NICE National Institute for Health and Care Excellence

NICE quality standard

# Prostate cancer

Quality standard

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# Contents

This standard is based on CG175 and CSG2.

This standard should be read in conjunction with QS89, QS13, QS15, QS45, QS106 and QS124.

## Introduction

This quality standard covers the care of men referred to secondary care with suspected or diagnosed prostate cancer, and men having follow-up for prostate cancer in primary care.

It does not cover the recognition and referral of men with suspected prostate cancer in primary care. This topic is expected to be covered by a quality standard on suspected cancer.

For more information see the prostate cancer topic overview.

### *Why this quality standard is needed*

Prostate cancer is the most common cancer in men and makes up 26% of all male cancer diagnoses in the UK. According to Cancer Research UK's prostate cancer statistics there were 10,837 deaths from prostate cancer in the UK in 2012.

Prostate cancer is predominantly a disease of older men (aged 65–79 years) but around 25% of cases occur in men younger than 65.

Family history has been shown to be a risk factor. The relative risk rises as the number of first-degree relatives diagnosed with prostate cancer increases.

Ethnicity has also been shown to be a risk factor for prostate cancer, with higher rates seen in men of black African or Caribbean family origin and the lowest in men of Asian family origin.

Cases of prostate cancer are expected to increase, even if the incidence rate stays constant, because of the ageing population. The financial burden of treatment, including the need for treatment facilities and trained specialists, will grow as more men are diagnosed with the disease.

Men with prostate cancer have more emergency than elective hospital admissions during their last year of life (National End of Life Care Intelligence Network 2012). In those dying from prostate cancer, the average cost of hospital admissions is nearly half (47%) of the average cost of care

during the last year of life (National End of Life Care Intelligence Network 2012). The estimated total cost of inpatient care per man during his last year of life is reported to be £6931 for prostate cancer.

The quality standard is expected to contribute to improvements in the following outcomes:

- quality of life
- the need for care and support
- premature deaths from prostate cancer
- patient experience of hospital care.

## *How this quality standard supports delivery of outcome frameworks*

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- Adult Social Care Outcomes Framework 2015–16
- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–16.

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

### Table 1 Adult Social Care Outcomes Framework 2015–16

| Domain | Overarching and outcome measures |
|---|---|

| | |
|---|---|
| 1 Enhancing quality of life for people with care and support needs | *Overarching measure*<br>1A Social care-related quality of life*<br>*Outcome measures*<br>**People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to meet their needs**<br>1B Proportion of people who use services who have control over their daily lives<br>1C Proportion of people using social care who receive self-directed support, and those receiving direct payments<br>**Carers can balance their caring roles and maintain their desired quality of life**<br>1D Carer-reported quality of life* |
| 2 Delaying and reducing the need for care and support | *Outcome measures*<br>**Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services**<br>2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services** |

| | |
|---|---|
| 3 Ensuring that people have a positive experience of care and support | *Overarching measure*<br>**People who use social care and their carers are satisfied with their experience of care and support services**<br>3A Overall satisfaction of people who use services with their care and support<br>3B Overall satisfaction with social services of carers<br>Placeholder 3E Effectiveness of integrated care<br>*Outcome measures*<br>**Carers feel that they are respected as equal partners throughout the care process**<br>3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for<br>**People know what choices are available to them locally, what they are entitled to, and who to contact when they need help**<br>3D The proportion of people who use services and carers who find it easy to find information about support<br>**People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual**<br>*This information can be taken from the Adult Social Care Survey and used for analysis at the local level* |

| | |
|---|---|
| 4 Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm | *Overarching measure*<br>4A The proportion of people who use services who feel safe*<br>*Outcome measures*<br>**Everyone enjoys physical safety and feels secure**<br>**People are free from physical and emotional abuse, harassment, neglect and self-harm**<br>**People are protected as far as possible from avoidable harm, disease and injuries**<br>**People are supported to plan ahead and have the freedom to manage risks the way that they wish**<br>4B The proportion of people who use services who say that those services have made them feel safe and secure<br>*Placeholder 4C Proportion of completed safeguarding referrals where people report they feel safe* |
| **Aligning across the health and care system**<br>* Indicator complementary<br>** Indicator shared | |

Table 2 NHS Outcomes Framework 2015–16

| Domain | Overarching indicators and improvement areas |
|---|---|
| 1 Preventing people from dying prematurely | *Overarching indicators*<br>1B Life expectancy at 75<br>i Males<br>*Improvement areas*<br>**Reducing premature mortality from the major causes of death**<br>1.4 Under 75 mortality rate from cancer* |

| | |
|---|---|
| 2 Enhancing quality of life for people with long-term conditions | *Overarching indicators*<br>2 Health-related quality of life for people with long-term conditions**<br>*Improvement areas*<br>**Ensuring people feel supported to manage their condition**<br>2.1 Proportion of people feeling supported to manage their condition<br>**Improving functional ability in people with long-term conditions**<br>2.2 Employment of people with long-term conditions***<br>**Enhancing quality of life for carers**<br>2.4 Health-related quality of life for carers** |
| 3 Helping people to recover from episodes of ill health or following injury | *Overarching indicators*<br>3a Emergency admissions for acute conditions that should not usually require hospital admission |

| | |
|---|---|
| 4 Ensuring that people have a positive experience of care | *Overarching indicators*<br>4a Patient experience of primary care<br>i GP services<br>ii GP out-of-hours services<br>4b Patient experience of hospital care<br>*4c Friends and family test*<br>*Improvement areas*<br>**Improving people's experience of outpatient care**<br>4.1 Patient experience of outpatient services<br>**Improving hospitals' responsiveness to personal needs**<br>4.2 Responsiveness to in-patients' personal needs<br>**Improving access to primary care services**<br>4.4 Access to i GP services<br>**Improving the experience of care for people at the end of their lives**<br>4.6 Bereaved carers' views on the quality of care in the last 3 months of life<br>**Improving people's experience of integrated care**<br>*4.9 People's experience of integrated care*** |
| **Alignment with Adult Social Care Outcomes Framework (ASCOF) and/or NHS Outcomes Framework (NHSOF)**<br>* Indicator is shared<br>** Indicator is complementary<br>*Indicators in italics are in development* | |

Table 3 Public health outcomes framework for England, 2013–16

| Domain | Objectives and indicators |
|---|---|

| | |
|---|---|
| 4 Healthcare public health and preventing premature mortality | *Objective*<br>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities<br>*Indicators*<br>4.5 Mortality from cancer |
| **Alignment with Adult Social Care Outcomes Framework (ASCOF) and/or Public Health Outcomes Framework (PHOF)**<br>* Indicator is shared<br>** Indicator is complementary<br>*Indicators in italics are in development* | |

## *Patient experience and safety issues*

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to prostate cancer.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

## *Coordinated services*

The quality standard for prostate cancer specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole prostate cancer care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to men with prostate cancer.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality prostate cancer service are listed in related quality standards.

## Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating men with prostate cancer should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

## Role of families and carers

Quality standards recognise the important role families and carers have in supporting men with prostate cancer. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

## List of quality statements

Statement 1. Men with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

Statement 2. Men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable are also offered the option of active surveillance.

Statement 3. Men with intermediate- or high-risk localised prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination.

Statement 4. Men with adverse effects of prostate cancer treatment are referred to specialist services.

Statement 5. Men with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer multidisciplinary team (MDT).

## Quality statement 1: Discussion with a named nurse specialist

### *Quality statement*

Men with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

### *Rationale*

Nurse specialists are key points of contact for men with prostate cancer. They provide information about treatment options, answer questions or concerns and support men to make decisions about their care. This is particularly important immediately after diagnosis and when difficult choices about treatment need to be made. Nurse specialists also provide personalised care plans and information about support services.

### *Quality measures*

#### Structure

Evidence of local arrangements to ensure that men with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

***Data source:*** Local data collection, National Prostate Cancer Audit and National Cancer Patient Experience Survey 2014.

#### Process

Proportion of men with prostate cancer who have a recorded discussion about treatment options and adverse effects with a named nurse specialist.

Numerator – the number in the denominator who have a recorded discussion about treatment options and adverse effects with a named nurse specialist.

Denominator – the number of men with prostate cancer.

***Data source:*** Local data collection, National Prostate Cancer Audit and National Cancer Patient Experience Survey 2014.

### Outcome

Rates of men with prostate cancer satisfied with the discussion about treatment options and adverse effects.

***Data source:*** Local data collection and National Cancer Patient Experience Survey 2014.

## *What the quality statement means for service providers, healthcare professionals and commissioners*

**Service providers** (such as hospitals, specialist prostate cancer multidisciplinary teams and specialist prostate cancer services) ensure that men with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

**Healthcare professionals** ensure that men with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

**Commissioners** (such as clinical commissioning groups and NHS England area teams) ensure that the services they commission have sufficient nurse specialists available to offer a discussion about treatment options and adverse effects to men with prostate cancer.

## *What the quality statement means for patients and carers*

**Men with prostate cancer** have a discussion about treatment options and adverse effects with a named nurse with experience in prostate cancer. The man can then feel informed about his treatment options and their side effects, and supported to make decisions about his treatment.

## *Source guidance*

- Prostate cancer (2014) NICE guideline CG175, recommendations 1.1.1, 1.1.9 (key priority for implementation) and 1.1.12
- Improving outcomes in urological cancers (2002) NICE cancer service guidance

## *Definitions of terms used in this quality statement*

### Adverse effects

Adverse effects of prostate cancer treatment may include:

- sexual dysfunction
- loss of libido
- impotence
- urinary incontinence
- radiation-induced enteropathy
- hot flushes
- osteoporosis
- cardiovascular complications
- gynaecomastia
- fatigue
- weight gain
- metabolic syndrome.

[Adapted from Prostate cancer (NICE guideline CG175)]

## Nurse specialist

A nurse with a urology or oncology background who is a specialist in the management of prostate cancer.

[Expert opinion]

## Support services

Supportive care includes a number of services, both generalist and specialist, that may be required to support people with cancer and their carers.

[Adapted from Improving supportive and palliative care for adults with cancer (NICE cancer service guidance)]

## *Equality and diversity considerations*

Men of black African or Caribbean family origin are more likely to develop prostate cancer than other men. Despite this, awareness of prostate cancer is low among men in these groups and the nurse specialist should be aware of this when discussing prostate cancer with these men.

Similarly, older men are at higher risk of developing prostate cancer than younger men, but may be less likely to continue to engage with health services after the initial contact. The nurse specialist should be aware of this when discussing prostate cancer with older men.

Gay and bisexual men, and transgender women have a risk of developing prostate cancer. Healthcare professionals should be aware of their psychosexual needs, lifestyle and the impact of different treatment options.

## Quality statement 2: Treatment options

### *Quality statement*

Men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable are also offered the option of active surveillance.

### *Rationale*

Men who are diagnosed with low-risk localised prostate cancer can be offered different treatment options, including radical prostatectomy, radical radiotherapy and active surveillance. It is important that men for whom it is suitable know that active surveillance is also an option for low-risk localised prostate cancer. This can reduce overtreatment and increase capacity for rapid treatment of high-risk disease. It can also reduce the number of men unnecessarily having radical treatment and therefore experiencing adverse effects, and decrease the cost of treating and managing these adverse effects. By discussing all the treatment options available to them, men can make an informed decision on their preferred option.

### *Quality measures*

#### Structure

Evidence of local arrangements to ensure that men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable are also offered the option of active surveillance.

***Data source:*** Local data collection.

#### Process

Proportion of men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable who are also offered the option of active surveillance.

Numerator – the number in the denominator who are also offered the option of active surveillance.

Denominator – the number of men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable.

***Data source:*** Local data collection.

## Outcome

a) Rates of men with low-risk localised prostate cancer on active surveillance.

*Data source:* Local data collection.

b) Rates of men with low-risk localised prostate cancer satisfied with their chosen treatment option.

*Data source:* Local data collection.

## *What the quality statement means for service providers, healthcare professionals and commissioners*

**Service providers** (such as hospitals, specialist urological cancer multidisciplinary teams and specialist prostate cancer services) ensure that systems are in place to offer the option of active surveillance to men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable.

**Healthcare professionals** ensure that they offer the option of active surveillance to men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable.

**Commissioners** (such as clinical commissioning groups and NHS England area teams) should monitor the treatment options offered to men with low-risk localised prostate cancer.

## *What the quality statement means for patients and carers*

**Menwhose cancer has not spread outside the prostate and whose future risk from the cancer is low** are offered the option of having regular tests but no treatment (known as active surveillance) if surgery to remove the prostate (radical prostatectomy) or radiation treatment to destroy cancer cells (radiotherapy) would also be suitable treatments for them. This may delay or prevent the need for surgery or radiation treatment, which both have side effects.

## *Source guidance*

- Prostate cancer (2014) NICE guideline CG175, recommendations 1.3.7 and 1.3.8 (key priorities for implementation)

## *Definitions of terms used in this quality statement*

### Active surveillance

Part of a curative strategy for men with localised prostate cancer for whom radical treatments are suitable. It keeps these men within a 'window of curability' whereby only those whose tumours are showing signs of progressing or those with a preference for intervention are considered for radical treatment. Active surveillance may therefore avoid or delay the need for radiation or surgery.

Active surveillance follows the protocol outlined in table 2 in prostate cancer (NICE guideline CG175).

[Prostate cancer (NICE guideline CG175) full guideline]

### Low-risk localised prostate cancer

Prostate-specific antigen (PSA) less than 10 ng/ml, Gleason score 6 or below and clinical stage T1–T2A (confined to the prostate gland).

[Adapted from Prostate cancer (NICE guideline CG175)]

### Radical prostatectomy

Removal of the entire prostate gland and lymph nodes by open surgery or a keyhole technique (laparoscopic or robotically assisted laparoscopic prostatectomy).

[Prostate cancer (NICE guideline CG175) full guideline]

### Radical radiotherapy

Radiation, usually X-rays or gamma rays, used to destroy tumour cells, by external beam radiotherapy or brachytherapy.

[Prostate cancer (NICE guideline CG175) full guideline]

## *Equality and diversity considerations*

Men of black African or Caribbean family origin are more likely to develop prostate cancer than other men. Despite this, awareness of prostate cancer is low among men in these groups. Similarly,

older men are at higher risk of developing prostate cancer than younger men, but may be less likely to continue to engage with health services even after the initial contact with the service. For men in these groups for whom active surveillance is suitable, healthcare professionals should highlight its importance as a treatment option.

Gay and bisexual men, and transgender women have a risk of developing prostate cancer. Healthcare professionals should be aware of their psychosexual needs, lifestyle and the impact of different treatment options.

## Quality statement 3: Combination therapy

### *Quality statement*

Men with intermediate- or high-risk localised prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination.

### *Rationale*

Androgen deprivation therapy and radiotherapy are 2 of the treatment options available for men with intermediate- or high-risk localised prostate cancer. Combining androgen deprivation therapy with radical radiotherapy can increase the effectiveness of treatment and the chances of survival compared with either androgen deprivation therapy or radical radiotherapy alone.

### *Quality measures*

#### Structure

Evidence of local arrangements to ensure that men with intermediate- or high-risk localised prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination.

***Data source:*** Local data collection.

#### Process

Proportion of men with intermediate- or high-risk localised prostate cancer receiving non-surgical radical treatment, who receive radical radiotherapy and androgen deprivation therapy in combination.

Numerator – the number in the denominator who received radical radiotherapy and androgen deprivation therapy in combination.

Denominator – the number of men with intermediate- or high-risk localised prostate cancer receiving non-surgical radical treatment.

***Data source:*** Local data collection.

## *What the quality statement means for service providers, healthcare professionals and commissioners*

**Service providers** (such as hospitals, specialised urological cancer multidisciplinary teams and specialised prostate cancer services) ensure that healthcare professionals know that radical radiotherapy and androgen deprivation therapy should be used only in combination for men with intermediate- or high-risk localised prostate cancer.

**Healthcare professionals** ensure that men with intermediate- or high-risk localised prostate cancer who are offered non-surgical radical treatment receive radical radiotherapy and androgen deprivation therapy in combination.

**Commissioners** (such as clinical commissioning groups and NHS England area teams) monitor whether men with intermediate- or high-risk localised prostate cancer offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination. Commissioners may wish to ask providers for evidence of practice.

## *What the quality statement means for patients and carers*

**Menwhose cancer has not spread outside the prostate and whose future risk from the cancer is medium or high** are offered treatment of combined radiation treatment to destroy the cancer cells (called radiotherapy) and a drug that blocks the production of androgen, a hormone that helps cancer cells to grow (called androgen deprivation therapy). Having radiotherapy together with androgen deprivation therapy usually works better than having just one of these treatments on its own.

## *Source guidance*

- Prostate cancer (2014) NICE guideline CG175, recommendation 1.3.19 (key priority for implementation)

## *Definitions of terms used in this quality statement*

### Androgen deprivation therapy

Treatment with a luteinising hormone-releasing hormone agonist such as goserelin to lower testosterone levels.

[Adapted from Prostate cancer (NICE guideline CG175) full guideline]

### High-risk localised prostate cancer

Prostate-specific antigen (PSA) greater than 20 ng/ml, Gleason score 8–10 or clinical stage T2C or greater.

[Prostate cancer (NICE guideline CG175)]

### Intermediate-risk localised prostate cancer

PSA 10–20 ng/ml, Gleason score 7 or clinical stage T2B.

[Prostate cancer (NICE guideline CG175)]

### Radical radiotherapy

Radiation, usually X-rays or gamma rays, used to destroy tumour cells by external beam radiotherapy or brachytherapy.

[Prostate cancer (NICE guideline CG175) full guideline]

## *Equality and diversity considerations*

Some older men may have previously been offered androgen deprivation therapy alone. Focusing on the benefits of combination therapy for older men with intermediate- or high-risk localised prostate cancer should help to reduce such inequalities.

Gay and bisexual men, and transgender women have a risk of developing prostate cancer. Healthcare professionals should be aware of their psychosexual needs, lifestyle and the impact of different treatment options.

## Quality statement 4: Managing adverse effects of treatment

### *Quality statement*

Men with adverse effects of prostate cancer treatment are referred to specialist services.

### *Rationale*

Treatments for prostate cancer have various adverse effects that can continue after the treatment is completed. Adverse effects include sexual dysfunction, loss of libido, impotence, urinary incontinence, radiation-induced enteropathy, hot flushes, osteoporosis, cardiovascular complications, gynaecomastia and fatigue. These adverse effects can also have an emotional and psychological impact on men. Specialist services that provide interventions such as counselling, drug therapy, radiotherapy, physiotherapy and aerobic exercise can help to manage adverse effects of treatment and substantially improve the man's quality of life.

### *Quality measures*

#### Structure

Evidence of local arrangements to ensure that men with adverse effects of prostate cancer treatment are referred to specialist services.

***Data source:*** Local data collection and the National Prostate Cancer Audit.

#### Process

Proportion of men with adverse effects of prostate cancer treatment who use specialist services.

Numerator – the number in the denominator who use specialist services.

Denominator – the number of men with adverse effects of prostate cancer treatment.

***Data source:*** Local data collection and the National Prostate Cancer Audit.

## *What the quality statement means for service providers, healthcare professionals and commissioners*

**Service providers** (such as hospitals, specialist urological cancer multidisciplinary teams and specialist prostate cancer services) ensure that systems are in place for men with adverse effects of prostate cancer treatment to be referred to specialist services.

**Healthcare professionals** refer men with adverse effects of prostate cancer treatment to specialist services.

**Commissioners** (such as clinical commissioning groups and NHS England area teams) have pathways in place to ensure that men with adverse effects of prostate cancer treatment are referred to specialist services.

## *What the quality statement means for patients and carers*

**Men who have side effects from prostate cancer treatment** are referred to specialist services (such as erectile dysfunction or continence services) to help stop or ease the side effects.

## *Source guidance*

- Prostate cancer (2014) NICE guideline CG175, recommendations 1.3.31 (key priority for implementation), 1.3.34, 1.3.37 (key priority for implementation), 1.4.3, 1.4.8, 1.4.13, 1.4.14, 1.4.16, 1.4.18 and 1.4.19

## *Definitions of terms used in this quality statement*

### Adverse effects

Adverse effects include:

- sexual dysfunction
- loss of libido
- impotence
- urinary incontinence
- radiation-induced enteropathy

- hot flushes
- osteoporosis
- cardiovascular complications
- gynaecomastia
- fatigue
- weight gain
- metabolic syndrome.

[Adapted from Prostate cancer (NICE guideline CG175)]

### Specialist services

The specialist services include erectile dysfunction services, continence services and psychosexual counselling.

[Adapted from Prostate cancer (NICE guideline CG175)]

## *Equality and diversity considerations*

Older men may need encouragement to engage with specialist services as they tend not to use the health service as much as other people.

Gay and bisexual men, and transgender women have a risk of developing prostate cancer. Healthcare professionals should be aware of their psychosexual needs, lifestyle and the impact of different treatment options.

## Quality statement 5: Hormone-relapsed metastatic prostate cancer

### *Quality statement*

Men with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer multidisciplinary team (MDT).

### *Rationale*

Discussion by the urological cancer MDT is a means of ensuring that an opinion from an oncologist and/or palliative care specialist is obtained. Having a variety of opinions from experts who are aware of all current treatment options means that there is a better chance to identify the best options for the man. Those options can then be discussed with the man.

### *Quality measures*

#### Structure

Evidence of local arrangements to ensure that men with hormone-relapsed metastatic disease have their treatment options discussed by the urological cancer MDT.

***Data source:*** Local data collection and the National Prostate Cancer Audit.

#### Process

Proportion of men with hormone-relapsed metastatic disease who have their treatment options discussed by the urological cancer MDT.

Numerator – the number in the denominator who have their treatment options discussed by the urological cancer MDT.

Denominator – the number of men with hormone-relapsed metastatic prostate cancer.

***Data source:*** Local data collection and the National Prostate Cancer Audit.

## *What the quality statement means for service providers, healthcare professionals and commissioners*

**Service providers** (such as hospitals, specialist urological cancer MDTs and specialist prostate cancer services) ensure that systems are in place for men with hormone-relapsed metastatic prostate cancer to have their treatment options discussed by the urological cancer MDT.

**Healthcare professionals** ensure that men with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer MDT.

**Commissioners** (such as clinical commissioning groups and NHS England area teams) monitor whether providers have systems in place to ensure that men with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer MDT.

## *What the quality statement means for patients and carers*

**Men with cancer that has spread outside the prostate and whose drug treatment (to block the production of hormones that help cancer cells to grow) has stopped working** have their treatment options discussed by a specialist team of healthcare professionals with different kinds of expertise in prostate cancer. This is to make sure that all the different treatment options are discussed and all suitable treatments are offered.

## *Source guidance*

- Prostate cancer (2014) NICE guideline CG175, recommendation 1.5.10

## *Definitions of terms used in this quality statement*

### Hormone-relapsed prostate cancer

Prostate cancer after failure of primary androgen deprivation therapy.

[Prostate cancer (NICE guideline CG175) full guideline]

### Urological cancer MDT

A team that includes specialists in urology, oncology, pathology, radiology, palliative care, diet and nursing.

[Adapted from Prostate cancer (NICE guideline CG175) full guideline and MDT (multi-disciplinary team) guidance for managing prostate cancer (British Uro-Oncology Group and British Association of Urological Surgeons)]

# Using the quality standard

## *Quality measures*

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's what makes up a NICE quality standard? for further information, including advice on using quality measures.

## *Levels of achievement*

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

## *Using other national guidance and policy documents*

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in development sources and NICE's cancer service guidance on improving outcomes in urological cancers and the National Cancer Peer Review Programme's Manual for cancer services: urology cancer.

## *Information for the public*

NICE has produced information for the public about this quality standard. Patients and carers can use it to find out about the quality of care they should expect to receive and as a basis for asking questions about their care.

## Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between healthcare professionals and men with suspected or diagnosed prostate cancer is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Men with suspected or diagnosed prostate cancer should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

## Development sources

Further explanation of the methodology used can be found in the quality standards process guide.

### *Evidence sources*

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Prostate cancer (2014) NICE guideline CG175

### *Policy context*

It is important that the quality standard is considered alongside current policy documents, including:

- Healthcare Quality Improvement Partnership (2014) National Prostate Cancer Audit
- Department of Health (2013) Improving outcomes: a strategy for cancer – impact assessment
- Department of Health (2013) Improving outcomes: a strategy for cancer – third annual report
- Department of Health (2012) National cancer patients' experience survey programme 2012/13
- Department of Health (2011) Cancer: systematic delivery of interventions to reduce cancer mortality and increase cancer survival at population level
- Department of Health (2011) Commissioning cancer services

### *Definitions and data sources for the quality measures*

- Healthcare Quality Improvement Partnership (2014) National Prostate Cancer Audit
- Prostate cancer (2014) NICE guideline CG175

## Related NICE quality standards

### *Published*

- Lower urinary tract symptoms in men (2013) NICE quality standard 45
- Patient experience in adult NHS services (2012) NICE quality standard 15
- End of life care for adults (2011) NICE quality standard 13

### *Future quality standards*

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Referral for suspected cancer.

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

# Quality Standards Advisory Committee and NICE project team

## *Quality Standards Advisory Committee*

This quality standard has been developed by Quality Standards Advisory Committee 4. Membership of this committee is as follows:

**Miss Alison Allam**
Lay member

**Dr Harry Allen**
Consultant Old Age Psychiatrist, Manchester Mental Health and Social Care Trust

**Dr Jo Bibby**
Director of Strategy, The Health Foundation

**Mrs Jane Bradshaw**
Lead Nurse Specialist in Neurology, Norfolk Community Health and Care

**Dr Allison Duggal**
Consultant in Public Health, Public Health England

**Mr Tim Fielding**
Consultant in Public Health, North Lincolnshire Council

**Mrs Frances Garraghan**
Lead Pharmacist for Women's Health, Central Manchester Foundation Trust

**Mrs Zoe Goodacre**
Network Manager, South Wales Critical Care Network

**Mr Malcolm Griffiths**
Consultant Obstetrician and Gynaecologist, Luton & Dunstable University Hospital NHS Foundation Trust

**Dr Jane Hanson**
Head of Cancer National Specialist Advisory Group Core Team, Cancer National Specialist Advisory Group, NHS Wales

**Ms Nicola Hobbs**
Assistant Director of Quality and Contracting, Northamptonshire County Council

**Mr Roger Hughes**
Lay member

**Mr John Jolly**
Chief Executive Officer, Blenheim Community Drug Project, London

**Dr Damien Longson (Chair)**
Consultant Liaison Psychiatrist, Manchester Mental Health and Social Care Trust

**Dr Rubin Minhas**
GP Principal, Oakfield Health Centre, Kent

**Mrs Julie Rigby**
Quality Improvement Programme Lead, Strategic Clinical Networks, NHS England

**Mr Alaster Rutherford**
Primary Care Pharmacist, NHS Bath and North East Somerset

**Mr Michael Varrow**
Information and Intelligence Business Partner, Essex County Council

**Mr John Walker**
Head of Operations, Greater Manchester West Mental Health NHS Foundation Trust

The following specialist members joined the committee to develop this quality standard:

**Dr Sarah Cant**
Lay member, Prostate Cancer UK, London

**Dr John Graham**
Consultant in Clinical Oncology, Taunton & Somerset NHS Foundation Trust

**Professor Peter Hoskin**
Consultant Clinical Oncologist, Mount Vernon Cancer Centre and University College London

**Mr Sanjeev Madaan**
Consultant Urological Surgeon, Darent Valley Hospital, Dartford

**Mr Brian McGlynn**
Nurse Consultant Urology Oncology, University Hospital Ayr

**Dr Jonathan Rees**
GP, Backwell and Nailsea Medical Group, North Somerset

**Dr Jonathan Richenberg**
Consultant Radiologist, Brighton and Sussex University Hospitals NHS Trust

## *NICE project team*

**Nick Baillie**
Associate Director

**Karen Slade**
Consultant Clinical Adviser

**Rachel Neary-Jones**
Programme Manager

**Nicola Greenway/Sabina Keane**
Technical Adviser

**Karyo Angeloudis**
Lead Technical Analyst

**Jenny Mills**
Project Manager

**Lisa Nicholls**
Coordinator

# Update information

### Minor changes since publication

**December 2016:** Data source updated for statement 1.

## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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### *Endorsing organisation*

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

### *Supporting organisations*

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Primary Care Urology Society
- Royal College of General Practitioners
- Royal College of Pathologists
- Society and College of Radiographers
- National Osteoporosis Society