

Prostate cancer

Quality standard

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This standard is based on CSG2 and NG131.

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

Quality statements

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

Statement 2 People with Cambridge Prognostic Group (CPG) 1 localised prostate cancer for whom radical treatment is suitable are offered active surveillance.

Statement 3 People with Cambridge Prognostic Group (CPG) 2, 3, 4 and 5 localised or locally advanced prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination.

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

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

Quality statement 1: Discussion with a named nurse specialist

Quality statement

People 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 people with prostate cancer. They provide information about treatment options, answer questions or concerns and support people 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications or local protocols. The [National Prostate Cancer Audit](#) organisational audit provides information on whether NHS providers of prostate cancer services have clinical nurse specialists.

Process

Proportion of people 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 people with prostate cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The [National Prostate Cancer Audit](#) and the [National Cancer Patient Experience Survey](#) provide information on how people were informed about their treatment options, how treatment decisions were made and access to a clinical nurse specialist.

Outcome

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

Data source: [National Cancer Patient Experience Survey](#).

What the quality statement means for different audiences

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

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

Commissioners (such as integrated care systems, clinical commissioning groups and NHS England) ensure that the services they commission have sufficient nurse specialists available to offer a discussion about treatment options and adverse effects to people with prostate cancer.

People with prostate cancer have a discussion about treatment options and adverse effects with a named nurse with experience in prostate cancer. They feel informed about their treatment options and side effects, and supported to make decisions about their treatment.

Source guidance

- [Prostate cancer: diagnosis and management. NICE guideline NG131 \(2021\)](#), recommendations 1.1.1, 1.1.9 and 1.1.12
- [Improving outcomes in urological cancers. NICE guideline CSG2 \(2002\)](#)

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 [NICE's guideline on prostate cancer](#)]

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 [NICE's guideline on improving supportive and palliative care for adults with cancer](#)]

Equality and diversity considerations

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

Similarly, older people are at higher risk of developing prostate cancer than younger people, 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 people.

People who are gay, bisexual or transgender 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

People with Cambridge Prognostic Group (CPG) 1 localised prostate cancer for whom radical treatment is suitable are offered active surveillance.

Rationale

People who are diagnosed with localised prostate cancer and assigned a risk category of CPG 1, for whom radical treatment is suitable, are offered active surveillance because it can reduce overtreatment and increase capacity for rapid treatment of high-risk disease. It can also reduce the number of people unnecessarily having radical treatment and therefore experiencing adverse effects, and decrease the cost of treating and managing these adverse effects. By discussing the benefits and harms of active surveillance, people can make an informed decision. If active surveillance is not suitable or acceptable, radical prostatectomy or radical radiotherapy are alternative treatment options.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with CPG 1 localised prostate cancer for whom radical treatment is suitable are offered active surveillance.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications or local protocols. The [National Prostate Cancer Audit](#) collects data on treatment options including radical treatments and active surveillance.

Process

Proportion of people with CPG 1 localised prostate cancer for whom radical treatment is suitable on active surveillance.

Numerator – the number in the denominator who are on active surveillance.

Denominator – the number of people with CPG 1 localised prostate cancer for whom radical treatment is suitable.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The [National Prostate Cancer Audit](#) collects data on treatment options including radical treatments and active surveillance.

Outcome

Rates of people with CPG 1 localised prostate cancer satisfied with their chosen treatment option.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from surveys.

What the quality statement means for different audiences

Service providers (such as hospitals, specialist urological cancer multidisciplinary teams and specialist prostate cancer services) ensure that systems are in place to offer active surveillance to people with CPG 1 localised prostate cancer for whom radical treatment is suitable.

Healthcare professionals ensure that they discuss the benefits and harms of active surveillance with, and offer it to, people with CPG 1 localised prostate cancer for whom radical treatment is suitable. If active surveillance is not suitable or acceptable, they consider radical prostatectomy or radical radiotherapy.

Commissioners (such as integrated care systems, clinical commissioning groups and NHS

England) should monitor the treatment options offered to people with CPG 1 localised prostate cancer.

People whose cancer has not spread outside the prostate and has been assigned a risk category of CPG 1 discuss the benefits and harms of having regular tests but no treatment (known as active surveillance) and are offered this as a first option. If this is not suitable or acceptable, then surgery to remove the prostate (radical prostatectomy) or radiation treatment to destroy cancer cells (radiotherapy) may be alternative options.

Source guidance

Prostate cancer: diagnosis and management. NICE guideline NG131 (2021), recommendations 1.3.8, 1.3.13, 1.3.14 and 'active surveillance' as described in terms used in this guideline.

Definitions of terms used in this quality statement

Active surveillance

Part of a curative strategy for people with localised prostate cancer for whom radical treatments are suitable. It keeps these people 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 NICE's guideline on prostate cancer. [NICE's guideline on prostate cancer, terms used in this guideline]

Cambridge Prognostic Group (CPG) 1

Gleason score 6 (grade score 1); and prostate-specific antigen (PSA) less than 10 microgram/litre; and stages T1–T2. [NICE's guideline on prostate cancer, table 1]

Localised prostate cancer

Cancer that has been staged as T1 or T2 (confined to the prostate gland). [NICE's guideline on prostate cancer, terms used in this guideline]

Equality and diversity considerations

People of black African or Caribbean family origin are more likely to develop prostate cancer than others. Despite this, awareness of prostate cancer is low among people in these groups. Similarly, older people are at higher risk of developing prostate cancer than younger people, but may be less likely to continue to engage with health services even after the initial contact with the service. For people in these groups for whom active surveillance is suitable, healthcare professionals should highlight its importance as a treatment option.

People who are gay, bisexual or transgender 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

People with Cambridge Prognostic Group (CPG) 2, 3, 4 and 5 localised or locally advanced 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 people with CPG 2, 3, 4 and 5 localised or locally advanced 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with CPG 2, 3, 4 and 5 localised or locally advanced prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records or service protocols.

Process

Proportion of people with CPG 2, 3, 4 and 5 localised or locally advanced 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 people with CPG 2, 3, 4 and 5 localised or locally advanced prostate cancer receiving non-surgical radical treatment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

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 in combination for people with CPG 2, 3, 4 and 5 localised or locally advanced prostate cancer.

Healthcare professionals ensure that people with CPG 2, 3, 4 and 5 localised or locally advanced prostate cancer who are offered non-surgical radical treatment receive radical radiotherapy and androgen deprivation therapy in combination.

Commissioners (such as integrated care systems, clinical commissioning groups and NHS England) monitor whether people with CPG 2, 3, 4 and 5 localised or locally advanced 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.

People whose cancer has not spread outside the prostate, or has spread just outside the prostate, and has been assigned a risk category of CPG 2, 3, 4 or 5 are offered radiation treatment to destroy the cancer cells (called radiotherapy) combined with 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: diagnosis and management. NICE guideline NG131 (2021), recommendation 1.3.21

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 NICE's 2014 full guideline on prostate cancer]

Cambridge Prognostic Group (CPG) 2 to 5

Table of criteria for CPG 2, 3, 4 and 5 scores

CPG	Criteria
2	Gleason score 3 + 4 = 7 (grade group 2) or PSA 10 microgram/litre to 20 microgram/litre and Stages T1–T2
3	Gleason score 3 + 4 = 7 (grade group 2) and PSA 10 microgram/litre to 20 microgram/litre and Stages T1–T2 or Gleason 4 + 3 = 7 (grade group 3) and Stages T1–T2
4	One of: Gleason score 8 (grade group 4), PSA more than 20 microgram/litre, Stage T3

CPG	Criteria
5	Two or more of: Gleason score 8 (grade group 4), PSA more than 20 microgram/litre, Stage T3 or Gleason score 9 to 10 (grade group 5) or Stage T4

[[NICE's guideline on prostate cancer](#), table 1]

Locally advanced prostate cancer

For the purposes of this quality standard, this includes T3 and T4 prostate cancer. [[NICE's guideline on prostate cancer](#), terms used in this guideline]

Localised prostate cancer

Cancer that has been staged as T1 or T2 (confined to the prostate gland). [[NICE's guideline on prostate cancer](#), terms used in this guideline]

Radical radiotherapy

Radiation, usually X-rays or gamma rays, used to destroy tumour cells by external beam radiotherapy or brachytherapy. [[NICE's 2014 full guideline on prostate cancer](#)]

Equality and diversity considerations

Some older people may have previously been offered androgen deprivation therapy alone. Focusing on the benefits of combination therapy for older people with CPG 2, 3, 4 and 5 localised or locally advanced prostate cancer should help to reduce such inequalities.

People who are gay, bisexual or transgender 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

People 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 people. 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 person's quality of life.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local pathways that allow people with adverse effects of prostate cancer treatment to be referred to specialist services.

Data source: Data can be collected locally from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications. The [National Prostate Cancer Audit](#) includes information on whether cancer service providers have specialist services on site.

Process

Proportion of people with adverse effects of prostate cancer treatment referred to specialist services.

Numerator – the number in the denominator referred to specialist services.

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

Data source: Data can be collected locally from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

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

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

Commissioners (such as integrated care systems, clinical commissioning groups and NHS England) have pathways in place to ensure that people with adverse effects of prostate cancer treatment are referred to specialist services.

People 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: diagnosis and management. NICE guideline NG131 (2021), recommendations 1.3.36, 1.3.39, 1.3.42, 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 [NICE's guideline on prostate cancer](#)]

Specialist services

The specialist services include erectile dysfunction services, continence services and psychosexual counselling. [Adapted from [NICE's guideline on prostate cancer](#)]

Equality and diversity considerations

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

People who are gay, bisexual or transgender 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

People 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 person. Those options can then be discussed with the person.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications or local protocols.

Process

Proportion of people 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 people with hormone-relapsed metastatic prostate cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

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

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

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

People 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: diagnosis and management. NICE guideline NG131 (2021), recommendation 1.5.11

Definitions of terms used in this quality statement

Hormone-relapsed prostate cancer

Prostate cancer after failure of primary androgen deprivation therapy. [[NICE's guideline on prostate cancer](#), terms used in this guideline]

Urological cancer MDT

A team that includes specialists in urology, oncology, pathology, radiology, palliative care, diet and nursing. [Adapted from [NICE's 2014 full guideline on prostate cancer](#) and the [British Uro-Oncology Group and British Association of Urological Surgeons MDT \(multi-disciplinary team\) guidance for managing prostate cancer](#)]

Update information

December 2021: Changes have been made to align this quality standard with the updated NICE guideline on prostate cancer. Statement 2 has been amended so that 'Cambridge Prognostic Group (CPG) 1' replaces 'low-risk' localised prostate cancer and people in the population specified are now offered active surveillance. Statement 3 has been changed with 'CPG 2, 3, 4 and 5' replacing 'intermediate or high-risk' localised prostate cancer and to include people with locally advanced prostate cancer. Links, definitions and source guidance references have been updated throughout.

May 2019: Changes have been made to align this quality standard with the updated [NICE guideline on prostate cancer](#). Statement 2 has been amended so that active surveillance is now an equal choice alongside prostatectomy and radiotherapy for people with low-risk localised prostate cancer, in line with the updated guideline. Terminology has been changed from 'men' to 'people' throughout to ensure that people who do not identify as men but who have a prostate are included in the guideline. References and links to source guidance have also been updated.

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.

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, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standard advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the [resource impact report and template for the NICE guideline on prostate cancer](#) to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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.

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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 \(RCGP\)](#)
- [Royal College of Pathologists](#)
- [Society and College of Radiographers \(SOR\)](#)
- [National Osteoporosis Society](#)