Specialised penile cancer multidisciplinary teams should be established jointly by two to four neighbouring networks. Each of these teams should serve a population base of four million or more and expect to manage a minimum of 25 new patients each year. The team should include members of the specialist urological cancer team who work in the cancer centre within which it is based, and it should also have access to expertise in plastic surgery. Networks should agree referral protocols for patients with penile

cancer. These should ensure that each new case is reviewed by a specialist penile cancer team, with central pathology review, and that men who are likely to require radical surgery, radiotherapy, chemotherapy, inguinal and pelvic lymph node dissections or some form of reconstruction of the penis are treated by this team.

Other forms of treatment may be carried out by specialist urological cancer teams which do not specialise in penile cancer, but the penile cancer multidisciplinary team which reviews the case should remain responsible for the overall management.

The suggested pathway for new penile cancer patients is shown below:

Draft for public consultation only



All new referrals with suspected penile cancer should undergo an initial consultation with a consultant urological surgeon who is a core member of the supranetwork MDT.

All new patients referred to the SnMDT should have central pathology review by the SnMDT pathologist. This should occur prior to definitive therapy only if a biopsy or specimen has been taken from the patient. All histology from all surgical treatments related to a patient's penile cancer should be reviewed by the SnMDT pathologist.

The choice of treatment should be discussed with the patient in a meeting that includes a consultant urological surgeon and a specialist nurse and where appropriate a clinical oncologist.

Patients should be introduced at the start of their pathway to a 'key worker'; this is normally the clinical nurse specialist.

3.2.1 The Supranetwork Specialist Multidisciplinary Team

The specialist and supranetwork penile cancer multidisciplinary teams will deliver the service in line with the following:

- There is a weekly multidisciplinary team meeting to discuss the needs of each newly referred patient (and also other penile cancer patients as required) in detail and review other non-surgical aspects of their care; patients will be likely to require subsequent additional review at the multidisciplinary team meeting for example after treatment of the cancer or during surveillance.
- Treatment within the specialist/supranetwork multidisciplinary team should be in accordance with locally agreed treatment guidelines which should be consistent with nationally agreed guidelines
- If surgery is the first planned treatment then efforts should be made to give the patient a date for that surgery and arrange dates for staging investigations at the first visit. Written information relating to the surgery should be provided.
- A written summary of the consultation should be offered to the patient, as well as written information on penile cancer.

- Accurate and timely information should be shared with the patients' General Practitioner so that they can be in a position to support and advise the patient.
- Patients treated as in-patients are reviewed daily on a ward round supported by a consultant urological surgeon with input from the core multidisciplinary team as clinically required.
- The providers will hold other meetings regularly to address clinical, service delivery and governance issues.
- Audit should be undertaken as an integral part of improving the delivery of care to provide the evidence to improve and enhance the delivery of the clinical care provided. Patients should be actively invited to participate in clinical trials especially those approved by the National Cancer Research Network (NCRN).

Members of the specialist penile cancer supranetwork multidisciplinary teams

Each member of a specialist penile cancer supranetwork multidisciplinary team should have a specialist interest in urological cancer. The specialist urological cancer team should include one or more of each of the following individuals:

- Urologists (a minimum of two urologists in the team)
- Clinical Oncologist (with named cover)
- Medical Oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncologist core member)
- Radiologist with expertise in urological cancers (with named cover).
- Pathologist with specialist interest in urological cancers (with named cover)
- Clinical Nurse Specialist (with named cover)
- Pain management and palliative care specialist(s) (with named cover)
- Team co-ordinator (with named cover)
- Team secretary (with named cover)

The multidisciplinary team should also have access to:

- GPs/primary health care teams;

- Local urological cancer teams at linked cancer units;
- Plastic surgeon;
- Vascular Surgeon
- Dermatologist
- Liaison psychiatrist;
- Clinical psychologist trained in psychotherapy and cognitive behaviour therapy;
- Counsellor with expertise in treating psychosexual problems
- Lymphoedema specialist;
- Occupational therapist;
- Social worker;
- Palliative care teams.

The penile cancer supranetwork MDT should be linked with the Specialist Skin MDT.

There should be a single named lead clinician for the penile cancer supranetwork multidisciplinary team service(s) who should also be a core team member.

There should be a single named lead clinician responsible for trial management of patients within the supranetwork MDT service.

3.2.2 Patient experience

The service should be patient-centred and should respond to patient and carer feedback. Excellent communication between professionals and patients is essential in ensuring patient satisfaction. The service should be in line with the markers of high quality care set out in the NICE quality standard for patient experience in adult NHS services.

Patient experience is reported in the National Cancer Patient Survey. In this survey, patients who were in contact with a clinical nurse specialist reported much more favourably than those without, on a range of items related to information, choice and

care. The national programme for advanced communications skills training provides the opportunity for senior clinicians to improve communications skills, and all core multidisciplinary team members should have attended this.

3.2.3 Patient information

Every patient and family / carer must receive information about their condition in an appropriate format, designed so as to offer [the patient] easily accessible, reliable and relevant information to enable them to fully participate in their own healthcare decisions, and to support them in making choices.

Verbal and written information should be provided in a way that is clearly understood by patients and free from jargon. This must include information on:

- Penile Cancer in General
- Penile CIS
- Circumcision
- Glans resurfacing with split skin grafts
- Partial Penectomy
- Glansectomy with and with out Skin Graft
- Total Penectomy & Perineal Urethrostomy
- Dynamic Sentinel Node Biopsy
- Inguinal Lymphadenectomy
- Pelvic Lymphadenectomy
- Chemotherapy
- Radiotherapy
- Penile Prosthesis
- Phallic reconstruction

The information should include details of :

- Description of the disease
- Management of the disease within the scope of the commissioned service as described in the specification, clinical pathways and service standards
- Where treatment is delivered at different hospitals, there should be a clear explanation about where different aspects of their treatment will occur.

- Treatment and medication (including their side effects) commissioned in the clinical pathway
- Pain control
- Practical and social support
- Psychological support
- Sexual issues and fertility
- Self-management and care
- Local NHS service and care/treatment options
- Contact details of the patient's key worker/allocated CNS
- Possible benefits and compensation
- Support organisations or internet resources recommended by the clinical team
- Access to relevant clinical trials which may be available

A useful reference is the Information Prescription Service (IPS), which allows users, both professional and public, to create information prescriptions (IPs) for long-term health needs.

3.2.4 Referral processes and sources

Referrals to the service will come from either primary care or a local multidisciplinary team. Steps prior to referral to the specialist team include:

- The local team may already have made a diagnosis, confirmed by pathology, ultrasound, or CT or MRI
- Local Teams are encouraged to refer to the supranetwork MDT if there is a clinical suspicion. Pathological diagnosis is not always needed.
- The patient will have been informed of the diagnosis/potential diagnosis and given the date of a CT scan, where the latter is deemed necessary.
- The patient will have had staging investigations where necessary.
- The patient will have been discussed at their local multidisciplinary team
- The patient will have been referred to a specialist or supranetwork multidisciplinary team(s)
 - GPs should refer men with suspicious penile lesions such as abnormal growths

at or near the glans and foreskin, painless ulcers which do not appear to be due to infection, or other unexplained abnormalities such as plaques on the skin or foreskin of the penis.

All penile cancer cases should be discussed with the supranetwork team prior to proposed treatment if not referred directly to that team.

3.2.5 Imaging and pathology

The service should ensure that ultrasound / CT scanning / MRI and nuclear medicine imaging should be available to the patient as part of the pathway. The service should agree imaging modalities and their specific indications. The responsibility for the scan, its interpretation and any decision to inform treatment lies with the supranetwork multidisciplinary team.

Histological confirmation of tumour is required before treatment with chemotherapy or radiotherapy.

The pathology services should :

- comply with Clinical Pathology Accreditation (UK) Ltd (CPA) and the Human Tissue Authority (HTA).
- comply with Royal College Minimum Dataset
- provide acute diagnostics services and clinical pathology opinion 24 hours a day 7 days a week
- have access to digital pathology and networks services, including remote working
- have in place Blood management guidelines
- participate in and encourage clinical trial activity
- provide a framework for staff education

3.2.6 Diagnosis

The service should develop - with primary care, local urological services and their local cancer network - locally agreed guidelines on appropriate referral for patients with suspected penile cancer in line with national guidelines. Compliance with these

guidelines should be audited.

3.2.7 Staging

Providers must include staging information in their cancer registration dataset (this will become mandated in the Cancer Outcomes Service Dataset from early 2013). Staging data are essential for directing the optimum treatment, for providing prognostic information for the patient and are also essential to the better understanding of the reasons behind the UK's poor cancer survival rates. Cancer stage is best captured electronically at multidisciplinary team meetings and transferred directly to cancer registries. Staging and other pathological data can also be extracted direct from pathology reports and sent to cancer registries.

3.2.8 Treatment

Treatment delivered by the core members of the supranetwork penile cancer multidisciplinary team includes:

- Surgical excision of the primary tumour
- Localised therapies such laser and topical therapy
- Radiotherapy to the primary lesion where indicated
- Management of inguinal and pelvic lymph nodes by surgery, chemotherapy and radiotherapy where indicated.
- Penile Surgery for reconstruction and erectile dysfunction (including penile lengthening and implant procedures)

All possible management options should be discussed with the patient. The treatment each patient receives should be tailored to fit their individual needs, values and situation, so it is essential that patients are actively involved in decision-making. This requires that they receive adequate and accurate information, both through meetings with members of the multidisciplinary team, and in published forms that they can study at home. Patients should be given sufficient time to consider all the options available to them.

Chemotherapy and radiotherapy

Chemotherapy and radiotherapy are important components of the treatment of some

patients and should be carried out at designated centres by appropriate specialists as recommended by a supranetwork penile cancer multidisciplinary team. There should be a formal relationship between the penile cancer service and the provider of non-surgical oncology services that is characterised by agreed network protocols, good communication, and well-defined referral pathways. This relationship should be defined in writing and approved by the cancer network director and the lead clinicians of the specialist urological cancer supranetwork penile multidisciplinary teams. Audits of compliance with agreed protocols will need to be demonstrated.

Refer to the following documents for more detailed description of these services:

- Acute chemotherapy service specification
- Radiotherapy model service specification 2012/13

3.2.9 Follow-up

The IOG series of documents made recommendations on follow-up care. Providers will need to adhere to cancer-specific guidelines for follow-up, agreed through the network site specific group (NSSG), and ensure patients have a follow-up plan. The cancer-specific guidelines will identify that some patients will need to continue receiving follow-up from the specialised service but it is expected the majority will be able to receive follow-up locally.

The provider will need to ensure effective hand over of care and / or work collaboratively with other agencies to ensure patients have follow-up plans appropriate to their needs.

3.2.10 Rehabilitation

There should be appropriate assessment of patients' rehabilitative needs across the pathway and the provider must ensure that high-quality rehabilitation is provided in line with the network agreed pathways.

3.2.11 Supportive and palliative care

The provider will give high-quality supportive and palliative care in line with NICE guidance. The extended team for the multidisciplinary team includes additional specialists to achieve this requirement.

Patients who require palliative care will be referred to a palliative care team in the hospital and the team will be involved early to liaise directly with the community services. Specialist palliative care advice will be available on a 24-hour, seven days a week basis.

Each patient should be offered a holistic needs assessment at key points in their cancer pathway including at the beginning and end of primary treatment and the beginning of the end of life. A formal care plan should be developed. The nurse specialist(s) should ensure the results of patients' holistic needs assessment are taken into account in the multidisciplinary team decision making.

3.2.12 Survivorship

The National Cancer Survivorship Initiative (NCSI) is testing new models of care aimed at improving the health and well being of cancer survivors. The new model stratifies patients on the basis of need including a shift towards supported self management where appropriate. In some circumstances traditional outpatient follow-up may be replaced by remote monitoring. The model also incorporates care coordination through a treatment summary and written plan of care.

It will be important for commissioners to ensure that work from this programme is included and developed locally to support patients whose care will return to their more local health providers once specialist care is no longer required.

3.2.13 End of life care

The provider should provide end of life care in line with NICE guidance and in particular the markers of high quality care set out in the NICE quality standard for end of life care for adults.

3.2.14 Acute Oncology Service

All hospitals with an Accident and Emergency (A&E) department should have an “acute oncology service” (AOS), bringing together relevant staff from A&E, general medicine, haematology and clinical/medical oncology, oncology nursing and oncology pharmacy. This will provide emergency care not only for cancer patients who develop complications following chemotherapy, but also for patients admitted suffering from the consequences of their cancer. For full details on AOS please refer to the service specification for chemotherapy, which is currently being developed.

3.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England³; or otherwise the commissioning responsibility of the NHS in England (as defined in Who pays?: Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

Specifically, this service is for patients with suspected or confirmed penile cancer requiring specialised intervention and management, as outlined within this specification.

The service must be accessible to all patients with a suspected or confirmed penile cancer regardless of age, race, disability, religion or sexual orientation.. Providers require staff to attend mandatory training on equality and diversity and the facilities provided offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information available in multiple

languages.

The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation

3.4 Any acceptance and exclusion criteria

The role of the specialist penile cancer service is described in this document. There are other documents for the specification of other specialist urological cancer services and testicular cancer services. The detailed specification for local urological cancer services will be described in a separate document as these services are expected to be commissioned by the clinical commissioning groups (CCGs).

3.5 Interdependencies with other services

The management of penile cancer involves cross-linked teams:

- Primary health care team
- Urological Cancer Team:
 - Local urological multidisciplinary teams
 - Specialist urological multidisciplinary team
 - Supranetwork multidisciplinary teams
 - Specialist Palliative Care Team
 - Specialist Skin multidisciplinary team

3.6 Strategic Clinical Networks

Strategic clinical networks have been in place from April 2013 located in 12 areas across England. They will be established in areas of major healthcare challenge where a whole system, integrated approach is needed to achieve a real change in quality and outcomes of care for patients. Cancer has been identified as one of the conditions that

will be within this new framework. Strategic clinical networks will help commissioners reduce unwarranted variation in services and will encourage innovation. They will use the NHS single change model as the framework for their improvement activities.

Each area has a network covering penile cancer. This group is made up of clinicians across the network who specialise in urological cancers. It is the primary source of clinical opinion on issues relating to penile cancer within the network and is an advisor to the relevant commissioners. Each supranetwork penile cancer multidisciplinary team should ensure they fully participate in the SCN cancer systems for planning and review of services.

This group is responsible for developing referral guidelines, care pathways, standards of care and to share good practice and innovation. The supranetwork penile cancer multidisciplinary teams should also collectively implement NICE IOG, and National Guidance (where applicable) including the use of new technologies and procedures as appropriate and carry out network and national audits.

Each cancer network should agree an up-to-date list of appropriate clinical trials and other well designed studies for urological cancer patients and record numbers of patients entered into these trials/studies by each multidisciplinary team.

Each network should agree an up-to-date list of appropriate clinical trials and other well designed studies patients and record numbers of patients entered into these trials/studies by each multidisciplinary team.

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE, Royal College

Care delivered by the penile cancer service providers must be of a nature and quality to meet the CQC care standards, the IOG for urological cancers and existing National body guidelines. It is the Trust's responsibility to notify the commissioner on an exceptional basis should there be any breaches of the care standards. Where

there are breaches any consequences will be deemed as being the Trust's responsibility.

Penile cancer services are required to achieve the two week wait for all patients where penile cancer is suspected. In addition the services are required to meet the following standards for all penile cancer patients:

- 31 day wait from diagnosis to first treatment
- 31 day wait to subsequent treatment
- 62 day wait from urgent GP referral or screening referral or consultant upgrade to first treatment.

Teams should as a minimum aim to achieve the median value for compliance with the Cancer Peer Review measures, and if a team had immediate risks or serious concerns identified then remedial action plans should be in place. Further details are available at www.cquins.nhs.uk

The provider must be able to offer patient choice. This will be both in the context of appointment time and of treatment options and facilities including treatments not available locally.

The service will comply with the relevant NICE quality standards which defines clinical best practice.

4.2 Key Service Outcomes

The expected clinical outcomes the service is to monitor include:

- Should align with Quality Dashboard measures (Section 2)
- Should align with Quality and Performance Standards (see section 6)

5. Location of Provider Premises

The service is delivered across England by nominated cancer centres which provide cover all regions in England for the national caseload.

The supranetwork penile cancer multidisciplinary team services are based at:

Trust Code	Trust Site
RBV	The Christie NHS Foundation Trust
RR8	Leeds Teaching Hospitals NHS Trust
RR1	Heart of England NHS Foundation Trust
RRV	University College London Hospitals NHS Foundation Trust
RJ7	St Georges Healthcare NHS Trust
RVJ	North Bristol NHS Trust
RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust
RLN	University Hospitals of Leicester NHS Trust
	Sunderland Royal Hospital NHS Foundation Trust

6. Quality and Performance Standards

	<i>Performance Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
Quality				
Domains 1 and 5	% of cases undergoing primary surgery by the SnMDT that are discussed SnMDT	100%	Reported within national audit reports but not reported regularly to Board	NHS contract, General Conditions Clause (GC9)
	Follow up ratios		Not reported regularly	
	Other Quality Measures	100%	Quarterly	
Domains 1, 2, 3, 4, and 5	Percentage attendance by individual core members or their agreed cover at multidisciplinary team	67%	Reported in Peer Review Submissions	GC9
Domains 1, 2, 3, 4 and 5	Attendance at advanced communication skills course	100%.	Peer Review	GC9
	IOG Compliance with specified measures	Compliance with specific measures for tumour site as set out in IOG documentation	Regular updates to Board and Network Performance Report	GC9
Domains 1, 2, 3, 4 and 5	Compliance with all other Peer Review measures (other than where agreed with commissioners when the Provider should have an action plan in place	National median compliance level	National reports / regular verbal feedback to Board	GC9

	that has been agreed with the Commissioner)			
<u>Performance and Productivity</u>	The Provider should ensure that these targets are achieved for the part of the patient pathway that it delivers and that, when the patient pathway crosses outside the locality border, appropriate scheduling of patients/activity supports achievement of the target by other providers in the pathway wherever possible, except when informed patient choice or clinical appropriateness mitigate against this.			
Waiting Time Compliance				
Domains 1, 2, 3 4 and 5	62 day wait - % treated in 62 days from GP referral, consultant referral and referral from screening programme	>~86%	Reported on cancer waits database	GC9
Domains 1, 2, 3, 4 and 5	14 day suspected cancer referral standard performance (A20)	93%	Regularly reported to Board	GC9
Aggregate Measures	31 day first treatment standard performance (A15)	96%		GC9
	31 day subsequent treatment (Surgery) standard performance (A16)	94%		GC9
	31 day subsequent treatment (Drugs) standard performance (A16)	98%		GC9
	31 day subsequent	94%	Regularly reported to	GC9

	treatment (Radiotherapy) standard performance (A17)		Board	
	31 day subsequent treatment (Other Treatments) standard performance	TBC		GC9
	31 day subsequent treatment (Palliative) standard performance	TBC		GC9
	62 day standard from 14 day referral performance (A18)	85%	Regularly reported to Board	
	62 day standard from consultant upgrade performance (A19)	TBC	Regularly reported to Board	GC9
	Diagnostic Test Waiting Times	TBC	Not reported regularly to Board, no longer a national CQC target	

Activity Performance Indicators

Activity Performance Indicators		Threshold	Method of Measurement	Consequence of breach
Audits (Specification Point 2.3.4)	Annual review conducted		Penile Network	GC9
	Participation in National Audits	100%	Part of Network Performance Report but only in terms of submission	GC9

			not in terms of data quality	
	Additional Audits undertaken	N/A	Reported at Networks but not Board unless specific service change	
Activity (Specification Point 3.1.4)	Threshold for number of procedures	Establish baseline cancer activity data for :- number of procedures for elective, day case, non elective non emergency, non elective emergency, out- patient FA, out- patient FU, out- patient procedures all by speciality	Not currently regularly reported to Board	
	Length of stay benchmarking			
	Level of admissions			
	Choice			
Service User Experience Domains 2, 3, 4, and 5	National Cancer Patient Experience survey (ref A46 main contract)	National survey report when published	National findings reported to Board. Currently establishing a baseline.	If the provider does not take part they will be required to meet with the commissioners to explain reasons for not doing so and activity planned to enable the information to be captured through alternative mechanisms
Domains 2, 3, 4 and 5	Improving Service User Experience	Of responses received 75% should express overall satisfaction with the		GC9

		service. Trust to evidence the measures it has taken to improve service user experience and outcomes achieved and numbers / percentages stratified		
Domains 1, 2, 3, 4 and 5	Addressing Complaints	Trust to evidence the measures it has taken to address complaints and outcomes achieved		GC9
	Patient involvement	Trust to evidence the actions it has taken to engage with patients and demonstrate where this has impacted		
Staff Survey	Staff survey results			
Trial Activity (Specification Point 8.2.8) Domains 1, 2, 3, 4 and 5	Recruitment into trials	Patients eligible for an existing clinical trial should be offered the chance to be treated in a clinical trial	NCRN	GC9
Outcomes (Specification Point 8.2.6) Domains 1, 2, 3, 4 and 5	Post surgery mortality	Numbers and percentages baseline to be set in year	Not regularly reported to Board Reported at trust level	GC9
	30 day mortality		Registry data	
	1 yr survival		Part of Network Performance	
	5 yr survival			

			Report	
	30 day readmission rates for cancer patients	Numbers and percentage baseline to be set in year	Not currently reported to Board	
Data Submission (Specification Point 8.2.6)	Registry dataset submission status	As required by Registry	Not currently reported to Board	GC9
Domains 1 and 5	DCOs		Regular updates to Network	GC9
	Staging data (Specification Point 2.3.4)	As required by Registry	Not currently reported to Board	GC9

Additional information

Penile cancer is classified within the international classification of diseases version 10 (ICD10) as:

C60: Malignant neoplasm of penis - approximately 400 cases per year

Incidence rates are for patients diagnosed in 2009 in England. Source: UKCIS, data extracted August 2012

Cancer waiting times

Penile cancer is included within the urological reporting category for cancer waiting times.

Relevant Operational Codes for this service

The following is a list of relevant surgical codes utilised within the services described in this document (excluding radiotherapy and chemotherapy, which are found within separate specifications).

- N26.1 – Partial amputation of penis
- N26.2 Total amputation of penis
- N27.1 Excision of lesion on penis
- N28.2 Reconstruction of penis
- N28.7 – Graft to penis
- N29.1 Implantation of prosthesis to penis

N30.3 Circumcision
N32.1 Biopsy of lesion of penis
T91.1 Biopsy of sentinel lymph node
T85.5 Block dissection of inguinal lymph nodes
T85.6 Block dissection of Pelvic nodes
T86.7 Sampling of inguinal lymph nodes
T87.7 Excision of inguinal lymph node
N35.2 Dermatological non-operative intervention involving penis
Y08.2 Laser excision of lesion of organ
Y08.4 Laser destruction of lesion of organ
S27.4/27.8/27.9 Local flap of skin
S24.8/24.9 Local flap of skin/muscle

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