Title:

Urology Service Criteria (Prostate, Bladder, Renal)

Draft 0.5

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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 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

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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.