NICE prostate cancer quality standards

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NICE prostate cancer quality standards

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Abstract

Prostate cancer is the most common cancer in men in the United Kingdom. Over 42,000 men are diagnosed with prostate cancer every year. In June 2015, the National Institute for Health and Care Excellence (NICE) finally published five key statements regarding prostate cancer care. The quality standards are mostly derived from the NICE prostate cancer guidelines. In this article, we discuss the development process by the NICE Advisory Committee and highlight the five key priorities proposed by NICE to drive quality improvements in patient safety, patient experience and clinical effectiveness. We also discuss areas for potential improvement to improve the standard of care for men with prostate cancer.

Keywords

Prostate cancer, NICE, quality standards, guidelines, cancer nurse specialist

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Introduction

Prostate cancer is the most common cancer in men in the UK, with over 42,000 men being diagnosed with the condition every year.[1] According to Prostate Cancer UK, there are more than 330,000 men currently living with prostate cancer in the UK. The use of prostate-specific antigen (PSA) testing has led to an overall increase in the incidence of prostate cancer rates.[2] With early detection and more effective treatment, survival of patients with the disease has improved. However, despite improvements in care, there are significant variations in prostate cancer outcomes across the UK.[3] We therefore need to make sure that those men receive the best possible care and support they need to live with prostate cancer regardless of where they live. In June 2015, the National Institute for Health and Care Excellence (NICE) published its quality standards for prostate cancer to reduce inconsistencies in the care of patients diagnosed with prostate cancer.[4]

National Institute for Health and Care Excellence

NICE is an independent organization, which was originally set up by the government in 1999 as the National Institute for Clinical Excellence. Its aim was to end the 'postcode lottery' of care in the NHS and to ensure equal access to treatment irrespective of where someone lived. In 2005, NICE merged with the Health Development Agency and started developing public health guidelines. It changed its name to the National Institute for Health and Care Excellence. The Health and Social Care Bill 2012 re-established NICE as a non-departmental public body with an emphasis on the development of outcomes at a local and national level by creating clinical and public health guidelines as well as quality standards. NICE currently only provides guidance for the NHS in England and Wales.

NICE quality standards

The NICE quality standards programme was established in 2009. Quality standards are 'a comprehensive set of recommendations for a particular disease or condition, particular

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need or service'.[5] They are a set of concise, specific statements that 'act as markers of high-quality and cost-effective patient care'[5] and are derived from evidence-based guidance. They are developed to drive measurable quality improvements in areas where care is variable. Quality standards can be used both at a local level as audit criteria and at a national level as part of the Care Quality Commission inspection activities or national audits to achieve the best outcomes for patients.

Prostate cancer quality standards

The concept of prostate cancer standards was first developed in Europe in 2011 by the European School of Oncology (ESO) through its prostate cancer programme. In its collaborative article 'The requirements of a specialist prostate cancer unit: a discussion paper from the European School of Oncology', the ESO highlighted the importance of adopting a multidisciplinary approach to manage prostate cancer patients.[6] The paper introduced the idea of prostate cancer units (PCUs) and suggested reorganising prostate cancer care in Europe around a network of PCUs to improve standards of care and management. In 2012, the PCU initiative was therefore launched in Europe.[7] A multidisciplinary task force was created and after a two-year-long process, it came up with 40 standards deemed mandatory for quality prostate cancer care in PCUs.

In 2014, the European Association of Urology (EAU) noted the absence of standardised outcomes for men with localised prostate cancer. A working group was therefore put together to develop a 'standard set' of 10 to 15 outcomes that should be tracked for all patients with localised disease to compare differences in outcomes in different centres.[8]

Prostate Cancer UK published a report in 2013 on prostate cancer services in the UK, highlighting the so-called 'postcode lottery' of cancer care and the significant variations in the treatment that prostate cancer survivors receive. Differences were noted in prostate cancer incidence, patient experience, mortality and survival across the UK.[9] To address those issues, Prostate Cancer UK developed a quality checklist made up of 15 standards, which outlines the quality of care men with prostate cancer should expect to receive across the UK, regardless of where they live.[10]

In 2014, Tackle Prostate Cancer, a charity organisation in the UK, formed a working group consisting of prostate cancer patients and healthcare professionals, and identified nine quality standards to ensure that men with prostate cancer receive the best possible care and support.[11] The quality statements were also submitted to NICE to help with the development of its quality standards for prostate cancer.

In June 2015, NICE finally published five key statements regarding prostate cancer care to drive quality improvements in patient safety, patient experience and clinical effectiveness.[4] The quality standards, which are mostly derived from the NICE prostate cancer guidelines,[12] cover the care of men in secondary care who have been diagnosed with prostate cancer. They also cater for patients with prostate cancer who are being followed up in primary care. Unlike the Tackle Prostate Cancer statements, the NICE quality standards do not cover the recognition and referral of men with suspected prostate cancer in primary care. This will instead be covered in a separate quality standard document on referral for suspected cancer. The five NICE quality statements are listed in Table 1.

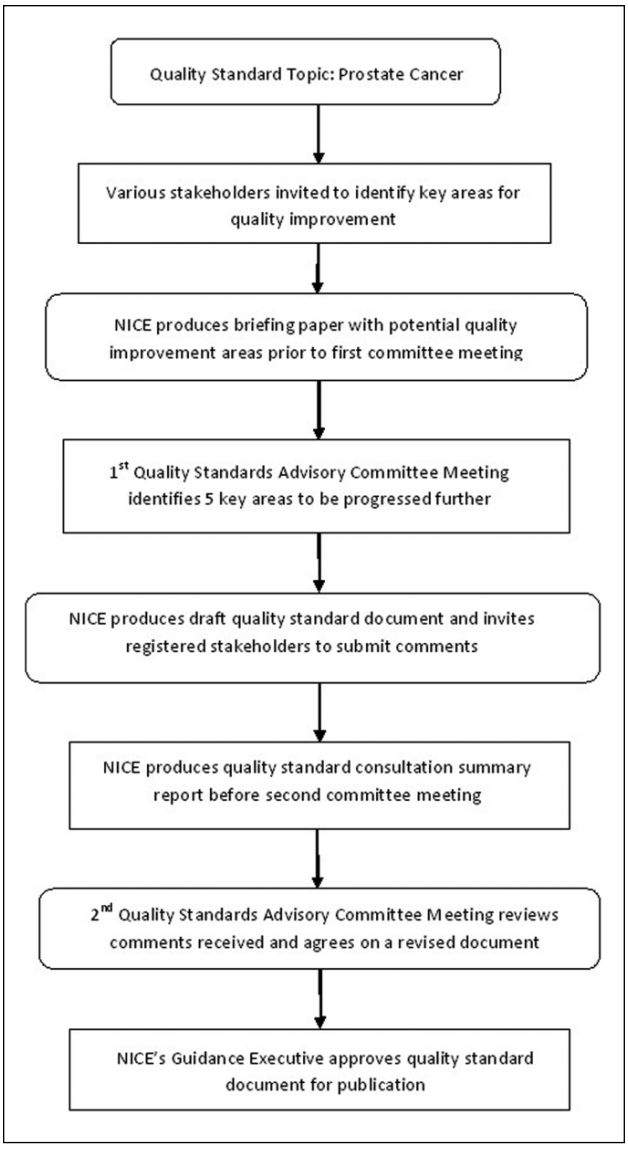

Figure 1. Flowchart showing the quality standards development process.

Quality statement 1: discussion with a named clinical nurse specialist

The 2014 National Cancer Patient Experience Survey (NCPES) highlighted that 88% of men diagnosed with prostate cancer were given the name of a clinical nurse specialist (CNS) compared to 93% of patients diagnosed with

Table 1. NICE quality standards for prostate cancer.

Quality standard 1	Men with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.
Quality standard 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.
Quality standard 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.
Quality standard 4	Men with adverse effects of prostate cancer treatment are referred to specialist services.
Quality standard 5	Men with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urology cancer multidisciplinary team.

breast cancer.[13] CNSs are key clinical contacts with whom patients can have a discussion about their treatment options immediately after diagnosis. They are there to answer any questions or concerns the patients might have during the course of their care. The NCPES showed that patients with a CNS are more likely to report a positive experience of their care. It is therefore vital that commissioners and prostate cancer services ensure that they have sufficient nurse specialists to support men with prostate cancer.

Quality statement 2: treatment options

Patients who have been diagnosed with low-risk prostate cancer should be offered the choice between radical treatment and active surveillance (AS). They should be offered the most up-to-date information and be given the opportunity to discuss the pros and cons of the various treatment options. AS can potentially reduce overtreatment and avoid treatment-related side-effects, thereby reducing costs.[14] Members of the urology multidisciplinary team (MDT) should therefore be trained in counselling patients to help them make an informed decision about their treatment, including AS.

Quality statement 3: combination therapy

Men with intermediate or high-risk localised prostate cancer, who are offered non-surgical treatment, should be offered radical radiotherapy in combination with androgen deprivation therapy (ADT). The combination has shown better outcomes compared to radical radiotherapy alone. A European randomised study demonstrated that a group who received combined luteinising hormone-releasing hormone analogue and radical radiotherapy had a 79% five-year overall survival compared with a group treated with radical radiotherapy alone.[15] This is now recommended in both NICE and EAU guidelines. In contrast, several studies have also shown that in locally advanced disease, combined radiotherapy and ADT is superior to ADT alone.[16–19] Healthcare professionals should familiarise themselves with the guidance to offer the best possible care to those patients.

Quality statement 4: managing adverse effects of treatment

Lower urinary tract symptoms and erectile dysfunction (ED) are common side-effects associated with prostate cancer treatment. Research into wellbeing services for men with prostate cancer has shown that 63% of men with prostate cancer suffer from ED and 38% complain of urinary incontinence.[20] Gastrointestinal symptoms after radical radiotherapy can also have an impact on quality of life, resulting in psychological distress and depression. According to the NCPES in 2014, 44% of patients were not fully counselled about the potential side-effects before they started treatment for prostate cancer. Local arrangements and pathways should therefore be put in place to allow patients to have access to specialist services to manage the adverse effects of treatment with on-going support from the urology MDT.

Quality statement 5: hormone-relapsed metastatic prostate cancer

Men with hormone-relapsed metastatic prostate cancer should have their treatment options discussed by the urology cancer MDT. Those patients often require the multidisciplinary involvement of the oncologist, urologist, cancer nurse specialist, palliative care and acute pain teams to optimise their comfort and quality of life. By discussing their cases in the MDT, we can involve the oncology team in their care from the start and we can discuss suitable treatment options for them, with palliative care made available if and when needed.

Discussion

To reduce the variation in treatment, NICE developed five quality standards to outline the care men with prostate

cancer are expected to receive, regardless of where they live. Among the key themes expressed in the NICE statements is the fact that patients need the appropriate support from a CNS to discuss their treatment options as well as support from specialist services to manage the adverse effects of prostate cancer treatment. Also, men should receive the best possible treatment based on current evidence and guidelines. AS should be offered as an option to patients with low-risk disease and radical radiotherapy should be offered in combination with ADT to patients with localised intermediate to high-risk disease being considered for non-surgical treatment. Those with hormone-relapsed metastatic disease should have their treatment options discussed in the urology cancer MDT. Finally, the quality statements highlight the role of the different members of the MDT to ensure that patients are fully supported at each stage of their cancer journey.

As mentioned previously, the quality standard does not cover the referral of men with suspected prostate cancer and PSA testing. This will be covered in a separate quality standard document. Although discussed by the advisory committee, the use of robotics was not an area for quality improvement and therefore was not included in the draft document. The committee felt that this area was already being addressed by NHS England as part of specialised commissioning.

Conclusions

Prostate cancer is expected to be the most common cancer in the UK by 2030.[9] With the increase in the number of new cases and the number of survivors, there is a need to improve the quality of care experienced across the UK. The development of the NICE prostate cancer quality standards is definitely a step in the right direction. However, there is still a long way to go when it comes to survivorship care and supported self-management of prostate cancer patients. Compliance with the NICE standards should nonetheless be audited in all prostate cancer units across the UK to achieve a gold standard of care.

Conflicting interests

SM is a specialist committee member of NICE prostate cancer quality standards team. AR has no conflicts of interest to declare.

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Ethical approval

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Informed consent

Not applicable.

Guarantor

SM.

Contributorship

SM conceived the idea. SM and AR drafted and edited the manuscript and approved the final version of the manuscript.

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