

B14/S/c

**2013/14 NHS STANDARD CONTRACT  
FOR CANCER: TESTICULAR (ADULT)**

**SECTION B PART 1 - SERVICE SPECIFICATIONS**

<b>Service Specification No.</b>	B14/S/c
<b>Service</b>	Cancer: Testicular (Adult)
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	12 months
<b>Date of Review</b>	

**1. Population Needs**

**1.1 National/local context and evidence base**

**National context**

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

- Prostate cancer, bladder cancer, kidney cancer, penile cancer
- Testicular cancer (or germ cell tumours of the testis)

Separate service specifications exist for specialised urology (prostate, bladder and kidney) cancer services and for penile cancer services

**Testicular cancer** is cancer that can derive from any cell type found in the testicles. There are two main types of testicular cancer, seminomas and non-seminomas. These develop from germ cells in the testes. Between 40 and 45 out of every 100 testicular cancers are pure seminomas. Most of the rest are mixtures of these other types of non-seminoma testicular cancers. Some testicular tumours have both seminoma cells and non-seminoma cells.

Very rarely, other types of cancer can start in the testicles. The commonest cancer found in the testicles in men over 50 is lymphoma, however the majority are germ cell tumours.

There were almost 1,850 cases of testicular cancer in England in 2009, with an

incidence rate of 7.3 cases per 100,000 population. One year relative survival estimates are high at 98 per cent.

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

### **Local context**

### **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**

- Improving Outcomes Guidance: Urological Cancer – NICE (2002)
- Improving Supportive and Palliative Care for adults with cancer – NICE (2004)
- Quality standard for end of life care for adults – NICE (2011)
- Quality standard for patient experience in adult NHS services – NICE (2012)

### **National Cancer Peer Review**

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

### **Other**

- Chemotherapy Services in England. National Chemotherapy Advisory Group (2009)

## **2. Scope**

### **2.1 Aims and objectives of service**

The aim of the specialised testicular cancer service is to deliver high quality holistic care so as to increase survival while maximising a patient's functional capability and quality of life and to ensure ready and timely access to appropriate supportive care for

patients, their relatives and carers. The service will be delivered through a specialist supra-network testicular cancer multi-disciplinary team.

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

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

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

The overall objectives of the services are:

- To provide an exemplary and comprehensive service for all referred patients with testicular cancers.
- To ensure radiological, pathological and diagnostic facilities are available and to use the most up-to-date validated diagnostic tools and knowledge in order to effectively review, diagnose, classify and stage the cancer prior to planning treatment.
- To advise and undertake investigations and to proceed to treatment options if clinically indicated, including high quality surgical treatment of patients with testicular 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 cancer patient.
- To provide appropriate follow-up and surveillance after definitive treatment.
- To ensure that all aspects of the service are delivered as safely as possible, conform to national standards and published clinical guidelines and are monitored by objective audit.
- To provide care with a patient and family centred focus to maximise the patient experience.
- To support local healthcare providers to manage patients with testicular cancer whenever it is safe to do so and clinically appropriate within the framework of the Improving Outcome Guidance (IOG).
- To provide high quality information for patients, families and carers in appropriate and accessible formats and media.
- To ensure 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 ensure compliance with Peer Review Cancer Measures and with clinical lines of enquiry when they are developed.
- To ensure compliance with Care Quality Commission regulations.

## **2.2 Service description/care pathway**

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

- There is a weekly multidisciplinary team meeting to discuss the needs of each newly referred patient (and other patients as required) in detail and review other non-surgical aspects of their care; patients will be likely to require subsequent additional review at the multidisciplinary team meeting for example after treatment or progression of the cancer
- Treatment within the specialist/supranetwork multidisciplinary team should be in accordance with locally agreed treatment guidelines which should be consistent with nationally agreed guidelines
- If surgery is the first planned treatment then efforts should be made to give the patient a date for that surgery at the first visit, and written information provided on that surgery. The timing of surgery is agreed on the basis of evidence based treatment protocols with the local cancer network.
- A written summary of the consultation should be offered to the patient as well as written information on the relevant type of testicular cancer.
- Patients should have access to a 'key worker'; this is normally the clinical nurse specialist.
- Accurate and timely information should be shared with the patients' General Practitioner so that they can be in a position to support and advise the patient
- Patients treated as surgical in-patients are reviewed daily on a ward round supported by a consultant urologist and oncological surgeon with input from the core multidisciplinary team as clinically required.
- The providers will hold other meetings regularly to address clinical, service delivery and governance issues.
- Audit should be undertaken as an integral part of improving the delivery of care to provide the evidence to improve and enhance the delivery of the clinical care provided.
- Patients should be actively invited to participate in clinical trials especially those approved by the National Cancer Research Network.

### **Members of the supra-network testicular cancer multidisciplinary team**

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

- Urological Surgeons (at least two urologists in the team)

- Clinical oncologist
- Medical oncologist (except where the clinical oncologist has specific expertise in systemic treatment for urological cancers)
- Radiologist with expertise in testicular cancers.
- Histopathologist with expertise in testicular cancer
- Testicular - Clinical nurse specialist
- Multidisciplinary team co-ordinator / Secretary

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

- GPs/primary health care teams;
- Local urological cancer teams at linked cancer units;
- Surgeon with responsibility for resection of post-chemotherapy residual masses (testicular)
- Clinical geneticist/genetics counsellor
- Liaison psychiatrist;
- Clinical psychologist trained in psychotherapy and cognitive behaviour therapy;
- Counsellor with expertise in treating psychosexual problems;
- Occupational therapist;
- Social worker;
- Palliative care teams.

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

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

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

### **Patient experience**

The service should be patient centred and should 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 contact with a clinical nurse specialist reported much more favourably than those without, on a range of items related to information, choice and care. The national programme for advanced communications skills training provides the opportunity for senior clinicians to improve communications skills and all core multidisciplinary team members should have attended this.

## **Patient information**

Every patient and 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
- Treatment and medication (including their side effects) commissioned in the clinical pathway
- Pain control
- Practical and social support
- Psychological support
- Sexual issues and fertility
- Self-management and care
- Local NHS service and care/treatment options
- Contact details of the patient's allocated named nurse
- Possible benefits and compensation
- Support organisations or internet resources recommended by the clinical team

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

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

The 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. [www.nhs.uk/IPG/Pages/AboutThisService.aspx](http://www.nhs.uk/IPG/Pages/AboutThisService.aspx)

## **Referral processes and sources**

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

- The local team will already have made a diagnosis, confirmed by ultrasound, CT or biopsy
- The patient will have been informed of the diagnosis and given the date of a CT scan
- The patient will have had staging investigations
- The patient will have been discussed at their local multidisciplinary team

## **Testicular cancer**

Patients being referred for treatment to specialist or supranetwork teams should be

made known to the receiving team within 24-hours of orchidectomy. 'High risk' patients (which should be precisely defined in the network guidelines) should be referred and made known to the supranetwork team pre-operatively, as soon as possible after diagnosis.

### **Imaging and pathology**

The service should ensure that chest x-ray / ultrasound / CT scanning / MRI should be available to the patient as part of the pathway. The service should agree imaging modalities and their specific indications. The responsibility for the scan, its interpretation and any decision to inform treatment lies with the supra-network multidisciplinary team.

When symptoms or imaging clearly show that the disease is metastatic or inoperable, or the patient is not sufficiently fit to undergo radical treatment, the team is to consider the appropriate palliative treatment. The patient will be referred back to the multidisciplinary team for discussion of results before a decision is made.

Histological confirmation of tumour is required before treatment with chemotherapy or radiotherapy. The pathology services should comply with Clinical Pathology Accreditation (UK) Ltd (CPA)<sup>1</sup> and the Human Tissue Authority (HTA).<sup>2</sup>

### **Diagnosis**

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

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

Providers should:

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

### **Staging**

Providers must include staging information in their cancer registration dataset (this will become mandated in the Cancer Outcomes and Services Dataset from early 2013).

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

<sup>2</sup> HTA Regulatory body for all matters concerning the removal, storage, use and disposal of human tissue. [www.hta.gov.uk](http://www.hta.gov.uk)

Staging data are essential for directing the optimum treatment, for providing prognostic information for the patient and are also essential to the better understanding of the reasons behind the UK's poor cancer survival rates. Cancer stage is best captured electronically at multidisciplinary team meetings and transferred directly to cancer registries. Staging and other pathological data can also be extracted direct from pathology reports and sent to cancer registries.

## **Treatment**

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

- Orchidectomy on high risk patients referred pre-operatively.
- Surgical resection of post-chemotherapy residual masses (retroperitoneum, mediastinum or elsewhere)– it is strongly recommended that these are undertaken by one surgeon for each such site of residual masses
- Treatment of all post radiotherapy and post chemotherapy recurrences. (Treatment of first recurrences occurring during surveillance should follow the network's agreed guidelines as for newly diagnosed cases, depending on parameters of disease stage and type.)
- All other treatment by any modality, excluding local care and the network's particular arrangements for specialist care.

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

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

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

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

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

## **Surveillance**

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

specialist team, may be undertaken by the supra- network team if desired and agreed by the patient and relevant consultants.

### **Chemotherapy and radiotherapy**

Chemotherapy and radiotherapy are important components of the treatment of some patients and should be carried out at designated centres by appropriate specialists as recommended by the supra-network testicular cancer multidisciplinary team. There should be a formal relationship between the testicular cancer service and the provider of non-surgical oncology services that is characterised by agreed network protocols, good communication, and well-defined referral pathways. This relationship should be defined in writing and approved by the cancer network director and the lead clinician in the supra-network multidisciplinary team. Audits of compliance with agreed protocols will need to be demonstrated.

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

- Adult Systemic Anti- Cancer Therapy (SACT/chemotherapy) service specification
- Radiotherapy model service specification 2012/13

### **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 (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 urology rehab pathway (in development) at:

[www.ncat.nhs.uk/our-work/living-with-beyond-cancer/cancer-rehabilitation](http://www.ncat.nhs.uk/our-work/living-with-beyond-cancer/cancer-rehabilitation)

### **Supportive and palliative care**

The provider will give high quality supportive and palliative care in line with NICE guidance. The extended team for the multidisciplinary team includes additional specialists to achieve this requirement. Patients who are managed by a supra-network testicular cancer multidisciplinary team will be allocated a key worker, normally the clinical nurse specialist.

Patients who require palliative care will be referred to a palliative care team in the hospital and the team will be involved early to liaise directly with the community

services. Specialist palliative care advice will be available on a 24 hour, seven days a week basis.

Each patient shall be offered an holistic needs assessment at key points in their cancer pathway including at the beginning and end of primary treatment and the beginning of the end of life. A formal care plan will be developed. The nurse specialist(s) shall ensure the results of patients' holistic needs assessment are taken into account in the multidisciplinary team decision making.

### **Survivorship**

The National Cancer Survivorship Initiative (NCSI) is testing new models of care aimed at improving the health and well being of cancer survivors. The new model stratifies patients on the basis of need including a shift towards supported self management where appropriate. In some circumstances traditional outpatient follow-up may be replaced by remote monitoring. The model also incorporates care coordination through a treatment summary and written plan of care.

It will be important for commissioners to ensure that work from this programme is included and developed locally to support patients whose care will return to their more local health providers once specialist care is no longer required.

### **End of life care**

The provider should provide end of life care in line with NICE guidance and in particular the markers of high quality care set out in the NICE quality standard for end of life care for adults.

### **Acute oncology service**

All hospitals with an Accident and Emergency (A&E) department should have an “acute oncology service” (AOS), bringing together relevant staff from A&E, general medicine, haematology and clinical/medical oncology, oncology nursing and oncology pharmacy. This will provide emergency care not only for cancer patients who develop complications following chemotherapy, but also for patients admitted suffering from the consequences of their cancer. For full details on AOS please refer to the service specification for chemotherapy.

### **Care pathways**

The local care pathway for testicular cancers should be consistent with the national pathway on Map of Medicine (currently in development). The process of producing the pathways and subsequent updates has been accredited by the National Cancer Action Team.

[http://directaccess.mapofmedicine.com/evidence/map/testicular\\_cancer1.html](http://directaccess.mapofmedicine.com/evidence/map/testicular_cancer1.html).

## 2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England<sup>3</sup>; 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 testicular cancers requiring specialised intervention and management, as outlined within this specification.

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

When required the providers will use translators and printed information available in multiple languages.

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

## 2.4 Any acceptance and exclusion criteria

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

## 2.5 Interdependencies with other services

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

- Primary health care team
- Urological cancer team:
  - Local urological multidisciplinary teams
  - Specialist urological multidisciplinary team
  - Supra-network penile multidisciplinary team
- Specialist palliative care team
- Teenage and Young Adult (TYA) service (15 per cent of testicular cancer patients are in the TYA age range). Link with TYA service specification.

The testicular cancer service providers are the leaders in the NHS for patient care in

this area. They provide a direct source of advice and support when other clinicians refer patients into the regional specialist services. This support will continue until the patient is transferred into the local or specialist urology centre or it becomes apparent that the patient does not have a testicular cancer.

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

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

Co-located services – Intensive/critical care services may be required for some patients undergoing complex surgery and providers will be required to refer to the service specification for critical care

### **2.5.1 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 network has a Network Site Specific Group covering urological cancers. This group is made up of clinicians across the network who specialise in urological cancers. It is the primary source of clinical opinion on issues relating to urological cancer within the cancer network and is an advisor to commissioners locally. Each supra-network multidisciplinary team should ensure they fully participate in the cancer network systems for planning and review of services.

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

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

## **3. Applicable Service Standards**

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

Care delivered by the testicular cancer service providers must be of a nature and quality to meet the CQC care standards and the IOG for urological cancers. It is the Trust's responsibility to notify the commissioner on an exceptional basis should there be any breaches of the care standards. Where there are breaches any consequences will be deemed as being the Trust's responsibility.

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

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

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

- 31 day wait from diagnosis to first treatment
- 31 day wait to subsequent treatment
- 62 day wait from urgent GP referral or screening referral or consultant upgrade to first treatment.

Teams should as a minimum aim to achieve the median value for compliance with the Cancer Peer Review measures, and if a team had immediate risks or serious concerns identified then remedial action plans should be in place. Further details are available at [www.cquins.nhs.uk](http://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 expected clinical outcomes/clinical lines of enquiry the service is to monitor are still being agreed but may include:

- One year and three year relative survival, adjusted for age, type and stage of cancer.
- Patients' quality of life and reduction in symptoms

Included below are some key commissioning questions from the cancer commissioning

guidance, which providers may wish to audit their service against:

### Testicular Cancer

- What is the time from diagnostic primary surgery to first consultation with a supra-network testicular cancer team?
- What percentage of cases with stage 1 non-seminomatous disease is given adjuvant chemotherapy?
- What percentage of cases with stage 1 seminoma is offered adjuvant radiotherapy/low dose chemotherapy/active surveillance?
- What percentage of cases is undergoing retroperitoneal lymph node dissection for residual masses? (Should be one in five of men with stage 2+ disease.)
- What percentage of cases requires/receives salvage chemotherapy?
- What is the mortality rate?

### 5. Location of Provider Premises

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

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

Code	Trust	Team
RNJ	Barts And The London NHS Trust	Multidisciplinary team – Barts & London
RPY	The Royal Marsden NHS Foundation Trust	Multidisciplinary team – Royal Marsden - Chelsea
RA7	University Hospitals Bristol NHS Foundation Trust	Multidisciplinary team - UHB

RTH	Oxford Radcliffe Hospitals NHS Trust	Multidisciplinary team – Oxford Radcliffe
RHM	Southampton University Hospitals NHS Trust	Multidisciplinary team - SUHT
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Multidisciplinary team - Newcastle
RX1	Nottingham University Hospitals NHS Trust	Multidisciplinary team – Nottingham University Hospitals NHS Trust

### Quality and Performance Standards

<b>Performance Indicator</b>	<b>Indicator</b>	<b>Threshold</b>	<b>Method of Measurement</b>	<b>Consequence of breach</b>
<b>Quality</b>				
	% of cases discussed at multidisciplinary team	100%	Reported within national audit reports	
	Follow up ratios		Not reported regularly	
	Other Quality Measures	TBC		
	Percentage attendance by individual core members or their agreed cover at multidisciplinary team	67%	National Cancer Peer Review	
	Attendance at advanced communication skills course	100%.	National Cancer Peer Review	
IOG Compliance	Compliance with specified measures	Compliance with specific measures for tumour site as set out in IOG documentation		
Compliance with Peer Review	Compliance with all other Peer Review measures (other than where agreed with commissioners)	National median compliance level		

	when the Provider should have an action plan in place that has been agreed with the Commissioner)			
<b><u>Performance and Productivity</u></b>	The Provider should ensure that these targets are achieved for the 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.			

<b>Performance Indicator</b>	<b>Indicator</b>	<b>Threshold</b>	<b>Method of Measurement</b>	<b>Consequence of breach</b>
Waiting Time Compliance				
	62 day wait - % treated in 62 days from GP referral, consultant referral and referral from screening programme	>~86%	Reported on cancer waits database	
Aggregate Measures	14 day suspected cancer referral standard performance (A20)	93%	As above	
	31 day first treatment standard performance (A15)	96%	As above	
	31 day subsequent treatment (Surgery) standard performance (A16)	94%	As above	
	31 day subsequent treatment (Drugs) standard performance (A16)	98%	As above	
	31 day subsequent treatment (Radiotherapy) standard performance (A17)	94%	As above	
	31 day subsequent treatment (Other Treatments) standard	TBC	As above	

	performance			
	31 day subsequent treatment (Palliative) standard performance	TBC	As above	
	62 day standard from 14 day referral performance (A18)	85%	As above	
	62 day standard from consultant upgrade performance (A19)	TBC	As above	
	Diagnostic Test Waiting Times	TBC	Some national data	

The CRG for Urology are currently in the process of formulating some Clinical Lines of Enquiry that should be considered for inclusion in the finalised service specification.

### Activity Performance Indicators

Activity Performance Indicators		Threshold	Method of Measurement	Consequence of breach
Audits	Annual review conducted			
	Participation in National Audits	100%		
	Additional Audits undertaken	N/A		
Activity	Threshold for number of procedures	Establish baseline cancer activity data for :- number of procedures for elective, day case, non elective non emergency, non elective emergency, out- patient FA, out- patient FU, out- patient procedures all by speciality		
	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		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 the chance to be treated in a clinical trial		

Outcomes	Post surgery mortality	Numbers and percentages baseline to be set in year		
	30 day mortality			
	1 yr survival			
	5 yr survival			
	30 day readmission rates for cancer patients	Numbers and percentage baseline to be set in year		
Data Submission	Registry dataset submission status	As required by Registry		
	DCOs			
	Staging data	As required by Registry		

### Additional information

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

- C62: Malignant neoplasm of testis - approximately 1,850 cases per year

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

### **Cancer waiting times**

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

Interim for adoption from 01/10/13