SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	B14/S/a
Service	Urological cancers – Specialised kidney, bladder and prostate cancer services
Commissioner Lead	
Provider Lead	
Period	36 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National context

Urological cancers include a range of tumours with different presentations including:

- Prostate cancer
- Bladder cancer
- Kidney cancer

Prostate cancer is a form of cancer that develops in the prostate and accounts for 25% of all male cancers. Advanced prostate cancer can spread to other parts of the body. In 2010, there were more than 40,000 newly diagnosed cases of prostate cancer in the UK, with a crude incidence rate of 136 cases per 100,000 population. One year relative survival estimates in England are very high at 95%.

Bladder cancer is any of several types of malignant growths of the urinary bladder. The most common type of bladder cancer begins in cells lining the inside of the bladder and is called transitional cell carcinoma. In UK there were over 10 000 new cases of bladder cancer diagnosed. The Incidence of bladder cancer is higher in

males than in females, The crude incidence rate per 100,000 population for bladder cancer is 25 in men and 9.0 in women. One year relative survival estimates for bladder cancer also differ between males and females at 78% and 64% respectively.

Kidney cancer is a form of cancer that develops in the kidneys. Kidney cancer is often asymptomatic until an advanced stage. In approximately one third of cases, the tumour is detected incidentally during imaging carried out for other reasons. The two most common types of kidney cancer, reflecting their location within the kidney, are renal cell carcinoma (RCC) and urothelial cell carcinoma (UCC) of the renal pelvis. The distinction between these two types (RCC and UCC) is important because their prognosis, staging and management are different. In 2010, there were over 9,639 newly diagnosed cases of kidney cancer in the UK. The crude incidence rate per 100,000 population is 15.9 in men and 9.6 in women. Cancer of the renal pelvis is less common with around 500 cases per year. Relative survival estimates for kidney cancer (excluding renal pelvis) are similar for both sexes at 70 per cent for males and 68 per cent for females.

There are different levels of care for urological cancers: local care, specialised care and supra-network care. This specification focuses on specialised care and specialised surgical services.

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)
- Prostate Cancer diagnosis and treatment Guidelines – NICE (2014)
- Quality Standards for Prostate Cancer - NICE (2015)
- Quality Standards for Bladder Cancer - NICE (2015)

National Cancer Peer Review/Quality Team

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

Other

- Chemotherapy Services in England. National Chemotherapy Advisory Group (2009)
- Summary of Review of Specialised Commissioning Documents – Pathology (2014)
- BAUS National Complex Operations Database
- European Association of Urology Clinical Guidelines
- Prostate Cancer Advisory Group (BAUS) Advice on the Development of Robotic Assisted Radical Prostatectomy in England – (2011 and 2012)

Published Evidence

Trinh QD(1), Bjartell A, Freedland SJ, Hollenbeck BK, Hu JC, Shariat SF, Sun M, Vickers AJ. A systematic review of the volume-outcome relationship for radical prostatectomy. Eur Urol. 2013 Nov;64(5):786-98. doi: 10.1016/j.eururo.2013.04.012. Epub 2013 Apr 19.

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premier perspective database. J Endourol. 2014 May;28(5):560-6. doi: 10.1089/end.2013.0534. Epub 2014 Feb 6.

Vesey SG(1), McCabe JE, Hounsome L, Fowler S. UK radical prostatectomy outcomes and surgeon case volume: based on an analysis of the British Association of Urological Surgeons Complex Operations Database.BJU Int. 2012 Feb;109(3):346-54. doi: 10.1111/j.1464-410X.2011.10334.x. Epub 2011 Jul 19.

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Urology. 2014 Nov;84(5):1106-11. doi: 10.1016/j.urology.2014.06.047. Epub 2014 Oct 24.

Secin FP(1), Savage C, Abbou C, de La Taille A, Salomon L, Rassweiler J, Hruza M,Rozet F, Cathelineau X, Janetschek G, Nassar F, Turk I, Vanni AJ, Gill IS, Koenig P, Kaouk JH, Martinez Pineiro L, Pansadoro V, Emiliozzi P, Bjartell A, Jiborn T, Eden C, Richards AJ, Van Velthoven R, Stolzenburg JU, Rabenalt R, Su LM, Pavlovich CP, Levinson AW, Touijer KA, Vickers A, Guillonneau B.The learning curve for laparoscopic radical prostatectomy: an international multicenter study. J Urol. 2010 Dec;184(6):2291-6. doi: 10.1016/j.juro.2010.08.003. Epub 2010 Oct

Eden CG(1), Neill MG, Louie-Johnsun MW. The first 1000 cases of laparoscopic radical prostatectomy in the UK: evidence of multiple 'learning curves'. BJU Int. 2009 May;103(9):1224-30. doi: 10.1111/j.1464-410X.2008.08169.x. Epub 2008 Nov 20.

Siemens DR, Mackillop WJ, Peng Y, Berman D, Elharram A, Rhee J, Booth CM. Processes of care and the impact of surgical volumes on cancer-specific survival: a population-based study in bladder cancer. Urology. 2014 Nov;84(5):1049-57. doi:0.1016/j.urology.2014.06.070. Epub 2014 Oct 24. PubMed PMID: 25443899.

Bhindi B, Yu J, Kuk C, Sridhar SS, Hamilton RJ, Finelli A, Jewett MA, Evans A, Fleshner NE, Zlotta AR, Kulkarni GS. The importance of surgeon characteristics on

impacting oncologic outcomes for patients undergoing radical cystectomy. J Urol. 2014 Sep;192(3):714-9. doi: 10.1016/j.juro.2014.02.093. Epub 2014 Mar 1. PubMed PMID: 24594406.

Kulkarni GS, Urbach DR, Austin PC, Fleshner NE, Laupacis A. Impact of provider volume on operative mortality after radical cystectomy in a publicly funded healthcare system. Can Urol Assoc J. 2013 Nov-Dec;7(11-12):425-9. doi:10.5489/cuaj.361. PubMed PMID: 24381661; PubMed Central PMCID: PMC3876442.

Kulkarni GS, Urbach DR, Austin PC, Fleshner NE, Laupacis A. Higher surgeon and hospital volume improves long-term survival after radical cystectomy. Cancer. 2013 Oct 1;119(19):3546-54. doi: 10.1002/cncr.28235. Epub 2013 Jul 9. PubMed PMID: 23839861.

Mayer EK, Bottle A, Darzi AW, Athanasiou T, Vale JA. The volume-mortality relation for radical cystectomy in England: retrospective analysis of hospital episode statistics. BMJ. 2010 Mar 19;340:c1128. doi: 10.1136/bmj.c1128. PubMed PMID: 20305302; PubMed Central PMCID: PMC2842924.

Toren P(1), Abouassaly R, Timilshina N, Kulkarni G, Alibhai S, Finelli A. Results of a national population-based study of outcomes of surgery for renal tumors associated with inferior vena cava thrombus. Urology. 2013 Sep;82(3):572-7. doi: 10.1016/j.urology.2013.04.054.

Banerjee M(1), Filson C(2), Xia R(3), Miller DC(4). Logic regression for provider effects on kidney cancer treatment delivery. Comput Math Methods Med. 2014;2014:316935. doi: 10.1155/2014/316935. Epub 2014 Mar 27.

Abouassaly R(1), Finelli A, Tomlinson GA, Urbach DR, Alibhai SM. Volume-outcome relationships in the treatment of renal tumors. J Urol. 2012 Jun;187(6):1984-8. doi: 10.1016/j.juro.2012.01.076. Epub 2012 Apr 11.

2. Scope

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 measures are outlined in Section 4.

Key Service Outcomes:

- 100% Percent of cases should be discussed at Multidisciplinary Team meeting (Domains 1 and 5).
- 100% compliance with population and specialist surgical configurations as outlined in this document (Domains 1, 2, 3, 4 & 5).
- Attendance of an individual member or their agreed cover should be at least 67% (Domains 1, 2, 3, 4 and 5).
- 100% compliance with specific tumour site measures as set out in IOG and this specification (Domains 1, 2, 3, 4 & 5).
- 100% Compliance with National Quality Standards (NICE) (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).
- 100% compliance with threshold numbers for tumour specific procedures as stated in this specification (Domains 1, 2, 3, 4 & 5):
    - Prostatectomy 100 per centre; 25 per Surgeon
    - Cystectomy 30 per centre; 15 per Surgeon
    - Specialised Renal Surgery 30 per centre; 15 per Surgeon
        - Renal tumour with caval thrombus 10 per centre on a supra-regional basis
- At least one tumour site should have community or self directed follow-up (Domains 2 and 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 Ur-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 in conjunction with other quality measures.

2.2 Aims and objectives of service

The aim of the specialised urological cancer service is to deliver high quality holistic care so as to increase survival while maximising a patient's functional capability and quality of life and to ensure ready and timely access to appropriate supportive care for patients, their relatives and carers. The service will be delivered through a specialist urology multi-disciplinary team.

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

- Service configuration and population coverage. When designing the specialist urological centre model in addition to meeting the surgical volumes the whole pathway should be considered to maximize where appropriate patient access to local services.
- Referral criteria, clinical protocols (including referral and management of pleural effusion and emergency protocols and pathways that enable rapid access for treatment of infections), network policies (including local surgical policies) and treatment pathways

2.2 Service description/care pathway

The specialist urological cancer multidisciplinary team 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 other 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 or progression of the cancer. It is acceptable to have a separate MDT for each tumour site where case load and configuration require this (see below).
- Treatment within the specialist multidisciplinary team should be in accordance with locally agreed treatment guidelines which should be consistent with nationally agreed guidelines
- After discussion with the patient, if surgery is the first planned treatment then efforts should be made to give the patient a date for that surgery at the first visit, and written information provided on that surgery. The timing of surgery is agreed on the basis of evidence based treatment protocols with the local cancer network.
- A written summary of the consultation should be offered to the patient as well as written information on the relevant type of urological cancer.
- Patients should have access to a 'key worker' - this is normally the Clinical Nurse Specialist with an expertise in Urological Cancers. Patients should meet their key worker as early as possible within their pathway of care
- 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 urologist and oncological 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).

Patients to be discussed at the Specialist MDT

The following patients should be discussed at the specialist MDT:
All New and Recurrent High Risk Non-Muscle Invasive Bladder Cancer
All New and Recurrent Muscle Invasive Bladder Cancer
All New and Recurrent Prostate Cancer
All New and Recurrent Renal Cancers
All New Testis and Penile Cancers (please refer to separate guidance)
Patients previously discussed, where subsequent imaging shows unexpected locally advanced or metastatic disease

(within all the above, ALL histological types are included)

Specialist MDT Centres

The service configuration can exist within **ONLY** one of the following categories:

Category A

The Service configuration has already aligned with IOG 2002 and is able to demonstrate that the Specialist MDT centre/s serve a minimum population of 1 million and that the centre/s offer all surgical treatments for each tumour site.

The Specialist MDT centre/s should fulfil the other requirements for the Specialist MDT and Co-dependencies/Co-locations as outlined in this specification.

Category B

Where Service configurations have been unable to align with IOG 2002 or have aligned but wish to improve beyond IOG 2002, only ONE of the following options can apply:

Option 1. For Networks with up to 1.9 million

a. 1 centre

Option 2. For Networks with 2 to 3.9 million population

b. 1 centre

OR

c. 2 centres, with no more than 1 geographic site for any one tumour site

Option 3. For Networks with 4 million population or greater

d. 1 centre

OR

e. 2 centres with no more than 1 geographic site for any one tumour site

OR

f. 3 centres with no more than 2 geographic sites for any one tumour site

In all Category B options the Specialist MDT centre/s should fulfil the other requirements for the Specialist MDT and Co-dependencies/Co-locations as outlined in this specification.

Radiotherapy and chemotherapy services should be offered as agreed within network guidelines but should be consistent with national guidelines where they exist.

Members of the specialist urological cancer multidisciplinary team

Each member of the specialist urological cancer team should have a specialist interest in urological cancer**.**

The specialist urological cancer team should include the following individuals:

- Urological Surgeons (at least 4 urological cancer surgeons
- Clinical oncologist.
- Medical oncologist (except where the clinical oncologist has specific expertise in systemic treatment for urological cancers).
- Radiologist with expertise in urological cancers.
- Histopathologist with expertise in urological cancers.
- Urological Cancer - Clinical Nurse Specialist.
- Multidisciplinary team co-ordinator / secretary.

The multidisciplinary team should also have access to (but not necessarily on the same site):

- GPs/primary health care teams;
- Local urological cancer teams at linked cancer units;
- Plastic surgery;
- Clinical geneticist/genetics counsellor
- Liaison psychiatrist;
- Clinical psychologist trained in psychotherapy and cognitive behaviour therapy;
- Counsellor with expertise in treating psychosexual problems;
- Stoma care nurse;
- Lymphoedema specialist;
- Occupational therapist;
- Social worker;
- Palliative care teams.
- Specialist services managing erectile dysfunction and urinary incontinence
- Renal Dialysis services
- Hepatobilliary Surgery
- Cardiothoriacic Surgery
- Vascular Surgery

There should be a single named lead clinician for the specialist urological cancer service who should also be a core team member. (This is in addition to a single named lead clinician for the local urological cancer service who should also be a core team member.)

A NHS employed member of the core or extended team should be nominated as having specific responsibility for user issues and information for patients and carers.

A core member must be identified as the individual responsible for recruitment into clinical trials and other well designed studies

Required co-dependencies/co-locations

Intensive care facility (level III)

High Dependency care

Named ward for the care of post operative patients undergoing urological cancer surgery with appropriately trained Nursing staff.

24/7 Interventional Uro-radiology facilities

Appropriate level of Consultant Specialist on call services

Renal Haemofiltration facility

For certain Renal Tumours (see below) Cardiothoracic and Vascular or Hepatobiliary Surgery should be co-located

Patient experience

The service should be patient centred and should respond to patient feedback. Excellent communication between professionals and patients brings widespread benefits. It also reduces the incidence of misunderstandings and mis-administrations, and in the process will reduce complaints.. 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 information

Every patient and family / carer must receive information about their condition in an appropriate format. Verbal and written information should be provided in a way that is clearly understood by patients and free from jargon. The information must cover:

- Description of the disease
- Evidence, effectiveness (risks and benefits) of diagnostic tests, such as PSA (where relevant)
- Management of the disease within the scope of the commissioned service as described in the specification, clinical pathways and service standards
- 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 allocated named nurse
- Social benefits and compensation support organisations
- Information regarding patient cancer support groups
- Out of hours advice/support
- Contact in case of concern or emergency

Referral Processes and Sources

Referrals to the service will come from either primary care or a local multidisciplinary team.

Steps prior to referral from the local team to the specialist team include:

- The local team will already have made a diagnosis, confirmed by ultrasound, CT
- or biopsy
- The patient will have been informed of the diagnosis
- The patient will have had staging investigations

Imaging and pathology

The service should ensure that chest x-ray / ultrasound / CT scanning / MRI/Nuclear Medicine 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 specialist urological cancer 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, inlcluding remote

working

- have in place Blood management guidelines
- participate in and encourage clinical trial activity
- provide a framework for staff education

Diagnosis

The service should develop with primary care, local urological services and their local cancer network agreed guidelines on appropriate referral for patients with suspected urological cancer into the specialist multidisciplinary team service in line with national guidelines. Compliance with these guidelines should be audited.

Tests should be available, including rapid assessments, to determine whether cancer is present, where possible as a one-stop service.

Staging

Providers must include staging information in their cancer registration dataset.

Treatment

The following should apply regardless of configuration option:

An 'Enhanced Recovery' approach to elective surgery should be adopted by all urological cancer teams. Enhanced recovery has been shown to shorten lengths of stay, facilitate early detection and management of complications, as well as improve patient experience with no increase in readmissions.

Treatment delivered by the specialist urology multidisciplinary team includes:

For kidney cancer

Procedures which should only be carried out in the host hospital of the specialist team include:

- Resection of metastatic disease*.
- Resection of both primary and associated metastatic disease.

- Resection of bilateral primaries.
- Resection of any primary where it is predicted that the patient will subsequently require dialysis.
- Surgical management of patients with von Hippel-Lindau disease or hereditary papillary tumours.
- Resection of urothelial cancers of the upper urological tract.
- Resection by nephron-sparing surgery or other nephron sparing techniques.
- Resection of non-renal cell kidney cancer, excluding transitional cell carcinoma of the kidney, treated by nephro-ureterectomy

Robotic Renal Surgery and other therapies for small renal masses should be undertaken in line with separate guidance, such as Clinical Commissioning Policies or Commissioning through Evaluation protocols, where these exists.

All patients with Stage T1a/b renal cancers should be discussed at the specialist MDT and must also be seen for consultation by a Specialist MDT Surgeon.

All Specialist MDT centres should undertake a minimum of 30 specialist renal cancer surgery cases per annum, with a minimum of 15 cases per Surgeon per annum.

For complex Renal cancer cases with thrombus in the inferior vena cava and/or heart, surgery should be undertaken in centres co-located or have a networked facility with vascular or hepatobiliary, and cardiothoracic surgery. Network pathways should reflect this need at a supra-regional level. Centres should undertake a minimum of 10 level II/III renal cancer inferior vena caval thrombus procedures per annum.

In cases where two Surgeons operate jointly on one patient, this case should be attributed to both Surgeons but should only account for one case in the centres total figures.

*In cases of bone, hepatic or thoracic metastases the host hospital should have access to the relevant organ site specialists.

Procedures and treatments where the site of delivery is determined by agreement in the network's guidelines:

- Adjuvant/Neadjuvant systemic therapy.
- Molecular targeted therapy.
- Non-surgical management of non-renal cell kidney cancer.

For bladder cancer

Procedures which should only be carried out in the host hospital of the specialist team:

- Radical surgery (cystectomy).
- Bladder reconstruction (Neobladder).
- Surgery for urinary diversion (ileal loop).
- Resection of urethral cancer (distal urethral tumours should be considered for treatment under the Penile Cancer SnMDT).
- Resection of squamous or adenocarcinoma.
- Partial cystectomy (indicated only for adenocarcinoma in the dome of the bladder).

Robotic Cystectomy Surgery should be undertaken in line with separate guidance, where this exists.

The host hospital should undertake a minimum of 30 radical cystectomy procedures per annum, with a minimum of 15 cases per Surgeon per annum. In cases where two Surgeons operate jointly on one patient, this case should be attributed to both Surgeons but should only account for one case in the centres total figures.

Procedures and treatments where the site of delivery is determined by agreement in the network's guidelines:

- Radical external beam radiotherapy.
- Adjuvant chemotherapy.
- Neo-adjuvant radiotherapy.*
- Neo-adjuvant chemotherapy.

- * Recommended only as part of the clinical trial

Sperm storage (cryopreservation) should be offered to all patients who may wish to father children. This should be available before surgery, chemotherapy or radiotherapy.

For prostate cancer

Procedures which should only be carried out in the host hospital of the specialist team:

- Radical prostatectomy, including open and laparoscopic (excluding Robotic Assisted Prostatectomy)
- Robot Assisted laparoscopic Prostatectomy should be undertaken in line with separate commissioning guidance

Each Specialist centre should undertake a minimum of 100 cases per annum, with a minimum of 25 cases per Surgeon per annum.

In cases where two Surgeons operate jointly on one patient, this case should be attributed to both Surgeons but should only account for one case in the centres total figures.

Procedures and treatments where the site of delivery is determined by agreement in the network's guidelines:

- Radical external beam radiotherapy techniques.
- Radical brachytherapy techniques. This is only available in a few networks. Many patients will need referring outside their own network for this therapy.
- Active surveillance and watchful waiting for appropriate patients
- Patients requiring Salvage Prostatectomy are small in number and should be undertaken by experienced Surgeons. Network pathways should reflect this need at a supra-regional level.

The service should develop rapid access to diagnosis and treatment for patients who could be at risk of fracture or spinal cord compression.

Sperm storage (cryopreservation) should be offered to all patients who may wish to father children. This should be available before surgery, chemotherapy or radiotherapy.

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 specialist urological cancer multidisciplinary team. There should be a formal relationship between the urological cancer service and the provider of non-surgical oncology services that is characterised by agreed network protocols, good communication, and well-defined referral pathways.

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

- Adult Systemic Anti-Cancer Therapy (SACT/ chemotherapy) service specification
- Radiotherapy Technique service specifications
- Chemotherapy service specifications

Follow-up

The Improving Outcomes Guidance 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 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 or within primary care. 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.

Specialist MDTs are encouraged to collaborate with Clinical Commissioning Groups to facilitate community follow up.

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 local guidelines.

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 are managed by a specialist urological cancer multidisciplinary team will be allocated a key worker, normally the clinical nurse specialist.

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 shall 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 shall be developed. The nurse specialist(s) shall ensure the results of patients' holistic needs assessment are taken into account in the multidisciplinary team decision making.

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 community based follow-up. 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.

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.

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.

Care Pathways

The local care pathway for kidney, bladder and prostate cancers should be consistent with the national pathways, where they exist.

2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England[1] 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 adults with urological cancers requiring specialised intervention and management, as outlined within this specification.

The service must be accessible to all patients with a suspected or establish Urological cancer regardless of sex, race, gender, adult age, disability or religion. Providers should require staff to attend mandatory training on equality and

[1] Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England

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.

2.4 Any acceptance and exclusion criteria

The role of the specialist urological cancer service is described in this document but the detailed specification for local urological cancer services is described in a separate document as these services are expected to be commissioned by the clinical commissioning groups (CCGs). Detailed specifications for the specialist supra-network testicular cancer services and supra-network penile cancer services are also described in separate documents.

2.5 Interdependencies with other services

The management of urological cancer involves three cross-linked teams:

- Primary health care team
- Urological cancer team:
    - Local urological multidisciplinary teams
    - Specialist urological multidisciplinary team
    - Supra-network (penile or testicular cancer) multidisciplinary teams
- Specialist palliative care team

The urological cancer service providers are the leaders in the NHS for patient care in this area. They provide a direct source of advice and support when other clinicians refer patients into the regional specialist services.
The urological cancer service providers also provide education within the NHS to raise and maintain awareness of urological cancers and their management.

The urological cancer service providers will form a relationship with local health

and social care providers to help optimise any care for urological cancer provided locally for the patient. This may include liaison with consultants, GPs, palliative care teams community nurses or social workers etc.

3. Applicable Service Standards

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

Care delivered by the urological cancer service providers must be of a nature and quality to meet this Specification, CQC care standards and the IOG for urological cancers. 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.

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

- 31 day maximum wait from diagnosis to first treatment,
- 31 day maximum wait to subsequent treatment,
- 62 day maxium 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 has 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 quality standards, recommendations and data collection outlined as followed:

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)
- Prostate Cancer diagnosis and treatment Guidelines – NICE (2014)
- Quality Standards for Prostate Cancer - NICE (2015)
- Quality Standards for Bladder Cancer - NICE (2015)

National Cancer Peer Review

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

Other

- Chemotherapy Services in England. National Chemotherapy Advisory Group (2009)
- Summary of Review of Specialised Commissioning Documents – Pathology (2014)
- BAUS National Complex Operations Database

4. Key Service Outcome Measures

All Providers delivering services outlined within this document are required to participate in national audits and data collection, where this exists.

Quality and Performance Standards

	Performance Indicator	*Threshold*	*Method of Measurement*	*Consequence of breach*
Quality				
Domains 1 & 5	% of cases discussed at multidisciplinary team	100%	Reported within national audit reports	As per standard NHS Contract, General Conditions Clause 9 (GC9)
Domains 1, 2, 3, 4 & 5	Percentage attendance by individual core members or their agreed cover at multidisciplinary team	67%	National Cancer Peer Review	GC9
Domains 1, 2, 3, 4 & 5	Attendance at advanced communication skills course	100%.	National Cancer Peer Review	GC9
Domains 1, 2, 3, 4 & 5	Compliance with specific measures for tumour site as set out in IOG documentation, NICE Quality Standards and this specification.	100%	National Cancer Peer Review	GC9
Domains 1, 2, 3, 4 & 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
	14 day suspected cancer referral standard	93%	As above	GC9

	performance (A20)			
	31 day first treatment standard performance (A15)	96%	As above	GC9
	31 day subsequent treatment (Surgery) standard performance (A16)	94%	As above	GC9
	31 day subsequent treatment (Drugs) standard performance (A16)	98%	As above	GC9
	31 day subsequent treatment (Radiotherapy) standard performance (A17)	94%	As above	GC9
	31 day subsequent treatment (Other Treatments) standard performance	TBC	As above	GC9
	31 day subsequent treatment (Palliative) standard performance			TBC
	62 day standard from 14 day referral performance (A18)	85%	As above	GC9
	62 day standard from 14 day referral performance (A18)	TBC	As above	GC9
	62 day standard from consultant upgrade performance (A19)	TBC	Some national data	GC9

Domains 2 & 5	Number of tumour sites where community or self follow up is integrated to care	Evidence of at least 1 of 3 tumour sites	Trust reported	GC9
Domains 1, 2, 3, 4 & 5	Ensuring all patients receive patient information	100%	National Cancer Peer Review	GC9
Domains 1, 2, 3, 4 & 5	Ensuring all patients have a named key worker who is a Uro-oncology trained CNS	100%	National Cancer Peer Review	GC9

Activity Performance Indicators		Threshold	Method of Measurement	Consequence of breach
Domains 1, 2, 3, 4 & 5	Annual review of Audits conducted	Yes/No	Trust Reported	GC9
	Participation in National Audits, including BAUS National Data Collection	100%	Trust Reported	GC9
Domains 1, 2, 3, 4 & 5	Threshold for number of procedures			
	Prostatectomy 100 per centre; 25 per surgeon	100%	Trust Reported	GC9
	Cystectomy 30 per centre; 15 per surgeon	100%	Trust Reported	GC9
	Specialised Renal Surgery 30 per centre 15 per surgeon. Renal Cancer with caval Surgery 10 per	100%	Trust Reported	GC9

	centres (supra-regional)			
Domains 1, 2, 3, 4 & 5	National Cancer Patient Experience survey (ref A46 main contract)	National survey report when published	NHS England	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 1, 2, 3, 4 & 5	Improving Service User Experience	Of responses received 75% should express overall satisfaction with the service. Trust to evidence the measures it has taken to improve service user experience and outcomes achieved and numbers / percentages stratified	NHS England	GC9
Domains 1, 2, 3, 4 & 5	Addressing Complaints	Trust to evidence the measures it has taken to address complaints and	Trust Reported	GC9

		outcomes achieved		
Domains 1, 2, 3, 4 & 5	Patient involvement	Trust to evidence the actions it has taken to engage with patients and demonstrate where this has impacted	Trust Reported	GC9
Domains 1, 2, 3, 4 & 5	Trial Activity; Recruitment into trials	90% of Patients eligible for an existing clinical trial should be offered the chance to be treated in a clinical trial	NCRN	GC9
Domains 1, 2, 3, 4 & 5	Post surgery mortality	Numbers and percentages baseline to be set in year for each specific tumour site surgery	Trust Reported	GC9
	30 day mortality			
	1 yr survival			
	5 yr survival			
	30 day readmission rates for cancer patients			
Domains 1, 2, 3, 4 & 5	Data Submission: Registry dataset submission status	As required by Registry	National Peer Review	GC9
	Data Submission: Staging data	As required by Registry	National Peer Review	GC9
	Data Submission:	90%	BAUS	GC9

	BAUS data completeness			

Additional information

Incidence and survival data within this document refers to urological cancers classified using the international classification of diseases (version 10 - ICD10) as follows:

- C61: Malignant neoplasm of prostate - approximately 35,000 cases per year
- C64: Malignant neoplasm of kidney, except renal pelvis - approximately 6,500 cases per year
- C65: Malignant neoplasm of renal pelvis - approximately 500 cases per year
- C67: Malignant neoplasm of bladder - approximately 8,800 cases per year

Incidence data for patients diagnosed in 2009, England. Source: UKCIS, data extracted August 2012. Emergency presentation data for patients diagnosed 2006-2008, source: NCIN.

Cancer waiting times

The urological cancer group for the 31-day reporting category comprises of ICD-10 codes C60-C68. For the 31/62-day (referral to treatment) reporting category, the group is urological (excluding testicular) and comprises C60-C68, excluding C62.

OPCS-4 codes

The following OPCS-4 codes have been agreed within the NCIN as operations that, if undertaken on a patient with prostate, bladder and kidney cancer, would be a major surgical resection:

Prostate

- M611 Total / Radical prostatectomy, Total excision of prostate and capsule
- M618 Open excision of prostate, other specified
- M619 Prostatectomy NEC. Open excision of prostate, unspecified
- LB69Z Major Robotic prostate and bladder neck (male) procedures

Bladder

- M341 Cystoprostatectomy M342 Cystourethrectomy M343 Cystectomy NEC
- M348 Other specified total excision of bladder
- M349 Unspecified total excision of bladder
- Neobladder reconstruction code
- Ileal loop code

Kidney

- M021 Nephrectomy and excision of perirenal tissue, Nephroureterectomy and excision of perirenal tissue
- M022 Nephroureterectomy NEC M023 Bilateral nephrectomy
- M024 Excision of half of horseshoe kidney
- M025 Nephrectomy NEC
- M028 Total excision of kidney, other specified M029 Total excision of kidney, unspecified M038 Other specified partial excision of kidney
- M039 Partial nephrectomy NEC, Partial excision of kidney, Unspecified
- M042 Open excision of lesion of kidney NEC M104 Endoscopic cryoablation of lesion of kidney M181 Total ureterectomy , Ureterectomy NEC M182 Excision of segment of ureter
- M183 Secondary ureterectomy
- M252 Open excision of lesion of ureter NEC

Appendix 1: Prescribed Services Manual and Information Rules

Adult specialist urology surgery services include all services provided by Adult Urology Surgery Centres including assessment if performed and the Specialist Centre.

Service Description	Type	NPOC	NCBPS
Specialist urology (adults)	**Adults**	**B14**	
Consisting of:			
Kidney, Bladder and Prostrate cancer			**01N**
Penile cancer			**01X**

Testicular cancer			**01Z**

Data Flows
The data flows used to support this service are: • Inpatient activity via SUS
How the activity for this service is identified
This service includes specified activity at specified centres.
How to use the identification rules
1. Inpatient activity can be identified via the appropriate diagnosis codes documented within the identification rules software tool.