

B14/S/a

**2013/14 NHS STANDARD CONTRACT  
FOR CANCER: SPECIALISED KIDNEY, BLADDER AND PROSTATE CANCER  
SERVICES (ADULT)**

**SECTION B PART 1 - SERVICE SPECIFICATIONS**

<b>Service Specification No.</b>	B14/S/a
<b>Service</b>	Cancer: Specialised kidney, bladder and prostate cancer services (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

**Prostate cancer** is a form of cancer that develops in the prostate. Advanced prostate cancer can spread to other parts of the body. In 2009, there were nearly 35,000 newly diagnosed cases of prostate cancer in England, with a crude incidence rate of 136 cases per 100,000 population. One year relative survival estimates in England are very high at 95%.

**Bladder cancer** is any of several types of malignant growths of the urinary bladder. The most common type of bladder cancer begins in cells lining the inside of the bladder and is called transitional cell carcinoma. Incidence of bladder cancer is higher in males than in females, with over 6,400 cases in 2009 in males compared to under 2,400 in females. The crude incidence rate per 100,000 population for bladder cancer is 25 in men and 9.0 in women. One year relative survival estimates for bladder cancer also differ between males and females at 78% and 64% respectively.

**Kidney cancer** is a form of cancer that develops in the kidneys. Kidney cancer is often asymptomatic until an advanced stage. In approximately one third of cases, the tumour is detected incidentally during imaging carried out for other reasons. The two most common types of kidney cancer, reflecting their location within the kidney, are renal cell carcinoma (RCC) and urothelial cell carcinoma (UCC) of the renal pelvis. The distinction between these two types (RCC and UCC) is important because their prognosis, staging and management are different. In 2009, there were over 4,000 cases of kidney cancer in males and over 2,500 in females. The crude incidence rate per 100,000 population is 15.9 in men and 9.6 in women. Cancer of the renal pelvis is less common with around 500 cases per year. Relative survival estimates for kidney (excluding renal pelvis) are similar for both sexes at 70 per cent for males and 68 per cent for females.

There are different levels of care for urological cancers: local care, specialised care and supra-network care. This specification focuses on specialised care and specialised surgical services.

### **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 – NCP, 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 urological 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 urology multi-disciplinary team.

The specialist urological cancer multidisciplinary team should cover a population of more than one million and carry out a combined total of at least 50 radical prostatectomies and/or total cystectomies per year.

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

- Service configuration and population coverage. When designing the specialist urological centre model in addition to meeting the surgical volumes the whole pathway should be considered to maximize where appropriate patient access to local services.
- Referral criteria, clinical protocols (including referral and management of pleural effusion 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 urological 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 urological cancers.
- 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 urological cancer whenever it is safe to do so and clinically appropriate within the framework of the 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 specialist urological cancer multidisciplinary team should treat the less common urological cancer or cancers that require complex treatment (radical surgery for prostate or bladder cancer).

The specialist urological 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 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 urological 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 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 (NCRN).

### **Members of the specialist urological cancer multidisciplinary team**

Each member of the specialist urological cancer team should have a specialist interest in urological cancer.

The specialist urological cancer team should include one or more of each of the following individuals:

- 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 urological cancers.
- Histopathologist with expertise in urological cancers.
- Urological - Clinical nurse specialist.
- Multidisciplinary team co-ordinator / secretary.

The multidisciplinary team should also have rapid access to:

- GPs/primary health care teams;
- Local urological cancer teams at linked cancer units;
- Plastic surgeon;
- Clinical geneticist/genetics counsellor
- Liaison psychiatrist;
- Clinical psychologist trained in psychotherapy and cognitive behaviour therapy;
- Counsellor with expertise in treating psychosexual problems;
- Stoma care nurse;
- Lymphoedema specialist;
- Occupational therapist;
- Social worker;
- Palliative care teams.

There should be a single named lead clinician for the specialist urological cancer service who should also be a core team member. (This is in addition to a single named lead clinician for the local urological cancer service who should also be a core team member.)

A NHS employed member of the core or extended team should 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
- Evidence, effectiveness (risks and benefits) of PSA testing (where relevant)
- 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 multidisciplinary team. Steps prior to referral to the specialist team include:

- 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

## 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 specialist urological cancer 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 should go back to the multidisciplinary team for a discussion of results before a decision is given.

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 urological cancer into the specialist multidisciplinary team service in line with national guidelines. Compliance with these guidelines should be audited.

Prostate assessment clinics and haematuria clinics should be provided in local hospitals and staffed accordingly with members of the local/specialist/supra-network urological multidisciplinary team. Tests should be available, including rapid assessments, to determine whether cancer is present in a single visit; range of tests to include ultrasonography, digital rectal examination (DRE) and prostate specific antigen (PSA) testing, ultrasound (TRUS), needle biopsy, clinical

<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)

examination, urine testing, flexible cystoscopy, and rapid access to MR prostate, prior to biopsy in line with guidelines for PSA and stage, ultrasound imaging and CT urography when required.

Patients who present as an emergency on their route to being diagnosed with cancer have poorer survival. In urological cancer 10 per cent of prostate cancer patients, 19 per cent of bladder cancer patients and 25 per cent of kidney 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). 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 specialist urology multidisciplinary team includes:

#### **For kidney cancer**

Procedures which should only be carried out in the host hospital of the specialist team:

- Resection of primary tumours which have or are suspected to have invaded renal vein, vena cava or heart.
- Resection of metastatic disease.
- Resection of both primary and associated metastatic disease.
- Resection of bilateral primaries.
- Resection of any primary where it is predicted that the patient will subsequently require dialysis.
- Surgical management of patients with von Hippel-Lindau disease or hereditary papillary tumours.
- Resection of urothelial cancers of the upper urology tract.
- Resection by nephron-sparing surgery.
- Resection of non-renal cell kidney cancer, excluding transitional cell carcinoma of the kidney, treated by nephro-ureterectomy

Procedures and treatments where the site of delivery is determined by agreement



in the network's guidelines:

- Adjuvant chemotherapy.
- Biological therapy.
- Non-surgical management of non-renal cell kidney cancer.

### **For bladder cancer**

Procedures which should only be carried out in the host hospital of the specialist team:

- Management of high risk non muscle invasive bladder cancer (NMIBC) – the roles of the local urology multidisciplinary team and the specialist urology multidisciplinary team should be explicitly defined in the agreed network guidelines
- Radical surgery (cystectomy).
- Bladder reconstruction.
- Surgery for urinary diversion.
- Resection of urethral cancer.
- Resection of squamous or adenocarcinoma.
- Partial cystectomy (indicated only for adenocarcinoma in the dome of the bladder).

Procedures and treatments where the site of delivery is determined by agreement in the network's guidelines:

- Radical external beam radiotherapy.
- Adjuvant chemotherapy.
- Neo-adjuvant radiotherapy.\*
- Neo-adjuvant chemotherapy.\*

\* Recommended only as part of the clinical trial

### **For prostate cancer**

Procedures which should only be carried out in the host hospital of the specialist team:

- Radical prostatectomy. cryoablation / radiofrequency ablation as appropriate

Procedures and treatments where the site of delivery is determined by agreement in the network's guidelines:

- Radical external beam radiotherapy.
- Radical brachytherapy. This is only available in a few networks. Many patients will need referring outside their own network for this therapy.

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.

Each individual surgeon must perform more than five radical prostatectomies or cystectomies per annum.

The combined total of radical prostatectomies and/or total cystectomies, recorded and performed under the care of the multidisciplinary team, should be 50 or more.

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 urological 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 a specialist urological cancer multidisciplinary team. There should be a formal relationship between the urological 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 specialist urological 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 service specifications
- Brachytherapy service specification (to be developed)

## **Follow-up**

The Improving Outcomes Guidance 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 specialist urological 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 shall 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 kidney, bladder and prostate 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. A pathway for testicular cancer is in development.

[http://directaccess.mapofmedicine.com/evidence/map/kidney\\_cancer1.html](http://directaccess.mapofmedicine.com/evidence/map/kidney_cancer1.html)

[http://directaccess.mapofmedicine.com/evidence/map/bladder\\_cancer1.html](http://directaccess.mapofmedicine.com/evidence/map/bladder_cancer1.html)

[http://directaccess.mapofmedicine.com/evidence/map/prostate\\_cancer1.html](http://directaccess.mapofmedicine.com/evidence/map/prostate_cancer1.html)

NICE have also developed an evidence based pathway for prostate cancer.

<http://pathways.nice.org.uk/pathways/prostate-cancer>

### **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 urological cancers requiring specialised intervention and management, as outlined within this specification.

The service must be accessible to all patients with a suspected or established urological 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

<sup>3</sup> 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

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

## **2.5 Interdependencies with other services**

The management of urological cancer involves three cross-linked teams:

- Primary health care team,
- Urological cancer team:
  - Local urological multidisciplinary teams
  - Specialist urological multidisciplinary team
  - Supra-network (penile or testicular cancer) multidisciplinary teams
- Specialist palliative care team

The urological 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 urological cancer.

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

The urological cancer service providers will form a relationship with local health and social care providers to help optimise any care for urological 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.

## **Cancer Networks**

### **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 area has a NSSG 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. Each Site Specific 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. The specialist and supra-network multidisciplinary teams 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 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 urological 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.

Urology cancer services are required to achieve the two week wait for all patients where urological cancer is suspected. 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 has 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 are still being agreed but provider services may wish to monitor:

- 1-year and 3-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 may be of help to service providers:

Prostate cancer

- Are any radical prostatectomies performed outside a specialist team centre? (There should be none.)
- What is the number of radical prostatectomies performed for prostate cancer, compared with the number receiving external beam radical radiotherapy, brachytherapy, other surgical treatments (e.g. HIFU, cryosurgery) and active surveillance as the first definitive treatment for early prostate cancer? (A reasonably even distribution between surgery, radiotherapy (any type) and active surveillance would be expected.)
- How many fractions are used in your radical radiotherapy regime? (Should be at least 37.)
- Are conformal delivery and access to brachytherapy available?
- What is the median length of stay for men undergoing radical prostatectomy?
- Are enhanced recovery programmes established in providers offering radical prostatectomy?
- Is a clinical audit dataset recorded for prostate surgery? A minimum dataset should be an absolute prerequisite for commissioning. This should include audited records of pre-operative PSA, pathological stage/ grade, pre- and post-operative International Index of Erectile Function (IIEF) and International Prostate Symptom Score (IPSS) urinary symptom scores, length of stay, margin positivity rates, PSAs at three and six months, the relative rate of post-surgical radiotherapy to the prostate bed and the rate of artificial sphincter insertion within two years of surgery.
- Is there a clinical audit dataset recorded for prostate radiotherapy?  
Measurements might include
  - mean nadir PSA stage for stage at one year

- rates of PSA failure (American Society for Radiation Oncology (ASTRO))
- definition of an increase of 2ng/ml above nadir)
- potency rates at 12 months
- referral rates to surgeons/physicians for urinary and bowel toxicity
- use of neo-adjuvant hormone therapy for cT3 disease
- use and duration of adjuvant hormone therapy for cT3 disease. For advanced disease:
- proportion of patients receiving chemotherapy for palliation
- number of palliative surgical interventions (nephrostomy/transurethral resection (TUR) channel).

### **Invasive Bladder Cancer**

- Are any radical cystectomies performed outside a specialist team centre? (There should be none.)
- What is the cystectomy rate?
- What is the number of neobladder reconstructions? (Procedure should be available and, when offered, be taken up by at least 20%.)
- What is the use of pelvic node dissection? (A bit more difficult to measure and quantify.)
- What is the length of post-operative stay?
- Are enhanced recovery programmes established in providers offering cystectomy?

### **Non Muscle Invasive Bladder Cancer**

- What is the provision of Bacillus Calmette-Guérin (BCG) ± maintenance as a percentage of the presenting patients within year 1?
- What is the provision for and the percentage of cases undergoing early resection for high risk NMIBC
- What is the provision for and the percentage of high risk cases discussed at the bladder specialist MDT

### **Kidney Cancer**

- What is the proportion of nephron-sparing procedures for T1a disease? (Should now be most cases.)
- What is the recurrence rate/re-operation rate for nephron sparing? (Should be no more than 2%.)
- What is the ratio of laparoscopic vs. open nephrectomy for T1b and T2 disease? (The majority should now be done laparoscopically.)
- What is the percentage of advanced cases having debulking surgery and immuno/targeted therapy?
- What is the number of cases performed involving renal vein/inferior vena cava (IVC)? (Should not be carried out outside a designated and functioning specialist urological cancer team.)
- What is the length of post-operative stay?
- What is the 30-day mortality? (Should be <2%.)



## Quality and Performance Standards

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
<b>Quality</b>				
	% of cases discussed at multidisciplinary team	100%	Reported within national audit reports	
	Follow up ratios			
	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 tumor site as set out in IOG documentation		
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		
<b>Performance and</b>	The Provider should ensure that these targets are achieved for the part of the patient pathway that it delivers and that, when the			

<b><u>Productivity</u></b>	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%	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	TBC	As above	

	treatment (Other Treatments) standard 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 14 day referral performance (A18)	TBC	As above	
	62 day standard from consultant upgrade performance (A19)	TBC	Some national data	
	Diagnostic Test Waiting Times			

### 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		
	Length of stay benchmarking			
	Level of			

	admissions Choice	elective, day case, non elective non emergency, non elective emergency, out- patient FA, out- patient FU, out- patient procedures all by speciality		
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 commissioner s 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	Trust to		

	Complaints	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 urological cancers classified using the international classification of diseases (version 10 - ICD10) as follows:

- C61: Malignant neoplasm of prostate - approximately 35,000 cases per year
- C64: Malignant neoplasm of kidney, except renal pelvis - approximately 6,500 cases per year
- C65: Malignant neoplasm of renal pelvis - approximately 500 cases per year
- C67: Malignant neoplasm of bladder - approximately 8,800 cases per year

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

### **Cancer waiting times**

The urological cancer group for the 31-day reporting category comprises of ICD-10 codes C60-C68. For the 31/62-day (referral to treatment) reporting category, the group is urological (excluding testicular) and comprises C60-C68, excluding C62.

### **OPCS-4 codes**

The following OPCS-4 codes have been agreed within the NCIN as operations that, if undertaken on a patient with prostate, bladder and kidney cancer, would be a major surgical resection:

#### **Prostate**

- M611 Total / Radical prostatectomy, Total excision of prostate and capsule
- M614 Perineal prostatectomy
- M618 Open excision of prostate, other specified
- M619 Prostatectomy NEC. Open excision of prostate, unspecified

#### **Bladder**

- M341 Cystoprostatectomy M342 Cystourethrectomy M343 Cystectomy NEC
- M348 Other specified total excision of bladder
- M349 Unspecified total excision of bladder

#### **Kidney**

- M021 Nephrectomy and excision of perirenal tissue, Nephroureterectomy and excision of perirenal tissue
- M022 Nephroureterectomy NEC M023 Bilateral nephrectomy
- M024 Excision of half of horseshoe kidney
- M025 Nephrectomy NEC
- M028 Total excision of kidney, other specified M029 Total excision of kidney, unspecified M038 Other specified partial excision of kidney
- M039 Partial nephrectomy NEC, Partial excision of kidney, Unspecified
- M042 Open excision of lesion of kidney NEC M104 Endoscopic cryoablation of

lesion of kidney M181 Total ureterectomy , Ureterectomy NEC M182 Excision of segment of ureter

- M183 Secondary ureterectomy
- M252 Open excision of lesion of ureter NEC

Interim for Adoption from 01/10/13