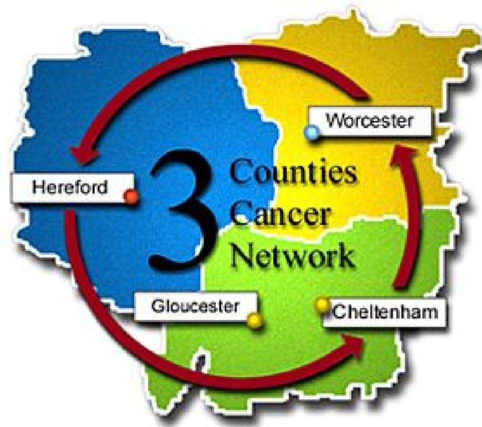

3 Counties Cancer Network

Urological Cancer Guidelines
April 2009

AGREED BY:

Graham Sole	**Jan Stubbings**
Chair of NSSG	**Chair of Network Board**
Date: 05.04.09	**Date: 06.05.09**

To be reviewed Mar 2010

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Appendices

1. MDT Meetings

Counties Cancer Network
Urological Cancer Clinical Guidelines

1.0 Introduction

The 3 Counties Cancer Network comprises Gloucestershire, Herefordshire, South Worcestershire and part of Powys. The population of the Network is 1,127,000:

PCT	Population ('000)
Gloucestershire	602
Herefordshire	180
Worcestershire (South)	285
Powys (part)	60
Total	1, 127

A number of organisations, national and international, produce and regularly update guidelines on the management of urological cancers. Each provides a valuable reference to help in the delivery of a uniformly high-quality service for patients suffering from this diverse group of diseases. However, these documents must only be regarded as guides; the protean nature of urological malignancy and the uncertain nature of optimal treatment mean that each and every patient must be considered a unique individual.

2.0 Urology Cancer Services Personnel

2.1 Cheltenham General Hospital Cancer Unit

Multidisciplinary Team

Urologist – Lead Clinician	Hugh Gilbert	08454 224271
Urologist	Richard Kinder	08454 223156
Urologist	Aloy Okeke	08454 222222
Clinical Oncologist	Peter Jenkins	08454 224019
Clinical Oncologist	Roger Owen	08454 224021
Clinical Oncologist	David Farrugia	08454 228596
Pathologist	Peter Toner	08454 224073
Radiologist	Jes Green	08454 224232
Cancer Nurse Specialist	Zoe Eastman	08454 224332

Extended Team

Palliative Care Consultant	Kath Blinman	08454 222311
Stoma Care Nurse	Jayne Edwards	08454 224363
Psychosexual Counsellor	Lynne Glover	08454 222222
Clinical Psychologist	Susan Savory	08454 222222
MDT Co-ordinator	Helen Dutton	08454 223126

2.2 Gloucestershire Royal Hospital Cancer Unit

Multidisciplinary Team

Urologist – Lead Clinician (Local)	David Jones	08454 226671
Urologist	Aloy Okeke	08454 222222
Urologist	Biral Patel	08454 226917
Clinical Oncologist	Roger Owen	08454 224021
Clinical Oncologist	Peter Jenkins	08454 224019
Clinical Oncologist	David Farrugia	08454 222596
Pathologist	Linmarie Ludemann	08454 225262
Radiologist	Phil Birch	08454 225550
Radiologist	Robert Lavis	08454 225550
Lead Cancer Nurse Specialist	Lucinda Poulton	08454 226913

Extended Team

Palliative Care Consultant	Collette Reid	08454 223447
Psychosexual Counsellor	Lynne Glover	08454 222222
Clinical Psychologist	Susan Savory	08454 222222
Stoma Care Nurse	Bernice Harding	08454 222222
Research Nurse	Clive Stokes	08454 222222
MDT Facilitator	Barbara Broomfield	08454 223126

2.3 Hereford County Hospital Cancer Unit

Multidisciplinary Team

Urologist - Lead Clinician (Local)	Graham Sole	01432 364124
Urologist	Anil Jha	01432 364439
Clinical Oncologist	Audrey Cook	08454 222871
Clinical Oncologist	Vacant	
Histopathologist	Dr M Hayes	01432 364083
Histopathologist	Dr C Caldwell	
Histopathologist	Dr E Owen	
Radiologist	Gillian Rowe	01432 355444 x1671
Radiologist	Phillip Garwood	01432 355444 x1671
Cancer Nurse Specialist	Vacant	
Clinical Nurse Specialist	Cara Watson	01432 355444 x5693

Extended Team

Clinical Trials Nurse	Anita Ashton	
Clinical Trials Nurse	Janine Birch	
Palliative Care Specialist	Ros Peter	01432 364107
MDT Facilitator	Laura Fuller	01432 364010

2.4 Worcestershire Royal Hospital Cancer Unit (Trust-wide MDT)

Multidisciplinary Team		
Urologist	Adel Makar	01905 760718
Urologist	Terry Chen	01905 734478
Urologist	Jon Eaton (Arden)	
Urologist	*Martin Lancashire (Arden)*	*01527 512155*
Urologist	*Jon Sullivan*	*01527 512155*
Urologist	*Paul Rajjayabun*	
Clinical Oncologist	Jo Bowen	08454 224017
Clinical Oncologist	Roger Owen	08454 224021
Clinical Oncologist	*Clive Irwin (Arden)*	01527 512028
Clinical Oncologist	*Jo Hamilton (Arden)*	01527 512028
Pathologist	*George Kondratowicz (Arden)*	01527 512161
Pathologist	*Jasmin Xureb*	
Radiologist	Bernd Wittkop	01905 760174
Radiologist	*Chris Phillips*	*01527 503030*
Radiologist	*Peter Holland*	*01527 503030 x 30828*
Radiologist	Umesh Udeshi	
Cancer Nurse Specialist	Helen Worth	01905 760875
Cancer Nurse Specialist	*Mary Symons (Black Country)*	01562 823424
Cancer Nurse Specialist	*Jackie Askew (Arden)*	01527 503030 x 44150
Cancer Nurse Specialist	*Lisa Hammond*	
Extended Team		
Palliative Care Specialist	Nicki Wilderspin	
Palliative Care Specialist	Ian Douglas	
MDT Co-ordinator	Carol Dunn	01905 763333 x 39499
MDT Co-ordinator	Margaret Watts	01527 503030 x 42060

Core Members and Arranged Cover

Each Individual Consultant is seen as a Core Member of the MDT and cover each other as follows:

Core Member	Designation	Hospital	Arranged Cover
Hugh Gilbert	Consultant Urologist	GHNHSfT	Richard Kinder
Richard Kinder	Consultant Urologist	GHNHSfT	Hugh Gilbert
David Jones	Consultant Urologist	GHNHSfT	Aloysius Okeke Biral Patel
Aloysius Okeke	Consultant Urologist	GHNHSfT	David Jones Biral Patel
Biral Patel	Consultant Urologist	GHNHSfT	David Jones Aloysius Okeke
Graham Sole	Consultant Urologist	HGH	Anil Jha
Anil Jha	Consultant Urologist	HGH	Graham Sole
Adel Makar	Consultant Urologist	WRH	Terry Chan – John Eaton
Terry Chan	Consultant Urologist	WRH	Adel Makar

John Eaton	Consultant Urologist	Redditch	Adel Makar
Peter Jenkins	Consultant Oncologist	Cancer Centre	Roger Owen
Roger Owen	Consultant Oncologist	Cancer Centre	Peter Jenkins
Jo Bowen	Consultant Oncologist	Cancer Centre	Audrey Cook
Audrey Cook	Consultant Oncologist	Cancer Centre	Jo Bowen
David Farrugia	Consultant Oncologist	Cancer Centre	Peter Jenkins/Roger Owen
Peter Toner	Consultant Pathologist	GHNHSfT	Linmarie Ludamann
Linmarie Ludamann	Consultant Pathologist	GHNHSfT	Peter Toner
Jes Green	Consultant Radiologist	GHNHSfT	Phil Birch Robert Lavis
Phil Birch	Consultant Radiologist	GHNHSfT	Jes Green Robert Lavis
Robert Lavis	Consultant Radiologist	GHNHSfT	Jes Green Phil Birch
Lucinda Poulton	CNS	GHNHSfT	Zoë Eastman
Zoë Eastman	CNS	GHNHSfT	Lucinda Poulton
Cara Watson	CNS	HGH	Linda Killeen
Helen Worth	CNS	WRH	Jackie Askew
Barbara Broomfield	MDT Co-ordinator	GHNHSfT	Helen Dutton

3.0 Multidisciplinary Team Working

3.1 Specialist Multidisciplinary Team

- Lead Clinician – Mr Hugh Gilbert
- The specialist multidisciplinary team is comprised of all the members of the four local teams
- Meetings are held at 1530 every Friday by videoconference links
- The hub venue varies between all four unit sites according to a published timetable
- Any case of urological cancer can be discussed at the request of any member of the specialist MDT
- In principle, any case in which radical or multi-modal treatment should be considered must be presented and discussed.
- All new cases referred by a local MDT must be discussed

3.2 Local Multidisciplinary Team

3.2.1 Cheltenham

- Lead Clinician – Mr Hugh Gilbert
- Meetings are held at 2.00 on every 2nd and 4th Friday of each month in the pathology seminar room
- All new cases of urological cancer must be discussed and those required to be referred to the specialist meeting are identified and recorded
- The meeting is coordinated by Helen Dutton with the help of the CNS and the urological specialist registrar

3.2.2 Gloucester

- Lead Clinician – Mr David Jones
- Local MDT is weekly on Monday 1-2pm
- All new cases of urological neoplasia must be discussed and those required to be referred to the specialist meeting are identified and recorded
- The meeting is coordinated by Barbara Broomfield with the help of the CNS and the urological specialist registrar

3.3.3 Hereford

- Meetings are held 1st & 3rd Tuesday in the post graduate medical centre
- All new cases of urological neoplasia must be discussed and those required to be referred to the specialist meeting are identified and recorded
- The meeting is coordinated by Laura Fuller with the help of the CNS and the urological specialist registrar

3.3.4 Worcester

- Meetings are held weekly on a Tuesday in the MDT room, Alexandra Hospital, Redditch
- All new cases of urological cancer must be discussed and those required to be referred to the specialist meeting are identified and recorded
- The meeting is coordinated by Margaret Watts with the help of the CNS and the urological specialist registrar

4.0 Primary Care Guidelines for Urgent Referral

- All patients with suspected urological cancer should be referred urgently under the 2-week wait guidelines, as follows:
  - ✓ Macroscopic haematuria in adults
  - ✓ Microscopic haematuria in adults over 50 years
  - ✓ Swellings in the body of the testis
  - ✓ Palpable Kidney masses
  - ✓ Solid Kidney masses found on imaging
  - ✓ An elevated age specific PSA in men with a ten year life expectancy

- ✓ A high PSA (> 20ng/ml) in men with a clinically malignant prostate or bone pain

2 Week Wait Referrals by fax:

Gloucestershire	**08454 225994**
Herefordshire	**01432 372905**
Worcestershire	**01562 754312**

- Consultants screen all other referrals and should prioritise suspected urological cancer cases as urgent.

5.0 Prostate Cancer

5. 1 Referral to the specialist MDT (sMDT)

- Cases of prostate cancer which must be discussed at the sMDT, prior to treatment, include those in whom radical therapy should be considered. Therefore, all cases with apparently organ confined disease after appropriate staging (see section 5.3) including those in whom active surveillance may be the most appropriate management, must be presented.

- Anyone with prostate cancer who may be eligible for a clinical trial should be discussed.

5. 2 Referral to the Supra-network Teams

- No provision for supra-network MDT discussion is required.

5.3 Diagnosis and assessment

- Patients with suspected prostate cancer should be referred by their general practitioners using the two-week rule protocol. Consultants screening other referrals should prioritise suspected prostate cancer cases as urgent.

- Patients should be seen wherever possible in a dedicated Prostate Assessment Clinic. It is inappropriate to refer asymptomatic patients for assessment whose life expectancy, either because of age or co-morbidity, is less than 10 years.

- All patients with suspected prostate cancer should, after clinical assessment, have the opportunity to discuss the rationale for the early diagnosis of the disease with either a specialist urologist or a cancer nurse specialist.

- Recommended investigations include: digital rectal examination; serum PSA; transrectal ultrasound or digitally guided biopsy, MRI scan and bone scan. In men with lower urinary tract symptoms and with shorter-life expectancy it may be more appropriate to investigate the LUTS before considering further investigation of any suspected prostate cancer.

- Digital rectal examination is required in all patients

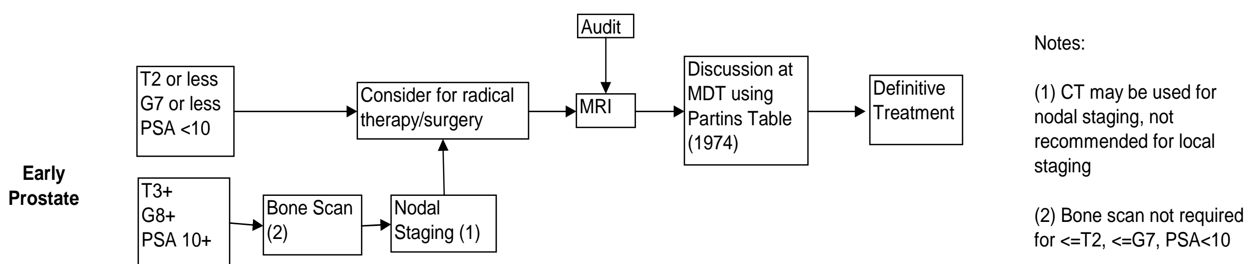
- Serum PSA measurement is indicated in all symptomatic men and in asymptomatic men with a life-expectancy of more than 10 years.

- Transrectal ultrasound scanning and biopsy is indicated in appropriately counselled men with an abnormal digital examination or an elevated age-specific PSA level. As an alternative digitally guided biopsy may be used in men with clinically advanced disease: a locally advanced tumour; a very high PSA; or evidence of metastatic disease.

- MRI scanning of the prostate may be appropriate in men, with histologically confirmed disease, being considered for radical therapy. Laparoscopic lymph node sampling may be considered in men with MRI abnormalities or a significant risk of nodal disease as estimated by Partin's tables.

- Bone scans are not required in men with proven prostate cancer when DRE suggests a T2 lesion or less, the presenting PSA is less than 10 and the Gleason score 7 or less.

The following flow diagram illustrates the agreed diagnostic pathway for early prostate cancer:



5.4 Management

Whenever possible, treatment of prostate cancer should be provided within an approved clinical trial. Management decisions should reflect the co-morbidity and life expectancy of the patient with prostate cancer.

Primary tumour

T1/2 Appropriate treatments include active surveillance, radical prostatectomy, external beam radiotherapy (with or without neo-adjuvant and adjuvant hormone therapy) and brachytherapy.

Radical prostatectomy should not be performed at any cancer unit that can not demonstrate the appropriate training, experience and facilities. In practice, the Gloucestershire Royal Hospital and Alexandra Hospital Resectional Units

External beam radiotherapy should only be provided by the named specialist team at the Oncology Centre, Cheltenham General Hospital.

Brachytherapy should only be provided by the named specialist team at the Oncology Centre, Cheltenham General Hospital.

T3 Appropriate treatments include radiotherapy, hormone therapy or a combination of both. Active surveillance can be considered for this group. In suitable cases patients in this group may be considered for radical surgery.

T4 Systemic hormone treatment, with or without radiotherapy, is likely to be necessary in this group. Watchful waiting is a treatment option for asymptomatic patients.

Lymph nodes

- The presence of lymph node metastases (suggested by staging imaging, nomograms or confirmed by LN sampling) means that local treatment is unlikely to be successful and the patient should be offered systemic hormone therapy. Whilst, in most patients, definitive lymph node staging is inappropriate, in some it may be required.

Metastases

- The patient should be considered for hormone therapy.

Hormone therapy

- First line hormone therapy should consist either of the continuous or intermittent administration of an LHRH analogue or by sub-capsular orchidectomy.

- Failure of this therapy can be managed by the addition of an anti-androgen.

- Further management is best delivered within the confines of a clinical trial or should be consistent with the BAUS Guidelines for Management of Metastatic Prostate Cancer.

5.4.1 Follow up

- All patients that have undergone radical prostatectomy must have their post-operative histology discussed at the sMDT; to consider the need for adjuvant treatment and to arrange appropriate follow-up.

- All patients will be followed up by local MDTs in conjunction with the specialist team with a maximum frequency of six monthly according to clinical need (appendices).

    - Following radical prostatectomy patients will normally be followed up by their operating surgeon's team.
    - Following external beam radiotherapy patients will be jointly followed up by the clinical oncologist's team alternating appointments with the referring urologist's team.

- Following brachytherapy, patients will be followed up by Dr JR Owen, Clinical Oncologist.
- In some cases, usually for reasons of geography, follow up may be carried out by another member of the specialist MDT. The follow up schedule should be agreed (see appendices for guidelines) and all correspondence must be copied to the consultant in charge of the original treatment.

- In stable advanced disease primary care review may be appropriate (appendix).

5.5 Specialist teams

The investigation, treatment and continuing management of men with prostate cancer is the responsibility of the local unit until referral is made to a specialist team.
Patients with organ confined prostate cancer will be counselled and supported by the local team for them to select their primary treatment option from curative surgery, curative radiotherapy or other options. Further information and support will be provided by the specialist team.

Radical prostatectomy

Site	Lead
Gloucestershire Royal Hospital	Mr G Sole/Mr A Okeke
Alexandra Hospital, Redditch	Mr A Makar

Radical external beam radiotherapy

Site	Lead
Gloucestershire Oncology Centre	Dr JR Owen
Gloucestershire Oncology Centre	Dr PJ Jenkins
Gloucestershire Oncology Centre	Dr A Cook
Gloucestershire Oncology Centre	Dr J Bowen

Brachytherapy

Site	Lead
Cheltenham General Hospital	Mr H Gilbert

6.0 Bladder

6. 1 Referral to the specialist MDT (sMDT)

- Any patient who after initial tumour resection is shown to have poorly differentiated (G3) superficial TCC or anyone with muscle invasive disease (T2+) should be discussed after appropriate staging has been completed and before definitive treatment is instigated.
- Bladder tumours of any histological type other than TCC should be discussed after appropriate staging.
- Anyone with bladder cancer who may be eligible for entry into a clinical trial should be discussed.

6. 2 Referral to the Supra-network Teams

- No provision for supra-network MDT discussion is required.

6.3 Diagnosis and assessment

- Patients with suspected urothelial cancer should be referred by their general practitioners using the two-week rule protocol. Consultants screening other referrals should prioritise suspected urothelial cancer cases as urgent.

- Patients should be seen wherever possible in a dedicated Haematuria Assessment Clinic. A single appointment clinic should allow an explanation of the likely diagnosis and a definitive plan of management.

- All patients with suspected urothelial cancer should, after clinical assessment, have the opportunity to discuss their diagnosis with either a specialist urologist or a cancer nurse specialist.

- Recommended investigations include: urine cytology; urine culture; intravenous urography; urinary tract ultrasonography; cystoscopy under local or general anaesthetic; transurethral resectional biopsy with bimanual examination under general anaesthetic; and magnetic resonance imaging or computerised tomography.

    - Urine cytology can aid the diagnosis of urological cancers and should be considered as part of the investigation of patients with haematuria. Urine microscopy and culture should be requested on any patient with suspected urothelial cancer.

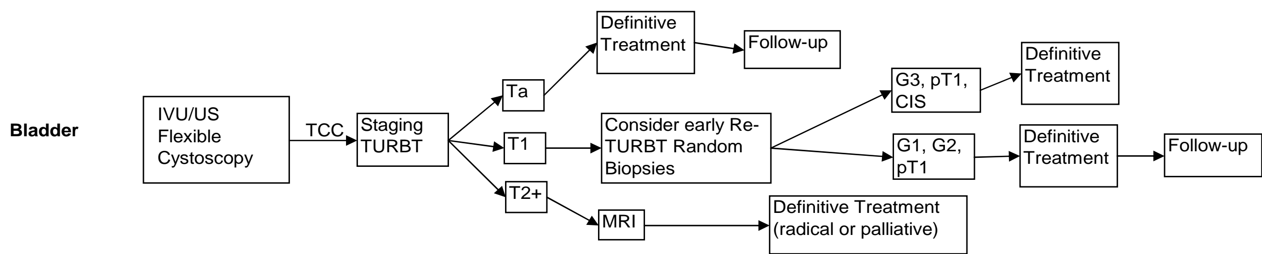
    - Upper tract imaging, either kidney ultrasonography or intravenous urography, is required in any case of haematuria. If either shows no abnormality in a case of macroscopic haematuria then the other should be considered. In microscopic haematuria a single imaging modality is usually adequate.

    - Cystoscopy is indicated in all cases of haematuria or suspected urothelial malignancy. Flexible cystoscopy under local anaesthesia should be considered initially unless the upper tract imaging indicates an abnormality that may require endoscopic treatment.

    - Retrograde pyelography or ureteroscopy should be considered to elucidate the nature of any upper tract abnormality consistent with urothelial cancer.

    - A bladder lesion identified at flexible cystoscopy or by upper tract imaging should be examined under general or spinal anaesthesia and a resectional biopsy should be performed. The findings of a bimanual examination after resection, as well as their site, size and number should be recorded.

    - CT scanning of the pelvis and abdomen should be used to assess the stage of any muscle-invasive tumour and the possibility of nodal spread



6.4 Management

- Whenever possible, treatment of urothelial cancer should be provided by entry into an approved clinical trial. Management decisions should reflect the co-morbidity and life expectancy of the patient with bladder cancer.

- Patients with high-risk superficial bladder cancer are managed by the local MDT following discussion at the sMDT.

Primary tumour

Tis Treatment with immunotherapy (BCG) or intravesical chemotherapy is effective and is appropriate for use at each cancer unit. If treatment fails early cystectomy should be considered. Maintenance BCG treatment should be considered.

Ta Transurethral resection of the tumour, or biopsy and cystodiathermy, are appropriate. Adjuvant intravesical therapy should be considered after the initial resection. A policy of regular cystoscopic surveillance at 3-12 monthly intervals is recommended, continuing for up to 5 years after recurrences cease to appear. After freedom from recurrence for three years, outpatient surveillance with cytology and/or ultrasound may be recommended. In cases of persistent recurrence, intravesical treatment with either immunotherapy or chemotherapy should be recommended.

T1 These tumours are known to be likely to progress; however, there is no agreement about optimal treatment. Early re-biopsy of the tumour site should be considered. Confirmation of well to moderately differentiated (G1 and 2) tumours should be managed in the same way as Ta tumours although the greater propensity for progression considered when arranging review examinations. **If muscle-invasion is excluded, in the case of poorly differentiated (G3) tumours, then immunotherapy, intravesical chemotherapy, cystectomy or radiotherapy should be considered at the sMDT.**

T2/3 Transurethral resection of the exophytic part of the tumour, bimanual examination under general or spinal anaesthetic and histological proof of muscle invasion are essential to establish the clinical stage. Primary radical treatment, when appropriate, may be with either radiotherapy or cystectomy. Neo-adjuvant chemotherapy should be considered in all cases at the sMDT.

For preservation of voiding function the option of orthotropic bladder reconstruction as well as urinary diversion should be available for patients choosing cystectomy.

Patients may be counselled for any treatment option by local teams in the network in order for them to select their primary treatment option. Patients should have the opportunity to discuss their treatment options with the named specialist teams including cancer nurse specialists. The potential benefits of neo-adjuvant chemotherapy should be explained to all patients.

Radical cystectomy with any form of urinary diversion should be performed only at either of the Networks Resectional Centres at Cheltenham General Hospital or the Alexandra Hospital, Redditch.

External beam radiotherapy and chemotherapy should only be provided by the named specialist teams.

T4a As for T2/3

T4b The management of these tumours should normally be restricted to palliative support but may include attenuated radiotherapy or chemotherapy.

Lymph nodes

- Lymphadenectomy or lymph node sampling should be combined with cystectomy. This provides accurate histological staging and may be of therapeutic benefit. If lymph nodes are involved, adjuvant chemotherapy should be considered.

Metastases

- Palliative treatment with the possibility of including chemotherapy may be considered.

Urethra

- Early lesions may be treated by local removal or topical chemotherapy, but for more extensive involvement urethrectomy is recommended. After cystectomy, urethral surveillance should be carried out at 6 monthly intervals either by cytological examination of urethral washings or by flexible urethroscopy.

Rare tumours

- Squamous cell carcinoma and adenocarcinoma of the bladder should be considered for early cystectomy, although radiotherapy or systemic chemotherapy may be considered in patients felt to be unsuitable for radical surgery.

6.4.1 Follow up

- All patients that have undergone radical cystectomy must have their post-operative histology discussed at the sMDT; to consider the need for adjuvant treatment and to arrange appropriate follow-up.

- All patients will be followed up by local MDTs (usually the original referring consultant's team) in conjunction with the specialist team (appendix).

- The follow up schedule for each patient should be determined by discussion at the appropriate sMDT following treatment.

6.5 Specialist teams

The investigation, treatment and continuing management of patients with bladder cancer are the responsibility of the local unit until referral is made to a specialist team. This includes counselling of patients for them to decide their treatment options.

Cystectomy with ileal conduit

Site	Lead
Cheltenham General Hospital	Mr R B Kinder/Mr H Gilbert
Worcestershire Royal Hospital	Mr A Makar

Cystectomy with reconstruction

Site	Lead
Cheltenham General Hospital	Mr R B Kinder
Worcestershire Royal Hospital	Mr A Makar

Radical external beam radiotherapy/Chemotherapy

Site	Lead
Gloucestershire Oncology Centre	Dr JR Owen
Gloucestershire Oncology Centre	Dr PJ Jenkins
Gloucestershire Oncology Centre	Dr A Cook
Gloucestershire Oncology Centre	Dr J Bowen

7.0 Testicular

7. 1 Referral to the specialist MDT (sMDT)

- All cases of testicular tumours should be discussed, by presentation of the notes, imaging and histology, at the specialist MDT, but this should not delay the responsible clinician from passing the same details to the 3CCN representative (Dr Roger Owen) of the supra-network MDT. This should allow early discussion of all cases at the supra-network MDT.

- Management plans after diagnoses are the responsibility of the Avon Somerset & Wiltshire supra-network MDT in discussion with the 3CCN representative. See relevant guidelines

7. 2 Referral to the Supra-network Teams

- The 3CCN is part of the Avon, Somerset & Wiltshire supra-network MDT for Testicular Cancers.

- The lead clinician for testicular cancer in the 3CCN coordinates discussion of cases at the supra-network MDT. All cases must be referred to the lead clinician. After the supra-network MDT discussion and treatment decision, in line with the Calman-Hine principles of cancer management, much of the treatment would normally be provided at the 3CCN centre, according to shared care arrangements.

- The surgical management of relapsed disease (retroperitoneal lymph node dissection) will continue to be provided by Mr T Whittlestone at Bristol Royal Infirmary. Lung resections are carried out at the Brompton Hospital in London.

7.3 Diagnosis and assessment

- Patients with suspected testicular cancer should be referred by their general practitioners using the two-week rule protocol. Consultants screening other referrals should prioritise suspected testicular cancer cases as urgent. Patients designated as such should whenever possible be seen at the next available outpatient clinic.

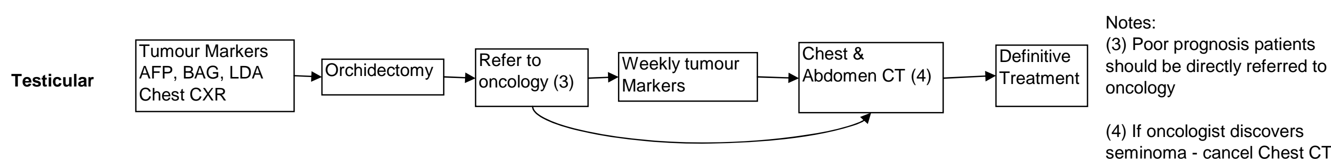
- All patients with suspected testicular cancer should, after clinical assessment, have the opportunity to discuss the rationale for the rapid diagnosis and management of the disease with either a specialist urologist or a cancer nurse specialist.

- Recommended investigations prior to histological diagnosis include: serum tumour markers (α-F-P, LDH and βHCG), chest x-ray, and scrotal ultrasound scan. After inguinal orchidectomy has provided histological confirmation of the diagnosis, recommended investigations include; serum tumour markers (α-F-P, LDH and βHCG) measured weekly, and, for seminoma, an abdominal CT scan, or, for teratoma, a chest and abdomen CT scan.

- Immediately after inguinal orchidectomy, the urologist should arrange for weekly serum tumour markers to be measured, request an abdominal and chest CT scan and refer the patient to the lead clinician for testicular tumours.

  In cases of fulminant advanced disease the patient should be referred directly to the lead clinician or a member of the supra-network MDT. Orchidectomy is not essential in patients with very high tumour markers and large volume metastases if they delay chemotherapy.

  Biopsy of the contra-lateral testis should be considered with a history of maldescent, atrophy or infertility.



7.4 Management

- Whenever possible, treatment of testicular cancer should be provided by entry into an approved clinical trial. Management decisions should reflect the co-morbidity and life expectancy of the patient with testicular cancer. Treatment following

orchidectomy should be provided by and monitored by the 3CCN clinical lead for testicular cancer with the co-operation of the supra-network MDT. The ASWCS guidelines contain parameters for good, intermediate and poor prognosis patients *(ASWCS Guidelines for the Management of Male patients with Germ Cell Tumours 2004, page 4).*

Seminoma

Stage I — Orchidectomy and radiotherapy to para-aortic or para-aortic and iliac lymph nodes. A single fraction of chemotherapy (carboplatin) may be considered in some cases.

Stage II-IV — Chemotherapy should be given according to nationally agreed trials at the cancer centre.

Non-seminomatous germ cell tumour (teratoma)

Stage I — Orchidectomy and surveillance is indicated for low-risk disease. Orchidectomy and chemotherapy is indicated for high-risk Stage I disease.

Stage II-IV — Chemotherapy should be given according to nationally agreed trials at the cancer centre. Residual masses of non-seminomatous germ cell tumours should be surgically excised at the supra-network centre (vide supra).

- The 3CCN and ASWCS have agreed that all patients with seminoma requiring radiotherapy or carboplatin chemotherapy can receive this within the 3CCN by the named lead (below). The named lead will also treat locally all good, and on a case by case basis, intermediate and poor prognosis patients with chemotherapy. The ASWCS guidelines contain parameters for good, intermediate and poor prognosis patients *(ASWCS Guidelines for the Management of Male patients with Germ Cell Tumours 2004, page 4).*

7.4.1 Follow up

- Surveillance will be carried out by the named lead for all patients residing within the 3CCN and will be followed up by local MDTs in conjunction with the specialist team with a maximum frequency of six monthly during the first two years after treatment. The follow up schedule for each patient should be determined by discussion at the appropriate MDT following treatment.

7.5 Specialist teams

- The investigation, treatment and continuing management of men with testicular cancer are the responsibility of the local unit until referral is made to a specialist or supra-network specialist team.

- The 3CCN have an agreement whereby all cases of testicular cancer are referred by fax, containing a summary sheet and patient history, to the ASWCS supranetwork testicular team following their diagnosis.

- The 3CCN has an agreement whereby referrals of orchidectomy specimen histology and histology of post-chemotherapy residual masses are sent to the named pathologist core member of the ASWCS supranetwork team for review and any imaging of post chemotherapy residual masses to the named radiologist core member of the ASWCS supranetwork team for review.

Testicular cancer specialist team

Site	**Lead**
Gloucestershire Oncology Centre	Dr JR Owen

8.0 Penile

8. 1 Referral to the specialist MDT (sMDT)

All cases of penile tumours should be discussed, by presentation of the notes, imaging and histology, at the sMDT, but this should not delay the responsible clinician from passing details of any case to the 3CCN representative (Mr David Jones) of the supra-network MDT. This should allow early discussion of all cases at the supra-specialist MDT.

8.2 Referral to the Supra-network Teams

- The 3CCN sMDT refers to a supra-network MDT comprising the Avon, Somerset & Wiltshire Cancer Networks and coordinated by the lead clinician for penile cancer of the 3 Counties Cancer Network, Mr David Jones.
- The 3CCN Lead Clinician for penile cancers will coordinate discussion of each case at the supra-network MDT. All cases should be referred directly or at the sMDT to the Lead Clinician.
- All cases of penile cancer are discussed at the supra-network MDT at which the type and location of treatment is decided. In line with the Calman-Hine principles of cancer management this should be within the 3CCN whenever appropriate.

8.3 Diagnosis and assessment

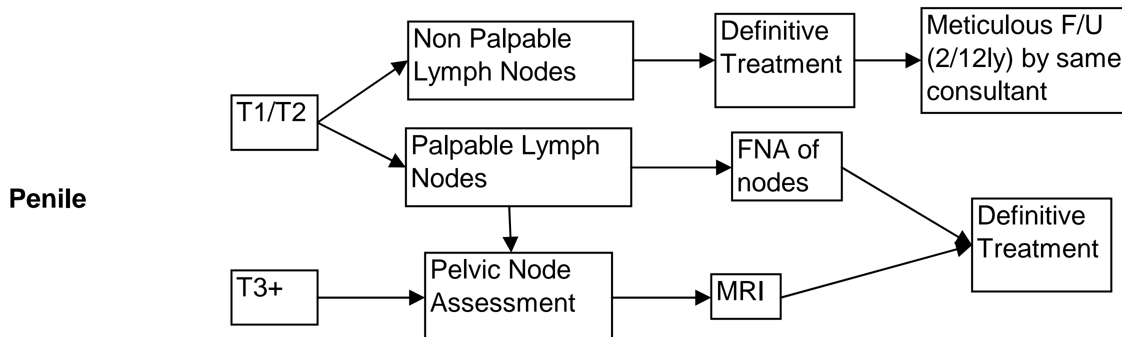
- Patients with suspected penile cancer should be referred by their general practitioners using the two-week rule protocol. Consultants screening other referrals should prioritise suspected penile cancer cases as urgent. All patients diagnosed with penile cancer should have their case notes presented to, and case discussed by, the sMDT which is acting as the relevant supranetwork team, at their next weekly meeting after the patient's diagnosis.

- All patients with suspected penile cancer should, after clinical assessment, have the opportunity to discuss the diagnosis and likely management of their disease with either a specialist urologist or a cancer nurse specialist.

- Recommended investigations include: circumcision and biopsy of the suspect lesion; chest x-ray; and MRI scan of the abdomen and pelvis.

- Circumcision and biopsy is the initial treatment of choice and establishes the diagnosis. The notes, imaging and histology should be reviewed at the next specialist MDT and advice should be sought from the supra-network MDT.

- Magnetic resonance imaging is the method of choice for the assessment of lymph node metastases.



8.4 Management

- Management decisions should reflect the co-morbidity and life expectancy of the patient with penile cancer.

Primary tumour

Stage I and II	If lymph nodes are not palpable, definitive treatment with either partial amputation or radiotherapy can proceed after MDT discussion. In younger patients, organ-sparing surgery and early reconstruction should be considered. If lymph nodes are palpable, fine needle aspiration cytology should proceed immediately.
Stage III-IV	Total amputation of the penis or radiotherapy are the definitive treatment options. Chemotherapy may be considered. Reconstruction should be considered.

Lymph nodes

- Careful bimonthly observation of inguinal lymph nodes, by a consultant urologist or oncologist, is needed before and after definitive treatment of the primary tumour.

- Men with positive, and operable, inguinal lymph nodes should undergo ipsilateral block dissection.

8.4.1 Follow up

- All patients will be followed up by local MDTs in conjunction with the supranetwork team with a maximum frequency of two monthly visits during the first two years after treatment. The follow up schedule for each patient should be determined by discussion at the supranetwork MDT following treatment.

8.5 Specialist teams

Penile cancer specialist team

Site	Lead
Gloucestershire Royal Hospital	Mr DJ Jones
Worcestershire	Mr A Makar
Radiotherapy	Dr P Jenkins/Dr JR Owen
Chemotherapy	Dr P Jenkins/Dr JR Owen

Penile cancer supra-network multidisciplinary team

Site	Lead
Bristol	David Dickerson
Birmingham	Mike Foster

9.0 Kidney - including upper tract tumours

9. 1 Referral to the specialist MDT (sMDT)

- Radical (open or laparoscopic) nephrectomy is the treatment of choice for uncomplicated tumours and in such cases (T2, N0, M0) this should proceed after discussion at the local MDT. More complex cases should be referred for discussion at the sMDT: tumours in a solitary kidney; bilateral tumours; where significant renal impairment exists; suspected T3b tumours as well as those presenting with LN or metastatic disease. Patients with tumours suitable for or requiring either a partial or laparoscopic nephrectomy should also be discussed at the sMDT.

9. 2 Referral to the Supra-network Teams

- Supra-network discussion is required for kidney tumours with (inferior vena cava) involvement where the tumour thrombus extends above the hepatic veins.
- Such cases should be discussed at the specialist MDT and when appropriate be referred to Mr Phil Matthews at Heath Hospital, Cardiff or Mr Mike Wallace in Birmingham for further management.

9.3 Diagnosis and assessment

- Patients with suspected kidney cancer should be referred by their general practitioners using the two-week rule protocol. Consultants screening other referrals should prioritise suspected Kidney cancer cases as urgent.

- Patients should be seen wherever possible in a dedicated rapid access haematuria clinic.

- All patients with suspected kidney cancer should, after clinical assessment, have the opportunity to discuss the rationale for the early diagnosis of the disease with either a specialist urologist or a cancer nurse specialist.

- Recommended investigations include: an assessment of renal function; urine cytology; renal ultrasound scan to include an assessment of the IVC; intravenous urography; retrograde pyelography; chest x-ray; abdominal and chest CT scan. Biopsy may be indicated.

    - Urine cytology can aid the diagnosis of urothelial cancers and should be considered as part of the investigation of patients with haematuria.

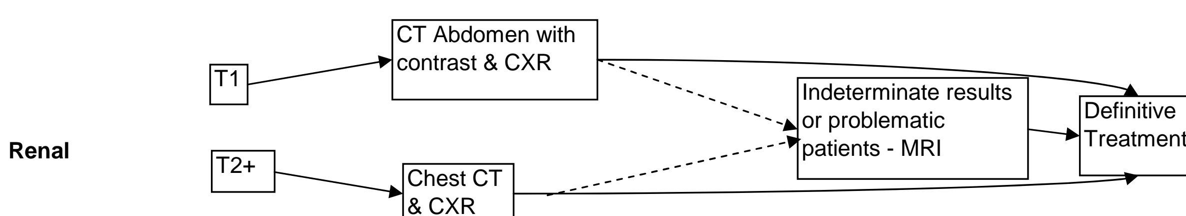
    - Urine microscopy and culture should be requested on any patient with suspected urothelial cancer.

    - Upper tract imaging, either renal ultrasonography or intravenous urography, is required in any case of haematuria. If either shows no abnormality in a case of macroscopic haematuria then the other should be considered. In microscopic haematuria a single imaging modality is usually adequate.

    - Retrograde pyelography or ureteroscopy should be considered to elucidate the nature of any upper tract abnormality consistent with urothelial cancer.

    - A chest x-ray is considered mandatory in the investigation of a kidney mass. In higher risk cases (T2+) a chest CT scan should be requested. Initial assessment of the IVC should be with ultrasound.

    - After the above investigations, in indeterminate cases MRI scanning, including MRI angiography or biopsy should be considered.



9.4 Management

Whenever possible, treatment of renal cancer should be provided by entry into an approved clinical trial. Management decisions should reflect the co-morbidity and life expectancy of the patient with kidney cancer.

Renal cell carcinoma and variants

Primary tumour

Radical nephrectomy is the treatment of choice for uncomplicated tumours, although partial nephrectomy should be considered for smaller tumours, and these treatments should be provided at each cancer unit. Laparoscopic nephrectomy can be considered for T1 and T2 tumours thought to be unsuitable for open partial nephrectomy,

The following cases should be referred to the specialist MDT for treatment planning:

- tumours suitable for partial or laparoscopic nephrectomy
- tumour in a solitary kidney
- bilateral tumours
- tumours in the presence of significant renal impairment
- tumour extending into the IVC and above the hepatic veins
- patients with metastatic disease
- tumours suitable for RFA

It may be appropriate for treatment, especially when a co-operative approach with nephrologists or cardiac surgeon is not needed, to proceed at the cancer unit after agreement at the specialist MDT.

Kidney tumours with involvement of the IVC above the hepatic veins should be referred to the supra-network MDT for treatment.

Adjuvant treatment should be considered at the sMDT usually within the context of a clinical trial

Lymph nodes

- Lymph nodes should be sampled and any palpably enlarged should be cleared for staging purposes.

Metastases

- The use of any agent for the control of metastatic disease should be considered in the context of a clinical trial. The surgical management of metastases should be discussed at the sMDT and referral made to the most appropriate national expert.

Urothelial tumours of the upper tracts

- Nephroureterectomy, either by conventional or laparoscopic approach, is the treatment of choice. Selected cases with well-differentiated histology, in which renal function is limited, may be appropriate for organ conserving treatment. Such cases should be discussed at the specialist MDT.

9.4.1 Follow up

- All patients will be followed up by local MDTs in conjunction with the specialist team with a maximum frequency of six monthly during the first two years after treatment

(appendix). The follow up schedule for each patient should be determined by discussion at the appropriate MDT following treatment.

9.5 Specialist teams

- The investigation, treatment and continuing management of patients with kidney cancer are the responsibility of the local unit until referral is made to a specialist team.

Kidney cancer specialist teams

Site	Lead
Cheltenham General Hospital	Mr R B Kinder
Gloucestershire Royal Hospital	Mr A Okeke
Hereford County Hospital	Mr A Jha
Worcestershire Royal Hospital	Mr A Makar

Kidney cancer laparoscopic team

Site	Lead
Gloucestershire Royal Hospital	Mr A Okeke
Worcestershire Royal Hospital	Mr T Chen

Chemotherapy/Immunotherapy

Site	Lead
Gloucestershire Oncology Centre	Dr D Farrugia

Radio Frequency Ablation

Site	Lead
Gloucestershire Royal Hospital	Dr P Birch

10.0 Clinical Trials

Entry into clinical trials is encouraged for all patients. Up-to-date list should be reviewed and discussed every two months at the sMDT.

11.0 Data Collection

- The BAUS minimum data set is the agreed MDS for the NSSG.
- Pathologists routinely collect the Royal College of Pathologists minimum dataset.

12.0 Audit

Local - Each unit should initiate and report on one audit project each year.

Network - An audit project should be under commission and report each year.

Regional - All units should co-operate with any regional audits.

National - All units should participate in audit projects initiated and conducted by the Section of Oncology, British Association of Urologists

13.0 Patient Information

A continuing process of Patient Information is established for all cancer sites. Each document should be reviewed on an annual basis by the Lead Clinician for each cancer site. Generic leaflets on chemotherapy and radiotherapy have been developed for use by all oncology patients.

The Urological Cancer Nurse Specialists are involved with the patients following diagnosis.

13.1 Prostate

- **Departments of Urology in all hospitals:**

  - Cheltenham General Hospital
  - Gloucestershire Royal Hospital
  - Hereford County Hospital
  - Worcestershire Royal Hospital

- **Information for Patients Undergoing Radiotherapy to The Prostate**

  Gloucestershire Oncology Information Centre, Cheltenham General Hospital

- **The Cotswold Prostate Cancer Support Group**

  Local support group for men with prostate cancer, their wives, partners and carers. Supported by the local Specialist MDT members.

  Meets monthly – 2nd Tuesday of month – 7.00pm

  75-81 Eastgate Street
  Gloucester
  GL1 1PN
  Telephone: 0770477391

- **The Prostate Cancer Charity**

  3 Angel Walk
  London W6 9HX

  Telephone Number: 020 8222 7622
  Website: www. prostate-cancer.org.uk

- **Cancerbackup**

  (British Association of Cancer United Patients)
  3 Bath Place
  Rivington Street
  London
  EC2A 3DR

  Cancerbackup Support Service: Phone 020 7739 2280 (standard Rate)

  Or Freephone: 0808 800 1234

  Lines staffed by cancer specialist nurses, Mon - Fri, 9am - 8pm.

  Cancerbackup Local Office: Tel: 024 7696 6052
  Cancerbackup Information Centre,
  Ground Floor,
  University Hospital,
  Clifford Bridge Road,
  Walsgrave,
  Coventry CV2 2DX

  Website: http://www.cancerbackup.org.uk
  www.be.macmillan.org.uk

- **Cancer Help UK**

  Cancer Information Department
  Cancer Research UK
  PO Box 123
  Lincoln Inn Fields
  London WC2A 3PX

  Cancer Information Nurses 020 7061 8355
  Freephone 0808 800 4040 9am-5pm Monday to Friday

  Website: http://www.cancerhelp.org.uk

13.2 Bladder

- **Departments of Urology in all hospitals:**

  - Cheltenham General Hospital
  - Gloucestershire Royal Hospital
  - Hereford County Hospital
  - Worcestershire Royal Hospital

- **Information for Patients with Bladder Cancer**
  Gloucestershire Oncology Information Centre, Cheltenham General Hospital

- **Cancerbackup**

  (British Association of Cancer United Patients)
  3 Bath Place
  Rivington Street
  London
  EC2A 3DR

  Cancerbackup Support Service: Phone 020 7739 2280 (standard Rate)

  Or Freephone: 0808 800 1234

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  Cancer Information Nurses 020 7061 8355
  Freephone 0808 800 4040 9am-5pm Monday to Friday

  Website: http://www.cancerhelp.org.uk

13.3 Testicular

- **Departments of Urology in all hospitals:**

  - Cheltenham General Hospital
  - Gloucestershire Royal Hospital
  - Hereford County Hospital
  - Worcestershire Royal Hospital

- **Information for Patients with Testicular Cancer**
  Gloucestershire Oncology Information Centre, Cheltenham General Hospital

- **Cancerbackup**

  (British Association of Cancer United Patients)
  3 Bath Place
  Rivington Street
  London
  EC2A 3DR
  Cancerbackup Support Service: Phone 020 7739 2280 (standard Rate)

  Or Freephone: 0808 800 1234

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  Freephone 0808 800 4040 9am-5pm Monday to Friday

  Website: http://www.cancerhelp.org.uk

13.4 Penile

- **Departments of Urology in all hospitals:**

  - Cheltenham General Hospital
  - Gloucestershire Royal Hospital
  - Hereford County Hospital
  - Worcestershire Royal Hospital

- **Information for Patients with Bladder Cancer**
  Gloucestershire Oncology Information Centre, Cheltenham General Hospital

- **Cancerbackup**

  (British Association of Cancer United Patients)
  3 Bath Place
  Rivington Street
  London
  EC2A 3DR
  Cancerbackup Support Service: Phone 020 7739 2280 (standard Rate)

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  Website: http://www.cancerhelp.org.uk

13.5 Kidney

- **Departments of Urology in all hospitals:**

  - Cheltenham General Hospital
  - Gloucestershire Royal Hospital
  - Hereford County Hospital
  - Worcestershire Royal Hospital

- **Information for Patients with Bladder Cancer**
  Gloucestershire Oncology Information Centre, Cheltenham General Hospital

- **Cancerbackup**

  (British Association of Cancer United Patients)
  3 Bath Place
  Rivington Street
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  EC2A 3DR

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  Walsgrave,
  Coventry CV2 2DX

  Website: http://www.cancerbackup.org.uk
  www.be.macmillan.org.uk

- **Kidney Cancer UK**

  Website: www.kcuk.org

- **Cancer Help UK**
  PO Box 123
  Lincoln Inn Fields
  London WC2A 3PX

  Cancer Information Department
  Cancer Research UK

  Cancer Information Nurses 020 7061 8355
  Freephone 0808 800 4040 9am-5pm Monday to Friday

  Website: http://www.cancerhelp.org.uk

Signed:

Graham Sole	Jan Stubbings	
Chair of NSSG	Chair of Network Board	Chair of ASW NSSG
Date: 05.05.09	Date: 06.05.09	Date:

Appendix

MDT Meetings

2009

Month	Location
January	**GRH**
February	**GRH**
March	**GRH**
April	**CGH with Video conferencing**
May	**CGH with Video conferencing**
June	**CGH with Video conferencing**
July	**CGH with Video conferencing**
August	**CGH with Video conferencing**
September	**CGH with Video conferencing**
October	**GRH with Video conferencing**
November	**GRH with Video conferencing**
December	**GRH with Video conferencing**

2010

January	**GRH with Video conferencing**
February	**GRH with Video conferencing**
March	**GRH with Video conferencing**
April	**CGH with Video conferencing**
May	**CGH with Video conferencing**
June	**CGH with Video conferencing**
July	**CGH with Video conferencing**
August	**CGH with Video conferencing**
September	**CGH with Video conferencing**
October	**GRH with Video conferencing**
November	**GRH with Video conferencing**
December	**GRH with Video conferencing**

Appendix 1
3 COUNTIES CANCER NETWORK

Urology NSSG Membership

Member	Job Title	Location
Anita Ashton	Senior Clinical Trials Coordinator	Hereford County Hospital
Jackie Askew	Clinical Nurse Specialist	Redditch Hospital
Sam Banerjee	Consultant Pathologist	Hereford County Hospital
Jo Bowen	Consultant Clinical Oncologist	Gloucestershire Oncology Centre
Melanie Burgoyne	Patient and Public Involvement Lead	3CCN
Carole Caldwell	Consultant Histopathologist	Hereford County Hospital
Terry Chen	Consultant Urologist	Worcestershire Royal Hospital
Audrey Cook	Consultant Clinical Oncologist	Gloucestershire Oncology Centre
Alan Donaldson	Consultant Clinical Geneticist	Herefordshire St Michael's Hospital
Zoe Eastman	Uro-oncology Clinical Nurse Specialist	Cheltenham General Hospital
John Eaton	Consultant Urologist	Redditch Hospital
David Farrugia	Consultant Medical Oncologist	Gloucestershire Oncology Centre
Phillip Garwood	Consultant Radiologist	Hereford County Hospital
Kathy Gibbons	***PA to Network Director (admin support)***	3CCN
Hugh Gilbert	***Deputy NSSG Chair/NSSG Service Improvement Lead/Consultant Urologist/MDT Lead Clinician***	Cheltenham General Hospital
Isabel Harrison	Service Improvement	Gloucestershire Hospitals
Jes Green	Consultant Radiologist	Cheltenham General Hospital
Peter Jenkins	Consultant Clinical Oncologist	Gloucestershire Oncology Centre
Anil Jha	Consultant Urologist	Hereford County Hospital
Terry Jones	Consultant Histopathologist	Worcestershire Royal Hospital
David Jones	Consultant Urologist	Gloucestershire Royal Hospital
Richard Kinder	Consultant Urologist	Cheltenham General Hospital
Robert Lavis	Consultant Radiologist	Gloucestershire Royal Hospital
Linmarie Ludemann	Consultant Pathologist	Gloucestershire Royal Hospital
Adel Makar	***Consultant Urologist/MDT Lead Clinician***	Worcestershire Royal Hospital

Garrett McGann	Consultant Radiologist	Cheltenham General Hospital
Vanessa Milner	Service Improvement	Worcestershire Royal Hospital
Aloy Okeke	Consultant Urologist	Gloucestershire Royal Hospital
Roger Owen	Consultant Oncologist	Gloucestershire Oncology Centre
Biral Patel	Consultant Urological Surgeon	Gloucestershire Royal Hospital
Lucinda Poulton	***Macmillan Lead Uro-Oncology Nurse Specialist/Joint Lead for Patients/Carers Information***	Gloucestershire Countywide
V R	Patient/carer representative	Herefordshire
Gillian Rowe	Consultant Radiologist	Hereford County Hospital
Graham Sole	***Consultant Urologist/Urology NSSG Chair/MDT Lead Clinician***	Hereford County Hospital
Caroline Stratford	***Service Improvement Manager***	Hereford County Hospital
Maxine Taylor	**Research Network Manager**	3CCN
Peter Toner	Consultant Histopathologist	Cheltenham General Hospital
Jayne Tyler	Senior Clinical Trials Coordinator	Worcestershire Royal Hospital
Umesh Udeshi	Consultant Radiologist	Worcestershire Royal Hospital
Anthony Walsh	Service Improvement Lead	3CCN
Cara Watson	***Urology Clinical Nurse Specialist/Joint Lead for Patients/Carers Information***	Hereford County Hospital
Nicky Wilderspin	Palliative Care Specialist	Worcestershire Royal Hospital
Bernd Wittkop	Consultant Radiologist	Worcestershire Royal Hospital
Helen Worth	Clinical Nurse Specialist - Urology	Worcestershire Royal Hospital
Suzanne Wright	General Manager – Cancer Services	Cheltenham General Hospital
Sue Wronski	Snr Clinical Trials Coordinator	Cheltenham General Hospital
Annie Young	Network Director	3CCN

Agreed by:

Mr Graham Sole
Chair of NSSG

Date: 05.05.09

Jan Stubbings
Chair of Network Board

Date: 06.05.09

Appendix 2

Key Worker

The Key Worker is a ‘person who, with the patients’ consent and agreement, takes a key role in co-ordinating the patients care and promoting continuity, ensuring the patient knows who to access for information and advice’ **(NICE, 2004**).

Each patient will have a named key worker, who will be identified at the MDT and recorded appropriately by the core member/s where the initial cancer diagnosis is made and treatment planning decisions discussed. The Key Worker will ideally be a Clinical Nurse Specialist at this point in the pathway. In the absence of a specialist nurse, a senior nurse or other health care professional will be nominated as Key Worker. The patient will be given a Key Worker Card on which the contact details of the key worker are recorded

The Key Worker may change during the cancer journey as the needs of the patient may change, as it is essential that the patient is being guided by the most appropriate health professional,

A change of Key Worker must be documented on the Key Worker Card and all the relevant professionals informed.

A clear handover of Key Worker needs to be negotiated. Changes must be kept to a minimal as the value of continuity cannot be over-stressed (Calman-Hine, 1995).

In the short-term absence of the Key Worker, an appropriately qualified colleague will provide cover. In the event of a lengthy absence of the Key Worker, another Key Worker must be nominated.

Key Workers are nominated at “Key Points” in the patient’s cancer journey

It is the responsibility of the current key worker, in discussion with the patient, to arrange the transfer to the next Key Worker.

APPENDIX 3a

3 Counties Cancer Network

Policy for Collection of Minimum Dataset

The Manual for Cancer Services 2004 states that the NSSG should agree a network-wide policy specifying which type of team should collect which portion of the MDS.

Each Team is responsible for collecting the sections of the dataset that relate to their direct management of the patient. Data collected by the unit MDT is shared with the centre MDT for patients requiring specialist surgery and vice versa. Currently there is no network or national care record therefore the storage of such information is duplicated at both the unit and the centre.

For the purposes of the NSSG it is the responsibility of each Team to report all patients that begin their cancer pathway in their Trust even though the patients may not receive their specialist treatment from that first Team.

The situation is slightly different for Cancer Waiting Times (CWT) data collection. If the patient is an Urgent GP Referral (2 week wait or Urgent Suspected Cancer) then the local Trust that receives that referral and first sees the patient is responsible for collecting and uploading the appropriate CWT dataset. Trusts are also responsible for uploading the treatment section of the CWT dataset.

Many data items are collected routinely through Trust PAS and local cancer information systems. However in most cases these systems are not linked and therefore MDT co-ordinators, cancer information and/or data managers or clinical staff have the task of transposing information or duplicating into ad hoc databases. Where data is not available from other primary sources reference is made to clinical and histology notes.

Signed:

Graham Sole	**Jan Stubbings**
Chair of NSSG	**Chair of Network Board**
Date: 05.05.09	**Date: 06.05.09**

3 Counties Cancer Network
Urology NSSG MDS 1C-110
Indicating Registry and Waiting Times data

	BAUS 2005	Registry	Waiting Times
Demographics			
NHS Number	✓	✓	✓
Hospital Number	✓	✓	
Postcode at date of diagnosis	✓	✓	
Sex	✓	✓	
Date of Birth	✓	✓	
Referrals			
Source of referral	✓		
Priority of referral	✓		✓
Date of decision to refer	✓		✓
Date first seen	✓		✓
Diagnosis			
Date of diagnosis	✓	✓	
Primary site	✓	✓	✓
Laterality	✓	✓	✓
Basis of diagnosis	✓	✓	
Histology	✓	✓	
Grade of differentiation	✓	✓	
Cancer Care Plan			
MDT discussion indicator	✓		✓
MDT team discussion date			✓
Management modality		✓	✓
Staging			
Final pre-treatment T category	✓	✓	
Final pre-treatment N category	✓	✓	
Final pre-treatment M category	✓	✓	
Surgery and other procedures			
Treatment intent	✓	✓	
Decision to treat date (surgery)			✓
Start date (surgery hospital provider spell)	✓	✓	✓
Main surgical procedure	✓	surgery date	
First sub-procedure		✓	
Pathology Details			
Pathological T category	✓	✓	
Pathological N category	✓	✓	
Pathological M category	✓	✓	
Service report identifier	✓		
Chemotherapy and other drugs			
Date of decision to treat with drug therapy			✓

3 Counties Cancer Network
Urology NSSG MDS 1C-110
Indicating Registry and Waiting Times data

	BAUS 2005	Registry	Waiting Times
Drug Therapy Type		✓	
Treatment intent		✓	
Drug treatment start date		✓	✓
Radiotherapy			
Date of decision to treat			✓
Treatment intent		✓	
Anatomical Treatment Site		✓	
Teletherapy start date		✓	✓
Radiotherapy (Brachytherapy)			
Hospital		✓	
Managing consultant		✓	
Date of decision to treat			✓
Treatment intent		✓	
Type of brachytherapy		✓	
Anatomical Treatment Site		✓	
Brachytherapy start date		✓	✓
Death details			
Date of death	✓	✓	

Other BAUS data collected
Consultant Number
Centre number
Delay to diagnosis
Serum tumour markers - PSA at diagnosis/Gleason Scores /S category
Other treatments

Signed

Graham Sole
Chair of Urology NSSG
Date: 05.05.09

Jan Stubbings
Chair of Network Board
Date: 06.05.09

3 Counties Cancer Network
Cancer Network Site Specific Group
Urology Terms of Reference

The Urology Network Site Specific Group (NSSG)

- The Urology NSSG is the Network Board's primary source of clinical opinion on issues relating to cancer for the network
- The Urology NSSG has responsibility, delegated by the board, for co-ordination and consistency across the Network for cancer policy in relation to Urology cancer, practice guidelines, audit, research and service improvement
- The Urology NSSG should consult with relevant 'cross-cutting' network groups on issues involving chemotherapy, cancer imaging, histopathology and laboratory investigation and specialist palliative care; and with the Head of Service on issues involving radiotherapy and with PCTs on issues involving the community skin cancer service.
- The Urology NSSG should have an agreed work programme and produce an annual report for the 3CCN Board.
- The Urology NSSG is the forum for working towards implementing the Improving Outcomes Guidance, where guidance is issued

Guidelines & Data collection

- The Urology NSSG should have agreed referral, clinical (including pathology and imaging) guidelines. These should be reviewed and updated annually
- The Urology NSSG should agree a minimum dataset

Audit

- The Urology NSSG should agree at least one network audit project. The NSSG should review and discuss the results of any network audit project.

Clinical Trials

- The Urology NSSG should agree and compile a list of clinical trials for their cancer site, into which patients managed by the MDTs for that cancer site in the network may be entered.
- A list of trials for Urology NSSG should be agreed by the chair of the group.

Service Improvement & Horizon Scanning

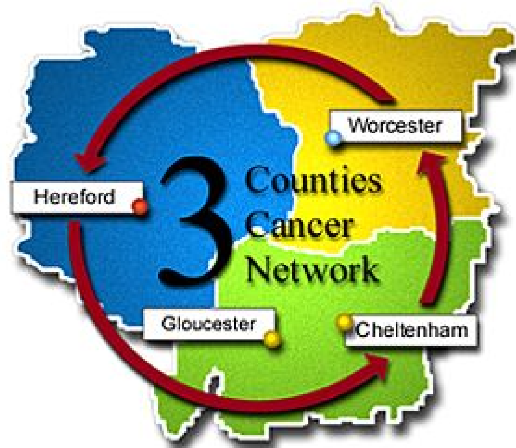
- The Urology NSSG should review, compare and discuss service improvement reports from its constituent MDTs
- The Urology NSSG should advise the Network management team on priority areas for investment

Organisation

- Membership as per attached list
- Meetings will be organised by the 3CCN team giving a minimum of 6 weeks notice and preferably planned out for the forthcoming year
- Meetings will only be cancelled at short notice in exceptional circumstances
- If the planned venue becomes unavailable at short notice attempts will be made to move meetings to a nearby location

Graham Sole, Chair of NSSG	Jan Stubbings, Chair of Network Board
Date: 05.05.09	Date: 06.05.09

Derived from the Manual for Cancer Services 2004
Updated February 2009



3 Counties Cancer Network

Urological Cancer

Operational policy and action plan

April 2009b

AGREED BY:

Graham Sole	**Jan Stubbings**
Chair of NSSG	**Chair of Network Board**
Date: 05.05.09	**Date: 06.05.09**

To be reviewed April 2010

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1. Introduction

The operational policy described in this document is derived from the guidelines agreed by the urology NSSG. The policy reflects the patient's journey through diagnosis and treatment with the support of a constant and reliable key worker.

The document describes the ideal operational policy, which will become established by a process of investment and re-organisation. It also describes current practice and defines the steps and timing of a programme designed to achieve the ideal. The plan is flexible and will need to adapt to future changes. The operational policy will be reviewed annually.

Signed:

Mr Hugh Gilbert
Lead Clinician of Specialist and Local Urology MDTs
Date: 05.05.09

2. Referral

All patients with suspected urological cancer should be referred, by the General Practitioner to whom the patient presents, using the 'two-week wait' referral process.

Any patient, with suspected cancer, referred from any other source should be allocated an urgent (2/52) out-patient appointment by the vetting consultant.

Audit of non 2/52 referrals?

Screening investigations may be arranged before the first appointment, but should not delay the appointment.

Written information regarding the likely process of management and the role of the MDT should be provided to each patient. However, although this is recognised as desirable, costs have prevented this development.

Area	***Issue***	***Action***	***Leads***	***Deadline***
Information Development	*Patient information*	*Further Development of individualised information*	*CNS team Service Improvement Team*	*April 2009 (NSSG)*

Each patient should meet their key worker (usually the CNS) and the core MDT member primarily responsible for their care (or a deputy) at the initial out-patient appointment.

Area	***Issue***	***Action***	***Leads***	***Deadline***
NSSG (April 2009)	*Provision of CNS team*	*Employment of 1 further CNS in Glos*	*Hugh Gilbert*	*Continuing*

Patients with haematuria should have access to a dedicated rapid investigation clinic.

Area	***Issue***	***Action***	***Leads***	***Deadline***
	Haematuria pathway	*Review and rationalise pathway*	*David Jones Lucinda Poulton*	*Away day (May 2009)*

Patients with suspected prostate cancer should have access to a dedicated rapid investigation clinic.

Area	***Issue***	***Action***	***Leads***	***Deadline***
	Prostate cancer pathway	***Review and rationalise pathway***	***Aloy Okeke***	***Away day (May 2009)***

3. The local MDT

Each cancer unit will convene a local MDT.

Local MDTs will meet once a week, details of the MDTs are as follows:

CGH	*To be established with SUIS*
GRH	*Established*
HCH	*Established*
WRH	*Established*

Attendance records will be kept.

The members of the MDT, and their roles, are listed in the 3CCN Urological Cancer Guidelines.

In the absence of a core member of the MDT should usually be provided by the core member of the same specialty from the same cancer unit. In unusual circumstances the specialist registrar from the same unit may provide cover.

The local MDT will discuss every new cancer case presenting to the cancer unit during the preceding week, and agree a plan of investigation.

Any member of the MDT may present any patient with an established diagnosis of urological cancer at the local or specialist MDT for discussion.

The investigation plan should be communicated to the referring general practitioner by the next working day.

Area	***Issue***	***Action***	***Leads***	***Deadline***
NSSG (April 2009)	*Real time recording and communication*	*Infoflex and co-ordinator development*	*H Gilbert*	*November 2009*

The investigation plan should be communicated to the patient by their key worker at the next available out-patient clinic.

Audit

In the event that urgent treatment planning decisions have to be made any, two core members of the MDT may agree to institute treatment. The case would normally be presented at the next MDT meeting. Immediate referrals may be made verbally to a clinician of the site specific team.

The local MDT will identify all cases that require discussion, as defined in the Network Guidelines, at the specialist and supranetwork MDTs.

Those cases not for discussion at the specialist MDT will have their treatment plan discussed and agreed at the local MDT.

The treatment plan should be communicated to the referring general practitioner by the next working day. This will be audited in the future.

The treatment plan should be communicated to the patient by their Key Worker at the next available out-patient clinic.

The dataset should be recorded for each new patient.

Patients treated by the local MDT are followed up by the primary clinician according to the network schedule.

Area	***Issue***	***Action***	***Leads***	***Deadline***
NSSG	***Follow up guidelines to be incorporated into full guideline document***	***Develop and agree***	***Hugh Gilbert***	***April 2008***

4. The Specialist MDT

The Urological Cancer SSG will convene a single specialist MDT.

The specialist MDT will meet once a week at the network resection centres.

Area	***Issue***	***Action***	***Leads***	***Deadline***
NSSG (October 2004)	*Meetings*	*Establish video conferencing*	*3CCN*	*Ongoing*

Attendance records will be kept.

The members of the specialist MDT, and their roles, are listed in the 3CCN Urological Cancer Guidelines

In the absence of a core member of the MDT cover should usually be provided by the core member of the same specialty from the same cancer unit. In unusual circumstances the specialist registrar from the same unit may provide cover.

The specialist MDT will discuss every new cancer case referred by the cancer units during the preceding week, and agree a plan of investigation.

Any member of the specialist MDT may present any patient with an established diagnosis of urological cancer at the local or specialist MDT for discussion.

The investigation plan should be communicated to the referring general practitioner by the next working day.

Area	*Issue*	*Action*	*Leads*	*Deadline*
NSSG (April 2009)	*Real time recording and communication*	*Infoflex and co-ordinator development*	*H Gilbert*	*November 2009*

The investigation plan should be communicated to the patient by their key worker at the next available out-patient clinic.

In the event that urgent treatment planning decisions have to be made any, two core members of the MDT may agree to institute treatment. The case would normally be presented at the next MDT meeting. Immediate referrals may be made verbally to a clinician of the site specific team.

The specialist MDT will confirm all cases that require discussion, as defined in the Network Guidelines, at the supranetwork MDTs.

Those cases not for discussion at the supranetwork MDT will have their treatment plan discussed and agreed at the local MDT.

The treatment plan should be communicated to the referring general practitioner by the next working day.

Area	*Issue*	*Action*	*Leads*	*Deadline*
NSSG (April 2009)	*Real time recording and communication*	*Infoflex and co-ordinator development*	*H Gilbert*	*November 2009*

The treatment plan should be communicated to the patient by their key worker at the next available out-patient clinic.

Audit?

The Network dataset should be recorded for each new patient by their key worker and the MDT co-ordinator.

Patients treated by the specialist MDT are followed up by the responsible consultant according to the network schedule. The patient should be offered follow up by the local MDT; any request is communicated by the specialist MDT

5. The Supranetwork MDT

Patients with confirmed penile cancer should be referred by the local MDT to the supranetwork MDT which will formulate a management plan.

Patients with confirmed testicular cancer should be referred by the local MDT directly to the Network Lead Clinician for testicular tumours who will discuss cases with the supranetwork MDT.

In the event that urgent treatment planning decisions have to be made any, two core members of the MDT may agree to institute treatment. The case would normally be presented at the next MDT meeting. Immediate referrals may be made verbally to a clinician of the site specific team.

6. The Resection Centre

Radical prostatectomy and cystectomy, as well as specialist renal surgery, is carried out at either of the network's two resection centres. (Radical Prostatectomy at GRH/Redditch and Cystectomy at CGH/Redditch)

Area	***Issue***	***Action***	***Leads***	***Deadline***
NSSG (April 2009)	*Single resection centre (Gloucestershire and Herefordshire)*	*Business case for SIUS*	*H Gilbert*	*NSSG (November 2009)*

7. Communication

Each patient has a named key worker, usually a cancer nurse specialist.

Each patient has a named primary clinician (consultant).

Each patient should be offered information on the role and responsibilities of the MDT and its members.

Each patient should be prospectively offered, at the time of diagnosis, written records of the discussions to be held at the MDT meetings.

GPs will receive a summary of all MDT discussions

The acceptance of a key worker, of information on the MDT and of management summaries should be entered on the network dataset and in the patient's notes.

GPs and PCTs will receive feedback on the appropriateness and timeliness of urgent referrals. Information on timeliness is sent routinely by trust information departments.

Patients are offered the opportunity of a permanent record of Consultation which will include where appropriate diagnosis, treatment options and plan and relevant follow-up arrangements

8. The Network Dataset

The dataset should be completed for all patients it includes cancer waiting times data and the cancer registration dataset

Where appropriate the dataset should be updated at the time of the MDT meetings.

The clinical data should be recorded by the MDT co-ordinator with the cancer nurse specialist

Non-clinical data should be entered by the Trust information services.

9. The role of the MDT co-ordinator

Each local MDT has a named urology co-ordinator

The specialist MDT is co-ordinated by the Gloucestershire local MDT urology co-ordinator

The referring team informs the relevant urology co-ordinator 48 hours prior to each meeting.

The urology co-ordinator ensures that all relevant records and investigations are available for review at the meeting

The co-ordinator informs the MDT radiologist or the radiology MDT co-ordinator of those cases requiring review and discussion 48 hours before each meeting

The radiology MDT co-ordinator will ensure that all relevant imaging is available to the MDT radiologist for review 48 hours before the meeting

The co-ordinator informs the MDT pathologist the pathology MDT co-ordinator of those cases requiring review and discussion 48 hours before each meeting

The urology co-ordinator finalises an agenda for each meeting to allow the optimal use of each member's time.

The urology co-ordinator, with the patient's key worker, completes the network dataset for each patient

The urology co-ordinator records the MDT discussion on the database, in the patient's notes and the MDT minutes.

10. The role of the CNS within the MDT

The CNS will contribute to the multidisciplinary discussion and patient assessment/care planning decision of the team at their regular meetings and provide nursing advice and assessment.

The CNS of the local MDT to which the patient originally presented is usually the key worker, if not the key worker; the CNS will be in charge of ensuring each patient has a named key worker

The CNS provides support and information to the patient and their carer throughout the process of investigation, treatment and follow-up.

The CNS supports the MDT co-ordinator in entering data into the network data set.

The CNS oversees the communication of all recommendations to the patient's general practitioner within one working day of the MDT.

The CNS will take a lead on patients'/carers' communication issues and co-ordination of the patient pathway for patients. They will ensure that all recommendations of the MDT are communicated to the patient by any prospectively agreed method.

The CNS ensures that clinic appointments are arranged, within 7 working days, to allow discussion of the MDTs recommendations.

The CNS arranges investigations recommended by the MDT.

The CNS will contribute to the management of the service.

The CNS will participate in clinical audit, research and contribute to the management of the service.

11. The role of the primary clinician

The primary clinician is the consultant responsible for the investigation, treatment and follow-up of the patient.

The primary clinician is responsible for ensuring that all presenting patients are discussed at the MDT, that their investigations are reviewed and that the treatment plan is carried out.

The primary clinician is responsible for verbal and written referral to other clinicians.

The primary clinician is responsible for ensuring that the MDT minutes and the network

dataset are both accurate records of the MDT proceedings.

12. Monitoring and audit

Referral guidelines
The national referral guidelines are adopted

Informing GPs of the timeliness and appropriateness of referrals
Re-audit for NSSG April 2010

Audit of the consistency of histological reporting
Continuing process

Patient experience surveys
AUDIT

Information to patients
All literature to be reviewed annually and revised bi-annually — *NSSG November 2009*

Clinical effectiveness
Annual audit of clinical activity — *Under development (GUARG)*

Area	***Issue***	***Action***	***Leads***	***Deadline***
NSSG (April 2009)	*Annual report*		*B Patel*	*GUARG (December 2009)*

Operational policy
Annual review — *NSSG April2009*

Clinical Guidelines
Annual review — *NSSG April 2009*

Network audit