E10/S/f

NHS STANDARD CONTRACT
FOR COMPLEX GYNAECOLOGY- SPECIALIST GYNAECOLOGICAL CANCERS

SCHEDULE 2- THE SERVICES A. SERVICE SPECIFICATIONS

Service Specification No.	E10/S/f
Service	Complex Gynaecology -Specialist Gynaecological Cancers
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National Context

For the purposes of this specification, Gynaecological cancers include ovarian (also fallopian tube and primary peritoneal), uterine, cervical, vulval and vaginal cancers. As the requirements for management of each type of cancer will vary, it is likely that separates specifications will be required in future for the specialist management of ovarian, uterine, cervical, and vulval/vaginal cancers.

The crude incidence rates per 100,000 populations for gynaecological cancers vary greatly by site. In England, the crude rates per 100,000 female populations are 22.3 for ovarian cancer, 24.9 for uterine cancer, 10.4 for cervical cancer, 0.9 for vaginal cancer and 3.7 for cancer of the vulva. 1 year relative survival estimates also vary for different gynaecological cancers from 71% for ovarian cancer to 91% for uterine cancer.

The optimum management of women of gynaecological cancer requires co- ordination between 3 levels of care:

Level 1: Primary care

Level 2: Local gynaecological cancer multidisciplinary team/stand alone diagnostic team (based in cancer units): Rapid assessment for all types of gynaecological cancers, and treat early stage cervical cancer (Stage 1a1) and low risk cancers of the endometrium

Level 3: Specialist gynaecological cancer multidisciplinary teams (based in cancer centres)

- Management of all women with ovarian cancer and other gynaecological cancers including endometrial cancer (other than low risk cancers), cancer of the cervix (other than early stage cancer), vulva and vagina

- Function as diagnostic (Level 2) service for local population and manage all gynaecological malignancies for this population

- Management of recurrence of gynaecological cancers

This specification focuses on the services to be provided at **Level 3: Specialist Gynaecological Cancer multidisciplinary teams (based in cancer centres)**

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)
- Improving Outcomes Guidance (IOG) in gynaecological cancers. Department of Health (1999)
- Guidance on commissioning cancer services – IOG in gynaecological cancers. Department of Health – The Research Evidence (1999)

NICE

- 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)
- Ovarian Cancer: The recognition and initial management of ovarian cancer – NICE (2011)
- Quality Standard for ovarian cancer – NICE (2012)

National Cancer Peer Review

- National Cancer Peer Review (NCPR) Handbook – NCPR, National Cancer Action Team (2011)
- Manual for Cancer Services: Gynaecological measures, version 3.0 – NCPR, National Cancer Action Team (2013)
- Gynaecology Clinical Lines of Enquiry Briefing Paper for NCPR 2012-13 (2012)
- Manual for Cancer Services acute oncology measures NCPR, National Cancer Action Team (April 2011)
- Manual for Cancer Services Chemotherapy measures NCPR, National Cancer Action Team (June 2011)

Other

Chemotherapy services in England. National Chemotherapy Advisory Group (2009).

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**	√

Outcome measures will be determined annually by national cancer peer review and the National Cancer Intelligence Network Gynaecological Clinical Reference Team, and presented as clinical lines of enquiry for the peer review process

The expected clinical outcomes the service is to monitor include:

- Accuracy of diagnosis - % of patients with staging data recorded.

- Caseload of ovarian cancer surgery – subspecialist gynaecological oncology surgeons to perform >15 operations for ovarian cancer per year (includes fallopian tube and primary peritoneal cancers).
- Post-operative length of stay data for uterine cancer surgery – to reflect implementation of enhanced recovery programmes (ERP).
- One, two and 5-year survival rates for each type of gynaecological cancer,
- Clinical Nurse Specialist (CNS) support to patients – to reflect results from the National Cancer Patient Experience survey.

3. Scope

3.1 Aims and objectives of service

The aim of the specialist gynaecological cancer service is to deliver high quality holistic care for patients with gynaecological cancers 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 gynaecological cancer multidisciplinary team.

The specialist gynaecological cancer service should work closely with primary care, local diagnostic teams and local gynaecological multidisciplinary team to ensure patients care is seamless and timely.

The specialist gynaecological cancer multidisciplinary team service is required to agree the following areas with their strategic clinical network:

- Service configuration and population coverage.
- Referral criteria, clinical protocols and network policies and treatment pathways in accordance with NICE guidelines and quality standards.
- Engagement with the local network groups and National Cancer Peer Review for gynaecological tumour.

The overall objectives of the service are:

- To provide an exemplary and comprehensive service for all eligible referred patients with gynaecological cancers.
- To ensure radiological, pathological and diagnostic facilities are available in order to effectively diagnosis, classify and stage the cancer prior to planning treatment.
- To advise and undertake investigations to proceed to treatment options if clinically indicated, including high quality surgical treatment of patients with gynaecological cancer.
- To carry out effective monitoring of patients to ensure that the treatment is safe and effective.

- To provide care which promotes optimal functioning and quality of life for each individual patient
- To provide appropriate follow up and surveillance after definitive treatment where this is not being provided elsewhere (e.g. Primary Care).
- To ensure all aspects of the service are delivered as safely as possible, conform to national standards and published clinical guidelines and are monitored by an 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 gynaecological cancer whenever it is safe to do so and clinically appropriate.
- To provide high quality information for patients, families and carers in appropriate and accessible formats and media.
- To ensure there is accurate and timely information given to the patient's general practitioner.
- To ensure that there is involvement of service users and carers in service development and review.
- To ensure there is a commitment to continual service improvement.
- To comply with national data returns and electronic data transfer, including information on cancer stage, to registries.
- To ensure compliance with peer review cancer measures.
- To ensure compliance with Care Quality Commission Regulations

3.2 Service description/care pathway

The local care pathway for endometrial cervical and ovarian (including peritoneal and fallopian tube) cancers should be consistent with the national pathways on map of medicine. The process of producing the pathways and subsequent updates has been accredited by the National Cancer Action Team. NICE has also developed information on this pathway.
http://pathways.nice.org.uk/pathways/ovarian-cancer

3.3 Service model

It is essential that all patients with a suspected gynaecological tumour are discussed at an expert multi-disciplinary team. All members of the team should be specialists in the management of gynaecological cancer. The number of people required to fulfil each role will depend on the team's workload.

The core membership of the specialist gynaecological multidisciplinary team should include:

- A minimum of two surgical gynaecological oncologists (subspecialist gynaecologists who specialise in surgery for gynaecological cancer).
- Radiotherapy specialist (clinical oncologist).

- Chemotherapy specialist (medical oncologist or clinical oncologist).
- Radiologist.
- Histopathologist.
- Cytopathologist.
- Clinical nurse specialist.
- Multidisciplinary team co-ordinator

Extended multidisciplinary team membership shall include:
Psychologist/Psychiatrist/Counsellor with experience in cancer and psychosexual problems.

- Cancer genetic specialist
- Social worker
- Palliative care specialist

There should be a single named lead clinician for the specialist gynaecological multidisciplinary team who should also be a core team member.

A member of the core team should be nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the multidisciplinary team

An NHS employed member of the multidisciplinary team should be nominated as having responsibility for user issues and information for patients and carers.

3.4 Referral processes and sources

Referrals to the service will come from either primary care or accident and emergency, other specialties, a local diagnostic service or a local multidisciplinary team. Steps prior to referral to the specialist team include:
The local team will usually have made a diagnosis, confirmed by ultrasound, CT or biopsy, and the Risk of Malignancy Index (RMI) will have been calculated where appropriate.

- The patient will have been informed of the diagnosis and given the date of a CT scan if indicated.
- The patient may have had staging investigations.
- The patient will have been discussed at their local multidisciplinary team (depending on network structure)

3.5 Treatment, Follow up, Supportive and Palliative care
This will follow agreed network guidelines. Network guidelines will be based on established national guidelines including IOG guidelines and will be reviewed annually by the network site specific group. The adequacy of Network guidelines will be assessed by the peer review process.

Treatment
All possible management options should be discussed with the patient. The treatment each

patient receives should be tailored to fit their individual 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.

Ovarian Cancer (including fallopian tube cancer and primary peritoneal cancer)
Surgery is the standard curative treatment and combines surgical removal of all disease and a staging procedure. Neoadjuvant chemotherapy is used in surgically un-resectable disease and interval surgery employed thereafter depending on the tumour response. Adjuvant chemotherapy is commonly prescribed as determined by the specialist multidisciplinary team following removal of the primary tumour and pathological assessment. Radiotherapy has no primary role in treatment for ovarian cancer. Women who may be at higher genetic risk should be offered referral to a cancer genetics clinic. Prophylactic oophorectomy should be available for women at high risk.

Endometrial Cancer
Women who may be at higher genetic risk should be offered referral to a cancer genetics clinic. Prophylactic hysterectomy should be available for women at high risk. Surgery is the treatment of choice for all cases of endometrial cancer where the tumour appears to be confined to the uterus or disease appears resectable. High risk histology cases may be treated with adjuvant radiotherapy and/or chemotherapy. Cases with confirmed metastatic disease may be treated with primary radiotherapy and / or chemotherapy.

Invasive Cervical Cancer
Surgery is appropriate for the majority of women with early cervical cancer. For women with late-stage or bulky cancers, radiotherapy is appropriate and concurrent chemo-radiotherapy should be considered. Organ sparing surgery (radical trachelectomy) should be available for cases deemed appropriate by the specialist multidisciplinary team. Supra - regional pathways for radical trachelectomy require further discussion and agreement nationally in view of the small number of cases involved.

Vaginal Cancer
Vaginal cancer is treated in most cases with radiotherapy and/or chemo-radiotherapy. There is an occasional role for exenterative surgery if recurrence occurs following radiotherapy.

Vulval Cancer
Surgery (including reconstructive surgery) is the main treatment for this cancer. Adjuvant radiotherapy and or/chemotherapy is required in some cases depending on the stage of the disease. Primary radiotherapy with or without chemotherapy may be required as primary treatment in more locally advanced disease in order to spare bladder and bowel function. Morbidity-spearing sentinel node surgery should be available for patients where appropriate

Enhanced Recovery
Enhanced recovery has been shown to shorten lengths of stay, facilitate early detection and management of complications as well as improve patient experience. This approach to

elective surgery should be adopted by all gynaecological teams.

Laparoscopic Surgery
Laparoscopic surgery with its recognised benefits in terms of earlier recovery and quicker return to normal activities should be the standard of care for appropriate cases of early stage endometrial cancer and should be considered for the treatment of selected cases of cervical cancer.

Exenterative Surgery
Pelvic exenteration as salvage surgery for recurrence of pelvic gynaecological cancer following radiotherapy should be carried out by a team with appropriate expertise which comprises gynaecological, colorectal and urological surgeons. In view of the small number of cases, supra-regional pathways for exenterative surgery require further discussion and agreement nationally.

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 gynaecological cancer 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 2012/13
- Brachytherapy service specification (in development)

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 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.

Supportive and palliative care
The provider shall 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 gynaecological cancer multidisciplinary team will be allocated a key worker.

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

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.

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 shall 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.

3.6 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 referred to above.

3.7 Patient-Centred Services
The service shall be patient centred and shall respond to patient and carer feedback. Excellent communication between professionals and patients is particularly important and can avoid complaints and improve 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 with access to 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.
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 and risk of recurrence.

- 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.
- Fertility issues.
- Practical and social support.
- Nutritional and dietetic support.
- Physiotherapy and occupational therapy.
- Psychological support and psychosexual counselling.
- Self-management and care.
- Contact details of the patient's allocated named nurse.
- Support organisations or internet resources recommended by the clinical team eg Information Prescription service http://www.nhs.uk/IPG/Pages/AboutThisService.aspx
- The service must also provide education to patients and carers on:
- Symptoms of infection and management of neutropenic sepsis and prophylaxis.
- Contact in case of concern or emergency

3.8 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 gynaecological cancers requiring specialised intervention and management, as outlined within this specification.

The service shall be accessible to all patients with a suspected gynaecological cancer regardless of race, age, sexual orientation or religion. Providers must 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.

3.9 Any acceptance and exclusion criteria and thresholds

[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.

The role of the specialist gynaecology cancer services is described in this document but the detailed specification for the local gynaecology cancer services will be described in separate documents, as these services are expected to be commissioned by the Clinical Commissioning Groups.

3.10 Interdependencies with other services/providers

The specialist gynaecological 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 specialist services.

The specialist gynaecological cancer service providers also provide education within the NHS to raise and maintain awareness of rare gynaecological cancer and their management.

The specialist gynaecological cancer service providers will form a relationship with local health and social care providers to help optimise any care for gynaecological cancer provided locally for the patient. This may include liaison with consultants, GPs, palliative care teams community nurses or social workers etc. Links with specialist maternity services will be required to provide care to pregnant women diagnosed with gynaecological cancers.

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.
- Co-location or accessibility to surgical oncology services for Urological Oncology, Colorectal, HPB/Upper GI surgery, and Plastic surgery will be required for some patients

3.11 Strategic Clinical Networks

Strategic Clinical Networks have been in place since April 2013 located in 12 areas across England. They have been 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 network currently has several NSSGs covering gynaecological cancer. Each group is made up of clinicians across the network who specialise in gynaecological cancers. The NSSGs are the primary source of clinical opinion on issues relating to gynaecological cancers within the clinical networks and will advise commissioners locally. Each specialist multidisciplinary team should ensure they fully participate in the clinical network 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. They should also collectively implement NICE IOG including the use of new technologies and procedures as

appropriate and carry out network and national audits.

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

4. Applicable Service Standards

4.1 Applicable national standards

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

- 31 day wait from decision to treat to first treatment or treatment of recurrence.
- 31 day wait to subsequent treatment.
- 62 day wait from urgent GP referral or screening referral or consultant upgrade to first treatment.

The service will comply with the national cancer peer review process and endeavour to meet all appropriate standards, achieving at minimum the national median compliance. Where these are not possible, the service will develop and implement an agreed action plan.

The provider is required to undertake annual patient surveys and develop and implement an action plan based on the findings.

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.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements will be determined and assessed annually by the national cancer peer review process. http://www.cquins.nhs.uk/download.php?d=resources/evidences/NCAT_INT_PEER_Ev

G_GynSpeMDT.pdf
6. Location of Provider Premises The service is delivered across England by 44 cancer centres which provide cover across all regions in England for the national caseload. These are listed in Appendix 2 because the Information Rules do not currently capture all the relevant data.

Appendix One

Quality standards specific to the Gynaecological cancer service:

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Domain 1: Preventing people dying prematurely			

NHS England E10/S/f
Gateway Reference 01370

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Mortality rate	Variable – assess for outlier status on national data supplied by Trent Cancer Registry	Relative survival and Mortality at one, three and five years.	Audit to evaluate causation and change in practice
Staging accuracy	>70%	% stage recorded in mdt database	Audit to assess reasons for non compliance Audit to evaluate causation and change in practice
% of cases discussed at MDT	100%	Reported within national audit reports	Audit and analysis of reasons for non-compliance
Compliance with national cancer waiting time targets	Variable	Cancer registry uploads	Assess reasons for difficulties with compliance – audit/process mapping
Compliance with NICE quality standards for ovarian cancer.	Variable depending on statement	Local audit	
Domain 2: Enhancing the quality of life of people with long-term conditions			
Maximising fertility preservation	>90% of appropriate cases	Patients offered consultation regarding fertility preservation	Audit to assess reasons for non-compliance Requires further discussion
Assessment and management of morbidity associated with surgery, chemotherapy and radiotherapy	Requires further discussion	Requires further discussion	
Domain 3: Helping people to recover from episodes of ill-health or following injury			
Assessment of	Comparison	Continuous audit	Audit to evaluate causation

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
peri-operative morbidity/ readmission rates/ unscheduled CCU admission	with previous audit data eg UKGOSOC	– requires further discussion and agreement at national level	and remedial action
Domain 4: Ensuring that people have a positive experience of care			
Implementation of Enhanced Recovery Programme Clinical Nurse Specialist (CNS) support to patients	100% of inpatients undergoing surgery 100% of patients to have access to CNS support	Post-operative length of stay in endometrial cancer patients Results from National Cancer Patient Experience Survey. Assessment of local recording of CNS contact.	Audit to evaluate causation and remedial action Audit to evaluate causation and remedial action
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
Caseload of ovarian cancer surgery Compliance with peer review	Subspecialist gynae oncology surgeons to perform > 15 operations for gynaecological cancer per year National median compliance level	Centres to record operative numbers National reports	Appropriate allocation of caseload. Assessment of manpower requirements. Audit of causation for non – compliance with specific measures.

Quality Requirement	Threshold	Method of Measurement	Consequence of breach

Appendix 2

Trust Code	Trust Name
RXN	Lancashire Teaching Hospitals NHS Foundation Trust
RW3	Central Manchester University Hospitals NHS Foundation Trust
RBV	The Christie NHS Foundation Trust
RM3	Salford Royal NHS Foundation Trust
RM2	University Hospital of South Manchester NHS Foundation Trust
REP	Liverpool Women's NHS Foundation Trust
RR8	Leeds Teaching Hospitals NHS Trust
RWA	Hull and East Yorkshire Hospitals NHS Trust
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust
RXK	Sandwell and West Birmingham Hospitals NHS Trust
RKB	University Hospitals Conventry and Warwickshire NHS Trust
RWG	West Hertfordshire Hospitals NHS Trust
RQN	Imperial College Healthcare NHS Trust
RRV	University College London Hospitals NHS Foundation Trust
RNJ	Barts and the London NHS Trust
RJ1	Guy's and St Thomas' NHS Foundation Trust
RPY	The Royal Marsden NHS Foundation Trust
RK9	Plymouth Hospitals NHS Trust
REF	Royal Cornwall Hospitals NHS Trust
RH8	Royal Devon and Exeter NHS Foundation Trust
RD3	Poole Hospital NHS Foundation Trust
RD1	Royal United Hospital Bath NHS Trust
RBA	Taunton and Somerset NHS Foundation Trust
RA7	University Hospitals Bristol NHS Foundation Trust
RTE	Gloucestershire Hospitals NHS Foundation Trust
RTH	Oxford Radcliffe Hospitals NHS Trust
RHU	Portsmouth Hospitals NHS Trust
RHM	Southampton University Hospitals NHS Trust
RA2	Royal Surrey County NHS Foundation Trust
RXH	Brighton and Sussex University Hospitals NHS Trust
RVV	East Kent Hospitals University NHS Foundation Trust
RWF	Maidstone and Tunbridge Wells NHS Trust
RJE	University of North Staffordshire NHS Trust
RL4	The Royal Wolverhampton Hospitals NHS Trust
RM1	Norfolk and Norwhich University Hospitals NHS Foundation Trust
RGT	Camrbidge University Hospitals NHS Foundation Trust
RGQ	Ipswich Hospital NHS Trust
RAJ	Southend University Hospital NHS Foundation Trust
RR7	Gateshead Health NHS Foundation Trust
RTR	South Tees Hospitals NHS Foundation Trust
RX1	Nottingham University Hospitals NHS Trust
RTG	Derby Hospitals NHS Foundation Trust
RNS	Northampton General Hospital NHS Trust

Appendix 3 ICD/OPCS codes

Relevant ICD10 codes, cancer waiting times and OPCS4 codes

Incidence rates and number of cases within this service specification are for newly diagnosed cancers in 2009. The cancer sites are coded within the international classification of diseases (version 10 - ICD10) as follows:

C51: Malignant neoplasm of vulva - approximately 1,000 cases per year

C52: Malignant neoplasm of vagina - approximately 200 cases per year

C53: Malignant neoplasm of cervix uteri - approximately 2,700 cases per year

C54-C55: Malignant neoplasm of corpus uteri and unspecified – approximately 6,500 cases per year.

C56-C57.4: Malignant neoplasm of ovary (including fallopian tube, broad ligament, round ligament, parametrium and uterine adnexa (unspecified) - approximately 5,300 cases per year

Survival estimates are for patients diagnosed in 2005-2009, followed up to 2010

Source: UKCIS, accessed August 2012.

Cancer waiting times

ICD-10 codes C51 to C58, (C58: Malignant neoplasm of placenta) are included within the gynaecological group for cancer waiting times.

OPCS4 Codes
The following OPCS4 codes have been agreed within the NCIN as operations that, if undertaken on a patient with ovarian, uterine or cervical cancer, would be a major surgical resection:

C56-C57.4: Ovarian
Q071 Radical Hysterectomy (removes uterus + cervix + vagina). Wertheims hysterectomy
Q072 Abdominal Hysterectomy and excision of periuterine tissue NEC.Radical Hysterectomy
Q073 Abdominal excision of Uterus, abdominal hysterocolpectomy nec
Q074 TAH, Panhysterectomy, hysterectomy NEC (removes uterus + cervix). Total abdominal hysterectomy NEC
Q075 Abdominal excision of Uterus, subtotal abdominal hysterocolpectomy
Q078 Abdominal excision of uterus, other specified
Q079 Abdominal excision of uterus, Unspecified

Q081 Vaginal excision of uterus, vaginal hysterocolpectomy
Q082 Vaginal excision of uterus, vaginal hysterectomy
Q083 Vaginal excision of uterus, vaginal hysterocolpectomy NEC Q088 Vaginal excision of uterus, other specified
Q089 Vaginal excision of Uterus, Unspecified
Q243 Oophorectomy NEC
Q223 Bilateral oophorectomy, excision of gonads
Q235 Unilateral oophorectomy NEC
Q491 Endoscopic extirpation of lesion of ovary NEC Q236 Oophorectomy of remaining solitary ovary NEC Q438 Other specified partial excision of ovary
Q439 Unspecified partial excision of ovary
Q232 Salpingoophorectomy of remaining solitary fallopian tube and ovary
Q241 Salpingoophorectomy NEC Q221 Bilateral salpingoophorectomy
Q231 Unilateral salpingoophorectomy NEC T361 Omentectomy
X141 Clearance of Pelvis, total exenteration X142 Clearance of Pelvis, Anterior exenteration
X143 Clearance of Pelvis, Posterior exenteration

C54-C55: Uterine cancer
Q071 Radical Hysterectomy (removes uterus + cervix + vagina). Wertheims hysterectomy
Q072 Abdominal Hysterectomy and excision of periuterine tissue NEC.Radical Hysterectomy
Q073 Abdominal hysterocolpectomy NEC, Hysterocolpectomy NEC
Q074 TAH, Panhysterectomy, hysterectomy NEC (removes uterus + cervix). Total abdominal hysterectomy NEC
Q079 Abdonimal excision of uterus, unspecified
Q081 Vaginal hysterocolpectomy and excision of periuterine tissue Q082 Vaginal hysterectomy and excision of periuterine tissue NEC Q083 Vaginal hysterocolpectomy NECQ088 Vaginal Excision of Uterus, other specified
Q089 Unspecified vaginal excision of uterus
Q078 Other specified abdominal excision of uterus
Q075 Subtotal abdominal Hysterectomy (does not remove cervix) Q093 Open excision of lesion of uterus NEC
Q161 Other vaginal operations on uterus, vaginal excision of lesion of uterus
Q229 Bilateral Excision of adnexa of uterus unspecified Q239 Unspecified unilateral excision of adnexa of uterus Q521 Excision of lesion of broad ligament of uterus
X141 Clearance of pelvis, Total exenteration X142 Clearance of pelvis, Anterior exenteration
X143 Clearance of pelvis, Posterior exenteration

C53: Cervix
P172 Excision of Vagina
Q011 Amputation of Cervix, Radical Trachelectomy
Q013 Excision of cervix uteri, Lesion of
Q018 Excision of cervix uteri, Other specified
Q071 Radical Hysterectomy (removes uterus + cervix + vagina). Wertheims hysterectomy
Q072 Abdominal Hysterectomy and excision of periuterine tissue NEC.Radical Hysterectomy
Q073 Abdominal excision of Uterus
Q074 TAH, Panhysterectomy, hysterectomy NEC (removes uterus + cervix). Total abdominal hysterectomy NEC

Q078 Other specified abdominal excision of uterus
Q079 Abdominal excision of Uterus, unspecified
Q081 Vaginal hysterocolpectomy and excision of periuterine tissue Q082 Vaginal hysterectomy and excision of periuterine tissue NEC Q083 Vaginal hysterocolpectomy NEC
Q088 Vaginal excision of Uterus
Q089 Unspecified vaginal excision of uterus X141 Clearance of Pelvis, total exenteration X142 Clearance of Pelvis, anterior exenteration X143 Clearance of pelvis, posterior exenteration.

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Change Notice for Published Specifications and Products developed by Clinical Reference Groups (CRG)

Amendment **to the Published Products**

Product Name	Complex Gynaecology- Specialised Gynaecological Cancers
Ref No	**E10/S/f**
CRG Lead	Anthony Smith

Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
	Put the previous year's specification in a new specification template, this has created a new section linked to the National Outcome Framework and domains	Section 2 and appendix 1	To ensure consistency with specification formatting	CRG	January 2014
	Revise the definition of the specification	Section 1, paragraph 1	Further clarity	CRG	January 2014
	Clarify outcome measures	Section 2.1	Further clarity	CRG	January 2014
	Update the care pathway in	Section 3.2 and 3.5	Further clarity	CRG	January 2014

	line with national guidance				
	Update the network information	Section 3.11	Further clarity	CRG	January 2014
	Incorporate a new section for audit and governance.	Appendix 1	Further clarity	CRG	January 2014