SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	B14/S/c
Service	Urological cancers – Specialised Testicular 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

Testicular cancer can derive from any cell type found in the testicles and encompasses male germ cell tumours, Leydig and Sertoli cell tumours and other tumours of the testis/paratesticular structures).

There are two main types of testicular cancer, both are germ cell tumours: seminomas and non seminomatous germ cell tumours (NSGCTs). Approximately half are pure seminomas. The remainder comprise one or more of the histological subtypes of non-seminomas.

Germ cell tumours may also arise from extragonadal primary sites such as the retroperitoneum and mediastinum. These patients essentially present as metastatic disease with treatment similar to systemic disease from testicular primaries, and are included within this specification.

Other rare tumours can arise in the testicles including lymphoma which is

generally in men over 50 usually reflecting systemic disease. Tumours arising from paratesticular structures may also present with an initial diagnosis of a testicular tumour. These include a range of sarcomas (rhabdosarcoma. Liposarcoma) and are best definitively managed within the context of a Sarcoma service. Urologists may however be involved with their initial care including orchidectomy – with the potential of positive margins with this surgery creating additional management issues for this rare group of patients.

There were almost 1,871 cases of testicular cancer in England in 2010, with an incidence rate of 7.2 cases per 100,000 population. One year relative survival estimates are high at 98 per cent with deaths reflecting both refractory disease and treatment related complications.

There are different levels of care for all urological cancers: local care and specialist supranetwork care. This specification focuses on supranetwork care services for testicular cancer.

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)

- Suspected Cancer: Recognition and Referral – NICE NG12 (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

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):
    - Retroperitoneal Lymph Node Dissection 10 per centre; 10 per Surgeon (cases may be attributed jointly between 2 Consultants)

- There should be 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 testicular cancer service is to deliver high quality 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 supra-network testicular cancer multi-disciplinary team.

The supra-network specialist testicular cancer multidisciplinary team should cover a population of at least two million.

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

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

The overall objectives of the services are:

- To provide an exemplary and comprehensive service for all referred patients with testicular cancer.
- 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 advise and proceed to treatment options if clinically indicated.
- To carry out effective 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 and that they conform to national standards and published clinical guidelines, and are monitored by objective audit.
- To provide care with a patient and family-centred focus to maximise the patient experience.
- To support local healthcare providers to manage patients with testicular cancer whenever it is safe to do so and clinically appropriate within the framework of the Improving Outcome Guidance (IOG).
- To provide high-quality information for patients, families and carers in appropriate and accessible formats and media.
- To ensure accurate and timely information is given to the patient's General Practitioner.
- To ensure the active involvement of service users and carers in service development and review.
- To ensure a commitment to continual service improvement
- To ensure compliance with Peer Review Cancer Measures and with clinical lines of enquiry when they are developed.
- To ensure compliance with Care Quality Commission regulations.

2.2 Service description/care pathway

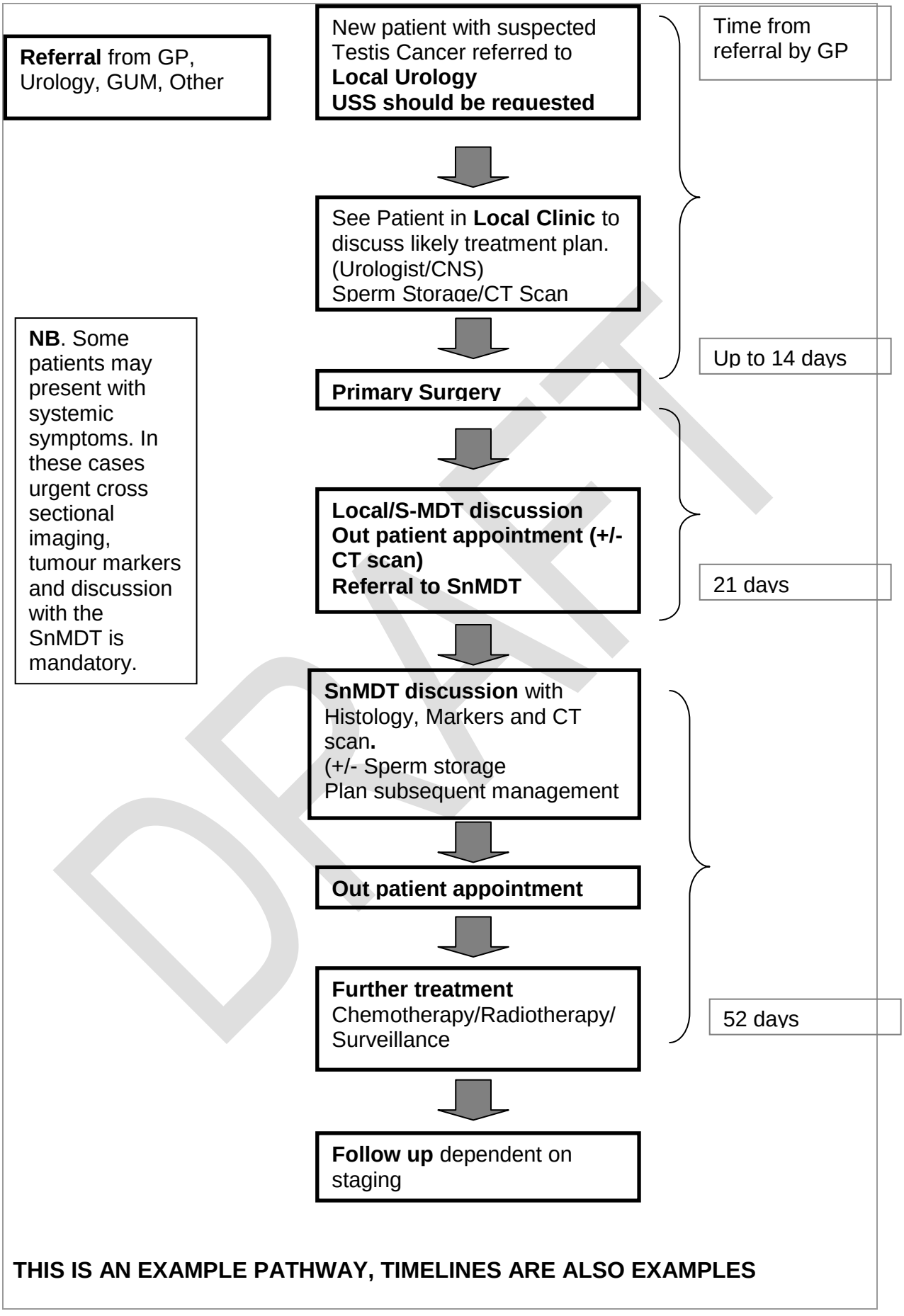
The supra-network testicular cancer multidisciplinary team will deliver the service in line with the following:

- There is a weekly multidisciplinary team meeting to discuss the needs of each newly referred patient. Other patients are likely to require discussion at the multidisciplinary team meeting, for example after treatment or on progression of the cancer
- 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, chemotherapy or radiotherapy is the first planned treatment then efforts should be made to give the patient a date for that treatment at the first visit, and written information provided on that treatment. The timing of treatment 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 testicular cancer.
- Patients should be introduced to a 'key worker'; this is normally the clinical nurse specialist.
- Accurate and timely information should be shared with the patient's 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 oncological surgeon or medical/clinical oncologist 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.

A suggested patient pathway is shown below, this is an example of how a pathway may work (note timelines are also examples and do not detract form national targets):


Referral from GP, Urology, GUM, Other
New patient with suspected Testis Cancer referred to Local Urology
USS should be requested
Time from referral by GP
See Patient in Local Clinic to discuss likely treatment plan. (Urologist/CNS)
Sperm Storage/CT Scan
NB. Some patients may present with systemic symptoms. In these cases urgent cross sectional imaging, tumour markers and discussion with the SnMDT is mandatory.
Up to 14 days
Primary Surgery
Local/S-MDT discussion
Out patient appointment (+/- CT scan)
Referral to SnMDT
21 days
SnMDT discussion with Histology, Markers and CT scan.
(+/- Sperm storage
Plan subsequent management
Out patient appointment
Further treatment
Chemotherapy/Radiotherapy/ Surveillance
52 days
Follow up dependent on staging
THIS IS AN EXAMPLE PATHWAY, TIMELINES ARE ALSO EXAMPLES

Patients to be discussed at the Specialist MDT

The following patients should be discussed at the specialist MDT:

All New and Recurrent Testicular Cancer

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

Specialist MDT Centres

The service is delivered across England by 13 cancer centres which provide cover across all regions in England for the national caseload. The supra-network testicular cancer multidisciplinary team services are based at:

Code	Trust	Team
RBV	The Christie NHS Foundation Trust	Multidisciplinary team – Christie Hospital
RQ6	Royal Liverpool University Hospitals NHS Trust	Multidisciplinary team - Royal Liverpool
RR8	Leeds Teaching Hospitals NHS Trust	Multidisciplinary team – Leeds Teaching
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	Multidisciplinary team - Sheffield
RRK	University Hospital Birmingham NHS Foundation Trust	Multidisciplinary team – University Hospitals Birmingham Foundation Trust
RQN	Imperial College Healthcare NHS Trust	Multidisciplinary team – Charing Cross

Code	Trust	Team
RNJ	The London NHS Trust	Multidisciplinary team – London
RPY	The Royal Marsden NHS Foundation Trust	Multidisciplinary team – Royal Marsden - Chelsea
RA7	University Hospitals Bristol NHS Foundation Trust	Multidisciplinary team - UHB
RTH	Oxford Radcliffe Hospitals NHS Trust	Multidisciplinary team – Oxford Radcliffe
RHM	Southampton University Hospitals NHS Trust	Multidisciplinary team - SUHT
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Multidisciplinary team - Newcastle
RX1	Nottingham University Hospitals NHS Trust	Multidisciplinary team – Nottingham University Hospitals NHS Trust

Members of the specialist urological cancer multidisciplinary team

Each member of the supra-network testicular cancer multidisciplinary team shall have a specialist interest in urological cancer**.** Members of the supra- network testicular cancer multidisciplinary team shall include:

- Urological Surgeons (at least two urologists)
- Clinical oncologist/Medical oncologist (at least two members)
- Radiologist (with named cover) with expertise in testicular cancers
- Histopathologist (with named cover) with expertise in testicular cancer
- Testicular Clinical Nurse Specialist (with named cover)
- Multidisciplinary team co-ordinator / Secretary (with named cover)

The supra-network multidisciplinary team should also have access to:

- An Andrologist/Urologist with expertise in ultrasound guided-biopsies and local excision of small tumours
- GPs/primary health care teams
- Local urological cancer teams at linked cancer units
- Thoracic surgeon for resection of chest/supraclavicular masses
- An endocrinologist
- A fertility service including a Urologist with expertise in Andrology and resources to provide semen analysis, sperm collection and banking and assisted fertilisation
- A Teenage and Young Adult Cancer Service(TYACS) – http://www.nhs.uk/young-cancer-care/Pages/teenage-young-adult-cancer-units.aspx
- Clinical geneticist/genetics counsellor
- Liaison psychiatrist
- Clinical psychologist trained in psychotherapy and cognitive behaviour therapy
- Counsellor with expertise in treating psychosexual problems
- Occupational therapist
- Social worker
- Palliative care teams.

There shall be a single named lead clinician for the supra-network testicular cancer multidisciplinary team service who will also be a core team member.

An NHS-employed member of the core or extended team shall be nominated as having specific responsibility for user issues and information for patients and carers including patient participation, and ensuring the existence of a Cancer Services User Group.

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) and High Dependency care services may be required for patients undergoing RPLND and providers will be required to refer to the service specification for critical care.

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

Appropriate level of Consultant Specialist on call services

Patient experience

The service should be patient centred and should respond to patient and carer feedback. Excellent communication between professionals and patients is essential to ensure 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 NHS services.

Patient experience is reported in the National Cancer Patient Survey. In this survey patients who are 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.

Patient information

Every patient and their 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
- 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 allocated named nurse
- Possible benefits and compensation
- Support organisations or internet resources recommended by the clinical team

The service must also provide appropriate education to patients and carers on:

- Symptoms of infection and management of neutropenic sepsis and prophylaxis
- Out of hours advice/support
- Contact in case of concern or emergency

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

term health needs.

Referral Processes and Sources

Referrals to the service will come from either primary care or a local or specialist multidisciplinary team. Steps prior to referral to the supra-network team might include the following although the supranetwork multidisciplinary team may also arrange the investigations (please refer to local network guidelines):

- The local team will normally already have made a diagnosis, confirmed by ultrasound, CT, Orchidectomy/biopsy and tumour marker estimations
- The patient should have been informed of the diagnosis (or potential diagnosis)
- The patient may have had staging investigations
- The patient may have been discussed at their local multidisciplinary team
- In patients being considered for partial orchidectomy/local excision, individual cases should be discussed with the sMDT prior to surgery

Patients being referred for treatment to the supranetwork team should be made known to the receiving team in a timely manner, so that they are seen for their specialist consultation as soon as possible after the histopathological diagnosis is available. High risk' patients (which should be precisely defined in the network guidelines) should be referred and made known to the supranetwork team pre-operatively (some patients with metastatic disease may undergo systemic therapy prior to orchidectomy) or as soon as possible after diagnosis..

Imaging and pathology

The service should ensure that chest x-ray / ultrasound / CT scanning / MRI 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 supra-network multidisciplinary team.

When symptoms or imaging clearly show that the disease is metastatic the patient will be referred to the multidisciplinary team for discussion of results before a treatment decision is made.

Local histopathological diagnosis is crucial for the appropriate referral of testis cancer cases. This must be available within two weeks of orchidectomy or biopsy.

Histological confirmation of tumour is usually required before treatment with chemotherapy or radiotherapy. Supranetwork teams may require review of the pathology by a pathologist who is a core member of the team prior to treatment decisions.

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

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 testicular cancer into the supra-network multidisciplinary team service in line with national guidelines. Compliance with these guidelines should be audited.

Patients who present as an emergency on their route to being diagnosed with cancer have poorer survival. Approximately 10 per cent of testicular cancer patients present through an emergency route so it is important to have good emergency systems in place. Providers should:

- Develop an algorithm to support decision-making in A&E or primary care
- Set up an emergency communication alert system service for GPs/A&E/Assessment units/ clinicians to enable rapid specialty assessment

and outpatient investigations

Staging

Providers must include staging information in their cancer registration dataset (this Is mandated in the Cancer Outcomes and Services Dataset). 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.

Treatment

Treatment delivered by the supra-network testicular cancer multidisciplinary team includes:

- Orchidectomy on high-risk patients referred pre-operatively.

- Surgical resection of post-chemotherapy residual masses (retroperitoneum, mediastinum or elsewhere) – it is strongly recommended that these are undertaken by a surgical team serving a population of sufficient size to generate a practice that will maintain expertise. For RPLND surgery, centres should ensure surgeons have and maintain expertise in retroperitoneal surgery. Where necessary cases can be undertaken and attributed jointly between two consultants.

- Treatment of all post-radiotherapy and post-chemotherapy recurrences. (Treatment of first recurrences occurring during surveillance should follow the network's agreed guidelines as for newly diagnosed cases, depending on parameters of disease stage and type.)

- All other treatment by any modality, excluding local care and the network's particular arrangements for specialist care.

Some named specialist urology multidisciplinary teams, by agreement with the network urology site-specific group, may carry out:

- Radiotherapy for seminoma (for specified categories of patients)
- Chemotherapy for germ cell cancer; for stage I and 'good prognosis' metastatic cases.

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. It is preferable that, after counselling, this is offered prior to orchidectomy but in appropriate cases can be undertaken before chemotherapy or radiotherapy.

An 'Enhanced Recovery' approach to elective surgery should be adopted by all testicular 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.

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 the supra-network testicular cancer multidisciplinary team. There should be a formal relationship between the testicular 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 clinician in the supra-network multidisciplinary team. Audits of compliance with agreed protocols will need to be demonstrated.

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

- Adult Systemic Anti- Cancer Therapy (SACT/chemotherapy) service specification
- Radiotherapy model service specification

Follow-up

The network urological cancer site-specific group should, as part of their referral guidelines, and in consultation with the relevant supra-network testicular team, agree a list of named specialist teams who may carry out surveillance and specify for which specific categories of patients this is appropriate. Otherwise it should be carried out by the supra- network team. The network may agree that surveillance should only be carried out by the supra-network team. Also, surveillance which might otherwise be carried out by an agreed specialist team, may be undertaken by the supra- network team if desired and agreed by the patient and relevant consultants.

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.

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 rehab pathway.

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. Normally the clinical nurse specialist or

other keyworker will facilitate this.

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 at the beginning of the end of life. A formal care plan will 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 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.

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 testicular cancers should be consistent with the national pathway on Map of Medicine.

2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England; 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 and teenagers with testicular cancers requiring specialised intervention and management, as outlined within this specification.

The service must be accessible to all patients with a suspected or established testicular cancer regardless of sex, race, or gender**.** Providers require staff to attend mandatory training on equality and diversity, and the facilities provided should offer appropriate disabled access for patients, family and carers.

When required, the providers will use translators and/or printed information 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 supra-network testicular cancer service is described in this document but 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). Detailed specifications for the specialist urology cancer services and supra-network penile cancer services are also described in separate documents.

2.5 Interdependencies with other services

The management of testicular cancer involves four cross-linked teams:

- Primary health care team
- Urological cancer team:
    - Local urological multidisciplinary teams
    - Specialist urological multidisciplinary team
- Supra-network testicular cancer multidisciplinary team
- Specialist palliative care team
- Teenage and Young Adult Cancer Service

The testicular 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. This support will continue until the patient is transferred into the local or specialist urology centre, or it becomes apparent that the patient does not have a testicular cancer.

The testicular cancer service providers also provide education within the NHS to raise and maintain awareness of testicular cancers and their management.

The testicular cancer service providers will form a relationship with local health and social care providers to help optimise any care for testicular cancer provided locally for the patient. This may include liaison with consultants, GPs, palliative care teams community nurses or social workers etc.

Co-located services – Intensive/critical care services may be required for some

patients undergoing complex surgery and providers will be required to refer to the service specification for critical care

Strategic clinical networks, in place from April 2013, are located in 12 areas across England. They will be established in medical 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 network has a Network Site Specific Group covering urological cancers, made up of clinicians across the network who specialise in urological cancers. It is the primary source of clinical opinion on issues relating to urological cancer within the cancer network and is an advisor to commissioners locally. Each supra-network multidisciplinary team should ensure they fully participate in the cancer network systems for planning and review of services.

This group is responsible for developing referral guidelines, care pathways and standards of care, and for sharing good practice and innovation. The specialist and supra-network multidisciplinary teams should also collectively implement NICE IOG, including the use of new technologies and procedures as appropriate, and should 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.

3. Applicable Service Standards

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

Care delivered by the testicular cancer service providers must be of a nature and quality to meet the 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.

Testicular cancer services are required to achieve the two week wait for all patients where urological cancer is suspected.

There is general agreement in testicular cancer that patients presenting with ultrasonic evidence of testicular cancer should have an orchidectomy within 2 weeks, particularly to support patients presenting with metastatic disease.

In addition the services are required to meet the following standards for all urology 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 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)

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	% of cases	100%	Reported	As per

1 & 5	discussed at multidisciplinary team		within national audit reports	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 performance (A20)	93%	As above	GC9
	31 day first treatment standard performance (A15)	96%	As above	GC9
	31 day subsequent	94%	As above	GC9

	treatment (Surgery) standard performance (A16)			
	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	Ensuring community or self follow up is integrated to care	100%	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	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.	NHS England	GC9

		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 & 5	Addressing Complaints	Trust to evidence the measures it has taken to address complaints and outcomes achieved	Trust Reported	GC9
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 (RPLND)	Numbers and percentage	Trust Reported	GC9

		baseline to be set in year for RPLND		
	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: BAUS data completeness	90%	BAUS	GC9

Additional information

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

- C62: Malignant neoplasm of testis - approximately 1,850 cases per year
- Incidence data for England, 2009. Source: UKCIS, data extracted August 2012. Emergency presentation data for patients diagnosed 2006-2008, source: NCIN.

Cancer waiting times

Testicular cancer forms part of the wider urological report group for 31-day reporting category but has a separate testicular group (C62 only) for 31/62-day (referral to treatment) reporting category.

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:

Relevant operational codes for this service

Intervention	OPCS Classification of Interventions 3 digit categories
RPLND/ Excision of retroperitoneal tumour	T 85.4/ T85.8/ T39.1
Ureterolysis	M25.3
Ureteric Stent	M27.4/ M27.8
Aortic replacement	L23
IVC Procedure	L79.2/L79.8
Retrocrural node dissection	T85.9/ T87.8/ T87.9
Nephrectomy	M02
Pancreatectomy/ Splenectomy	J57.1/J69.0
Colonic/ Small Bowel Resection	H10.0/H07.0 G60.8
Liver resection	J02
Porta hepatis node excision	T87.6
3 day BEP	X 70.2
5 day BEP	X 70.3
Carboplatin (AUC 2-4)	X 70.2
Carboplatin (AUC 5-9)	X 70.3
XRT	X 65.4 Y 91.2