

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	170108S
Service	Penile Cancer
Commissioner Lead	<i>For local completion</i>
Provider Lead	<i>For local completion</i>

1. Scope
<p>1.1 Prescribed Specialised Service</p> <p>This Service Specification (the “Specification”) covers the provision of penile cancer surgery services (adults).</p> <p>1.2 Description</p> <p>The scope of specialised services is set out within the Prescribed Specialised Services Manual (the “Manual”). The Manual states that NHS England commissions specialist cancer services for rare cancers including urological cancers; this includes penile cancer surgery.</p> <p>Penile cancer services are delivered by nine designated providers working in conjunction with other units on a supra-urology network basis. There are different levels of care for penile cancer: local care, specialist care and supra-urology network care. This specification focuses on specialist and supra-urology network care services.</p> <p>1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners</p> <p>NHS England commissions all specialist cancer services for penile cancer from designated providers. Local urological cancer services are commissioned by Clinical Commissioning Groups (CCGs). Some other aspects of care that providers deliver is commissioned by NHS England, for example chemotherapy and radiotherapy.</p>
2. Care Pathway and Clinical Dependencies
<p>2.1 Service Organisation</p> <p>The service will be delivered through supra-urology network specialist penile cancer multidisciplinary teams (MDTs), with some elements, (e.g., radiotherapy/chemotherapy) delivered at a local level depending upon the needs of the patient. Urology networks are defined within the</p>

Kidney, Bladder and Prostate (KBP) service specification, however, these are characterised by a Specialist Urology MDT, based in the specialist urology centre, together with a network of referring local urology centres.

All patients with penile cancer, both new and existing, must be managed by specialist urological cancer MDTs. These teams must be established in large hospitals or cancer centres.

The national model requires penile cancer services to be managed at a supra-urology network level with appropriate commissioner, clinical, user and Cancer Alliance representation. The specialist penile cancer MDT primarily receives referrals from: local urology teams in addition to cross referrals from related specialties such as dermatology, genitourinary medicine (GUM) services and General Practitioners (GPs).

Representatives from the specialist penile cancer service work with members of the specialist urological cancer teams to develop treatment and referral protocols and ensure that the service works in a co-ordinated way.

Strategic oversight for improving population cancer outcomes will be exercised by Cancer Alliances. This body will take a whole population, whole pathway approach to provide a focus for improvement and leadership on cancer in defined geographies. This is alongside existing arrangements described within the contract for quality surveillance and performance monitoring.

Because penile cancer is uncommon, its management must be formalised, with a degree of specialisation similar to that for testicular cancer. Specialised penile cancer MDTs must be established jointly by two to four neighbouring urology networks. Each of these specialist penile cancer teams must serve a population base of four million or more and expect to manage a minimum of 25 new patients each year. The team must include members of the specialist urological cancer team who work in the cancer centre within which it is based, and it must also have access to expertise in plastic surgery. Urology networks must agree referral protocols for patients with penile cancer. These must ensure that each new case is reviewed by a specialist penile cancer team, with central pathology review, and that men who are likely to require radical surgery, radiotherapy, chemotherapy, inguinal and pelvic lymph node dissections or some form of reconstruction of the penis are treated by this team.

All operations carried out by the specialist penile cancer team must be carried out in a single hospital, which must also provide post-operative care and host the specialist penile cancer MDT meetings.

Other forms of treatment may be carried out by specialist urological cancer teams which do not specialise in penile cancer, but the specialist penile cancer MDT which reviews the case must remain responsible for the overall management.

Documented clinical policies for referral and treatment must be agreed between cancer leads in primary care and lead clinicians representing urological, oncology and palliative care services throughout the supra-urology network specialist penile cancer service, and signed off by the lead clinician for the specialist penile cancer service.

Effective systems will be required to ensure rapid communication and efficient co-ordination between teams.

Referrals to the service will come from either primary care or a local MDT. Steps prior to referral to the specialist team include:

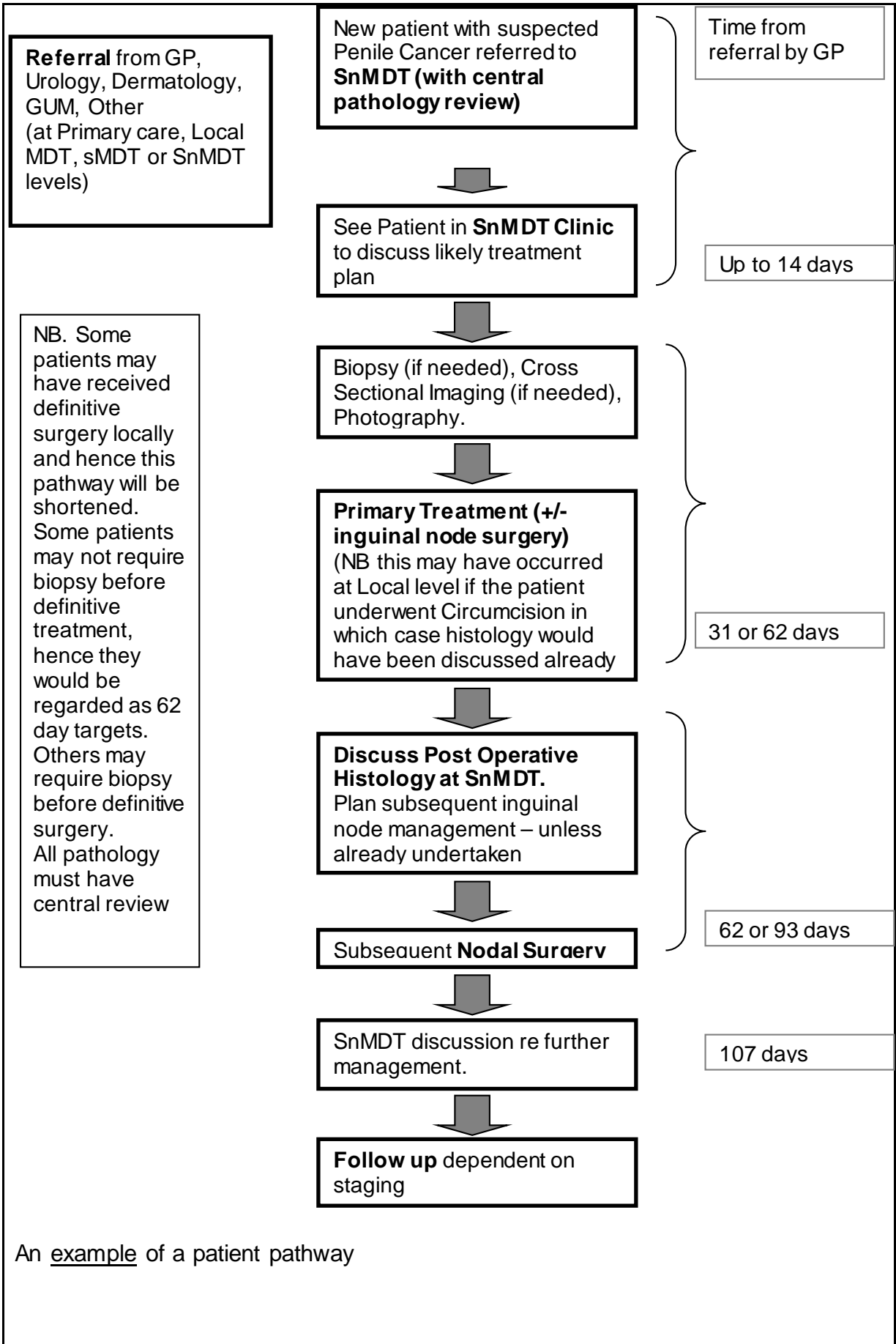
- The local team may already have made a diagnosis, confirmed by pathology, ultrasound, CT or MRI.
- Local Teams are encouraged to refer to the specialist penile cancer MDT if there is a clinical suspicion. Pathological diagnosis is not always needed.
- The patient may have been informed of the diagnosis/potential diagnosis and given the date of a CT scan, where the latter is deemed necessary.
- The patient will have had staging investigations where necessary.
- The patient will have been discussed at their local urology MDT

- GPs must refer men with suspicious penile lesions such as abnormal growths at or near the glans and foreskin, painless ulcers which do not appear to be due to infection, or other unexplained abnormalities such as plaques on the skin or foreskin of the penis.

All penile cancer cases must be discussed with the specialist penile cancer MDT prior to proposed treatment if not referred directly to that team.

Please note that access to treatment will be guided by any applicable NHS England national clinical commissioning policies.

The suggested pathway for new penile cancer patients is shown below:



2.2 Supra-urology network specialist teams

Patients with penile cancer must be managed by specialist penile cancer MDTs working at the supra-urology network level. Such teams must serve up to four urology networks, with a combined population base of at least four million. These teams must liaise closely and regularly with local urological cancer teams, who themselves will be responsible for some aspects of the diagnosis and treatment of these cancers.

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

- Service configuration and population coverage;
- Referral criteria, clinical protocols (including referral and management of post-operative patients, emergency protocols, and pathways that enable rapid access for treatment), network policies (including local surgical policies) and treatment pathways.
- Engagement with the local urology network groups for penile cancers under urological tumours.

2.3 The Supra-urology network specialist MDT

The specialist penile cancer MDT must deliver the service in line with the following:

- There must be a weekly MDT meeting to discuss the needs of each newly referred patient (and also other penile cancer 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 MDT meeting for example after treatment of the cancer or during surveillance.
- Treatment within the specialist penile MDT must be in accordance with locally agreed treatment guidelines which must be consistent with NHS England clinical commissioning policy together with nationally agreed guidelines and guidance.
- If surgery is the first planned treatment then efforts must be made to give the patient a date for that surgery and arrange dates for staging investigations at the first visit. Written information relating to the surgery must be provided.
- A written summary of the consultation must be offered to the patient, as well as written information on penile cancer.
- Accurate and timely information must be shared with the patients' GP so that they can be in a position to support and advise the patient.
- Patients treated as in-patients must be reviewed daily on a ward round supported by a consultant urological surgeon with input from the core MDT as clinically required.
- The providers must hold other meetings regularly to address clinical, service delivery and governance issues.
- Audit must 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 must be actively invited to participate in clinical trials especially those approved by the National Cancer Research Network (NCRN).

2.4 Members of the specialist penile cancer supra-urology network specialist penile MDT

Each member of a specialist penile cancer MDT must have a specialist interest in urological cancer. The specialist urological cancer team must include one or more of each of the following individuals:

- Urologists (a minimum of two urologists in the team)
- Clinical Oncologist (with named cover)
- Medical Oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncologist core member)
- Radiologist with expertise in urological cancers (with named cover).
- Pathologist with specialist interest in urological cancers (with named cover)
- Clinical Nurse Specialist (with named cover)
- Pain management and palliative care specialist(s) (with named cover)
- Team co-ordinator (with named cover)

- Team secretary (with named cover)

The MDT must also have access to:

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

The specialist penile cancer MDT must be linked with the Specialist Skin MDT.

There must be a single named lead clinician for the specialist penile cancer MDT service who must also be a core team member.

There must be a single named lead clinician responsible for trial management of patients within the specialist penile cancer MDT service.

2.5 Patient experience

The service must be patient-centred and must respond to patient and carer feedback. Excellent communication between professionals and patients is essential in ensuring patient satisfaction. The service must 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 who were in contact with a clinical nurse specialist (CNS) reported much more favourably than those without, on a range of items related to information, choice and care. Advanced communications skills training (based on the Connected training course) provides the opportunity for senior clinicians to improve communications skills, and all core MDT members must have attended this.

2.6 Patient information

Every patient and family / carer must receive information about their/the condition in an appropriate format, designed to offer easily accessible, reliable and relevant information to enable them to fully participate in their own healthcare decisions, and to support them in making choices.

Verbal and written information must be provided in a way that is clearly understood by patients and free from jargon. This must include information on:

- Penile cancer;
- Penile carcinoma in situ/Penile Intra-epithelial Neoplasia (PeIN)
- Circumcision
- Glans resurfacing with split skin grafts
- Partial penectomy
- Glansectomy with and without skin graft
- Total penectomy & perineal urethrostomy

- Dynamic sentinel node biopsy
- Inguinal lymphadenectomy
- Pelvic lymphadenectomy
- Chemotherapy
- Radiotherapy
- Penile prosthesis
- Phallic reconstruction

The information must include details of:

- 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
- Where treatment is delivered at different hospitals, there must be a clear explanation about where different aspects of their treatment will occur.
- 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 key worker/allocated CNS
- Possible benefits and compensation
- Support organisations or internet resources recommended by the clinical team
- Access to relevant clinical trials which may be available

After treatment patients should be provided with an education and support event, such as a Health and Wellbeing Clinic, to prepare them for the transition to supported self-management. The event should include advice on relevant consequences of treatment, recognition of issues and who to contact. They should also be given information and support on work and finance, healthy lifestyle and physical activity.

2.7 Imaging and pathology

The service must ensure that ultrasound / CT scanning / MRI and nuclear medicine imaging must be available to the patient as part of the pathway. The service must agree imaging modalities and their specific indications. The responsibility for the scan, its interpretation and any decision to inform treatment lies with the supra-urology network specialist penile cancer MDT.

Histological confirmation of tumour is required before treatment with chemotherapy or radiotherapy.

The pathology services must :

- Comply with Clinical Pathology Accreditation (UK) Ltd (CPA) and the Human Tissue Authority (HTA).
- Comply with Royal College Minimum Dataset
- Provide acute diagnostics services and clinical pathology opinion 24 hours a day 7 days a week
- Have access to digital pathology and networks services, including remote working
- Have in place Blood management guidelines

- Participate in and encourage clinical trial activity
- Provide a framework for staff education

2.8 Diagnosis

The service must develop - with primary care, local urological services and the appropriate Cancer Alliance(s) - locally agreed guidelines on appropriate referral for patients with suspected penile cancer in line with national guidelines. Compliance with these guidelines must be audited.

2.9 Staging

Providers must include staging information in their cancer registration dataset (this is mandated in the Cancer Outcomes Service Dataset). 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 cancer survival rates. Cancer stage is best captured electronically at MDT 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.

2.10 Treatment

Treatment delivered by the core members of the specialist penile cancer MDT includes:

- Surgical excision of the primary tumour
- Localised therapies such laser and topical therapy
- Radiotherapy to the primary lesion where indicated
- Management of inguinal and pelvic lymph nodes by surgery, chemotherapy and radiotherapy where indicated.
- Penile Surgery for reconstruction and erectile dysfunction (including penile lengthening and implant procedures)

All possible management options must be discussed with the patient. The treatment each patient receives must be tailored to fit their individual needs, 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 MDT, and in published forms that they can study at home. Patients must be given sufficient time to consider all the options available to them.

An 'Enhanced Recovery After Surgery' (ERAS) approach to elective surgery must 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. All Centres undertaking specialist surgery should have ERAS embedded as standard of care for all patients falling within this specification.

A Treatment Summary should be completed at the end of each acute treatment phase and a copy sent to both the patient and their GP, in line with the Recovery Package specified by the Independent Cancer Taskforce Report (2015).

2.10.1 Chemotherapy and radiotherapy

Chemotherapy and radiotherapy are important components of the treatment of some patients and must be carried out at designated centres by appropriate specialists as recommended by the specialist penile cancer MDT. There must be a formal relationship between the penile cancer service and the provider of non-surgical oncology services that is characterised by agreed protocols, good communication, and well-defined referral pathways. Audits of compliance with agreed protocols must be demonstrated.

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

- Chemotherapy service specification
- Radiotherapy service specification

2.11 Follow-up arrangements

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 Cancer Alliances 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 must ensure effective hand over of care and / or work collaboratively with other agencies to ensure patients have follow-up plans appropriate to their needs. Providers must build on the work of the National Cancer Survivorship Initiative (NCSI) which tested 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 and providers to ensure that work from this programme (and successor programmes such as the Cancer Taskforce Report) 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.

2.12 Rehabilitation

There must 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 pathways.

2.13 Supportive and palliative care

The provider must give high-quality supportive and palliative care in line with NICE guidance. The extended team for the MDT includes additional specialists to achieve this requirement. Patients who are managed by a specialist urological cancer MDT must be allocated a key worker, normally the CNS.

Patients who require palliative care must be referred to a palliative care team in the hospital and the team must be involved early to liaise directly with the community services. Specialist palliative care advice must be available on a 24-hour, seven days a week basis.

Each patient must be offered a holistic needs assessment, in line with the Recovery Package specified by the Independent Cancer Taskforce Report (2015), 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 must be developed. The nurse specialist(s) must ensure the results of patients' holistic needs assessment are taken into account in the MDT decision making.

2.14 End of life care

The provider must 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.

2.15 Acute Oncology Service

All hospitals with an Accident and Emergency (A&E) department must 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.

2.16 Interdependence with other services

The management of penile cancer involves cross-linked teams:

- Primary health care team
- Urological Cancer Team
- Local urological MDT
- Specialist urological MDT
- Supra-urology network specialist penile cancer MDT
- Specialist Palliative Care Team
- Specialist Skin MDT

The specialist penile cancer MDT is responsible for developing and agreeing referral guidelines, care pathways, standards of care and to share good practice and innovation across its network geography. The specialist penile cancer MDTs must also collectively implement NICE IOG, and National Guidance (where applicable) including the use of new technologies and procedures as appropriate and carry out network and national audits.

Each specialist penile cancer MDT is responsible for working with partner organisations to 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 MDT.

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

The service outlined in this specification is for patients ordinarily resident in England; 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 patients with suspected or confirmed penile cancer requiring specialised intervention and management, as outlined within this specification.

The service must be accessible to all patients with a suspected or confirmed penile cancer regardless of age, race, disability, religion or sexual orientation. 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

3.2 Population Needs

Penile cancer treatment is delivered under specialist urological cancer services. Cancer of the penis is rare in England and is most often diagnosed in men aged 50 and over, although it does also occur in younger men. There are just over 400 cases of penile cancer diagnosed in England each year, with a crude incidence rate of 1.3 per 100,000 male population.

The most common treatment for the primary lesion is surgery although radiotherapy is occasionally used. Topical chemotherapy (5-FU or imiquimod), surgery or laser treatment can be used for pre-malignant lesions of the penis (carcinoma in situ). Radiotherapy or systemic chemotherapy is also used for metastatic disease.

3.3 Expected Significant Future Demographic Changes

Not applicable.

3.4 Evidence Base

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

Department of Health / NHS England

- Improving Outcomes; a Strategy for Cancer – Department of Health (2011)
- Cancer Commissioning Guidance - Department of Health (2011)
- Five Year Forward View – NHS England (2014)
- Report of the Independent Cancer Taskforce - 'Achieving World-Class Cancer Outcomes: A Strategy for the NHS 2015-2020'

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, Version 2.0 – NCPR, National Cancer Action Team (2011)
- Manual for Cancer Services Acute Oncology Measures NCPR National Cancer Action Team (April 2011)
- Manual for Cancer Services Acute Oncology Measures NCPR National Cancer Action Team (June 2011)

*Cancer Peer Review is now delivered by the Specialised Commissioning Quality Surveillance Team as part of the Comprehensive Peer Review programme.

Other

- Chemotherapy Services in England. National Chemotherapy Advisory Group (2009)
- Summary of Review of Specialised Commissioning Documents – Pathology (2014)
- European Association of Urology Clinical Guidelines

4. Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

The aim of the specialist penile cancer service is to deliver high-quality MDT care aimed at increasing survival while maintaining sexual and urinary function, and quality of life. It also ensures ready and timely access to appropriate supportive care for patients, their relatives and carers.

The overall objectives of the services are:

- To provide care with a patient- and family-centred focus to deliver the best possible patient experience, contributing to and learning from patient experience and outcome measures.
- To provide an exemplary and comprehensive service for all referred patients.
- To ensure that 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 provide expert diagnosis.
- To advise and undertake investigations and to proceed to treatment options if clinically

- indicated, including high-quality and modern surgical treatment for patients.
- To conduct 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 that they are monitored by regular objective audits.
- To support local healthcare providers to manage patients with penile cancer whenever it is safe to do so and clinically appropriate within the framework of the Improving Outcomes Guidance.
- To provide high-quality and up-to-date information for patients, families and carers in appropriate and accessible formats and media.
- To ensure that the patient's General Practitioner receives accurate and timely information within 24 hours of the diagnosis.
- To ensure the active 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 the Quality Surveillance Comprehensive Peer Review Programme (formerly Cancer Peer Review).
- To ensure compliance with Care Quality Commission regulations.

NHS Outcomes Framework Domains

Domain 1	Preventing people from dying prematurely	√
Domain 2	Enhancing quality of life for people with long-term conditions	√
Domain 3	Helping people to recover from episodes of ill-health or following injury	√
Domain 4	Ensuring people have a positive experience of care	√
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	√

4.2 Indicators Include:

Number	Indicator	Data Source	Outcome Framework	CQC Key question
Clinical Outcomes				
101	Number of newly diagnosed patients first seen at this Trust.	Provider / NCRAS	1	effective
102	Percentage of patients with a performance status of 0-1	Provider / NCRAS	1, 5	effective, responsive

103	Percentage of patients discussed at MDT.	Provider / NCRAS	1, 3, 4, 5	well-led, effective,
104	Percentage of patients presenting via the	Provider / NCRAS	1, 4, 5	effective, responsive
105	Percentage of patients presenting as an emergency.	Provider / NCRAS	1, 5	effective, responsive
106	Percentage of patients with a valid stage recorded.	Provider / NCRAS	1, 5	effective
107	Percentage of patients with early stage	Provider / NCRAS	1, 5	effective
108	Percentage of patients with a histological confirmed diagnosis.	Provider / NCRAS	1, 5	effective
109	Percentage having CNS contact recorded.	Provider / NCRAS	1, 4, 5	effective, caring,
110	Percentage of patients having surgery.	Provider / NCRAS	1, 3	effective, responsive
111	Percentage of patients that undergo chemotherapy.	Provider / NCRAS	1, 3	effective, responsive
112	Percentage of patients that undergo radiotherapy.	Provider / NCRAS	1, 3	effective, responsive
113	Percentage of patients entered into a clinical trial.	Provider / NCRAS	2, 3, 4	effective, responsive
114	Percentage who died within a year of diagnosis.	Provider / NCRAS	1, 3	effective
Patient Experience				
201	There is information for patients and carers.	Self declaration	4	caring , responsive
202	The Specialist team has undertaken a patient experience exercise.	CPES	4	caring , responsive
Structure and Process				
301	The MDT serves a population of at least four million.	Self declaration	2.3	effective
302	The MDT managed at least 25 new patients per annum.	Self declaration	2.3	effective
303	There is a named lead clinician.	Self declaration	2.3	Well led, effective
304	There is an MDT.	Self declaration	2.3	effective
305	There is a MDT meeting for treatment planning.	Self declaration	2.3	effective
306	Lymphadenectomy and /or reconstruction surgery is carried out in the same named hospital of the host trust.	Self declaration	2.3	effective
307	There are clinical guidelines in place.	Self declaration	2.3	effective

Detailed definitions of indicators, setting out how they will be measured, is included in schedule 6.

4.3 Commissioned providers are required to participate in an annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

4.4 Applicable CQUIN goals are set out in Schedule 4D

5. Applicable Service Standards

5.1 Applicable Obligatory National Standards

Care delivered by the penile cancer service providers must be of a nature and quality to meet the CQC care standards, the IOG for urological cancers and existing National body guidelines. 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.

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

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 included treatments not available locally.

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

5.2 Other Applicable National Standards to be met by Commissioned Providers

Not applicable.

5.3 Other Applicable Local Standards

Not applicable.

6. Designated Providers (if applicable)

The service is delivered across England by nominated cancer centres which provide cover all regions in England for the national caseload.

The specialist penile cancer services are based at:

Trust Code	Trust
RBV	Christie NHS Foundation Trust
RR8	Leeds Teaching Hospitals NHS Trust
RR1	Heart of England NHS Foundation Trust
RRV	University College London Hospitals NHS Foundation Trust
RJ7	St Georges Healthcare NHS Foundation Trust
RVJ	North Bristol NHS Trust
RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust
RWE	University Hospitals of Leicester NHS Trust
RLN	City Hospitals Sunderland NHS Foundation Trust

7. Abbreviation and Acronyms Explained

The following abbreviations and acronyms have been used in this document:

IOG = Improving Outcomes Guidance

MDT = Multidisciplinary Team

S-MDT = Specialist Multidisciplinary Team

NCRN = National Clinical Research Network
NICE = National Institute for Clinical Excellence

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Appendix 1: Additional service information

Penile cancer is classified within the international classification of diseases version 10 (ICD10) as:

- C60: Malignant neoplasm of penis - approximately 400 cases per year
- Incidence rates are for patients diagnosed in 2009 in England. Source: UKCIS, data extracted August 2012

Relevant Operational Codes for this service

The following is a list of relevant surgical codes utilised within the services described in this document (excluding radiotherapy and chemotherapy, which are found within separate specifications).

- N26.1 – Partial amputation of penis
- N26.2 Total amputation of penis
- N27.1 Excision of lesion on penis
- N28.2 Reconstruction of penis
- N28.7 – Graft to penis
- N29.1 Implantation of prosthesis to penis
- N30.3 Circumcision
- N32.1 Biopsy of lesion of penis
- T91.1 Biopsy of sentinel lymph node
- T85.5 Block dissection of inguinal lymph nodes
- T85.6 Block dissection of Pelvic nodes
- T86.7 Sampling of inguinal lymph nodes
- T87.7 Excision of inguinal lymph node
- N35.2 Dermatological non-operative intervention involving penis
- Y08.2 Laser excision of lesion of organ
- Y08.4 Laser destruction of lesion of organ
- S27.4/27.8/27.9 Local flap of skin
- S24.8/24.9 Local flap of skin/muscle

Appendix 2: Manual and Identification Rules

Penile cancer services are defined as part of 'rare cancers' and is described within the Prescribed Services Manual in section '105. Specialist cancer services (adults), B3 – Specialised Cancer]'. This sets out that NHS England 'commissions specialist cancer services for adults, including services delivered on an outreach basis as part of a provider network. Specialist cancer services include all care provided by Specialist Cancer Centres for specified rare cancers...Urological cancers (testicular, penile)'.

The identification Rules, applicable from April 2017, state:

Service description	Type	NPoC	NCBPS
Specialist urology (adults) Consisting of: <ul style="list-style-type: none"> • Kidney, Bladder and Prostrate cancer • Penile cancer • Penile implants • Surgical Sperm removal • Testicular cancer • Urethral reconstruction 	Adults	B14	01N 01X 41P 41S 01Z 41U

Data Flows

The data flows used to support this service are:

- Inpatient activity via SUS

How the activity for this service is identified

This service includes specified activity at specified centres.

How to use the identification rules

1. Inpatient activity can be identified via the appropriate procedure and diagnosis codes documented within the identification rules software tool.