Consultation Report

Topic details

Title of service specification:	Urological cancers – Specialised kidney, bladder and prostate cancer services
Programme of Care:	Cancer
Clinical Reference Group:	Specialised Urology
URN:	170114S

1. Summary

This report summarises the outcome of a public consultation that was undertaken to test the revised service specification.

2. Background

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

- **Prostate cancer:** accounts for 25% of all male cancers. Advanced prostate cancer can spread to other parts of the body. In 2010, there were more than 40,000 newly diagnosed cases of prostate cancer in the UK

- **Bladder cancer:** comprises several different types of cancer, the most common affecting the cells lining the inside of the bladder. Over 10,000 new cases of bladder cancer are diagnosed every year in the UK. The Incidence of bladder cancer is higher in males than in females.

- **Kidney cancer:** comprises two common types reflecting their location within the kidney (Renal Cell Carcinoma and Urothelial Cell Carcinoma). There were approximately 9,639 newly diagnosed cases of kidney cancer in the UK in 2010.

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.

The CRG proposes a number of revisions to the service specification, as follows:

- Additional service models for health economies to use as guide where either centes have been unable to align to Improving Outcomes guidance (IOG) or where there is an appetite to go beyond IOG requirements;
- Clarification on how IOG standards can be met, i.e., the types of service configuration that are permitted;
- Clarification on procedure volumes which have been developed on the basis of clinical consensus within the CRG which includes the relevant professional association (BAUS) following consideration of incidence, procedure volume, and outcomes (BAUS database) / literature, as follows:
    - Prostatectomy, 100 per centre and 25 per Surgeon
    - Cystectomy, 30 per centre and 15 per Surgeon
    - Specialised Renal Surgery, 30 per centre and 15 per Surgeon:
        - Renal tumour with caval thrombus, 10 per centre on a supra-regional basis; and
- Revised service outcome metrics.

3. Publication of consultation

The service specification was published and sign-posted on NHS England's website and was open to consultation feedback for a period of 30 days from 18th March 2016 to 20th April 2016.

Four responses were received to the consultation and these were reviewed by the CRG lead for the service specification (the Chair of the CRG).

Respondents were asked the following consultation questions:

- Does the impact assessment fairly reflect the likely activity, budget and service impact? - If you selected 'No', please tell us what is inaccurate
- Does the document describe the key standards of care and quality standards you would expect for this service? - If you selected 'No', what is missing or should be amended?
- Please provide any comments that you may have about the potential impact on equality and health inequalities which might arise as a result of the proposed changes that we have described?
- Are there any changes or additions you think need to be made to this document, and why?

4. Results of consultation

Four responses were received, as follows:

1. In relation to the question about impact assessment, stakeholders raised the following points:

a. That category A, which requires that IOG standards for the minimum population is met, doesn't properly account for where higher incidence means that, irrespective of the population size, high volumes of procedures (for kidney cancer) are undertaken.
b. That the service specification and impact assessment do not mention BCG as the first line treatment for high risk NMIBC. This stakeholder also noted that robotic surgery should not be removed.
c. That the costs of reconfiguration were not factored into the impact assessment, except for the reference to the inclusion within tariff costs.

2. In relation to the key standards of care, one stakeholder confirmed that it did reflect the key standards and two stakeholders provided the following feedback:
    a. That Category B, which offers health economies a range of options where there is a commitment to move beyond IOG, favours site specialisation rather than the development of comprehensive cancer centres. The link to procedure volume was also raised.
    b. That the specification did not reference the NICE Bladder Cancer (Diagnosis and Treatment) Guideline.

3. In relation to issues of equality and/or inequality and one stakeholder did not provide any comment, with the remaining two stakeholders raising points as follows:
    a. Robotic cancer was essential for the treatment of bladder cancer, given the very personal, intimate and invasive nature of current treatments.
    b. That by allowing two distinct categories of service configuration that this would create inequalities in service provision. Furthermore, that if the evidence base for the category B configurations was sufficiently strong, that these models should be the basis for widespread commissioning.

4. In terms of any other required changes, stakeholders raised several points, as follows:
    a. That basing commissioning decisions on raw population data was illogical. This same stakeholder also raised the point relating to IOG requirements.
    b. That the specification makes minimal reference to (High Risk) NMIBC and no reference to BCG treatment etc. The stakeholder would like to see the specification also include a requirement for Specialist MDTs to discuss and consider all NMIBC treatment 'failures' (BCG toxicity or intolerance etc.) and not just "recurrence".

c. That a wider, more transparent debate is had around the move towards site specialisation and the minimum volumes associated with this. The stakeholder also highlighted a range of points (Table 1) relating mainly to clinical co-dependencies.

Table 1: Specific Issues Raised

Issue	CRG Response
As with minimum numbers for procedures undertaken, minimum standards are required for support services to be co-located, e.g. the minimum caseload for hemofiltration (all indications) on critical care units is 25 cases per site per year. Sites undertaking surgery where such intervention is required should meet that standard.	Renal dialysis is subject to alternative specification/policy. The current specification states the requirement.
Co-dependency for caval tumours is muddled (cardiothoracic plus vascular or hepatobiliary surgery). Arrangements need to be in place to provide all 3.	The specification reflects true life practice and hence allows flexibility in co-dependency.
Co-location of 24/7 vascular interventional radiology service is essential for undertaking partial nephrectomy.	This is within the specification.
Given that renal cases that potentially need dialysis should be performed in a centre that can provide that service, where there is a single site for renal tumours, that site must have a co-located dialysis service	The number requiring this are extremely small and most patients have dialysis lines placed pre-operatively. Hence the requirement is for haemofiltration service.
There is no reference to the requirement of an A&E to allow the immediate readmission of complications to the 'operating-site' if required.	Acute oncology configuration is stated within the specification. Additionally some centres may run as cold sites with dedicated urgent assessment units, the PWG consider that this is the global standard.
Robotic surgery – reference should be made to the Commissioning Policy for each tumour site	This is already stated.
There is no reference to the relationship between urological cancers and other cancer e.g. the requirement for a pelvic centre. The model must take account of the overall configuration of services across a network, and not just work for urology in isolation.	Previous CRG co-dependency mapping has been undertaken and the specification reflects this.

5. How have consultation responses been considered?

The responses have been considered by the Chair of the Specialised Urology CRG, who led the development of the service specification, as follows:

1. In response to (1):
    a. IOG requirements are unchanged from the current published service specification and therefore are not part of the consultation. However, in relation to the scenario provided by the stakeholder – a centre falling just short of IOG but that delivered the minimum procedure volumes (along with the remainder of the specification) would be classed as 'Option 1, Category B'. The intention of the specification is to enable structured diversity based on clinical expert opinion and consensus following consideration of disease incidence, procedure volume and outcomes (BAUS database) and not to simply 'close' units which fall below IOG population guidelines irrespective of the volume of disease in any particular health economy. The specification enables a more rounded discussion about local need and subsequent service provision.
    b. High-risk NMIBC is not within the portfolio of specialised services. However, the specification does include the requirement for the SMDT to discuss these cases.
    c. The specification presents two different categories. Category A mainly reflects existing IOG requirements and therefore should not represent a cost to implement or meet. The specification doesn't mandate that areas must adopt one of the Category B options, the specification and Impact Assessment highlight that this should be a decision taken jointly between local commissioners and providers and therefore any reconfiguration costs should be discussed and agreed in this way.

2. In response to (2):
    a. Category B options do tend towards site specialisation rather than comprehensive cancer centres. This is because the comprehensive cancer centre model is within Category A. The IOG requirement sets out a minimum floor of 1 million population, this is a minimum population and there is no reason why health economies could not explore a larger population catchment for a single comprehensive cancer centre.
    b. The NICE Quality Standard is referenced within the service specification and the need for the SMDT to discuss high-risk NMIBC is within the service specification.

3. In response to (3):
    a. Robotic surgery is outside the scope of the consultation on the service specification as it is the subject of a separate consultation.
    b. Category B options are intended to provide a framework for health economies to move beyond IOG where appropriate within a structured way. These options are based on clinical consensus and expertise of the CRG, drawing from published heath datasets and literature.

4. In response to (4):
    a. IOG is based on raw population data. This is already in existence and is unchanged within the revised specification (Category A). In many health economies this approach works well, however the CRG recognises that a 'one size fits all' approach isn't always right for every health economy. This is why Category B options have been included and the CRG considers that these offer a structured way of catering for differences in relevant factors other than simply raw population size.
    b. High-risk NMIBC is not within the specialised services portfolio, however the specification now reflects a requirement to discuss these cases at the SMDT.
    c. The relevant literature and sources have been included within the service specification and would be available to providers, professional groups and clinicians to review and use. Table 1 includes the CRG response to the clinical co-dependency issues raised.

6. Has anything been changed in the policy as a result of the consultation?

The service specification has been amended following public consultation as described within section 5 of this report.

7. Are there any remaining concerns outstanding following the consultation that have not been resolved in the final policy proposal?

There are no outstanding concerns arising from consultation or any other stage of the development process.