

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No:</b>	170114S
<b>Service</b>	Specialised kidney, bladder and prostate cancer services (Adults)
<b>Commissioner Lead</b>	<i>For local completion</i>
<b>Provider Lead</b>	<i>For local completion</i>

<b>1. Scope</b>
<p><b>1.1 Prescribed Specialised Service</b></p> <p>This Service Specification (the “Specification”) covers the provision of specialised kidney, bladder and prostate cancer services (adults and teenagers).</p> <p><b>1.2 Description</b></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 care and surgery for specialised kidney, bladder and prostate cancer.</p> <p>The management of urological cancers is through three cross-linked teams:</p> <ul style="list-style-type: none"> <li>• Primary health care teams.</li> <li>• Urological cancer teams which includes:             <ul style="list-style-type: none"> <li>○ Local urological multidisciplinary teams (MDTs)</li> <li>○ Specialist urological MDTs</li> <li>○ Supra-urology network specialist (penile or testicular cancer) MDTs</li> </ul> </li> <li>• Specialist palliative care team.</li> </ul> <p>This Specification focuses on specialised care and specialist surgery services for kidney, bladder and prostate cancer. These services are delivered by specialist urological MDTs, of which there are currently 54 centres across England. Each specialist urology MDT serves a network of local urological MDTs, together these are referred to as a urology network.</p> <p>Specialist testicular cancer services and specialist penile cancer services are excluded from this Specification and are subject to separate service specifications produced by NHS England.</p>

### **1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners**

NHS England commissions all specialist cancer services for urological cancers including specialised kidney, bladder and prostate cancer. Local urological cancer services are commissioned by Clinical Commissioning Groups (CCGs), however, some aspects of care that providers deliver are commissioned by NHS England, for example chemotherapy and radiotherapy.

## **2. Care Pathway and Clinical Dependencies**

### **2.1 Service Organisation**

Services must be delivered by specialist urology cancer centres. The centre is the leader in the NHS for patient care in this area. The centre provides a direct source of advice and support when other clinicians refer patients into the regional specialist services. The centre also provides education within the NHS to raise and maintain awareness of urological cancers and their management.

The service configuration can exist within ONLY one of the following categories:

#### **Category A**

The Service configuration has already aligned with IOG 2002 and is able to demonstrate that the Specialist MDT centre/s serves a minimum population of 1 million and that the centre/s offer all surgical treatments for each tumour site.

The Specialist MDT centre/s must fulfil the other requirements for the Specialist MDT and Co-dependencies/Co-locations as outlined in this specification.

#### **Category B**

Where Service configurations have been unable to align with IOG 2002 or have aligned but wish to improve beyond IOG 2002, only ONE of the following options can apply:

Option 1. For urology networks with 1 to 1.9 million

- a. 1 centre

Option 2. For urology networks with 2 to 3.9 million population

- b. 1 centre
- OR
- c. 2 centres, with no more than 1 geographic site for any one tumour site

Option 3. For urology networks with 4 million population or greater

- d. 1 centre
- OR
- e. 2 centres with no more than 1 geographic site for any one tumour site
- OR
- f. 3 centres with no more than 2 geographic sites for any one tumour site

In all Category B options, the Specialist MDT centre/s must fulfil the other requirements for the Specialist MDT and Co-dependencies/Co-locations as outlined in this specification.

Radiotherapy and chemotherapy services must be offered as agreed within urology network guidelines and only from commissioned centres. Services must be consistent with national guidelines where they exist.

The service is required to agree the following areas with local partners including referring Trusts, commissioners and Cancer Alliances:

- Service configuration and population coverage. When designing the specialist urological centre model in addition to meeting the surgical volumes the whole pathway must 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), and treatment pathways

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.

## **2.2 Referrals and Care Pathways**

Referrals to the service will come from either primary care or a local MDT. Steps prior to referral from the local team 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
- The patient will have had staging investigations.

The local care pathway for kidney, bladder and prostate cancers must be consistent with the national pathways, where they exist.

## **2.3 Specialist Urological Cancer MDT**

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

- There is a weekly MDT 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 MDT meeting for example after treatment or progression of the cancer. It is acceptable to have a separate MDT for each tumour site where case load and configuration require this (see below).
- Treatment within the specialist 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.
- After discussion with the patient, 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 urology network.
- A written summary of the consultation must be offered to the patient as well as written information on the relevant type of urological cancer.
- Patients must have access to a 'key worker' - this is normally the Clinical Nurse Specialist (CNS) with an expertise in Urological Cancers. Patients must meet their key worker as early as possible within their pathway of care
- Accurate and timely information must be shared with the patients' 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

urologist and oncological 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).

The following patients must be discussed at the specialist MDT:

- All New and Recurrent High Risk Non-Muscle Invasive Bladder Cancer
- All New and Recurrent Muscle Invasive Bladder Cancer
- All New and Recurrent Prostate Cancer
- All New and Recurrent Renal Cancers
- All New Testis and Penile Cancers (please refer to separate guidance)
- Patients previously discussed, where subsequent imaging shows unexpected locally advanced or metastatic disease.

(within all the above, ALL histological types are included).

#### **2.4 Members of the specialist urological cancer MDT**

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

The specialist urological cancer team must include the following individuals:

- Urological Surgeons (at least four urological cancer surgeons)
- 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 Cancer - CNS.
- MDT co-ordinator / secretary.

The MDT must also have access to (but not necessarily on the same site):

- GPs/primary health care teams.
- Local urological cancer teams at linked cancer units.
- Plastic surgery.
- 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.
- Specialist services managing erectile dysfunction and urinary incontinence.
- Renal Dialysis services.
- Hepatobiliary Surgery.
- Cardiothoracic Surgery.

- Vascular Surgery.

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

A 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.

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

## **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 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 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;
- Evidence, effectiveness (risks and benefits) of diagnostic tests, such as PSA (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, and its inherent side effects;
- Pain control;
- Practical and social support;
- Psychological support;
- Sexual issues, incontinence and fertility;
- Self-management and care;
- Local NHS service and care/treatment options;
- Contact details of the patient's allocated named nurse;
- Social benefits and compensation support organisations;
- Information regarding patient cancer support groups;
- Out of hours advice/support; and
- 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.

## **2.7 Imaging and pathology**

The service must ensure that chest x-ray / ultrasound / CT scanning / MRI/Nuclear Medicine 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 specialist urological 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 networked pathology 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 agreed guidelines on appropriate referral for patients with suspected urological cancer into the specialist MDT service in line with national guidelines. Compliance with these guidelines must be audited.

Tests must be available, including rapid assessments, to determine whether cancer is present, where possible as a one-stop service.

## **2.9 Staging**

Providers must include staging information in their cancer registration dataset.

## **2.10 Treatment**

The following must apply regardless of configuration option:

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).

Treatment delivered by the specialist urology MDT includes:

### **2.10.1 For kidney cancer**

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

- 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 urological tract.
- Resection by nephron-sparing surgery or other nephron sparing techniques.
- Resection of non-renal cell kidney cancer, excluding transitional cell carcinoma of the kidney, treated by nephro-ureterectomy

*\*In cases of bone, hepatic or thoracic metastases the host hospital must have access to the relevant organ site specialists.*

Robotic Renal Surgery and other therapies for small renal masses must be undertaken in line with separate guidance, where this exists.

All patients with Stage T1a/b renal cancers must be discussed at the specialist MDT and must also be seen for consultation by a Specialist MDT Surgeon.

All Specialist MDT centres must undertake a minimum of 30 specialist renal cancer surgery cases per annum, with a minimum of 15 cases per Surgeon per annum.

For complex Renal cancer cases with thrombus in the inferior vena cava and/or heart, surgery must be undertaken in centres co-located or have a networked facility with vascular or hepatobiliary, and cardiothoracic surgery. Urology network pathways must reflect this need at a supra-regional level. Centres must undertake a minimum of 10 level II/III renal cancer inferior vena caval thrombus procedures per annum.

In cases where two Surgeons operate jointly on one patient, this case may be attributed to both Surgeons but must only account for one case in the centres total figures.

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

- Adjuvant/Neoadjuvant systemic therapy.
- Molecular targeted therapy.
- Non-surgical management of non-renal cell kidney cancer.

### **2.10.2 For bladder cancer**

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

- Radical surgery (cystectomy) with bladder reconstruction (neobladder) or urinary diversion (ileal loop).
- Resection of urethral cancer (distal urethral tumours must be considered for treatment under the Penile Cancer SnMDT).
- Resection of squamous or adenocarcinoma.
- Partial cystectomy (indicated only for adenocarcinoma in the dome of the bladder).

Robotic Cystectomy Surgery must be undertaken in line with separate guidance, where this exists.

The host hospital must undertake a minimum of 30 radical cystectomy procedures per annum, with a minimum of 15 cases per Surgeon per annum. In cases where two Surgeons operate jointly on one patient, this case may be attributed to both Surgeons but must only account for one case in the centres total figures.

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

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

*\*\* Recommended only as part of the clinical trial*

Sperm storage (cryopreservation) must be offered to all patients who may wish to father children. This may be available before surgery, chemotherapy or radiotherapy.

### **2.10.3 For prostate cancer**

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

- Radical prostatectomy, including open and laparoscopic (excluding Robotic Assisted Prostatectomy)
- Robot Assisted laparoscopic Prostatectomy must be undertaken in line with separate guidance

Each Specialist centre must undertake a minimum of 100 cases per annum, with a minimum of 25 cases per Surgeon per annum.

In cases where two Surgeons operate jointly on one patient, this case may be attributed to both Surgeons but must only account for one case in the centres total figures.

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

- Radical external beam radiotherapy techniques.
- Radical brachytherapy techniques. This is only available in a few urology networks. Many patients will need referring outside their own urology network for this therapy.
- Active surveillance and watchful waiting for appropriate patients
- Patients requiring Salvage Prostatectomy are small in number and must be undertaken by experienced Surgeons. Urology network pathways must reflect this need at a supra-regional level.

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. This may be available before surgery, chemotherapy or radiotherapy.

#### **2.10.4 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 a specialist urological cancer MDT. There must be a formal relationship between the urological cancer service and the provider of non-surgical oncology services that is characterised by agreed urology network protocols, good communication, and well-defined referral pathways.

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

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

#### **2.11 Follow-up**

The Improving Outcomes Guidance series of documents made recommendations on follow-up care. Providers must adhere to cancer specific guidelines for follow up agreed through the urology network 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 or within primary care. 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.

Specialist MDTs are encouraged to collaborate with Clinical Commissioning Groups to facilitate community follow up.

#### **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 local guidelines.

#### **2.13 Supportive and palliative care**

The provider must provide 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 will 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, 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 Survivorship**

Providers must ensure services aimed at improving the health and well-being of cancer survivors is given appropriate support for each cancer e.g. andrology/erectile dysfunction, incontinence services, infertility services, psycho-sexual services.

The care must 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 community based follow-up. 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.

### **2.15 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.

### **2.16 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.

### **2.17 Interdependence with other Services**

The following services are required to be co-located with specialist urological cancer centres providing specialist kidney, bladder and prostate services:

- Intensive care facility (level III)
- High Dependency care
- Named ward for the care of post-operative patients undergoing urological cancer surgery with appropriately trained Nursing staff.
- 24/7 Interventional Uro-radiology facilities
- Appropriate level of Consultant Specialist on call services
- Renal Haemofiltration facility

For certain Renal Tumours, Cardiothoracic and Vascular or Hepatobiliary Surgery must be co-located.

The specialist urological cancer service providers must 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.

***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 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, gender, adult age, disability or religion. Providers must 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**

**Prostate cancer** is a form of cancer that develops in the prostate and 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, 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. In UK there were over 10 000 new cases of bladder cancer diagnosed. The incidence of bladder cancer is higher in males than 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 2010, there were over 9,639 newly diagnosed cases of kidney cancer in the UK. 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 cancer (excluding renal pelvis) are similar for both sexes at 70 per cent for males and 68 per cent for females.

### **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**

- 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)
- Prostate Cancer diagnosis and treatment Guidelines – NICE (2014)
- Quality Standards for Prostate Cancer - NICE (2015)
- Quality Standards for Bladder Cancer - NICE (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
- European Association of Urology Clinical Guidelines
- Prostate Cancer Advisory Group (BAUS) Advice on the Development of Robotic Assisted Radical Prostatectomy in England – (2011 and 2012)

### **4. Outcomes and Applicable Quality Standards**

#### **4.1 Quality Statement – Aim 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.

#### **NHS Outcomes Framework Domains**

<b>Domain 1</b>	<b>Preventing people from dying prematurely</b>	<b>X</b>
<b>Domain 2</b>	<b>Enhancing quality of life for people with long-term conditions</b>	<b>X</b>
<b>Domain 3</b>	<b>Helping people to recover from episodes of ill-health or following injury</b>	<b>X</b>
<b>Domain 4</b>	<b>Ensuring people have a positive experience of care</b>	<b>X</b>

Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X
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#### 4.2 Indicators Include:

##### CLINICAL QUALITY INDICATORS FOR BLADDER, PROSTATE AND KIDNEY

Number	Indicator	Data Source	Outcome Framework Domain	CQC Key question
<b>Clinical Outcomes</b>				
101	Number of newly diagnosed patients first seen at this Trust.	PROVIDER / NCRAS	1	effective, well-led
102	Percentage of patients with a performance status of 0-1 recorded.	PROVIDER / NCRAS	1, 3	safe, effective
103	Percentage of patients discussed at MDT.	PROVIDER / NCRAS	1, 3, 5	safe, effective, caring, well-led
104	Percentage of patients presenting via GP referral.	PROVIDER / NCRAS	1, 3	safe, effective, responsive
105	Percentage of patients presenting via emergency referral.	PROVIDER / NCRAS	1, 3	safe, effective, responsive
106	Percentage of patients with a valid stage recorded.	PROVIDER / NCRAS	1, 3	safe, effective
107	Percentage of patients with early stage (stage 1 or 2) recorded.	PROVIDER / NCRAS	1, 3	safe, effective
108	Percentage of patients with a histological confirmed diagnosis.	PROVIDER / NCRAS	1, 3	safe, effective
109	Percentage of patients having CNS contact recorded.	PROVIDER / NCRAS	3, 4	effective, caring, responsive
110	Percentage of patients having surgery.	PROVIDER / NCRAS	1, 3	safe, effective
111	Percentage of patients having chemotherapy.	PROVIDER / NCRAS	1, 3	safe, effective
112	Percentage of patients having radiotherapy.	PROVIDER / NCRAS	1, 3	safe, effective
113	Percentage of patients entered in to a clinical trial.	PROVIDER / NCRAS	1, 3	safe, effective
114	Mortality rate. Percentage of patients who died within a year of diagnosis.	PROVIDER / NCRAS	1, 3	effective

##### PATIENT EXPERIENCE INDICATORS FOR BLADDER, PROSTATE AND KIDNEY

201	There is information for patients and carers	Self declaration	4	caring , responsive
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202	The Specialist team has undertaken a patient experience exercise.	CPES	4	caring , responsive
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**BLADDER SPECIFIC STRUCTURE AND PROCESS INDICATORS**

305	Each surgical core team member must undertake at least 15 cases per annum as specified in the service specification for their respective tumour site.	Self declaration	2, 3	effective
306	The specialist MDT must treat at least 30 bladder cases per annum.	Self declaration	2, 3	effective
314	Operations and acute post-operative specialist care are carried out in the same hospital.	Self declaration	2, 3, 5	effective, safe

**PROSTATE SPECIFIC STRUCTURE & PROCESS INDICATORS**

305	Each surgical core team member must undertake at least 25 cases per annum as specified in the service specification for their respective tumour site.	Self declaration	2, 3	effective
306	The specialist MDT must treat at least 100 prostate cases per annum.	Self declaration	2, 3	effective
314	Operations and acute post-operative specialist care are carried out in the same hospital.	Self declaration	2, 3, 5	effective, safe

**KIDNEY SPECIFIC STRUCTURE AND PROCESS INDICATORS**

305	Each surgical core team member must undertake at least 15 cases per annum as specified in the service specification for their respective tumour site	Self declaration	2, 3	effective
306	The specialist MDT must treat at least 30 renal cancer cases per annum	Self declaration	2, 3	effective
314	Operations and acute post-operative specialist care are carried out in the same hospital.	Self declaration	2, 3, 5	effective, safe

**GENERIC STRUCTURE AND PROCESS INDICATORS FOR BLADDER, PROSTATE & KIDNEY**

301	There is a named lead clinician with responsibility for specialised prostate, bladder and kidney cancer services.	Self declaration	2, 3	Well led, effective
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302	There is an MDT that meets the requirements as specified in the national service specifications.	Self declaration	2, 3	effective
303	There is a weekly MDT meeting for treatment planning.	Self declaration	2, 3	effective
304	The specialist team meet the population requirements as defined within the service specification.	Self declaration	2, 3	effective
307	Patients are offered a joint meeting to discuss treatment options.	Self declaration	2, 3, 4	caring , responsive
308	Enhanced recovery is in place for all elective surgery	Self declaration	3, 4, 5	safe, effective, caring, responsive
309	There are clinical guidelines in place	Self declaration	2, 3	effective
310	There are patient pathways in place	Self declaration	2, 3, 4	effective, caring
311	Patients are offered sperm storage (cryopreservation) before chemotherapy, radiation or surgery.	Self declaration	2, 3, 4	effective, caring
312	90% of patients are considered for inclusion in clinical trials at MDT meeting.	Self declaration	2,3,4	effective, caring
313	Data collection	Self declaration	1, 4	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 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 urological cancer service providers must be of a nature and quality to meet this Specification, 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 maximum wait from diagnosis to first treatment.

- 31 day maximum wait to subsequent treatment.
- 62 day maximum 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.

## **5.2 Other Applicable National Standards to be met by Commissioned Providers**

Not applicable.

## **5.3 Other Applicable Local Standards**

Not applicable.

## **6. Abbreviation and Acronyms Explained**

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

BAUS – British Association of Urological Surgeons  
CHI – Clinical Health Indicators  
COSD – Cancer Outcomes and Services Dataset  
CPES – Cancer Patient Experience Survey  
NICE – National Institute for Clinical Excellence  
MDT – Multi Disciplinary Team

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## Appendix 1

### 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

### 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
- M618 Open excision of prostate, other specified
- M619 Prostatectomy NEC. Open excision of prostate, unspecified
- LB69Z Major Robotic prostate and bladder neck (male) procedures

#### Bladder

- M341 Cystoprostatectomy M342 Cystourethrectomy M343 Cystectomy NEC
- M348 Other specified total excision of bladder
- M349 Unspecified total excision of bladder
- Neobladder reconstruction code
- Ileal loop code

#### 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