E10/S/f

NHS STANDARD CONTRACT
FOR COMPLEX GYNAECOLOGY- SPECIALIST GYNAECOLOGICAL CANCERS

SCHEDULE 2- THE SERVICES A. SERVICE SPECIFICATIONS

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>E10/S/f</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Complex Gynaecology -Specialist Gynaecological Cancers</td>
</tr>
<tr>
<td>Commissioner Lead</td>
<td></td>
</tr>
<tr>
<td>Provider Lead</td>
<td></td>
</tr>
<tr>
<td>Period</td>
<td>12 months</td>
</tr>
<tr>
<td>Date of Review</td>
<td></td>
</tr>
</tbody>
</table>

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)

**NICE**

- Quality Standard for patient experience in adult NHS services – NICE (2012)
- Ovarian Cancer: The recognition and initial management of ovarian cancer – NICE (2011)

**National Cancer Peer Review**
Other


2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain</th>
<th>Preventing people from dying prematurely</th>
<th>√</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Enhancing quality of life for people with long-term conditions</td>
<td>√</td>
</tr>
<tr>
<td>Domain</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
<td>√</td>
</tr>
<tr>
<td>Domain</td>
<td>Ensuring people have a positive experience of care</td>
<td>√</td>
</tr>
<tr>
<td>Domain</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
<td>√</td>
</tr>
</tbody>
</table>

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 unresectable 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-sparing 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](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
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:

<table>
<thead>
<tr>
<th>Quality Requirement</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of breach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 1: Preventing people dying prematurely</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Requirement</td>
<td>Threshold</td>
<td>Method of Measurement</td>
<td>Consequence of breach</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------</td>
<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Mortality rate</td>
<td>Variable – assess for outlier status on national data supplied by Trent Cancer Registry</td>
<td>Relative survival and Mortality at one, three and five years.</td>
<td>Audit to evaluate causation and change in practice</td>
</tr>
<tr>
<td>Staging accuracy</td>
<td>&gt;70%</td>
<td>% stage recorded in mdt database</td>
<td>Audit to assess reasons for non compliance</td>
</tr>
<tr>
<td>% of cases discussed at MDT</td>
<td>100%</td>
<td>Reported within national audit reports</td>
<td>Audit to evaluate causation and change in practice</td>
</tr>
<tr>
<td>Compliance with national cancer waiting time targets</td>
<td>Variable</td>
<td>Cancer registry uploads</td>
<td>Audit and analysis of reasons for non-compliance</td>
</tr>
<tr>
<td>Compliance with NICE quality standards for ovarian cancer.</td>
<td>Variable depending on statement</td>
<td>Local audit</td>
<td>Assess reasons for difficulties with compliance – audit/process mapping</td>
</tr>
</tbody>
</table>

**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 |
| Assessment and management of morbidity associated with surgery, chemotherapy and radiotherapy | Requires further discussion | Requires further discussion | Requires further discussion |

**Domain 3: Helping people to recover from episodes of ill-health or following injury**

<table>
<thead>
<tr>
<th>Assessment of</th>
<th>Comparison</th>
<th>Continuous audit</th>
<th>Audit to evaluate causation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Requirement</td>
<td>Threshold</td>
<td>Method of Measurement</td>
<td>Consequence of breach</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>peri-operative morbidity/ readmission rates/ unscheduled CCU admission</td>
<td>with previous audit data eg UKGOSOC</td>
<td>— requires further discussion and agreement at national level</td>
<td>and remedial action</td>
</tr>
</tbody>
</table>

**Domain 4: Ensuring that people have a positive experience of care**

| Implementation of Enhanced Recovery Programme | 100% of inpatients undergoing surgery                                      | Post-operative length of stay in endometrial cancer patients                           | Audit to evaluate causation and remedial action            |
| Clinical Nurse Specialist (CNS) support to patients | 100% of patients to have access to CNS support                              | Results from National Cancer Patient Experience Survey. Assessment of local recording of CNS contact. | Audit to evaluate causation and remedial action            |

**Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm**

<p>| Caseload of ovarian cancer surgery | Subspecialist gynae oncology surgeons to perform &gt; 15 operations for gynaecological cancer per year | Centres to record operative numbers | Appropriate allocation of caseload. Assessment of manpower requirements. |
| Compliance with peer review       | National median compliance level                                            | National reports                  | Audit of causation for non – compliance with specific measures.         |</p>
<table>
<thead>
<tr>
<th>Quality Requirement</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of breach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 2

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


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
Q076 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
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, hysterecology NEC (removes uterus + cervix). Total abdominal hysterecology NEC
Q079 Abdominal excision of uterus, unspecified
Q081 Vaginal hysterocolpectomy and excision of periuterine tissue NEC
Q082 Vaginal hysterectomy and excision of periuterine tissue NEC
Q083 Vaginal hysterocolpectomy NEC
Q088 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, hysterecology NEC (removes uterus + cervix). Total abdominal hysterecology 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.
## Change Notice for Published Specifications and Products
developed by Clinical Reference Groups (CRG)

### Amendment to the Published Products

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Complex Gynaecology- Specialised Gynaecological Cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ref No</td>
<td>E10/S/f</td>
</tr>
<tr>
<td>CRG Lead</td>
<td>Anthony Smith</td>
</tr>
</tbody>
</table>

### Description of changes required

<table>
<thead>
<tr>
<th>Describe what was stated in original document</th>
<th>Describe new text in the document</th>
<th>Section/Paragraph to which changes apply</th>
<th>Describe why document change required</th>
<th>Changes made by</th>
<th>Date change made</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Section 2 and appendix 1</td>
<td>To ensure consistency with specification formatting</td>
<td>CRG</td>
<td>January 2014</td>
<td></td>
</tr>
<tr>
<td>Revise the definition of the specification</td>
<td>Section 1, paragraph 1</td>
<td>Further clarity</td>
<td>CRG</td>
<td>January 2014</td>
<td></td>
</tr>
<tr>
<td>Clarify outcome measures</td>
<td>Section 2.1</td>
<td>Further clarity</td>
<td>CRG</td>
<td>January 2014</td>
<td></td>
</tr>
<tr>
<td>Update the care pathway in</td>
<td>Section 3.2 and 3.5</td>
<td>Further clarity</td>
<td>CRG</td>
<td>January 2014</td>
<td></td>
</tr>
<tr>
<td>line with national guidance</td>
<td>Section 3.11</td>
<td>Further clarity</td>
<td>CRG</td>
<td>January 2014</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------------</td>
<td>----------------</td>
<td>-----</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Update the network information</td>
<td>Appendix 1</td>
<td>Further clarity</td>
<td>CRG</td>
<td>January 2014</td>
<td></td>
</tr>
<tr>
<td>Incorporate a new section for audit and governance.</td>
<td>Appendix 1</td>
<td>Further clarity</td>
<td>CRG</td>
<td>January 2014</td>
<td></td>
</tr>
</tbody>
</table>