

A08/S/g

**NHS STANDARD CONTRACT
FOR CANCER: ANAL (ADULT)**

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	A08/S/g
Service	Cancer: Anal (Adult)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National context

Anal cancer is a relatively rare disease which arises from the anus, the distal orifice of the gastrointestinal tract. It is a distinct entity from the more common colorectal cancer. The aetiology, risk factors, clinical progression, staging, and treatment are all different. Anal cancer is typically a squamous cell carcinoma that arises near the squamocolumnar junction. It can usually be successfully treated with concurrent radiotherapy and chemotherapy. Surgery may be used if medical treatment fails.

There are around 900 newly diagnosed cases of anal cancer in England each year. The incidence rate is 1.3 per 100,000 population for men and 2.1 per 100,000 population for women. Survival, however, is good with current 1-yr relative survival estimated at 84%.

Specific expertise is important to optimise outcomes for patients. All patients with anal cancer should therefore be referred to multi-disciplinary anal cancer teams which can provide specialist management.

Evidence base

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

DH

- Improving Outcomes; a Strategy for Cancer – Department of Health (2011)
- Cancer Commissioning Guidance - Department of Health (2011)

NICE

- Improving Supportive and Palliative Care for adults with cancer - NICE(2004)
- Improving Outcomes in Colorectal Cancers – NICE (2004)
- Referral guidelines for suspected cancer - NICE Clinical Guideline 27(2005)
- Colorectal cancer: the diagnosis and management of colorectal cancer – NICE (Nov 2011)
- 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: Colorectal Measures, Version 3.1 – NCPR, National Cancer Action Team (2011)
- Manual for Cancer Services Acute Oncology Measures NCPR, NCAT (April 2011)
- Manual for Cancer Services Chemotherapy measures, NCPR, NCAT (June 2011)

Other

- Guidelines for the Management of Colorectal Cancer - The Association of Coloproctology of Great Britain and Ireland (2007) www.acpgbi.org.uk
- Chemotherapy Services in England. National Chemotherapy Advisory Group (2009)

2. Scope

2.1 Aims and objectives of service

The aim of the service is to deliver high quality holistic care for anal cancer patients 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 specialist anal cancer service will be delivered through a colorectal multidisciplinary team which has an extended role and membership to ensure the team has specialist expertise to treat anal cancer.

The specialist colorectal cancer multidisciplinary team (MDT) treating anal cancer (referred to in the remainder of this document as the specialist anal cancer multidisciplinary team) should be the only MDT serving that population. The service is required to agree the following areas with the relevant commissioners

- Service configuration and population coverage
- Referral criteria, clinical protocols and network policies and treatment pathways
- Engagement with the local network groups and National Cancer Peer Review for anal colorectal cancer, ensuring that the pathway for anal cancer is fully represented.

The objectives of the services are:

- To provide an exemplary and comprehensive service for all patients with anal cancers.
- To ensure radiological, pathological and diagnostic facilities are available in order to effectively diagnose, classify and stage the condition prior to planning treatment.
- To advise and undertake investigations to proceed to treatment options if clinically indicated specifically high quality chemoradiation treatment and surgical salvage for patients with anal cancer.
- 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 patient.
- To provide appropriate follow up and surveillance after definitive treatment.
- To ensure that all aspects of the service are delivered as safely as possible, conform to national standards and published clinical guidelines and 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 anal 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.

2.2 Service description/care pathway

The specialist anal cancer multidisciplinary team

It is essential that all patients with suspected anal cancer are discussed at the specialist anal cancer multidisciplinary team.

The specialist anal cancer multidisciplinary team service will be delivered through a colorectal multidisciplinary team which has an extended role and extended membership to ensure the team has specialist expertise to treat anal cancer.

The extended core team includes a consultant gynaecologist and a consultant plastic surgeon. The core team members and the extended core team members of the multidisciplinary team should include:

- Two colorectal surgeons, under whose care all operations for anal cancer take place
- Clinical oncologist
- Medical oncologist
- Imaging specialist
- Histopathologist
- Colonoscopist (surgeon, physician or specialist nurse)
- Colorectal nurse specialist
- Multidisciplinary team co-ordinator/secretary
- Gynaecologist, with a surgical practice in the treatment of vulval cancer
- Plastic surgeon

The specialist anal cancer service shall provide high quality clinical care to patients with suspected anal cancer and provide chemoradiation or specialist surgical treatment for patients with a confirmed diagnosis of anal cancer.

The specialist anal cancer multidisciplinary teams are designated by commissioners and are usually one of the agreed colorectal multidisciplinary teams based in cancer centres with radiotherapy facilities. This formally designated specialist anal cancer multidisciplinary team has the necessary expertise for the management of anal cancer.

The service is expected to agree with commissioners where patients with anal cancer should be treated and develop clear referral systems and pathways to ensure that responsibility for the management of every patient with anal cancer is passed to the appropriate specialist anal cancer team when the initial diagnosis is made.

The specialist anal cancer multidisciplinary team will ensure:

- There is a weekly specialist anal cancer multidisciplinary team meeting to discuss the needs of each newly referred patient and other patients as required, for example after treatment or progression of the cancer.
- All curative anal cancer surgery is carried out by the designated surgical

teams by one and no more than two anal cancer surgeons at one cancer centre.

- There are evidence based care pathways agreed with commissioners
- The providers will hold other meetings regularly to address clinical, service delivery and governance issues.
- Audit of referral and treatment of patients with anal cancer is undertaken to ensure that patients are managed by the appropriate specialist anal cancer service.
- A written summary of the consultation should be offered to the patient as well as written information on anal cancer.
- Patients are actively recruited to national clinical trials.

Patient experience

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 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 who have direct clinical contact with patients should have attended this. As the Cancer Patient Experience Survey does not specifically report on anal cancer patients it would be considered best practice for the anal cancer multidisciplinary team to review patient experience for this patient group at least every three years.

Patient information

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

The information must cover:

- Description of the disease.
- Management of the disease within the scope of the commissioned service as described in the specification, clinical pathways and service standards.
- Diagnostic procedures.
- Treatment options and their effects (including potential adverse effects) including the effect on bowel function.
- Information about the likelihood of having a stoma, why it might be necessary, and how long it might be needed for and the care and management of stomas.
- Specific information on managing the effects of treatment on bowel function. This could include information on incontinence, diarrhoea, difficulty emptying

bowels, bloating, excess flatus and diet, and where to go for help in the event of symptoms.

- Realistic assessment of predicted outcome.
- Drugs and other treatments commissioned in the clinical pathway.
- Self-management and care.
- Dietary and nutrition information.
- Contact details of the patient's allocated key worker.
- Support organisations or internet resources recommended by the clinical team.

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

- Symptoms of infection.
- Wound healing problems.
- Contact in case of concern.

A useful reference is the Information Prescription Service (IPS) which allows users, both professional and public, to create information prescriptions (IPs) for long-term health needs. <http://www.nhs.uk/IPG/Pages/AboutThisService.aspx>

Referral processes and sources

Referrals are accepted by any qualified doctor from the specialist anal cancer multidisciplinary team where the patient has confirmed or suspected anal cancer including squamous cell carcinoma

Referrals to the service will come from a local multidisciplinary team, including genitourinary and gynaecological services, but where possible referrals ought to go straight to the specialist multidisciplinary team to avoid unnecessary delays. Steps prior to referral to the specialist team may include:

- The local colorectal multidisciplinary team will already have made a diagnosis, confirmed by examination under anaesthetic (EUA) biopsy.
- The patient will have been informed of the diagnosis and given the date of a Computerised Tomography (CT) scan.
- The patient will have had staging investigations.
- The patient will have been discussed at their local colorectal multidisciplinary team.
- The patient will have been referred to a specialist anal multidisciplinary team.

Diagnosis

Patients are likely to have the following tests to confirm a diagnosis of anal cancer as part of the referral pathway to the specialist service:

- EUA Biopsy - a biopsy under anaesthetic
- Endoscopy - The endoscopic services at the regional specialist centre should be Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accredited^[2].

^[2] The Joint Advisory Group on Gastrointestinal Endoscopy assumes an active role in the quality assurance of endoscopy training and services across the UK www.thejag.org

¹ CPA, the principle accrediting body of clinical pathology services and External Quality Assessment (EQA) Schemes in the UK. Modernising Pathology Services. Department of Health (2004)

² HTA Regulatory body for all matters concerning the removal, storage, use and disposal of human tissue. www.hta.gov.uk

- Pathology - The pathology services should comply with Clinical Pathology Accreditation (UK) Ltd (CPA)¹ and the Human Tissue Authority (HTA).²
- Imaging - CT Colonography, Magnetic Resonance Imaging (MRI) and where appropriate Positron Emission Tomography – Computerised Tomography (PET-CT).
- Specialist anal cancer multidisciplinary team(s) within each network should agree local clinical guidelines for diagnostic investigations to detect anal cancer in all potential patient groups, the use of which should be audited throughout the network. These should deal with establishing the initial diagnosis, pre-operative assessment, follow-up procedures, and surveillance of patients at high risk.

Staging

Providers must include staging information in their cancer registration dataset. This will become mandated in the Cancer Outcomes Service Dataset from early 2013. Staging data is essential for directing the optimum treatment, for providing prognostic information for the patient and is 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

All possible management options should be discussed with the patients. 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.

Concurrent chemoradiotherapy, is appropriate for most patients. Other forms of treatment, such as surgical excision, may be considered by anal cancer multidisciplinary teams, but surgery is usually reserved for salvage.

Enhanced recovery pathways have 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. This modern approach to elective surgery should be adopted by all anal cancer multidisciplinary teams.

There are still some areas of uncertainty about optimum treatment, and eligible patients should be encouraged to participate in clinical trials.

Chemotherapy and Radiotherapy

Chemotherapy and radiotherapy should be carried out at designated centres by appropriate specialists as recommended by a specialist anal 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:

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

There should be a formal relationship between the specialist anal cancer multidisciplinary team 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 network director and the lead clinician in the specialist anal cancer multidisciplinary team. Audits of compliance with these protocols will need to be demonstrated.

Follow-up

The Improving Outcomes Guidance (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 colorectal rehab pathway at: www.ncat.nhs.uk/our-work/living-with-beyond-cancer/cancer-rehabilitation

Supportive Care

Although anal cancer is a curative disease patients usually require significant psychological support which may be related to the stigma of having anal cancer, severe perineal pain and wound break down and HIV testing. The provider will give high quality supportive 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 an anal cancer multidisciplinary team will be allocated a key worker.

Each patient should be offered an 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 patients' holistic needs assessment are taken into account in the multidisciplinary team decision making.

Palliative care

The provider will give high quality palliative care in line with NICE guidance. 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 wellbeing 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 which is currently being developed.

Care Pathways

At the current time there is no recognised care pathways developed for this service.

A link is provided to the Yorkshire Cancer Network website for their pathway.

<http://www.ycn.nhs.uk/html/downloads/ycn-colorectal-analcancerpathway- v2-1-oct2011.pdf>

³ 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

2.3 Population covered

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

Specifically, this service is for adults with anal cancers requiring specialised intervention and management, as outlined within this specification.

The service shall be accessible to all patients with a suspected anal cancer regardless of sex, race, or gender. Providers require staff to attend mandatory training on equality and diversity and the facilities provided offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information available in multiple languages.

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

2.4 Any acceptance and exclusion criteria

Most of the colorectal cancer pathway will be commissioned by clinical commissioning groups (CCGs) for which a separate specification has been developed. A high quality anal cancer service depends on local and specialist services working seamlessly together.

2.5 Interdependencies with other services

The specialist anal cancer multidisciplinary team 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 this service. The specialist anal cancer multidisciplinary team also provides education within the NHS to raise and maintain awareness of anal cancer and its management.

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

The specialist anal cancer multidisciplinary team service will link into multiple clinical and administrative teams:

- Endoscopy service at District General Hospital (DGHs)
- Local colorectal multidisciplinary team (DGHs)
- Local and specialist palliative care Teams

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

Strategic clinical networks will be in place from April 2013 located in 12 areas across England. They will be established in areas of major healthcare challenge where a whole system, integrated approach is needed to achieve a real change in quality and outcomes of care for patients. Cancer has been identified as one of the conditions that will be within this new framework. Strategic clinical networks will help commissioners reduce unwarranted variation in services and will encourage innovation. They will use the NHS single change model as the framework for their improvement activities.

Each population area has a Network Specific Site Group (NSSG) covering colorectal cancer. This group is made up of clinicians across the area who specialise in colorectal cancer. It is the primary source of clinical opinion on issues relating to colorectal cancer for that population and is an advisor to commissioners locally. Each specialist anal cancer multidisciplinary team should ensure they fully participate in the 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 Improving Outcomes Guidance 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 anal 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

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

Care delivered by the specialist anal cancer multidisciplinary team service providers must be of a nature and quality to meet the Care Quality Commission (CQC) care standards. It is the Trust's responsibility to notify the commissioner on an exceptional basis should there be any breaches of the care standards.

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

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

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

4. Key Service Outcomes

The service is expected to monitor the following clinical outcomes:

- 1 year and 5 year survival rate
- Percentage of patients with anal cancers discussed at a specialist anal cancer multidisciplinary team
- Quality of life for patients

Clinical Lines of Enquiry are currently being developed but are likely to include:

- The proportion of newly registered colorectal cancers being submitted to the national audit of bowel cancer (NBOCAP)
- Compliance within each Trust of the Royal College of Pathologists Minimum Data Set for surgical resections

Surgical Treatment:

- Returns to theatre within 30 days.
- Re-admission rates within 30 days.
- Proportion of newly diagnosed cases not undergoing a surgical excision.
- Proportion of patients treated under enhanced recovery pathways.

Quality and Performance Standards				
Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of breach
<u>Quality</u>				
	% of cases discussed at the specialist anal cancer multidisciplinary team	100%	Reported within national audit reports but not reported regularly to Board	
	Follow Up Ratios		Not regularly reported	
	Other Quality Measures			
	Percentage attendance by individual core members or their agreed cover at multidisciplinary team	67%	Reported in Peer Review Submissions	
	Attendance at advanced communications course	100%	Peer Review	
IOG Compliance	Compliance with specified measures	Compliance with specific measures for tumour site as set out in IOG documentation	Regular updates to Board and Network Performance Report	
Compliance with Peer Review	Compliance with all other Peer Review measures (other than where agreed with commissioners when the Provider should have an action plan in place that has been agreed with the Commissioner)	National median compliance level	National reports / Regular verbal feedback to Board	
<u>Performance</u>	The Provider should ensure that these targets are achieved for the			

<u>& Productivity</u>	part of the patient pathway that it delivers and that when the patient pathway crosses outside the locality border, appropriate scheduling of patients/activity supports achievement of the target by other providers in the pathway wherever possible, except when informed patient choice or clinical appropriateness mitigate against this.			
Waiting Time Compliance				
	62 day wait - % treated in 62 days from GP referral, consultant referral and referral from screening programme	>~86%		
Aggregate Measures	14 day suspected cancer referral standard performance (A20)	93%	Regularly reported to Board	
	31 day first treatment standard performance (A15)	96%		
	31 day subsequent treatment (Surgery) standard performance (A16)	94%		
	31 day subsequent treatment (Drugs) standard performance (A16)	98%		
	31 day subsequent treatment (Radiotherapy) standard performance (A17)	94%	Live from 1 January 2011 and regularly reported to Board	
	31 day subsequent treatment (Other Treatments)	TBC	Live from 1 st January 2011 and regularly reported to	

	standard performance		Board	
	31 day subsequent treatment (Palliative) standard performance	TBC	Live from 1 st January 2011 and regularly reported to Board	
	62 day standard from 14 day referral performance (A18)	85%	Regularly reported to Board	
	62 day standard from screening referral performance (A19)	90%		
	62 day standard from consultant upgrade performance (A19)	TBC	Live from December 2008 and regularly reported to Board	
	Diagnostic Test Waiting Times	TBC	Not regularly reported to Board, no longer a national CQC target	

Activity Performance Indicators

Activity Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of breach
Audits	Annual review conducted		NSSG	
	Participation in National Audits	100%	Part of Network Performance Report but only in terms of submission not in terms of data quality	

	Additional Audits undertaken	N/A	Reported at NSSGs but not Board unless specific service change	
Activity	Threshold for number of procedures (Audit of numbers of major anal operations, and the number of new anal patients referred annually)	Establish baseline cancer activity data for :- number of procedures for elective, day case , non elective non emergency, non elective emergency, outpatient FA, outpatient FU, outpatient procedures all by specialities.	Not currently regularly reported to Board	
	Length of stay benchmarking			
	Level of admissions			
	Choice			
Service User Experience	National Cancer Patient Experience survey (ref A46 main contract)	National survey report when published	National findings reported to Board. Currently establishing a baseline.	If the provider does not take part they will be required to meet with the commissioners to explain reasons for not doing so and activity planned to enable the information to be captured through alternative mechanisms
	Improving Service User Experience	Of responses received 75% should express overall satisfaction with the		

		service .Trust to evidence the measures it has taken to improve service user experience and outcomes achieved and numbers / percentages stratified		
	Addressing Complaints	Trust to evidence the measures it has taken to address complaints and outcomes achieved		
	Patient involvement	Trust to evidence the actions it has taken to engage with patients and demonstrate where this has impacted		
Staff survey	Staff survey results			
Trial Activity	Recruitment into trials	Patients eligible for an existing clinical trial should be offered to the chance to be treated in a clinical trial	Reported to Board on a regular basis but not part of the performance report	
Outcomes	Post Treatment mortality	Numbers and percentages baseline to be set in year	Not regularly reported to Board	
	30 day mortality (following surgery/treatment?)		Registry data	
	1 yr survival		Part of	

	5 yr survival		Network performance Report	
	30 day readmission rates for cancer patients	Numbers and percentage baseline to be set in year	Not currently regularly reported to Board	
Data Submission	Registry dataset submission status	As required by Registry	Not currently regularly reported to Board	
	DCOs		Regular updates to Network	
	Staging data	As required by Registry	Not currently regularly reported to Board	

Additional Information
ICD10 codes

Anal cancers are classified using the international classification of diseases version 10 (ICD10) as:

C21: Malignant neoplasms of the anus and anal canal. There were approximately 900 cases of anal cancer in England in 2009, around 550 of which occurred in females. The overall crude incidence rate is 1.7 per 100,000 population.

Incidence rates are for patients diagnosed in 2009, England. One-year relative survival estimates are for patients diagnosed in England in 2005-2009, followed up to 2010. Source: UKCIS, accessed August 2012.

Cancer waiting times

Cancer of the anus is included within the broader “lower gastrointestinal” group within cancer waiting times.