Urology Service Criteria (Prostate, Bladder, Renal)

Version 1

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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 should be provided in a number of different formats and as a minimum in Braille, Large Print, British Sign Language DVD, Sign Supported English DVD, and translated into local minority languages.

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. Patients in the age range 19 – 24 will then be given a choice as to where they receive their treatment.

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, including current or presenting symptoms;
- Histology of primary tumour, including a specimen for review;
- 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;
- Names of key worker and 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 can and should be drawn from any of the disciplines represented in order to 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 pathology, 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 encourage the embedding of best practice with respect to referrals of patients to the Urology Specialist MDT and their ongoing treatment. The centre should be responsible for auditing best practice across the Network service and reporting the results to commissioners.

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, which need not be sited within the surgical centre:

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

It is anticipated that a robotic prostatectomy service will continue to be commissioned from NICE compliant providers undertaking a minimum of 150 procedures per annum. Until this figure can be reached and the surgical minimum numbers maintained for such a service within Essex, the centre is expected to form a sustainable relationship with a compliant provider of robotic services.

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 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

The service must submit Cancer Services Outcomes Dataset (COSD) data on a regular basis in conformance with the COSD instructions – see https://nww.cancerstats.nhs.uk/users/sign_in

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

7.1 Current activity levels within the Essex Cancer Network

Please note that these figures **exclude** West Essex CCG populations as their figures are not yet available. They are provided to allow a comparison between current activity and future predicted activity only.

This data has been collated by Essex Cancer Network from their own records.

Data on brachytherapy and radiotherapy has been provided for contextual purposes only.

		2010/11	2011/12	2012/13	2013/14	2014/15
Prostate Cancers						
	Incidence	**924**	**866**	**930**	**735**	**979**
	Prostatectomy Numbers	**56**	**82**	**119**	**124**	**106**
	Brachytherapy Numbers	*61*	*75*	*118*	*112*	*141*
	Radiotherapy Numbers		*272*	*322*	*377*	*306*
Bladder Cancers						
	Incidence	**>227**	**278**	**312**	**153**	**307**
	Cystectomy Numbers	**66**	**78**	**79**	**53**	**57**
	Radiotherapy Numbers		*31*	*26*	*34*	*26*
Renal Cancers						
	Incidence	**229**	**197**	**189**	**157**	**190**
	Partial Nephrectomies	**23**	**38**	**52**	**35**	**48**
New patients discussed at SMDT		**412**	**472**	**765**	**829**	**981**

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.

The prostatectomy figures include those patients who may choose to have a robotic prostatectomy, if offered.

Please note that these figures **include** West Essex CCG populations as Princess Alexandra Hospital have said they are likely to offer patients the choice of the Essex IOG-compliant centre.

Data on brachytherapy and radiotherapy has been provided for contextual purposes only.

		Notes	2016/17	2017/18	2018/19	2019/20	2020/21
Prostate Cancers							
	Incidence		408	1797	1977	2174	2392
	Prostatectomy Numbers	1	41	180	198	217	239
	Brachytherapy Numbers	*1*	*41*	*180*	*198*	*217*	*239*
	Radiotherapy Numbers	*1*	*41*	*180*	*198*	*217*	*239*
Bladder Cancers							
	Incidence		105	463	509	560	616
	Cystectomy Numbers	1	16	69	76	84	92
	Radiotherapy Numbers	*1*	*5*	*23*	*25*	*28*	*31*
Renal Cancers							
	Incidence		87	381	419	461	507
	Partial Nephrectomies	1, 2	19	91	109	129	152
New patients discussed at SMDT		1	224	987	1086	1194	1314

Notes

1 2016 numbers reflect one quarter of the fiscal year prediction, based on service launch in Q4 2016/17

2 These figures include any complex full nephrectomies that may also be carried out at the surgical centre

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.

In order to assess the effectiveness of the urology cancer service, the SMDT and the surgical centre, particular emphasis should be placed on:

- COSD staging data completeness at MDT discussion
- Percentage of patients diagnosed at Stages 1 and 2, as this can be an enabler for greater access to surgery
- Percentage of patients with WHO performance status of 0, 1, 2, 3 and 4 at point of SMDT treatment plan decision
- Percentage of patients having
    - Prostatectomy
    - Cystectomy
    - Partial nephrectomy
    - Brachytherapy
    - Radiotherapy as a prostate cancer patient
    - Radiotherapy as a bladder cancer patient
    - No planned cancer treatment – and why.
- 30 day mortality following surgery
- 1 year survival
- 5 year survival

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

Version	Agreed By	Date	Comments
Draft 0.4	Essex Urology Information Day Group	08/06/15	Subject to comments raised at the 8th June 2015 meeting being incorporated
Draft 0.5	Shared with Essex Joint Health Oversight Scrutiny Committee	13/07/15	No changes required
Draft 0.5	Financial Directors of each of the 4 Essex Trusts in question	30/07/15	Acknowledged by all four recipients and contact names provided. BTUH had no specific comment or input. SUHFT provided no comment. MEHT provided no comment. CHUFT agreed the document and provided some comments for the evaluation criteria.
Draft 0.6	Essex Senior Oversight Group	26/10/15	Agreed subject to any final comments from Trusts and CCGs being received by 13/11/15. Comments from CHUFT received 12/11/15. An acknowledgement received on 13/11/15 from NHS Thurrock CCG to say that they had no further comments.
Version 1	Published as agreed	26/11/15	

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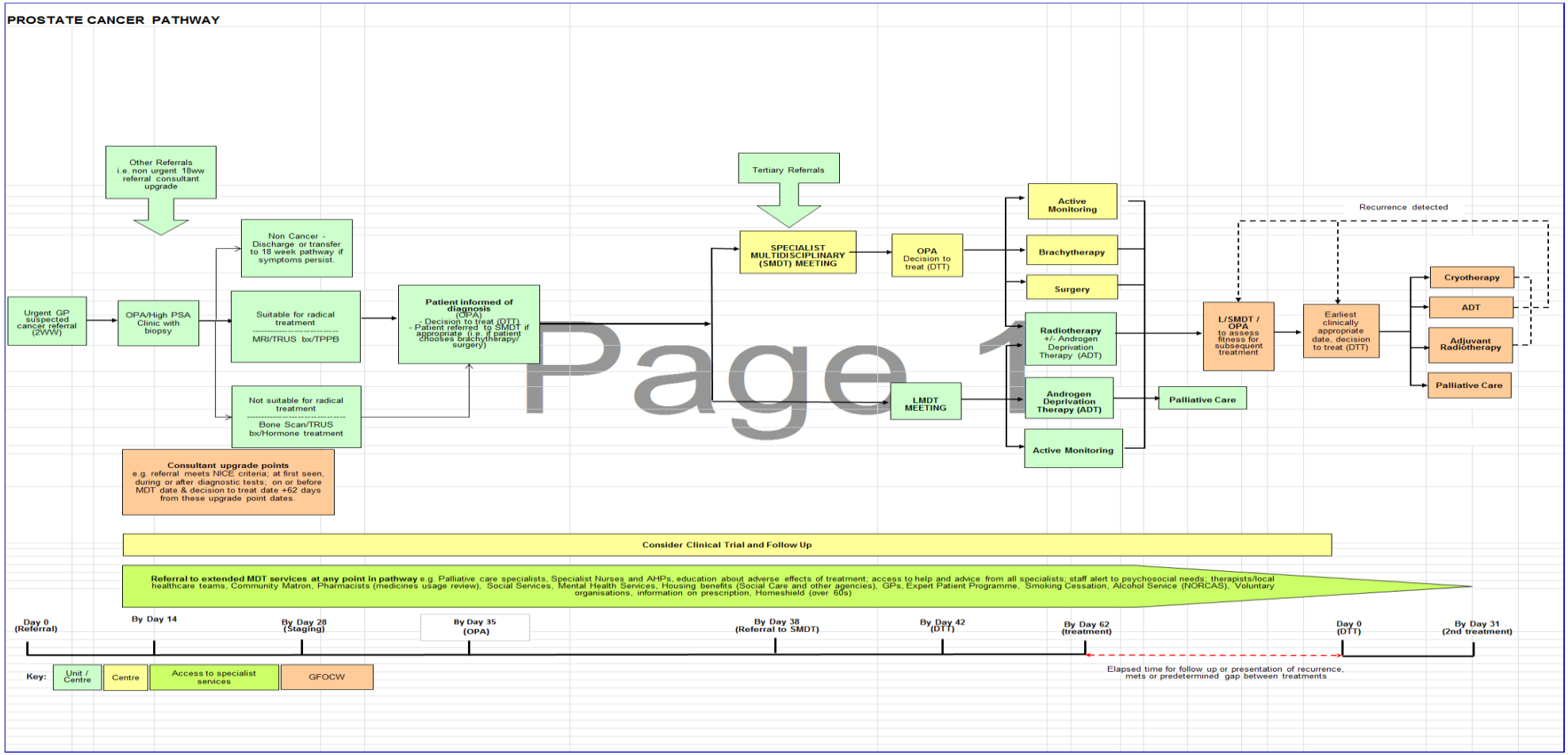
10 Appendices

Appendix A – Patient pathway

Please note that this is the current Network Cancer Group approved pathway for Urology patients in Essex.

There is work being carried out in the latter half of 2015/16 to agree a best practice pathway for prostate cancer patients which may differ slightly from the pathway as represented below.


PROSTATE CANCER PATHWAY
Other Referrals i.e. non urgent 18ww referral consultant upgrade
Tertiary Referrals
Non Cancer - Discharge or transfer to 18 week pathway if symptoms persist.
SPECIALIST MULTIDISCIPLINARY (SMDT) MEETING
OPA Decision to treat (DTT)
Active Monitoring
Brachytherapy
Surgery
Radiotherapy +/- Androgen Deprivation Therapy (ADT)
Androgen Deprivation Therapy (ADT)
Active Monitoring
Recurrence detected
L/SMDT / OPA to assess fitness for subsequent treatment
Earliest clinically appropriate date, decision to treat (DTT)
Cryotherapy
ADT
Adjuvant Radiotherapy
Palliative Care
Palliative Care
Urgent GP suspected cancer referral (2WW)
OPA/High PSA Clinic with biopsy
Suitable for radical treatment
MRI/TRUS bx/TPPB
Patient informed of diagnosis (OPA)
- Decision to treat (DTT)
- Patient referred to SMDT if appropriate (i.e. if patient chooses brachytherapy/ surgery)
LMDT MEETING
Not suitable for radical treatment
Bone Scan/TRUS bx/Hormone treatment
Consultant upgrade points
e.g. referral meets NICE criteria; at first seen, during or after diagnostic tests; on or before MDT date & decision to treat date +62 days from these upgrade point dates.
Consider Clinical Trial and Follow Up
Referral to extended MDT services at any point in pathway e.g. Palliative care specialists, Specialist Nurses and AHPs, education about adverse effects of treatment; access to help and advice from all specialists; staff alert to psychosocial needs; therapists/local healthcare teams, Community Matron, Pharmacists (medicines usage review), Social Services, Mental Health Services, Housing benefits (Social Care and other agencies), GPs, Expert Patient Programme, Smoking Cessation, Alcohol Service (NORCAS), Voluntary organisations, information on prescription, Homeshield (over 60s)
Day 0 (Referral)
By Day 14
By Day 28 (Staging)
By Day 35 (OPA)
By Day 38 (Referral to SMDT)
By Day 42 (DTT)
By Day 62 (treatment)
Day 0 (DTT)
By Day 31 (2nd treatment)
Key:
Unit / Centre
Centre
Access to specialist services
GFOCW
Elapsed time for follow up or presentation of recurrence, mets or predetermined gap between treatments

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

Document available separately

Appendix C – Activity Level Forecasting

Assumptions

1. Calculations will be based on incidence figures of urological cancer in Essex provided by Public Health England.
2. An annual rate of increase of incidence of 10% will be used – as endorsed by Ref 1. This is much higher than actual incidence rates over the period of Q4 2008/9 to Q3 2013/14, so should be going some way to cater for age and population growth impacts as well.
3. 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.]
4. Numbers of patients estimated to have radical treatment plans agreed will be calculated as 30% of prostate incidence, 20% bladder incidence, and 75% renal patients – based on Ref 2 but with prostate figures amended by input from Essex clinicians on 08/06/15.
5. 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).
6. 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 75:25 based on the opinion of Essex clinicians on 08/06/15. Both of these can be with or without neo-adjuvant chemotherapy. Only those with metastases are likely to have chemotherapy alone.
7. 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), rising to 30% at the end of the next 5 years, as agreed by Essex clinicians on 08/06/15. This number should reflect all partial nephrectomies plus full nephrectomies for patients with an advanced stage of the disease.
8. 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).
9. 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.

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) – which is about the situation and the patient numbers in their locality of North and East London and West Essex
Ref 3: Improving Outcomes Guidance for Urological Cancers (2002)
Ref 4: Bladder Cancer: Diagnosis and Management NICE Guidelines (February 2015)