Joint Health Overview and Scrutiny Committee to review proposals for the provision of urological cancer surgery in Essex

15:00	**Monday, 13 July 2015**	**Committee Room 1, County Hall, Chelmsford, Essex**

PLEASE NOTE THERE WILL BE A PRIVATE PRE-MEETING FOR ALL MEMBERS COMMENCING AT 14:30 IN COMMITTEE ROOM 1

Quorum: 3 - with at least one member from each of the three participating authorities

Membership:

Braintree District Councillor Jo Beavis (Essex HOSC representative)
Essex County Councillor Ann Naylor (Essex HOSC representative)
Essex County Councillor Andy Wood (Essex HOSC representative)
Southend Councillor Lawrence Davies (Southend HOSC Representative)
Southend Councillor Mary Betson (Southend HOSC Representative)
Thurrock Councillor Leslie Gamester (Thurrock HOSC Representative)
One further Thurrock HOSC Representative – to be confirmed.

For information about the meeting please ask for:
Graham Hughes, Scrutiny Officer
Telephone: 033301 34573
Email: graham.hughes@essex.gov.uk
www.essex.gov.uk/scrutiny

Essex County Council

Essex County Council and Committees Information

All Council and Committee Meetings are held in public unless the business is exempt in accordance with the requirements of the Local Government Act 1972.

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Please note that an audio recording may be made of the meeting – at the start of the meeting the Chairman will confirm if all or part of the meeting is being recorded.

Part 1

(During consideration of these items the meeting is likely to be open to the press and public)

		Pages
1	**Nominations for, and appointment of Chairman and Vice Chairman** To seek nominations and agree Chairman and Vice Chairman for the Joint Committee.	
2	**Committee Membership, Apologies and Substitution** To be noted.	
3	**Declarations of Interest** To note any declarations of interest to be made by Members in accordance with the Members' Code of Conduct	
4	**Constitution and Terms of Reference** To consider report UCJHOSC/01/15.	**5 - 12**
5	**Project timetable** To consider report UCJHOSC/02/15.	**13 - 14**
6	**Service criteria** To consider report UCJHOSC/03/15.	**15 - 56**
7	**Date of Next Meeting** To be confirmed.	
8	**Urgent Business** To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.	

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

9 Urgent Exempt Business

To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

AGENDA ITEM 4

UCJHOSC/01/15

Committee Joint Committee to Review Urological Cancer Surgery proposals

Date 13 July 2015

Constitution, Terms of Reference and Membership

Report by: Graham Hughes, Scrutiny Officer, Essex County Council
Contact details: graham.hughes@essex.gov.uk Tel: 033301 34574

Background:

A draft Constitution and Terms of Reference for the Joint Committee is attached for consideration.

Required action:

To consider and amend as necessary the draft submitted and approve a Constitution and Terms of Reference for the Joint Committee

ESSEX, SOUTHEND AND THURROCK JOINT HEALTH SCRUTINY COMMITTEE TO REVIEW UROLOGICAL CANCER SURGERY PROPOSALS

DRAFT TERMS OF REFERENCE

1.	**Legislative basis**
1.1	The National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Localism Act 2011 sets out the regulation-making powers of the Secretary of State in relation to health scrutiny. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 which came into force on 1st April 2013.
1.2	Where an NHS body consults more than one local authority on a proposal for a substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. Only that Joint Committee may: • make comments on the proposal to the NHS body; • require the provision of information about the proposal; • require an officer of the NHS body to attend before it to answer questions in connection with the proposal.
1.3	This Joint Committee has been established on a task and finish basis, by Essex County Council, Southend-on-Sea Borough Council (Unitary) and Thurrock Council (Unitary).
2.	**Purpose**
2.1	The purpose of the Joint Committee is to consider NHS England's proposal for the reconfiguration of urological cancer services affecting patient pathways for the populations of Essex, Southend and Thurrock, in relation to: • the extent to which the proposals are in the interests of the health service in Essex, Southend and Thurrock; • the impact of the proposals on patient and carer experience and outcomes and on their health and well-being; • the quality of the clinical evidence underlying the proposals; • the extent to which the proposals are financially sustainable.
2.2	To make a response to NHS England and other appropriate agencies on the proposals, at appropriate times during the pre-tender and evaluation processes, taking into account NHS England's current timetable for these processes and their intention to start the new reconfigured service in October 2016.
2.3	To consider and comment on the extent to which patients and the public have been involved in the development of the proposals and the extent to which their views have been taken into account.

2.4	Prior to the start of the Joint Committee, a private briefing was given to the wider memberships of Essex, Southend and Thurrock on 8 June 2015. Thereafter, the Joint Committee's review will commence in July 2015 and operate during the pre-tender and evaluation processes as deemed necessary.
3.	**Membership/chairing**
3.1	The Joint Committee will consist of 3 members representing Essex, 2 members representing Southend and 2 members representing Thurrock, as nominated by the respective health scrutiny committees.
3.2	Each authority may nominate up to 2 substitute members.
3.3	The proportionality requirement will not apply to the Joint Committee, provided that each authority participating in the Joint Committee agrees to waive that requirement, in accordance with legal requirements and their own constitutional arrangements.
3.4	Individual authorities will decide whether or not to apply political proportionality to their own members.
3.5	The Joint Committee members will elect a Chairman and Vice-Chairman at its first meeting.
3.6	The Joint Committee will be asked to agree its Terms of Reference at its first meeting.
3.7	Each member of the Joint Committee will have one vote.
4.	**Co-option**
4.1	The Joint Committee may co-opt representatives of organisations with an interest or expertise in the issue being scrutinised as non-voting members, but with all other member rights.
4.2	Any organisation with a co-opted member will be entitled to nominate a substitute member.
5.	**Supporting the Joint OSC**
5.1	The lead authority will be decided by negotiation with the participating authorities.
5.2	The lead authority will act as secretary to the Joint Committee. This will include: • appointing a lead officer to advise and liaise with the Chairman and Joint Committee members, ensure attendance of witnesses, liaise with the consulting NHS body and other agencies, and produce reports for submission to the health bodies concerned; • providing administrative support; • organising and minuting meetings.

5.3	The lead authority's Constitution will apply in any relevant matter not covered in these terms of reference.
5.4	Where the Joint Committee requires advice as to legal or financial matters, the participating authorities will agree how this advice is obtained and any significant expenditure will be apportioned between participating authorities. Such expenditure, and apportionment thereof, would be agreed between the participating authorities before it was incurred.
5.5	The lead authority will bear the staffing costs of arranging, supporting and hosting the meetings of the Joint Committee. Other costs will be apportioned between the authorities. If the Joint Committee agrees any action which involves significant additional costs, such as obtaining expert advice or legal action, the expenditure will be apportioned between participating authorities. Such expenditure, and the apportionment thereof, would be agreed with the participating authorities before it was incurred.
5.6	[Essex/Southend/ Thurrock] councils will appoint a link officer to liaise with the lead officer and provide support to the members of the Joint Committee.
5.7	Meetings shall be held at venues, dates and times agreed between the participating authorities.
6.	**Powers**
6.1	In carrying out its function the Joint Committee may: • require officers of appropriate local NHS bodies to attend and answer questions; • require appropriate local NHS bodies to provide information about the proposals; • obtain and consider information and evidence from other sources, such as local Healthwatch organisations, patient groups, members of the public, expert advisers, local authorities and other agencies. This could include, for example, inviting witnesses to attend a Joint Committee meeting; inviting written evidence; site visits; delegating committee members to attend meetings, or meet with interested parties and report back. • make a report and recommendations to the appropriate NHS bodies and other bodies that it determines, including the local authorities which have appointed the joint committee. • consider the NHS bodies' response to its recommendations; • if the joint committee considers: ➢ it is not satisfied that consultation with the joint committee has been adequate in relation to content, method or time allowed; ➢ that the proposal would not be in the interests of the health service in its area to consider further negotiation and discussions with the NHS Bodies and any appropriate arbitration. If the joint committee remains dissatisfied on either or both of the above it may make recommendations to Essex, Southend and Thurrock. Each council will then consider whether or not they wish to refer this matter to the Secretary of State or take any further action.

7.	**Public involvement**
7.1	The joint committee will meet in public, and papers will be available at least 5 working days in advance of meetings
7.2	The participating authorities will arrange for papers relating to the work of the Joint Committee to be published on their websites, or make links to the papers published on the lead authority's website as appropriate.
7.3	A press release will be circulated to local media at the start of the process.
7.4	Local media will be invited to all meetings.
7.5	Patient and voluntary organisations and individuals will be positively encouraged to submit evidence and to attend.
7.6	Members of the public attending meetings may be invited to speak at the discretion of the Chairman.
8.	**Press strategy**
8.1	The lead authority will be responsible for issuing press releases on behalf of the joint committee and dealing with press enquiries
8.2	Press releases made on behalf of the joint committee will be agreed by the Chairman or Vice-Chairman of the Joint Committee.
8.3	Press releases will be circulated to the link officers.
8.4	These arrangements do not preclude participating local authorities from issuing individual statements to the media provided that it is made clear that these are not made on behalf of the Joint Committee.
9.	**Report and recommendations**
9.1	The lead authority will prepare a draft report on the deliberations of the Joint Committee, including comments and recommendations agreed by the committee. The report will include whether recommendations are based on a majority decision of the committee or are unanimous. The draft report will be submitted to the representatives of participating authorities for comment.
9.2	The final version of the report will be agreed by the Joint Committee Chairman.
9.3.	In reaching its conclusions and recommendations, the Joint Committee should aim to achieve consensus. If consensus cannot be achieved, minority reports may be attached as an appendix to the main report. The minority report/s shall be drafted by the appropriate member(s) or authority (ies) concerned.
9.4	The report will include an explanation of the matter reviewed or scrutinised, a summary of the evidence considered, a list of the participants involved in the review or scrutiny; and an explanation of any recommendations on the matter

	reviewed or scrutinised.
9.5	If the Joint Committee makes recommendations to the NHS body and the NHS body disagrees with these recommendations, such steps will be taken as are "reasonably practicable" to try to reach agreement in relation to the subject of the recommendation.
9.6	The Joint Committee does not have the power to refer the matter to the Secretary of State.
10.	**Quorum for meetings**
10.1	The quorum will be a minimum of three members, with at least one from each of the participating authorities.

AGENDA ITEM 5

UCJHOSC/02/15

Committee Joint Committee to Review Urological Cancer Surgery proposals

Date 13 July 2015

Urological cancer surgery proposals – project timetable

Report by: Graham Hughes, Scrutiny Officer, Essex County Council

Contact details: graham.hughes@essex.gov.uk Tel: 033301 34574

An update from NHS England will be given at the meeting.

AGENDA ITEM 6

UCJHOSC/03/15

Committee Joint Committee to Review Urological Cancer Surgery proposals

Date 13 July 2015

Urological cancer surgery proposals – draft service criteria

Report by: Graham Hughes, Scrutiny Officer, Essex County Council
Contact details: graham.hughes@essex.gov.uk Tel: 033301 34574

Background:

The documents below are attached and will be introduced by NHS England representatives at the meeting.

(i) the latest copy of the Urology Service Criteria (Prostate, Bladder, Renal) – the document describes in detail the service that will be provided by a single specialist centre and as such will reflect national guidance and standards and also include specific local requirements of the service;

(ii) the NHS England Service Specification on which the local service criteria document is based to add context to the local document.

Action required:

NHS Representatives in attendance at the meeting will invite comment on the Urology Service Criteria prior to it being finalised and sent out to prospective bidders.

Title:

Urology Service Criteria (Prostate, Bladder, Renal)

Draft 0.5

Prepared by: Sarah Steele, SCN

Date: 01 July 2015

1 Introduction

This document is being provided to the Midlands and East Specialised Commissioning Team (M&E SCT) East of England Hub as clinical guidance on the criteria that an Essex Cancer Network Urology Service is expected to demonstrate compliance with, to support them in their commissioning of an IOG-compliant specialised Urology cancer service.

It is acknowledged that an overarching National Specialised Kidney, Bladder and Prostate Cancer Service Specification (B/14/S/a) has been published by the NHS England Clinical Reference Group for Specialised Urology. It is intended that this document is complementary to that national service specification. As such, the ordering of section 3 and beyond aligns with the order that topics are discussed in the national service specification.

In that context, the content of this document has been validated by the Chair of that expert group.

Please note that, in the rest of this document, any reference to urological cancer encompasses the surgical service for prostate, bladder and renal cancer only. It is accepted that the current Essex pathways for penile and testicular cancer are in place and robust.

2 Guiding principles

This service criteria document focuses on the detail of the elements of the service that are changing and must now be provided by a single centre, and sets them in the context of the overall patient care pathway.

It is important to recognise the contribution to the current service that staff across the Network make, and a major part of the role of the single centre is to sustain this contribution to ensure appropriate local care continues to be considered in the future service model, and to ensure that all opportunities for joint working by healthcare professionals across the region are considered.

The guiding principle is that patients are cared for by healthcare professionals across the Network collaborating throughout the care pathway, with as many elements as possible of that care pathway delivered locally to the patient. By default, only surgery and immediate follow up should occur at the centre (unless the centre is also the patient's local Trust).

During the implementation process the emphasis will be on collaboration with referring hospitals and key stakeholders to ensure that pathway planning around local services will be considered. Evidence of collaboration will be an on-going requirement of this service.

3 National/local context and evidence base

The NICE guidance on Improving Outcomes in Urological Cancers (IOG) was published in 2002. It recommends that the more complex cases (as defined in section 5.3 of this document) should be referred to a single Specialist MDT hosted by a single surgical centre with a catchment population of at least 1 million.

Whilst many aspects of the IOG were implemented within the Essex Cancer Network some time ago, there have continued to be two separate surgical centres in operation, despite the total population base being only of the order of 1.4 million. There has been a single Specialist MDT operating, and the responsibility for hosting it has alternated every 2 years between the current 2 surgical centres.

This document forms part of the process for achieving full IOG compliance of the Essex Urology Cancer Service.

4 Aims and objectives of the service

The overarching aims of this service are:

- To ensure equitable access to surgery and other radical treatment for patients with urological cancers;
- To continue to improve the survival rates for patients with urological cancers by commissioning a surgical service with outcomes in line with the best in this country and Europe;
- To provide information to support ongoing development of the service.

These aims are in line with the Improving Outcomes: A Strategy for Cancer 2011 publication which promotes the delivery of high quality outcomes for patients.

The objectives are:

- To have an IOG-compliant service for urological cancers within the Essex Cancer Network, providing a local centre of choice for the population of Essex;
- To have a single surgical centre within the Network for patients with urological cancers;
- To have a single Urology Specialist MDT within the Network, hosted at the same site as the single surgical centre, to whom all patients meeting the referral criteria are referred (see section 5.3 for referral criteria);
- To have the majority of non-surgical care provided at a location that is as local as possible to the patient.

5 Service description/care pathway

Appendix A provides a diagrammatic overview of the care pathway.

5.1 Governance

Any patient referred to the Urology Specialist MDT shall remain the responsibility of the referring clinician until a clinician from the Urology Specialist MDT has formally written to the referring clinician stating that they will take on (temporary) responsibility for the patient.

Responsibility for the patient will be handed back to the party agreed within the treatment plan (normally expected to be the initial referring clinician) when treatment, and any agreed period of follow up at the centre, has completed.

Following discussion at the SMDT it is the responsibility of the Chair of the SMDT to ensure that a comprehensive opinion is communicated using a proforma. The completed proforma (patient details, clinical history and action plan) shall be distributed by the SMDT co-ordinator within one working day to the following:

- Electronic copy to core and extended members;
- Electronic (or faxed) copy to GP;
- Electronic copy to referring clinician;
- Electronic copy to local key worker;
- Electronic copy to referring MDT Coordinator and/or pathway tracker.

The Chair may also dictate a letter to the referring consultant with a copy to the GP and other relevant clinicians, summarising the treatment options to be recommended.

Following any treatment at the specialist centre, a detailed end of treatment record shall be returned within one working week to the referring local MDT /clinician including the operation record, radiotherapy and chemotherapy treatment, complications, final pathological stage and details of follow up requirements.

Further details of the governance principles to be embraced by this service can be found in the document Guidelines for Governance between LMDTs and SMDTs (see Appendix B).

In a similar manner, the patient shall remain the responsibility of their local key worker/CNS until a key worker/CNS from the specialist centre has made their first contact with the patient. Responsibility for the patient will be handed back to the local key worker/CNS when treatment, and any agreed period of follow up at the centre, has completed. During the period of treatment and follow up at the centre, the local key worker/CNS shall be kept fully informed of their patient's progress and likely discharge date.

5.2 Patient and carer information and experience

The service shall support patients and their families throughout the pathway.

Patients and their families/carers shall initially be provided with written information about urological cancers and their treatment by their local MDT or key worker, either at or before the clinic appointment where they receive their diagnosis.

The specialist centre, in conjunction with referring Trusts, shall ensure that referring hospitals also have written information to provide to their patients which clearly shows where the patient will need to go to if invited to the specialist centre for further diagnostics or joint oncology clinics. This information should clarify public transport and car parking arrangements, as well as signpost them to local sources of travel grant and other benefits advice. The information shall be given to them prior to the patient's first appointment at the specialist centre.

For prostate cancer patients, the specialist centre shall provide joint clinics at which the patient can discuss the treatment modalities and their potential side effects with a range of healthcare professionals with experience of all the treatment modalities, including as a minimum a clinical nurse specialist, a surgeon and an oncologist.

The specialist centre shall provide written information on local accommodation, car parking, public transport, social support, benefits, and facilities within the centre at the point at which the patient agrees to treatment at the centre. This should be provided with the initial contact or appointment letter.

Note that information may be required in a number of different formats.

5.3 Referral Criteria

All patients in the age range 16 – 24 (known as TYA patients) must be referred to the TYA MDT applicable to Essex – currently at UCLH – where their treatment plan will be decided.

All adult patients (25+ years of age) meeting the urology cancer referral criteria must be referred to the Essex Urology Specialist MDT.

In order to keep within the 62 day cancer waiting times target for GP referral to first treatment, patients shall be referred to the Specialist MDT by day 38 at the latest.

In outline, this service will be for patients who meet the following criteria:

- Adult urology cancer patients with diagnosed prostate cancer who are being considered for radical treatment (surgery, brachytherapy, external beam conformal radiotherapy);
- All adult urology cancer patients with diagnosed high-risk superficial or muscle-invasive bladder cancer;
- Adult urology cancer patients with suspected or diagnosed renal cancer who are being considered for partial nephrectomy surgery;
- Adult urology cancer patients with suspected or diagnosed renal cancer where the tumour may have invaded the renal vein or inferior vena cava or the heart;
- Adult urology cancer patients with metastases who might benefit from surgery or combined surgery and systemic therapy;
- Any adult with suspected urology cancer who is proving difficult to clearly diagnose.

A more detailed specification of referral criteria will be found in the network clinical guidelines.

An important part of this service will be for the service provider to ensure that referring hospitals improve their referral rates to this specialist service. It is anticipated that this will be done through policy development and ensuring that enhanced referral information is available. Evidence that hospitals with poor referral rates have had specific centre intervention will be required.

Templates for referral to the Urology Specialist MDT and the Specialist MDT Outcome Proforma are to be defined by the Specialist MDT.

The referral template must include, as a minimum:

- Full medical history of the patient;
- Histology of primary tumour;
- Relevant imaging as defined in the Urology Clinical Guidelines;
- Name of referring clinician and referring MDT;
- Reason for referral;
- Known co-morbidities;
- Views on eligibility for surgery;
- 62 day target date.

The outcome template must include, as a minimum:

- Full description of treatment plan or rationale for endorsement of the referring MDT's recommendation;
- Name of clinician taking on responsibility for the patient at the surgical centre, if applicable.

Patients referred to the Urology Specialist MDT are considered to be covered by all Cancer Waiting Times targets including the 31 day target (Decision to Treat to start of Second or Subsequent Treatment), and the 62 day target (Consultant Upgrades).

5.4 Urology Specialist MDT

The Urology Specialist MDT shall be hosted by the same Trust that provides the urology surgical service. Leadership of the MDT should reflect the multidisciplinary nature of this service, particularly taking into account developments in oncology.

It is expected that the Urology Specialist MDT shall be a video-conferenced MDT giving all referring Trusts and clinicians the opportunity to participate fully in the discussion of their patients. A whole team approach to the MDT with input from oncology and radiology from all referring hospitals is to be encouraged.

If the Urology Specialist MDT decision is to treat the patient at the surgical centre

- a key worker shall be identified for the patient and their name recorded in the patient notes;

- the follow-up team shall be decided based on clinical/geographical need and patient choice, with due regard to the guiding principle outlined in section 2 of this document.

5.5 Clinical Guidelines

The Urology specialist MDT may only operate under guidelines that have been agreed and signed off by the Essex Urology Network Cancer Group and the Clinical Director (Cancer) of East of England Strategic Clinical Network. These guidelines must be reviewed regularly (at least every two years)

5.6 Urology Specialist MDT operational policy

The Urology Specialist MDT shall produce an operational policy for the proposed service which articulates the service vision and guiding principles, describes the high level objectives and clearly sets out the service configuration and operational model which should comply with the National Peer Review Measures for a Urology SMDT.

It is essential that the centre actively engages with the referring Trusts to ensure that best practice with respect to referrals of patients to the Urology Specialist MDT and their ongoing treatment is embedded within the Network service.

The operational model shall demonstrate how communication, joint learning and joint working amongst clinicians across the Network will be achieved (for example, through a programme of visits by the centre's clinicians to other cancer units, or through joint data collection and analysis).

The operational model shall also demonstrate that it has service accessibility for patients at its heart.

The operational policy must include the following:

- Name of Organisation;
- Organisational arrangements for prostate and haematuria clinics;
- Organisational arrangements for MDT working, and for any decisions required outside of the normal MDT meeting times;
- Organisational arrangements for joint oncology clinics;
- Clinical Leadership of the service and how this will develop to ensure appropriate clinical engagement in the patient pathway across the network, ensuring a standardised approach is achieved and maintained;
- Membership of the core MDT*;
- Extended membership of the MDT;
- Clinical expertise available*;
- Clinical facilities available*;
- Referral arrangements into the MDT (including an MDT referral template) and policy for clinical responsibility for patients at different points in their pathway;
- The Model of Care and operation of the MDT and the role of local services in the following:
    - Pre-diagnostics
    - Diagnostics

    - Pre-treatment
    - Treatment
    - Emergency care
    - Follow-up
    - Supportive care
- Communication to referrers and how the MDT will manage whole system relationships, sharing information between all constituent organisations and clinicians in order to manage patients across their care pathway. To include:
    - Key Worker policy
    - SMDT outcomes and treatment planning decisions
    - Emergency cover arrangements*
    - Re-referral arrangements;
- Service User information policy which outlines how patients will be communicated with and provided with informed choice throughout their pathway;
- Service User feedback policy which will describe how patient experience data will be used to improve and develop working practice within the Trust and in the wider Network of care;
- Patient access, transport and accommodation information, ensuring these are considered across the whole Network area;
- Proposed working with the urology network cancer group and other relevant groups;
- Demonstration of how system wide priorities for improvement will be identified and agreed;
- Plans for data collection and audit;
- Evidence of a positive culture of research within the organisation and an assessment of how this is implemented for patient benefit. This should include leadership arrangements for research and the arrangements for promoting access to high quality clinical trials;
- Description of video-conferencing equipment – make, model, year of installation and duration of current maintenance contract.

*where posts need to be appointed to or facilities increased a clear recruitment/development plan needs to be available to meet the implementation date.

5.7 Treatment

The surgical centre shall carry out all complex surgery, including all radical prostatectomies (open and laparoscopic), cystectomies (open and laparoscopic) and partial nephrectomies (open and laparoscopic), on the same site and shall have ITU and HDU facilities on site that support the forecast volume of patients (see section 7.2). A full list of specialist procedures can be found in the national service specification (B/14/S/A).

The provider shall ensure that there is an emergency care specialist surgical service available with 24/7 cover and access to expert opinion for both patients and clinicians. The emergency care pathway shall be defined within both the Network Clinical Guidelines for Urology and the SMDT Operational Policy. The emergency care pathway shall clarify the management responsibilities falling to both specialist and local clinicians in the case of a post-operative emergency, wherever the patient first presents.

The service should have access to the following services brachytherapy and radiotherapy services, which need not be sited within the surgical centre:

- Brachytherapy
- Cryoablation
- Radiofrequency ablation (RFA)
- Radiotherapy.

The service is expected to demonstrate that it has robust links between the Urology Specialist MDT and the supra-network teams for penile and testicular cancer, to ensure that any care given by the Urology Specialist Centre is under the overall management and under the agreement of the supra-network MDT.

It is anticipated that the service will have the potential to provide a full range of modern technology as NHS England develop their commissioning policies for the treatment of urological cancers. However, these technologies (such as the use of robotic surgery) are likely to be the subject of separate national policy and service specification documents and thus remain outside the scope of this service criteria document.

5.8 Service dataset

Note that this section will be updated for Draft 0.6 of this document (due out mid July) and will include the data items that are jointly considered to be key data items, whilst still referencing the full datasets.

The service must submit Cancer Services Outcomes Dataset (COSD) data on a regular basis in conformance with the COSD instructions – see http://ncrsreports.phe.nhs.uk/cosd/.

The service must also submit chemotherapy data on a regular basis in conformance with SACT instructions – see http://www.chemodataset.nhs.uk/home – and radiotherapy data in conformance with NATCANSAT instructions – see http://www.rtds.nhs.uk/microsite/rtds/.

The service is also expected to contribute data, where requested, to any relevant national audit such as the National Prostate Cancer Audit.

Responsibilities for upload of data to COSD

The Local MDT is responsible for the initial upload of data.

The treating Trust is responsible for uploading treatment data.

The MDT that finalises the patient's staging data is responsible for uploading that data to COSD. This could therefore be the local MDT for some prostate and bladder patients, but will always be the Specialist MDT for renal patients.

5.9 Key Relationships for the Urology Specialist MDT

Key relationships shall be with all Essex Cancer Network urology MDTs, the Essex Cancer Network Urology Network Cancer Group, and GPs.

The Specialist MDT shall ensure that they have a programme of frequent visits and communications with all referring local urology MDTs.

The Lead Clinician of the Urology Specialist MDT (or their representative) must attend at least two-thirds of the Urology Network Cancer Group meetings.

Referring MDTs, and the patient's GP, must be informed of the decision of the Urology specialist MDT in writing within one working day of the Specialist MDT meeting.

6 Key service outcomes

- All urology cancer patients in Essex having access to the full range of treatments as per NICE Guidelines;
- A single, high volume surgical centre for all Essex Cancer Network patients with prostate, bladder or renal cancer;
- A single Urology Specialist MDT reviewing the diagnostic data and agreeing the treatment plans of all patients with urological cancers meeting the referral criteria;
- An increased expertise within the Urology Specialist MDT members, the surgeons and their supporting teams, generated by the higher number of patients seen and treated, enabling innovation in the treatment of patients with urological cancers;
- The majority of non-surgical care being provided at a location that is as local as possible to the patient.

See Section 8 for the details of service outcomes to be measured.

7 Urology SMDT and surgical activity plan

The activity levels are currently being worked on with the Trusts and will be inserted into Draft 0.6 of this document.

7.1 Current activity levels within the Essex Cancer Network

7.2 Expected activity levels within the new urology cancer surgical service

These future activity levels are calculated using a set of assumptions outlined in Appendix C.

7.3 Capacity requirements

Current national guidance states that each pelvic surgeon should carry out a minimum of 5 prostatectomies/cystectomies per year. The centre overall should carry out a minimum of 50 such operations per year.

Guidance on behalf of the Department of Health from Frontier Economics 2010 indicates that an optimal Uro-oncology CNS workload is 100 new patients plus 500 in follow-up.

8 Service improvement and outcome measurement

Service improvement shall be driven, as a minimum, by the outcome measures listed in Section 4 of the National Service Specification. *(Please note that these could be added to by stakeholders before this document is finalised).*

The M&E SCT, the East of England SCN and the Essex Urology NCG will take an active role in reviewing these standards on a regular basis.

A specific report, one year after service implementation, demonstrating the audit of referral and resection rates, mortality and readmission rates is required for local authority health scrutiny purposes.

The service shall be subject to peer review and shall produce a Work Programme, Annual Report and Operational Policy that clearly reflect how the service is being monitored and how recommendations for service improvement are derived.

9 Evidence of Agreement

To be completed

.

10 Appendices

Appendix A – Patient pathway

To be completed

Appendix B - Guidelines for Governance and Communication between Local and Specialist Multi-Disciplinary Teams

Document circulated separately

Appendix C – Activity Level Forecasting

References

Ref 1: Mr Vijay Sangar, Chair of the Specialised Urology Clinical Reference Group (meetings and e-mails, 2015)
Ref 2: London Cancer Case for Change (2011/12)
Ref 3: Improving Outcomes Guidance for Urological Cancers (2002)
Ref 4: Bladder Cancer: Diagnosis and Management NICE Guidelines (February 2015)

Assumptions

1. Calculations will be based on incidence figures of urological cancer in Essex.
2. Incidence figures taken from the Cancer Commissioning Toolkit – the numbers correlate well with Cascade (replacement for UKCIS) and are slightly higher than those from Urology Hub.
3. An annual rate of increase of incidence of 10% will be used – as endorsed by Ref 1.
4. Incidence numbers will be split prostate (66%), bladder (17%) and renal (14%), based on NCIN Urology Hub figures for 2010-2012 which are in alignment with evidence from Ref 2 (of a 66%/17%/17% split) and endorsed by Ref 1. [The remaining 3% of incidence from the NCIN Urology Hub figures is for testicular cancer incidence.]
5. Numbers of patients estimated to have radical treatment plans agreed will be calculated as 15% of prostate incidence, 20% bladder incidence, and 75% renal patients – based on Ref 2.
6. For prostate cancer radical treatments to be managed by the Specialist MDT with surgery at the specialist surgical centre, the expected split between surgery, brachytherapy and radiotherapy is calculated as one third to each (Ref 1).
7. For bladder cancer radical treatments to be managed by the Specialist MDT with surgery at the specialist surgical centre, the expected split between surgery and radiotherapy is 50:50. Both of these can be with or without neo-adjuvant chemotherapy. Only those with metastases are likely to have chemotherapy alone (Ref 1).
8. For renal cancer, the proportion of patients expected to have surgical treatment carried out at the specialist surgical centre is approximately 20% of all renal cancer patients (Ref 3). This number should reflect all partial nephrectomies plus full nephrectomies for patients with an advanced stage of the disease.
9. To estimate activity levels for **new prostate and renal cancer patients** to be discussed at SMDT, the assumption is that this will equate to all prostate and renal cancer patients being considered for specialist radical treatment (surgery/radiotherapy/brachytherapy as appropriate).
10. To estimate activity levels for **new bladder cancer patients** to be discussed at SMDT (muscle-invasive and high-risk superficial non-muscle invasive cancers), Ref 4 refers to 20%-25% of bladder cancer patients having muscle-invasive cancers. This needs to be increased by 10%-20% for the high risk superficial non-muscle invasive cancers (figure endorsed by Ref 2). Hence a figure of 35% of bladder cancer incidence will be used.

B14/S/a

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

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	B14/S/a
Service	Cancer: Specialised kidney, bladder and prostate cancer services (Adult)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National context

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

- Prostate cancer
- Bladder cancer
- Kidney cancer

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

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

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

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

Evidence base

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

Department of Health

- Improving Outcomes; a Strategy for Cancer – Department of Health (2011)
- Cancer Commissioning Guidance - Department of Health (2011)

NICE

- Improving Outcomes Guidance: Urological Cancer – NICE (2002)
- Improving Supportive and Palliative Care for adults with cancer – NICE (2004)
- Quality standard for end of life care for adults – NICE (2011)
- Quality standard for patient experience in adult NHS services – NICE (2012)

National Cancer Peer Review

- National Cancer Peer Review Handbook – 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)

Other

- Chemotherapy Services in England. National Chemotherapy Advisory Group (2009)

2. Scope

2.1 Aims and objectives of service

The aim of the specialised urological cancer service is to deliver high quality holistic care so as to increase survival while maximising a patient's functional capability and quality of life and to ensure ready and timely access to appropriate supportive care for patients, their relatives and carers. The service will be delivered through a specialist urology multi-disciplinary team.

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

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

- Service configuration and population coverage. When designing the specialist urological centre model in addition to meeting the surgical volumes the whole pathway should be considered to maximize where appropriate patient access to local services.
- Referral criteria, clinical protocols (including referral and management of pleural effusion and emergency protocols and pathways that enable rapid access for treatment of infections), network policies (including local surgical policies) and treatment pathways
- Engagement with the local network groups and National Cancer Peer Review for urological tumours

The overall objectives of the services are:

- To provide an exemplary and comprehensive service for all referred patients with urological cancers.
- To ensure radiological, pathological and diagnostic facilities are available and to use the most up-to-date validated diagnostic tools and knowledge in order to effectively review, diagnose, classify and stage the cancer prior to planning treatment.
- To advise and undertake investigations and to proceed to treatment options if clinically indicated, including high quality surgical treatment of patients with urological cancers.
- To carry out effective monitoring of patients to ensure that the treatment is safe and effective.
- To provide care that promotes optimal functioning and quality of life for each individual cancer patient.
- To provide appropriate follow-up and surveillance after definitive treatment.
- To ensure that all aspects of the service are delivered as safely as possible, conform to national standards and published clinical guidelines and are monitored by objective audit.
- To provide care with a patient and family centred focus to maximise the patient

experience.

- To support local healthcare providers to manage patients with urological cancer whenever it is safe to do so and clinically appropriate within the framework of the IOG.
- To provide high quality information for patients, families and carers in appropriate and accessible formats and media.
- To ensure there is accurate and timely information given to the patient's General Practitioner.
- To ensure that there is involvement of service users and carers in service development and review.
- To ensure there is a commitment to continual service improvement.
- To ensure compliance with Peer Review Cancer Measures and with clinical lines of enquiry when they are developed.
- To ensure compliance with Care Quality Commission regulations.

2.2 Service description/care pathway

The specialist urological cancer multidisciplinary team should treat the less common urological cancer or cancers that require complex treatment (radical surgery for prostate or bladder cancer).

The specialist urological cancer multidisciplinary team will deliver the service in line with the following:

- There is a weekly multidisciplinary team meeting to discuss the needs of each newly referred patient (and other patients as required) in detail and review other non-surgical aspects of their care; patients will be likely to require subsequent additional review at the multidisciplinary team meeting for example after treatment or progression of the cancer
- Treatment within the specialist multidisciplinary team should be in accordance with locally agreed treatment guidelines which should be consistent with nationally agreed guidelines
- If surgery is the first planned treatment then efforts should be made to give the patient a date for that surgery at the first visit, and written information provided on that surgery. The timing of surgery is agreed on the basis of evidence based treatment protocols with the local cancer network.
- A written summary of the consultation should be offered to the patient as well as written information on the relevant type of urological cancer.
- Patients should have access to a 'key worker' - this is normally the Clinical Nurse Specialist.
- Accurate and timely information should be shared with the patients' General Practitioner so that they can be in a position to support and advise the patient
- Patients treated as in-patients are reviewed daily on a ward round supported by a consultant urologist and oncological surgeon with input from the core multidisciplinary team as clinically required.
- The providers will hold other meetings regularly to address clinical, service

delivery and governance issues.
- Audit should be undertaken as an integral part of improving the delivery of care to provide the evidence to improve and enhance the delivery of the clinical care provided.
- Patients should be actively invited to participate in clinical trials especially those approved by the National Cancer Research Network (NCRN).

Members of the specialist urological cancer multidisciplinary team

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

The specialist urological cancer team should include one or more of each of the following individuals:
- Urological Surgeons (at least two urologists in the team).
- Clinical oncologist.
- Medical oncologist (except where the clinical oncologist has specific expertise in systemic treatment for urological cancers).
- Radiologist with expertise in urological cancers.
- Histopathologist with expertise in urological cancers.
- Urological - Clinical nurse specialist.
- Multidisciplinary team co-ordinator / secretary.

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

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

A NHS employed member of the core or extended team should be nominated as having specific responsibility for user issues and information for patients and carers.

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

Patient experience

The service should be patient centred and should respond to patient and carer feedback. Excellent communication between professionals and patients is particularly important and can avoid complaints and improve patient satisfaction. The service should be in line with the markers of high quality care set out in the NICE quality standard for patient experience in adult NHS services.

Patient experience is reported in the National Cancer Patient Survey. In this survey patients with contact with a clinical nurse specialist reported much more favourably than those without, on a range of items related to information, choice and care. The national programme for advanced communications skills training provides the opportunity for senior clinicians to improve communications skills and all core multidisciplinary team members should have attended this.

Patient information

Every patient and family / carer must receive information about their condition in an appropriate format. Verbal and written information should be provided in a way that is clearly understood by patients and free from jargon. The information must cover:

- Description of the disease
- Evidence, effectiveness (risks and benefits) of PSA testing (where relevant)
- Management of the disease within the scope of the commissioned service as described in the specification, clinical pathways and service standards
- Treatment and medication (including their side effects) commissioned in the clinical pathway
- Pain control
- Practical and social support
- Psychological support
- Sexual issues and fertility
- Self-management and care
- Local NHS service and care/treatment options
- Contact details of the patient's allocated named nurse
- Possible benefits and compensation support organisations or internet resources recommended by the clinical team

The service must also provide appropriate education to patients and carers on:

- Symptoms of infection and management of neutropenic sepsis and prophylaxis
- Out of hours advice/support
- Contact in case of concern or emergency

The useful reference is the Information Prescription Service (IPS), which allows users, both professional and public, to create information prescriptions (IPs) for long- term health needs. www.nhs.uk/IPG/Pages/AboutThisService.aspx

Referral Processes and Sources

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

- The local team will already have made a diagnosis, confirmed by ultrasound, CT or biopsy
- The patient will have been informed of the diagnosis and given the date of a CT scan
- The patient will have had staging investigations
- The patient will have been discussed at their local multidisciplinary team

Imaging and pathology

The service should ensure that chest x-ray / ultrasound / CT scanning / MRI should be available to the patient as part of the pathway. The service should agree imaging modalities and their specific indications. The responsibility for the scan, its interpretation and any decision to inform treatment lies with the specialist urological cancer multidisciplinary team.

When symptoms or imaging clearly show that the disease is metastatic or in-operable, or the patient is not sufficiently fit to undergo radical treatment, the team is to consider the appropriate palliative treatment. The patient should go back to the multidisciplinary team for a discussion of results before a decision is given.

Histological confirmation of tumour is required before treatment with chemotherapy or radiotherapy. The pathology services should comply with Clinical Pathology Accreditation (UK) Ltd (CPA)[1] and the Human Tissue Authority (HTA).[2]

Diagnosis

The service should develop with primary care, local urological services and their local cancer network agreed guidelines on appropriate referral for patients with suspected urological cancer into the specialist multidisciplinary team service in line with national guidelines. Compliance with these guidelines should be audited.

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

[1] CPA, the principal accrediting body of clinical pathology services and External Quality Assessment (EQA) Schemes in the UK. Modernising Pathology Services. Department of Health (2004)

[2] HTA Regulatory body for all matters concerning the removal, storage, use and disposal of human tissue. www.hta.gov.uk

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

Patients who present as an emergency on their route to being diagnosed with cancer have poorer survival. In urological cancer 10 per cent of prostate cancer patients, 19 per cent of bladder cancer patients and 25 per cent of kidney cancer patients present through an emergency route so it is important to have good emergency systems in place. Providers should:

- Develop an algorithm to support decision-making in A&E or primary care
- Set up an emergency communication alert system service for GPs/A&E/ Assessment Units/ clinicians to enable rapid specialty assessment and outpatient investigations

Staging

Providers must include staging information in their cancer registration dataset (this will become mandated in the Cancer Outcomes and Services Dataset from early 2013). Staging data are essential for directing the optimum treatment, for providing prognostic information for the patient and are also essential to the better understanding of the reasons behind the UK's poor cancer survival rates. Cancer stage is best captured electronically at multidisciplinary team meetings and transferred directly to cancer registries. Staging and other pathological data can also be extracted direct from pathology reports and sent to cancer registries.

Treatment

Treatment delivered by the specialist urology multidisciplinary team includes:

For kidney cancer

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

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

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

in the network's guidelines:

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

For bladder cancer

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

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

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

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

* Recommended only as part of the clinical trial

For prostate cancer

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

- Radical prostatectomy. cryoablation / radiofrequyency ablation as appropriate

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

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

All possible management options should be discussed with the patient. The treatment each patient receives should be tailored to fit their individual values and situation, so it is essential that patients are actively involved in decision-making.

This requires that they receive adequate and accurate information, both through meetings with members of the multidisciplinary team, and in published forms that they can study at home. Patients should be given sufficient time to consider all the

options available to them.

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

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

The service should develop rapid access to diagnosis and treatment for patients who could be at risk of fracture or spinal cord compression.

Sperm storage (cryopreservation) should be offered to all patients who may wish to father children. This should be available before chemotherapy or radiotherapy to the contralateral testis.

An 'Enhanced Recovery' approach to elective surgery should be adopted by all urological cancer teams. Enhanced recovery has been shown to shorten lengths of stay, facilitate early detection and management of complications, as well as improve patient experience with no increase in readmissions.

Surveillance

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

Chemotherapy and radiotherapy

Chemotherapy and radiotherapy are important components of the treatment of some patients and should be carried out at designated centres by appropriate specialists as recommended by a specialist urological cancer multidisciplinary team. There should be a formal relationship between the urological cancer service and the provider of non-surgical oncology services that is characterised by agreed network protocols, good communication, and well-defined referral pathways. This relationship should be defined in writing and approved by the cancer network director and the lead clinician in the specialist urological cancer multidisciplinary team. Audits of compliance with agreed protocols will need to be demonstrated.

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

- Adult Systemic Anti-Cancer Therapy (SACT/ chemotherapy) service specification
- Radiotherapy service specifications
- Brachytherapy service specification (to be developed)

Follow-up

The Improving Outcomes Guidance series of documents made recommendations on follow-up care. Providers will need to adhere to cancer specific guidelines for follow up agreed through the network site specific group (NSSG) and ensure patients have a follow up plan. The cancer specific guidelines will identify that some patients will need to continue receiving follow up from the specialised service but it is expected the majority will be able to receive follow up locally. The provider will need to ensure effective hand over of care and / or work collaboratively with other agencies to ensure patients have follow up plans appropriate to their needs.

Rehabilitation

There should be appropriate assessment of patients' rehabilitative needs across the pathway and the provider must ensure that high quality rehabilitation is provided in line with the network agreed urology rehab pathway (in development) at: www.ncat.nhs.uk/our-work/living-with-beyond-cancer/cancer-rehabilitation

Supportive and palliative care

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

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

Each patient shall be offered an holistic needs assessment at key points in their cancer pathway including at the beginning and end of primary treatment and the beginning of the end of life. A formal care plan shall be developed. The nurse specialist(s) shall ensure the results of patients' holistic needs assessment are taken into account in the multidisciplinary team decision making.

Survivorship

The National Cancer Survivorship Initiative (NCSI) is testing new models of care aimed at improving the health and well being of cancer survivors. The new model stratifies patients on the basis of need including a shift towards supported self management where appropriate. In some circumstances traditional outpatient follow- up may be replaced by remote monitoring. The model also incorporates care coordination through a treatment summary and written plan of care.

It will be important for commissioners to ensure that work from this programme is included and developed locally to support patients whose care will return to

their more local health providers once specialist care is no longer required.

End of life care

The provider should provide end of life care in line with NICE guidance and in particular the markers of high quality care set out in the NICE quality standard for end of life care for adults.

Acute Oncology Service

All hospitals with an Accident and Emergency (A&E) department should have an "acute oncology service" (AOS), bringing together relevant staff from A&E, general medicine, haematology and clinical/medical oncology, oncology nursing and oncology pharmacy. This will provide emergency care not only for cancer patients who develop complications following chemotherapy, but also for patients admitted suffering from the consequences of their cancer. For full details on AOS please refer to the service specification for chemotherapy.

Care Pathways

The local care pathway for kidney, bladder and prostate cancers should be consistent with the national pathways on Map of Medicine. The process of producing the pathways and subsequent updates has been accredited by the National Cancer Action Team. A pathway for testicular cancer is in development.
http://directaccess.mapofmedicine.com/evidence/map/kidney_cancer1.html
http://directaccess.mapofmedicine.com/evidence/map/bladder_cancer1.html
http://directaccess.mapofmedicine.com/evidence/map/prostate_cancer1.html
NICE have also developed an evidence based pathway for prostate cancer.
http://pathways.nice.org.uk/pathways/prostate-cancer

2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England[3] 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 establish edurological cancer regardless of sex, race, or gender**.** Providers require staff to attend mandatory training on equality and diversity and the facilities provided offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information available in multiple

[3] Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England

languages.

The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation

2.4 Any acceptance and exclusion criteria

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

2.5 Interdependencies with other services

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

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

The urological cancer service providers are the leaders in the NHS for patient care in this area. They provide a direct source of advice and support when other clinicians refer patients into the regional specialist services. This support will continue until the patient is transferred into the local or specialist urology centre or it becomes apparent that the patient does not have a urological cancer.

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

The urological cancer service providers will form a relationship with local health and social care providers to help optimise any care for urological cancer provided locally for the patient. This may include liaison with consultants, GPs, palliative care teams community nurses or social workers etc.

Co-located services – Intensive/critical care services may be required for some patients undergoing complex surgery and providers will be required to refer to the service specification for critical care.

Cancer Networks

Strategic Clinical Networks

Strategic clinical networks will be in place from April 2013 located in 12 areas across England. They will be established in areas of major healthcare challenge where a whole system, integrated approach is needed to achieve a real change in quality and outcomes of care for patients. Cancer has been identified as one of the conditions that will be within this new framework. Strategic clinical networks will help commissioners reduce unwarranted variation in services and will encourage innovation. They will use the NHS single change model as the framework for their improvement activities.

Each network area has a NSSG covering urological cancers. This group is made up of clinicians across the network who specialise in urological cancers. It is the primary source of clinical opinion on issues relating to urological cancer within the cancer network and is an advisor to commissioners. Each Site Specific multidisciplinary team should ensure they fully participate in the network systems for planning and review of services.

This group is responsible for developing referral guidelines, care pathways, standards of care and to share good practice and innovation. The specialist and supra-network multidisciplinary teams should also collectively implement NICE Improving Outcomes Guidance including the use of new technologies and procedures as appropriate and carry out network and national audits.

Each NSSG should agree an up-to-date list of appropriate clinical trials and other well designed studies for urological cancer patients and record numbers of patients entered into these trials/studies by each multidisciplinary team.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

Care delivered by the urological cancer service providers must be of a nature and quality to meet the CQC care standards and the IOG for urological cancers. It is the Trust's responsibility to notify the commissioner on an exceptional basis should there be any breaches of the care standards. Where there are breaches any consequences will be deemed as being the Trust's responsibility.

Urology cancer services are required to achieve the two week wait for all patients where urological cancer is suspected. In addition the services are required to meet the following standards for all urology cancer patients,

- 31 day wait from diagnosis to first treatment,
- 31 day wait to subsequent treatment,
- 62 day wait from urgent GP referral or screening referral or consultant upgrade to first treatment.

Teams should as a minimum aim to achieve the median value for compliance with the Cancer Peer Review measures, and if a team has immediate risks or serious

concerns identified then remedial action plans should be in place. Further details are available at www.cquins.nhs.uk

The provider must be able to offer patient choice. This will be both in the context of appointment time and of treatment options and facilities including treatments not available locally.

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

4. Key Service Outcomes

The expected clinical outcomes/clinical lines of enquiry are still being agreed but provider services may wish to monitor:

- 1-year and 3-year relative survival, adjusted for age, type and stage of cancer.
- Patients' quality of life and reduction in symptoms

Included below are some key commissioning questions from the cancer commissioning guidance, which may be of help to service providers:

Prostate cancer

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

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

Invasive Bladder Cancer

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

Non Muscle Invasive Bladder Cancer

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

Kidney Cancer

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

Quality and Performance Standards

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Consequence of breach*
Quality				
	% of cases discussed at multidisciplinary team	100%	Reported within national audit reports	
	Follow up ratios			
	Other Quality Measures	TBC		
	Percentage attendance by individual core members or their agreed cover at multidisciplinary team	67%	National Cancer Peer Review	
	Attendance at advanced communication skills course	100%.	National Cancer Peer Review	
IOG Compliance	Compliance with specified measures	Compliance with specific measures for tumor site as set out in IOG documentation		
Compliance with Peer Review	Compliance with all other Peer Review measures (other than where agreed with commissioners when the Provider should have an action plan in place that has been agreed with the Commissioner)	National median compliance level		
Performance and	The Provider should ensure that these targets are achieved for the part of the patient pathway that it delivers and that, when the			

Productivity	patient pathway crosses outside the locality border, appropriate scheduling of patients/activity supports achievement of the target by other providers in the pathway wherever possible, except when informed patient choice or clinical appropriateness mitigate against this.			
Waiting Time Compliance				
	62 day wait - % treated in 62 days from GP referral, consultant referral and referral from screening programme	>~86%	Reported on cancer waits database	
Aggregate Measures	14 day suspected cancer referral standard performance (A20)	93%	As above	
	31 day first treatment standard performance (A15)	96%	As above	
	31 day subsequent treatment (Surgery) standard performance (A16)	94%	As above	
	31 day subsequent treatment (Drugs) standard performance (A16)	98%	As above	
	31 day subsequent treatment (Radiotherapy) standard performance (A17)	94%	As above	
	31 day subsequent	TBC	As above	

	treatment (Other Treatments) standard performance			
	31 day subsequent treatment (Palliative) standard performance	TBC	As above	
	62 day standard from 14 day referral performance (A18)	85%	As above	
	62 day standard from 14 day referral performance (A18)	TBC	As above	
	62 day standard from consultant upgrade performance (A19)	TBC	Some national data	
	Diagnostic Test Waiting Times			

Activity Performance Indicators

Activity Performance Indicators		Threshold	Method of Measurement	Consequence of breach
Audits	Annual review conducted			
	Participation in National Audits	100%		
	Additional Audits undertaken	N/A		
Activity	Threshold for number of procedures	Establish baseline cancer activity data for :- number of procedures for		
	Length of stay benchmarking			
	Level of			

	admissions	elective, day case, non elective non emergency, non elective emergency, out- patient FA, out- patient FU, out-patient procedures all by speciality		
	Choice			
Service User Experience	National Cancer Patient Experience survey (ref A46 main contract)	National survey report when published		If the provider does not take part they will be required to meet with the commissioners to explain reasons for not doing so and activity planned to enable the information to be captured through alternative mechanisms
	Improving Service User Experience	Of responses received 75% should express overall satisfaction with the service. Trust to evidence the measures it has taken to improve service user experience and outcomes achieved and numbers / percentages stratified		
	Addressing	Trust to		

	Complaints	evidence the measures it has taken to address complaints and outcomes achieved		
	Patient involvement	Trust to evidence the actions it has taken to engage with patients and demonstrate where this has impacted		
Staff Survey	Staff survey results			
Trial Activity	Recruitment into trials	Patients eligible for an existing clinical trial should be offered the chance to be treated in a clinical trial		
Outcomes	Post surgery mortality	Numbers and percentages baseline to be set in year		
	30 day mortality			
	1 yr survival			
	5 yr survival			
	30 day readmission rates for cancer patients	Numbers and percentage baseline to be set in year		
Data Submission	Registry dataset submission status	As required by Registry		
	DCOs			
	Staging data	As required by Registry		

Additional information

Incidence and survival data within this document refers to urological cancers classified using the international classification of diseases (version 10 - ICD10) as follows:

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

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

Cancer waiting times

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

OPCS-4 codes

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

Prostate

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

Bladder

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

Kidney

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

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

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