

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	B14/S/c
Service	Urological cancers – Specialised Testicular Cancer services
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 specialised testicular cancer services (adults and teenagers).</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 specialised testicular cancer surgery.</p> <p>Testicular cancer services are delivered by 13 designated providers working in conjunction with other units through supra-urology network basis. This Specification covers the role of the specialist testicular cancer service.</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 testicular cancer from designated providers. Local urological cancer services are commissioned by Clinical Reference Groups, though some aspects of the care that these providers deliver are commissioned by NHS England, for example chemotherapy and radiotherapy.</p>
2. Care Pathway and Clinical Dependencies
<p>2.1 Service Organisation</p> <p>Care is delivered through a supra-urology network specialist testicular cancer multidisciplinary team (MDT).</p>

The supra-urology network specialist testicular cancer MDT must cover a population of at least two million.

The supra-urology network specialist testicular cancer MDT is responsible for developing referral guidelines, care pathways and standards of care, and for sharing good practice and innovation. The supra-urology network specialist MDT must also collectively implement NICE IOG, including the use of new technologies and procedures as appropriate, and must carry out urology network and national audits.

The service is required to agree the following areas with their local urology 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 Specialised Commissioning's Quality Surveillance Team in respect of the Comprehensive Peer Review Programme

Each testicular network must 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.

Referrals to the service will come from either primary care or a local or specialist urology MDTs. Steps prior to referral to the supra-urology network specialist testicular cancer team may include the following, although the supra-urology network specialist testicular cancer MDT may also arrange the investigations (please refer to local urology network guidelines):

- The local urology team will normally have made a diagnosis, confirmed by ultrasound, CT Orchidectomy/biopsy and tumour marker estimations.
- The patient must have been informed of the diagnosis (or potential diagnosis).
- The patient may have had staging investigations.
- The patient may have been discussed by the local urology MDT.
- In patients being considered for partial orchidectomy/local excision, individual cases must be discussed with the specialist testicular cancer MDT prior to surgery.

Patients being referred for treatment to the supra-urology network specialist testicular cancer team must be made known to the receiving team in a timely manner so that they are seen for their specialist consultation as soon as possible after the histopathological diagnosis is available. High risk' patients (which must be precisely defined in the urology network guidelines) must be referred and made known to the supra-urology network team pre-operatively (some patients with metastatic disease may undergo systemic therapy prior to orchidectomy) or as soon as possible after diagnosis.

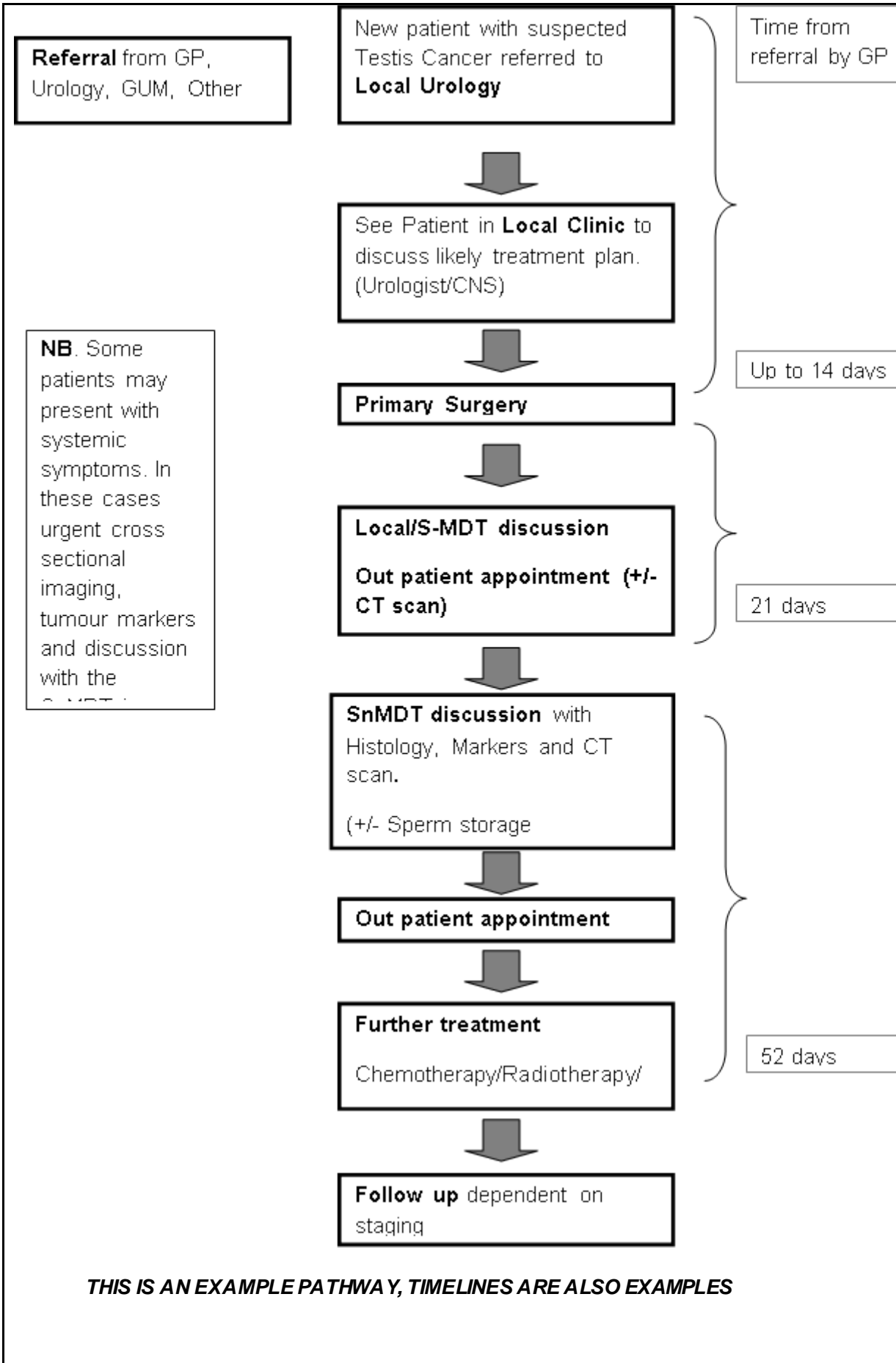
The supra-urology network specialist testicular cancer MDT will deliver the service in line with the following:

- There must be a weekly MDT meeting to discuss the needs of each newly referred patient. Other patients are likely to require discussion at the MDT meeting, for example after treatment or on progression of the cancer.
- Treatment within the specialist urology MDT or supra-urology network specialist testicular cancer 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, chemotherapy or radiotherapy is the first planned treatment then efforts must be made to give the patient a date for that treatment at the first visit, and written information provided on that treatment. The timing of treatment is agreed on the basis of evidence based treatment protocols with the local urology network.
- A written summary of the consultation must be offered to the patient as well as written information on the relevant type of testicular cancer.

- Patients must be introduced to a 'key worker'; this is normally the clinical nurse specialist.
- Accurate and timely information must be shared with the patient's General Practitioner (GP) 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 oncological surgeon or medical/clinical oncologist with input from the core MDT as clinically required.
- The providers will 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.

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.

A suggested patient pathway is shown below, this is an example of how a pathway may work (note timelines are also examples and do not detract from national targets):



2.2 Members of the specialist urological cancer MDT

Each member of the supra-urology network specialist testicular cancer MDT must have a specialist interest in urological cancer. Members of the supra-urology network testicular cancer MDT must include:

- Urological Surgeons (at least two urologists)
- Clinical oncologist/Medical oncologist (at least two members)
- Radiologist (with named cover) with expertise in testicular cancers
- Histopathologist (with named cover) with expertise in testicular cancer
- Testicular Clinical Nurse Specialist (with named cover)
- MDT co-ordinator / Secretary (with named cover)

The supra-urology network specialist testicular MDT must also have access to:

- An Andrologist/Urologist with expertise in ultrasound guided-biopsies and local excision of small tumours
- GPs/primary health care teams
- Local urological cancer teams at linked cancer units
- Thoracic surgeon for resection of chest/supraclavicular masses
- An endocrinologist
- A fertility service including a Urologist with expertise in Andrology and resources to provide semen analysis, sperm collection and banking and assisted fertilisation
- A Teenage and Young Adult Cancer Service(TYACS) – <http://www.nhs.uk/young-cancer-care/Pages/teenage-young-adult-cancer-units.aspx>
- 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 must be a single named lead clinician for the supra-urology network specialist testicular cancer MDT service who will also be a core team member.

An NHS-employed member of the core or extended team must be nominated as having specific responsibility for user issues and information for patients and carers including patient participation, and ensuring the existence of a Cancer Services User Group.

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

2.3 Patient experience

The service must be patient centred and must respond to patient and carer feedback. Excellent communication between professionals and patients is essential to ensure 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 NHS services.

Patient experience is reported in the National Cancer Patient Experience Survey. In this survey patients who are in contact with a clinical nurse specialist 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.

2.4 Patient information

Every patient and their family / carer must receive information about their condition in an appropriate format. Verbal and written information must 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
- 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 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

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.

2.5 Imaging and pathology

The service must ensure that chest x-ray / ultrasound / CT scanning / MRI 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 testicular MDT. When symptoms or imaging clearly show that the disease is metastatic the patient will be referred to the MDT for discussion of results before a treatment decision is made.

Local histopathological diagnosis is crucial for the appropriate referral of testis cancer cases. This must be available within two weeks of orchidectomy or biopsy.

Histological confirmation of tumour is usually required before treatment with chemotherapy or radiotherapy. Supra-urology network specialist testicular cancer teams may require review of the pathology by a pathologist who is a core member of the team prior to treatment decisions.

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

2.6 Diagnosis

The service must 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-urology network specialist testicular MDT service in line with national guidelines. Compliance with these guidelines must be audited.

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

Providers must:

- 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

2.7 Staging

Providers must include staging information in their cancer registration dataset (this is mandated in the Cancer Outcomes and Services 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.

2.8 Treatment

Treatment delivered by the supra-urology network specialist testicular cancer MDT includes:

- Orchiectomy 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 a surgical team serving a population of sufficient size to generate a practice that will maintain expertise. For RPLND surgery, centres must ensure surgeons have and maintain expertise in retroperitoneal surgery. Where necessary cases can be undertaken and attributed jointly between two consultants.
- Treatment of all post-radiotherapy and post-chemotherapy recurrences (treatment of first recurrences occurring during surveillance must follow the urology 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 urology network's particular arrangements for specialist care.

Some named specialist urology MDTs, 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 must develop rapid access to diagnosis and treatment for patients who could be at risk of fracture or spinal cord compression.

Sperm storage (cryopreservation) must be offered to all patients who may wish to father children. It is preferable that, after counselling, this is offered prior to orchidectomy but in appropriate cases can be undertaken before chemotherapy or radiotherapy.

An 'Enhanced Recovery After Surgery' (ERAS) approach to elective surgery must 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. 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).

2.9 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 supra-urology network specialist testicular cancer MDT. There must 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. Audits of compliance with agreed protocols will need to be demonstrated.

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

- Chemotherapy service specification; and
- Radiotherapy service specification.

2.10 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 urology network agreed rehabilitation pathway.

2.11 Follow-up arrangements

The supra-urology network specialist testicular cancer MDT must, as part of their referral guidelines, and in consultation with the relevant supra-urology network specialist testicular cancer team, agree a list of named specialist teams who may carry out surveillance and specify for which specific categories of patients this is appropriate. Otherwise it must be carried out by the supra-urology network specialist testicular cancer team. The urology network may agree that surveillance must only be carried out by the supra-urology network specialist testicular cancer team. Also, surveillance which might otherwise be carried out by an agreed specialist team, may be undertaken by the supra-urology network specialist testicular cancer team if desired and agreed by the patient and relevant consultants.

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 models stratify 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 Supportive and palliative care

The provider must give high quality supportive and palliative care in line with NICE guidance. The extended team for the specialist testicular cancer 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 clinical nurse specialist.

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.

2.13 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.

2.14 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 must 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.

2.15 Interdependence with other services

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

- Primary health care team
- Urological cancer team:
 - Local urological MDTs
 - Specialist urological MDTs
- Supra-urology network specialist testicular cancer MDT
- Specialist palliative care team
- Teenage and Young Adult Cancer Service

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.

The following services must be co-located:

- 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.
- Named ward for the care of post-operative patients undergoing urological cancer surgery with appropriately trained Nursing staff.
- Appropriate level of Consultant Specialist on call services.

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

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 adults and teenagers 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 must offer appropriate disabled access for patients, family and carers.

When required, the providers will use translators and/or printed information 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

Testicular cancer can derive from any cell type found in the testicles and encompasses male germ cell tumours, Leydig and Sertoli cell tumours and other tumours of the testis/paratesticular structures).

There are two main types of testicular cancer, both are germ cell tumours: seminomas and non seminomatous germ cell tumours (NSGCTs). Approximately half are pure seminomas. The remainder comprise one or more of the histological subtypes of non-seminomas.

Germ cell tumours may also arise from extragonadal primary sites such as the retroperitoneum and mediastinum. These patients essentially present as metastatic disease with treatment similar to systemic disease from testicular primaries, and are included within this specification.

Other rare tumours can arise in the testicles including lymphoma which is generally in men over 50 usually reflecting systemic disease. Tumours arising from paratesticular structures may also present with an initial diagnosis of a testicular tumour. These include a range of sarcomas (rhabdosarcoma. Liposarcoma) and are best definitively managed within the context of a Sarcoma service. Urologists may however be involved with their initial care including orchidectomy – with the potential of positive margins with this surgery creating additional management issues for this rare group of patients.

There were almost 1,871 cases of testicular cancer in England in 2010, with an incidence rate of 7.2 cases per 100,000 population. One year relative survival estimates are high at 98 per cent with deaths reflecting both refractory disease and treatment related complications.

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)
- Suspected Cancer: Recognition and Referral – NICE NG12 (2015)

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)

*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)
- BAUS National Complex Operations Database

4. Outcomes and Applicable Quality Standards

o Quality statement – Aim of service

The aim of the specialised testicular cancer service is to deliver high quality 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 overall objectives of the services are:

- To provide an exemplary and comprehensive service for all referred patients with testicular cancer.
- 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 advise and proceed to treatment options if clinically indicated.
- 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 safely and that they 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 accurate and timely information is given to the patient's General Practitioner.
- To ensure the active involvement of service users and carers in service development and review.
- To ensure 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	√

Indicators Include:

Number	Indicator	Data Source	Outcome Framework Domain	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 GP two week referral.	Provider / NCRAS	1, 4, 5	effective, responsive
105	Percentage of patients presenting via emergency referral.	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 (stage 1 or 2) recorded	Provider / NCRAS	1, 5	effective

108	Percentage of patients with a histological confirmed diagnosis	Provider / NCRAS	1, 5	effective
109	Percentage of patients having a CNS contact recorded.	Provider / NCRAS	1, 4, 5	effective, caring, responsive
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	1 year mortality rate.	Provider / NCRAS	1, 3	effective
115	Number of retroperitoneal lymph node resections undertaken.	Provider / NCRAS	1,3	effective, responsive
Patient Experience - PROMS PREMS can be difficult to gather if no national survey can put in process indicator if required				
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	There is a named lead clinician	Self declaration	2,3	Well led, effective
302	There is an MDT in place.	Self declaration	2,3,	effective
303	There is a MDT meeting for treatment planning	Self declaration	2,3	effective
304	Operations to resect residual masses are carried out in the same named hospital of the host trust	Self declaration	2,,3	effective
305	Population served by the testicular service is at least 2 million.	Self declaration	2,3	effective
306	Each Consultantsurgeon undertakes at least 10 retroperitoneal lymph node dissection per annum.	Self declaration	2.3,4	effective. Caring
307	There is a twenty four hour, seven day a week consultant on call rota	Self declaration	2.3,4	effective. Caring
308	There are clinical guidelines in place which, where available, reflect national guidelines for testicular cancer.	Self declaration	2,3	effective
309	There are agreed patient pathways in place for testicular cancer.	Self declaration	2.3,4	effective. Caring
310	Sperm storage is offered to all patients prior to chemotherapy, radiation or surgery.	Self declaration	2,3,4	effective, caring
311	At MDT meetings at least 90% of patients are considered for inclusion in clinical trials.	Self declaration	2,3,4	effective, caring
312	Data collection	Self declaration	1, 4	effective

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

- Commissioned providers are required to participate in 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
- Applicable CQUIN goals are set out in Schedule 4D

5. Applicable Service Standards

5.1 Applicable Obligatory National Standards

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.

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 and data collection outlined as followed:

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*

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- Manual for Cancer Services: Urological Measures (2011)
- Manual for Cancer Services Acute Oncology Measures (April 2011)
- Manual for Cancer Services Chemotherapy Measures (June 2011)

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

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)

Specialist MDT centres

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

Code	Trust	Team
RBV	The Christie NHS Foundation Trust	MDT – Christie Hospital
RQ6	Royal Liverpool University Hospitals NHS Trust	MDT - Royal Liverpool
RR8	Leeds Teaching Hospitals NHS Trust	MDT – Leeds Teaching
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	MDT – Sheffield
RRK	University Hospital Birmingham NHS Foundation Trust	MDT – University Hospitals Birmingham Foundation Trust
RQN	Imperial College Healthcare NHS Trust	MDT – Charing Cross
RNJ	Barts Health NHS Trust	MDT – The Royal London
RPY	The Royal Marsden NHS Foundation Trust	MDT – Royal Marsden (Chelsea site)
RA7	University Hospitals Bristol NHS Foundation Trust	MDT – UHB
RTH	Oxford University Hospitals NHS Foundation Trust	MDT – John Radcliffe Hospital
RHM	University Southampton Hospital NHS Trust	MDT - SUHT
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	MDT - Newcastle
RX1	Nottingham University Hospitals NHS Trust	MDT – Nottingham University Hospitals NHS 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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