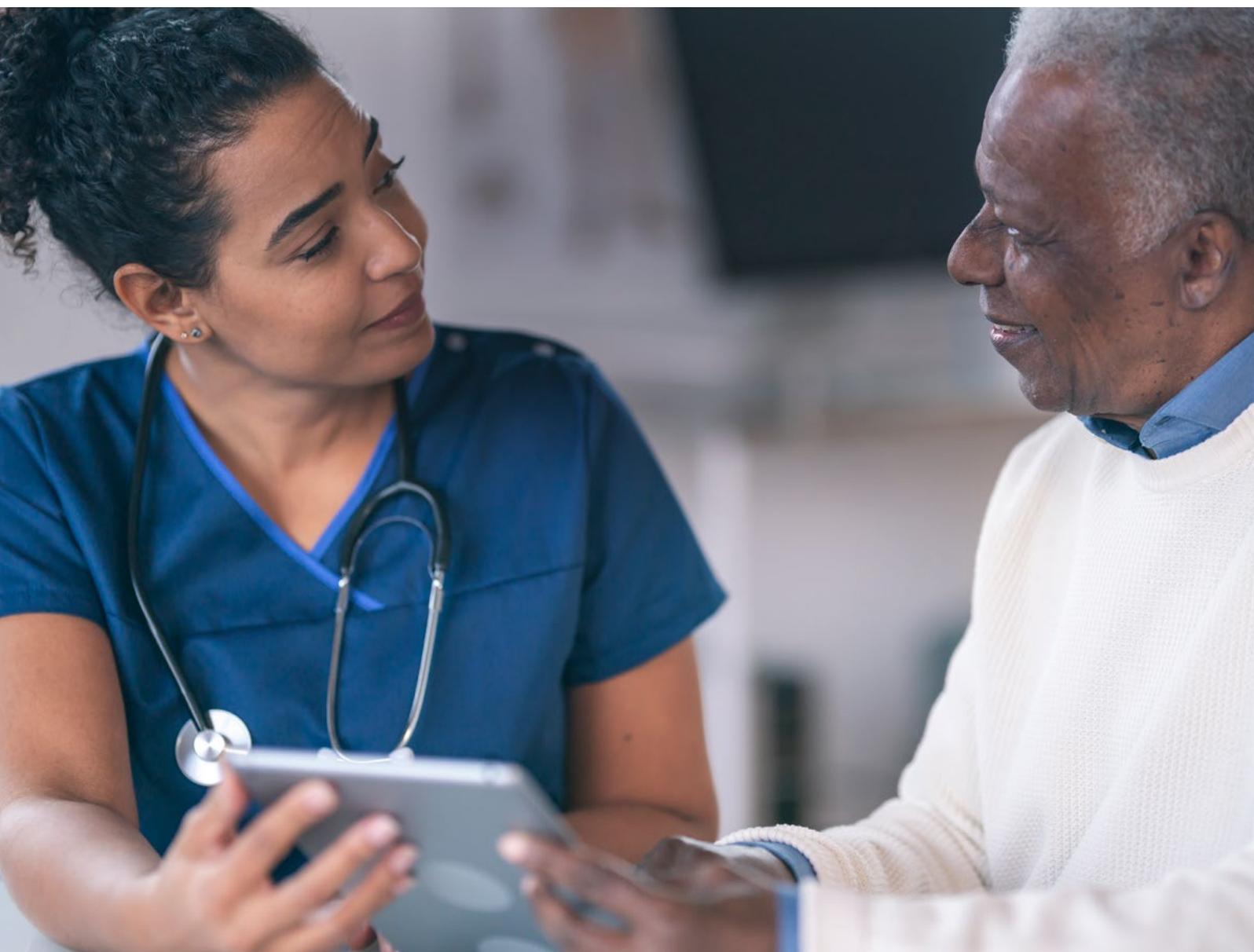


Patient Summary of Annual Report 2020 (Published May 2021)

Results of the NPCA Prospective Audit in England and Wales for men diagnosed from 1 April 2018 to 31 March 2019



National Prostate Cancer Audit

Patient Summary of Annual Report 2020 (Published May 2021)

London: The Royal College of Surgeons of England, 2021.



Royal College
of Surgeons
of England

Registered Charity No: 212808

The Royal College of Surgeons of England (RCS) is an independent professional body committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care. As part of this it supports Audit and the evaluation of clinical effectiveness for surgery.

The NPCA is based at the The Clinical Effectiveness Unit (CEU). The CEU is an academic collaboration between The Royal College of Surgeons of England and the London School of Hygiene and Tropical Medicine, and undertakes national clinical audits and research. Since its inception in 1998, the CEU has become a national centre of expertise in methods, organisation, and logistics of large-scale studies of the quality of surgical care. The CEU managed the publication of the NPCA Annual Report, 2020.

In partnership with:



THE BRITISH ASSOCIATION
OF UROLOGICAL SURGEONS

The British Association of Urological Surgeons (BAUS) was founded in 1945 and exists to promote the highest standards of practice in urology, for the benefit of patients, by fostering education, research and clinical excellence. BAUS is a registered charity and qualified medical practitioners practising in the field of urological surgery are eligible to apply for membership. It is intended that this website will be a resource for urologists, their patients, other members of the healthcare team and the wider public.



The British Uro-oncology Group (BUG) was formed in 2004 to meet the needs of clinical and medical oncologists specialising in the field of urology. As the only dedicated professional association for uro-oncologists, its overriding aim is to provide a networking and support forum for discussion and exchange of research and policy ideas.



Public Health
England

National Cancer Registration and Analysis Service (NCRAS), Public Health England collects patient-level data from all NHS acute providers and from a range of national data feeds. Data sources are collated using a single data processing system ('Encore') and the management structure is delivered through eight regional offices across England.

The NCRAS is the data collection partner for the NPCA.

Commissioned by:



Healthcare Quality
Improvement Partnership

The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes

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The glossary at the end of this report gives further explanations of the clinical terms used in this report.

DIAGNOSIS AND STAGING

for men diagnosed 18/19

52,580

men were diagnosed with prostate cancer in England and Wales between **1st April 2018 and 31st March 2019**

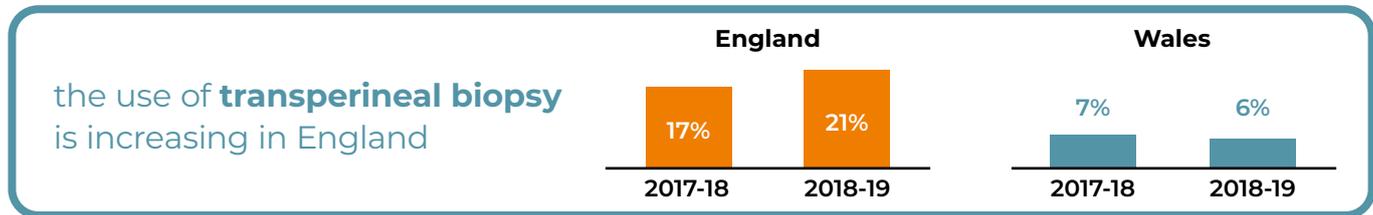


increase compared with **42,668 men** in 17/18

This may be explained by the diagnosis of two high-profile celebrities during the period, which was publicised by the media

54% of men were **70 years or older** – 56% of men in 17/18

13% of men presented with **metastatic disease** – 16% of men in 17/18



TREATMENT ALLOCATION

for men diagnosed 18/19

Low-risk, localised disease

5% of men had radical treatments and were potentially **'over-treated'** – 4% in 17/18

High-risk/locally advanced disease

29% of men did not have radical treatments and were potentially **'under-treated'** – 32% of men in 17/18

In England **18%** of men received radiation to their prostate plus lymph nodes**

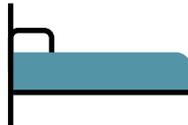
Metastatic disease

36% of men had primary docetaxel chemotherapy in England – 27% of men in 17/18*

* data currently unavailable in Wales

TREATMENT OUTCOMES

14% of men undergoing surgery 18/19 were **readmitted** within 3 months following surgery



This short-term outcome is stable compared with 17/18

Medium term outcomes are stable for men undergoing treatment in 2017 compared with 2016



Within **2 years of treatment** 1 in 10 men experienced a **severe genitourinary complication after surgery** or a **severe gastrointestinal complication after radical radiotherapy**



After surgery, men reported their **sexual function** to be **24** and **urinary continence** to be **73****

After external beam radiation, men reported their **sexual function** to be **18** and **bowel function** to be **85****

** mean scores on a scale of 1-100 with higher scores with higher scores representing better function

PATIENT EXPERIENCE OF CARE



87% of men said they were **'given the name of a clinical nurse specialist'** - 83% of men in the previous survey in 2018

91% of men **rated their care** as **8/10** OR HIGHER – 89% of men in 2018

Foreword

Welcome to the Patient Summary of the 6th Annual Report from the National Prostate Cancer Audit. This NPCA report, which covers a time period well before the pandemic, nonetheless reflects some exceptional circumstances. There was a 23% surge in prostate cancer cases diagnosed as a consequence of the diagnosis of two high-profile celebrities with prostate cancer in Feb/March 2018. Subsequently, the COVID-19 crisis has brought special challenges for both NHS staff and the NPCA team alike. However, we are pleased to report that many of the results included here, of how Trusts and Health Boards are diagnosing and treating men, show encouraging improvements from previous years, and that patient reported satisfaction is high.

That said, there are areas of practice highlighted in the report where there is significant variation between hospitals in aspects of prostate cancer diagnosis and treatment, particularly for those men with high-risk disease. For instance, the use of docetaxel, a form of chemotherapy, in newly diagnosed prostate cancer patients with advanced disease has shown a modest increase in usage from 27 to 36%, although the overall figure is still low.

The NPCA Quality Improvement (QI) Programme will continue to address issues such as this, building on its successes in 2019 and 2020, which include the addition of new quality standards, the organisation of a very well-received QI workshop and a designated QI section on the [NPCA website](#).

This year we include the results of our second patient survey. Detailed questionnaires were sent to just under 11,000 men, 18 months after they were diagnosed with prostate cancer. We would like to thank all the men who completed the survey enabling us to achieve an excellent response rate (78%). These results will enable future benchmarking, building as they do on the results of the highly successful first survey that was reported in the 2018 Annual Report.

Last year we were also fortunate that the newly formed NPCA Patient and Public Involvement Forum met for the first time, “virtually” given the COVID situation at the time. Members of the forum gave us feedback, helping us to produce last year’s Patient Summary and the report’s infographic. We met again in March 2021 and have had the benefit of their feedback again for this report. We look forward to working with them further to improve the work of the audit and the ways in which we disseminate information.



Noel Clarke

Noel Clarke
*Urological Clinical Lead
representing the British
Association of Urological
Surgeons*



Heather Payne

Heather Payne
*Oncological Clinical Lead
representing the British
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Prostate Cancer: Facts & Figures

Over 45,000 men are diagnosed with prostate cancer each year in the UK and around 400,000 men are living with and beyond prostate cancer. Around 1 in 8 men will be diagnosed with prostate cancer in their lifetime and over 11,500 men die because of the disease each year. This makes prostate cancer the second most common cause of cancer-related death for men in the UK.

What is the National Prostate Cancer Audit?

This is a national [Clinical Audit](#) of the quality of services and care provided to men with prostate cancer in England and Wales.

The National Prostate Cancer Audit (NPCA) collects information about the treatment and outcomes (what happens after treatment) of all patients newly diagnosed with prostate cancer. This includes information collected from hospital records about patients diagnosed with prostate cancer and about the care and treatment they received, and information gathered directly from patients diagnosed with prostate cancer. The information is analysed to see if hospitals are following national clinical standards, such as those published by the [National Institute for Health and Care Excellence \(NICE\)](#) and to determine whether hospitals are responding to new information from clinical studies which facilitate and inform clinicians of better ways to diagnose and treat prostate cancer. These findings are used to help define new standards for diagnosis and treatment outcomes, and to give us a better understanding of how people are being looked after. This will help NHS hospitals and other medical and healthcare practices to improve the care they provide to patients with prostate cancer.

Who is undertaking the National Prostate Cancer Audit?

The Audit is run by a team of clinicians, audit experts and cancer information specialists based at the [Royal College of Surgeons of England \(RCS\)](#), the [British Association of Urological Surgeons \(BAUS\)](#) and the [British Uro-oncology Group \(BUG\)](#).

How are data collected for the Audit?

- The Audit collects a range of different anonymised medical information from various hospital sources, which are then combined for analysis.
- [NHS Trusts](#) and [Health Boards](#) provide information about the diagnosis, treatment and outcomes for patients with prostate cancer to official organisations in England and Wales such as the [National Cancer Registration and Analytical Service \(NCRAS\)](#) and the [Wales Cancer Network](#). These organisations are allowed to collect data on patients diagnosed with cancer. Individuals can choose to exclude themselves from this process if they wish. Information on how to opt out of data collection is provided [here](#).

- The Audit also sends out a questionnaire to all men who have undergone radical treatment, in order to capture information on any side effects they might be experiencing (functional outcomes), how they were informed about their treatment options, how treatment decisions were made and to what extent they had access to a named clinical nurse specialist.
- The Audit works within strict rules covering data protection and confidentiality. The data we collect on individuals is anonymised and individual patients are not identifiable in the information provided to us.

Which patients are included in the NPCA?

The NPCA started on the 1st April 2013. All men diagnosed with prostate cancer have been included since 1st April 2014 in England and since 1st April 2015 in Wales.

What data are in the 2020 Annual Report?

The data in the 2020 Annual Report are for men diagnosed with prostate cancer between 1st April 2018 and 31st March 2019. This includes over 49,000 men diagnosed in England, and over 2,700 men diagnosed in Wales during this time period.

We report on all aspects of the care pathway for men with prostate cancer. We also compare the performance of NHS Hospital Trusts and Health Boards to identify any differences in patterns of care and to highlight where improvements may be needed.

132 NHS Hospital Trusts in England and 6 [Health Boards](#) in Wales provide prostate cancer services. All submit data for the National Prostate Cancer Audit.

We report on data from the following sources:

1. The clinical audit in England and Wales: We have collected data on 52,580 men diagnosed with prostate cancer between 1st April 2018 and 31st March 2019.
2. The patient survey in England and Wales: A questionnaire was sent to 10,756 men diagnosed with prostate cancer between 1st April and 30th September 2018 who underwent radical treatment. 8,356 men (7 in every 10 men) returned a completed questionnaire.

Key Findings in England and Wales

Data quality

- Data on the **staging/stage** of prostate cancer has been recorded well by hospitals across England and Wales. This can help the Audit measure and display information relating to the risks associated with having prostate cancer, depending on the **risk profiles** of the disease.
- Data related to both the general health status of patients and whether they had imaging tests to help provide their diagnoses remains less complete in England than in Wales. Data on other investigations to help with diagnosis remain well completed in both England and Wales.
- We are continuing to work closely with hospitals to find the best ways to help improve the quality of this information.

What are the characteristics of men who are diagnosed with prostate cancer?

- The number of men diagnosed with prostate cancer has risen quite significantly this year compared to the previous year: by 23% in both England and Wales. This is a larger year-on-year increase than we have seen previously and might be explained by the diagnoses of two high-profile celebrities with prostate cancer in February/March 2018 which were publicised in the media.
- There is a higher incidence of the disease in older men (at the time of diagnosis over one third of men were aged between 70 and 80) but much younger men can develop the condition: one third were aged between 60 and 70 and approximately 1 in 10 men were younger than 60.
- Over two thirds of men diagnosed in England, and over half of men diagnosed in Wales, were otherwise in very good health i.e. functioning normally in everyday life. In both nations 2% of men were in very poor health (i.e. symptomatic from other medical conditions and needing help in everyday life).
- 6% of men in England and 8% of men in Wales presented with **low risk** localised disease. 39% of men in England and 46% of men in Wales had **intermediate-risk** localised disease. 42% of men in England and 32% of men in Wales had disease which was **high-risk prostate cancers localised** or **locally advanced** (prostate cancer that had spread just outside the prostate but not to other areas of the body). Slightly fewer men were diagnosed with **metastatic disease** (disease which had spread beyond the prostate to other areas of the body) in England compared to last year (13% compared to 16%, which may be due to the higher numbers in other risk groups this year) but the proportion in Wales remained similar to last year at 14%.

What techniques are being used to diagnose prostate cancer?

- **Trans-rectal Ultrasound (TRUS) Guided Biopsy** is the most common method used to take samples of the prostate, as it has been in previous years. It is used in approximately 70% of patients having prostate biopsies. This type of biopsy is performed by passing a small ultrasound scanner into the rectum (back passage) and taking a series of small tissue samples from the prostate after the area has been numbed using an injection of local anaesthetic.
- 21% of patients in England and 6% of patients in Wales had biopsies performed via the perineum, which is the area of skin between the back of the scrotum and the anus (**trans-perineal biopsy**). The number of men diagnosed using this method of taking biopsies has increased over the last year compared to the number of men having trans-rectal biopsies. The trans-perineal method is able to target specific areas of the prostate more accurately in some men and this may help to improve diagnosis and make subsequent treatment more accurate. However, it is more complicated for patients and some will need to have a general anaesthetic for this procedure.
- The use of **multiparametric MRI** was not included in this report as only limited information was available. A new data item to capture mpMRI was introduced into the national cancer dataset in 2020 and the NPCA are encouraging hospitals to collect this information as a priority for subsequent reports.

What treatments are patients receiving?

- Most men with **low-risk** prostate cancer (prostate cancer unlikely to spread beyond the prostate) should be managed with **active surveillance**, a programme that includes careful monitoring to detect early signs of disease progression. A key concern is the possibility that patients with low-risk prostate cancer may have potentially unnecessary treatment which will result in an avoidable side-effect. These include sexual, urinary or bowel dysfunction. The current results show that active treatment of patients with this type of disease is very low and that most men in this group initially undergo active surveillance.
 - 1 in 25 men with low-risk prostate cancer received **radical treatment**, which is low, as it should be. The average remains stable compared to last year.
- Over two thirds of men with **locally advanced** prostate cancer are being treated with surgery to remove the prostate gland or **radiotherapy** techniques combined with hormone therapy to destroy all the cancerous cells in the prostate. However, there remains a concern, that some older men with locally advanced disease, particularly those who are otherwise healthy, are treated with hormone treatment alone. There may be very good reasons for this but in men who are otherwise fit and well, despite their age, this might represent “under-treatment”. Combined radiotherapy / hormone treatment rates have improved slightly from the previous year but substantial improvements may still be required.
 - “Under-treatment” varied greatly across the hospitals where men were treated. Some hospitals performed well, with fewer than 20 in every 100 men being found not to have had **radical treatment** (such as surgery or radiotherapy and hormone treatment combined). Other hospitals were found to have more than half of men with locally advanced prostate cancer not receiving radical treatment that they might be eligible for.
 - Two hospitals also performed significantly better than the average, outperforming the other hospitals, demonstrating that tackling under-treatment is possible and that other hospitals could be able to learn from these centres.
- In prostate cancer, the use of chemotherapy using a drug called docetaxel* is recommended for men with newly diagnosed advanced (**metastatic**) disease who are otherwise well and without other health problems. It is used in combination with other medications (ADT) that work by blocking male hormones which trigger prostate cancer cells to grow and divide. There has shown to be an increase this year in men with advanced (metastatic) disease receiving this treatment (36% compared to 27%).
- The **NICE** guidelines published in 2019 recommend that the majority of men with intermediate risk localised disease prostate cancer who are undergoing radical radiotherapy should receive **hypofractionated radiotherapy*** (safe delivery of the overall dose of radiation in fewer daily treatments) rather than **hyperfractionated radiotherapy** (radiotherapy delivered over a longer period and with many more individual “treatments” or “fractions”). The guidelines say that hypofractionated radiotherapy should be the preferred choice because it is more convenient for patients as it is given over fewer weeks, is as effective as conventional radiotherapy and is cheaper because it is less resource intensive. Our data demonstrate that for men with localised prostate cancer, more than 9 in every 10 men receiving radical radiotherapy are receiving the recommended hypofractionated treatment.
- For men with **high-risk prostate cancers** locally advanced prostate cancer who opt for radiotherapy, NICE has also endorsed the use of an additional treatment to supplement their radiotherapy, called **brachytherapy boost***. This works by putting a radioactive source into the prostate via the skin in front of the anus. This gives an extra dose of radiotherapy to the prostate. Currently only 1 in 20 men potentially eligible for this treatment are receiving this additional therapy.

*Information for use of docetaxel, hypofractionated radiotherapy and brachytherapy boost available for England only

What are the possible complications of radiotherapy or surgery?

90-day readmission

- Just over 1 in 10 men who had surgery for their prostate cancer in 2018/19 needed readmission to hospital within 90 days of their operation. The vast majority of surgical centres had readmission rates which were similar to each other.

Urinary complication after surgery

- Examples of urinary complications include bleeding, infection, narrowing or blockage of the urinary tract. A urinary complication is defined in this report as a patient needing a procedure for any of these problems within two years of their operation.
- Our results show that the rate of experiencing these severe complications following prostate cancer surgery is low. Fewer than 1 in 10 men who had surgery in 2017 experienced this type of complication.
- The proportion of these secondary procedures is largely consistent across all NHS Hospital Trusts in England and Wales which perform surgery.

Bowel complications

- Examples of side effects to the bowel include diarrhoea, bleeding, infection, ulceration, and rarely, [fistula](#) formation or strictures. A bowel complication is defined as a patient having a procedure of the large bowel and a diagnosis of radiation toxicity within two years of their [External Beam Radiotherapy \(EBRT\)](#).
- The rate of experiencing a bowel side effect following radiotherapy is also low. One in 10 men who had radiotherapy in 2017 experienced these side effects.
- The procedures used to examine and treat these side effects may involve a camera test, known as an endoscopy, to examine the cause of rectal bleeding (one of the commoner post-treatment complications) or rarely, and only in the very worst cases, bowel surgery. The proportion of side effects and secondary procedures is largely consistent across all radiotherapy centres in England and Wales.

What are the outcomes reported by men within 18 months of radical treatment?

- In the patient survey, we asked men about their views on their side effects ([functional outcomes](#)) after radical treatment.
- Men who received either surgery or [external beam radiotherapy \(EBRT\)](#) were asked to rate their function on a scale of 0 to 100 representing bad (low score) to good (high score) function.
- Overall, patients reported poor sexual function scores following radiotherapy aimed at curing the prostate cancer, with an average score of 18 out of 100. Sexual function scores following surgery to remove the prostate were also poor, with patients reporting an average score of 24 out of 100.
- Patients reported an average score of 73 out of 100 for urinary incontinence following radical prostatectomy.
- Patients reported an average score of 85 out of 100 for bowel function following external beam radiotherapy.

How do men report their experience of care?

- We also asked men about their views on their experience of care since they received a diagnosis of prostate cancer in the patient survey.
- The overall picture regarding men's experience of care is very positive.
- 8 in every 10 men were given the name of a [Clinical Nurse Specialist](#).
- 9 in every 10 men rated their overall care as 8 or above on the scale of 0 ('very poor') to 10 ('very good').

Recommendations for public and patients

1. Seek advice from a doctor if you experience any of the following: urinary symptoms, erectile problems, blood in your urine or unexplained back pain. This is also important for men who have already had treatment for prostate cancer.
2. Men with a family history of prostate, breast or ovarian cancer should have a higher vigilance for seeking advice from their GP about their prostate cancer risk.
3. Men with low-risk prostate cancer should be offered monitoring or [active surveillance](#) in the first instance as treatment is only needed if your cancer progresses. This protects men against the side effects of treatment, discussed above.
4. Men with localised prostate cancer who are offered prostate cancer treatment with combined radiotherapy and hormone treatment or radical prostatectomy should be made aware of the potential side effects including: loss of libido, problems getting or keeping erections, loss of ejaculatory function, a worsening of sexual experience, urinary incontinence and/or bowel side effects.
5. Specialist support services should be available for any man experiencing physical or psychological side effects during or following prostate cancer treatment. There should be early and ongoing access to these services, in keeping with national recommendations.
6. Sources of further information and support are available for men with prostate cancer and carers. These are accessible via GP services and from prostate cancer charities including Prostate Cancer UK (www.prostatecanceruk.org) and Tackle Prostate Cancer (www.tackleprostate.org). Both of these charities operate nationwide support networks. Information can also be found on the NHS website (www.nhs.uk/conditions/prostate-cancer/) and via Cancer Research UK (www.cancerresearchuk.org/about-cancer/prostate-cancer) and Macmillan Cancer Support (www.macmillan.org.uk/cancer-information-and-support/prostate-cancer). [Clinical Nurse Specialists](#), who should be assigned to every patient, are also an excellent source of information.

Annual Report 2020

The National Prostate Cancer Audit released the Seventh Annual Report in January 2021. This provides an in-depth analysis of the Audit's findings. This report, as well as previous Annual and Patient Reports, can be accessed [here](#).

In the future

- The National Prostate Cancer Audit will continue to work with [NHS Trusts](#) in England and [NHS Health Boards](#) in Wales to improve completeness of all data required by the National Prostate Cancer Audit.
- Working directly with individual care providers will help improve data quality and completeness to ensure the reliability of all the results we present.
- We will continue to publish our findings and highlight areas for improvement to clinicians, stakeholders, patients and the wider public to offer a benchmark of care for those receiving treatment for prostate cancer. The NPCA results are also utilised by other national initiatives including the [Clinical Outcomes Programme \(COP\)](#).
- We will carry out an additional organisational audit, giving a 'state-of-the-nation' overview of how prostate cancer services are being organised and delivered in England and Wales, in particular the provision of support services.
- We will also strengthen our collaborations with existing partners such as the British Association of the Urological Surgeons, the British Uro-oncology Group, and NHS Improvement's Getting it Right First Time programme in England, whilst reaching out to other groups to use the power of the NPCA prostate cancer data resource to monitor and improve the quality of care. A programme to establish formal collaborations will also be developed and instituted in the next two years.
- As more data becomes available the Audit will aim to develop new methods to measure additional performance indicators for individuals with prostate cancer. These will include looking at disease progression, the risks of recurrence and assessing the outcomes from newer treatments. As the data matures this will also include the reporting of mortality rates from prostate cancer. Additional time for patient follow up will be required before this can be assessed properly. The time scale for this is expected to be at least 5 years.

The next results will be published in the Audit's eight Annual Report in January 2022 and the corresponding Patient Summary by June 2022.

Glossary

Active Surveillance

This treatment is a way of monitoring prostate cancer that has a low risk of spreading and is contained within the prostate. Doctors monitor your cancer closely using PSA levels and MRI scans, and they can begin active treatment with surgery or Radiotherapy, with or without hormone therapy, if the cancer starts to grow.

Androgen Deprivation Therapy

Androgen deprivation therapy (ADT) is a hormone therapy that reduces the amount of testosterone and other male hormones (known as androgens) in a man's body. Prostate cancer cells need these androgens to grow or survive.

Brachytherapy

A treatment for prostate cancer using either the placement of permanent radioactive seeds into the prostate (termed low dose rate brachytherapy) or the temporary insertion of a source of radiation through needles temporarily placed in the prostate (termed high dose rate brachytherapy). Brachytherapy can deliver a high radiation dose to the prostate gland whilst avoiding radiation to the surrounding healthy tissue. This treatment can be used as the sole treatment but it is used more commonly in combination with conventionally delivered external beam radiotherapy in higher risk disease, known as a "brachytherapy boost".

Chemotherapy

A type of anti-cancer drug treatment, also known as "cytotoxic chemotherapy". These drugs act throughout the body (systemically) to target and kill the cancer cells. The cytotoxic drug used most commonly and effectively in prostate cancer is Docetaxel.

Clinical Nurse Specialist (CNS)

These are experienced senior nurses who have undergone specialist training in Urology. They help to administer treatment and they play an essential role in improving communication with cancer patients. They act as the first point of contact for the patient following prostate cancer diagnosis, coordinating and facilitating the patient's treatment.

Clinical Audit

Clinical audit is a method that health care professionals use to look at and improve patient care by comparing how patients are treated and studying the outcomes of care against set accepted standards and guidelines. In a clinical audit, information on the care received by patients is collected and analysed to see if individual clinicians and hospitals are following national clinical standards, such as those published by the National Institute for Health and Care Excellence (NICE). These audits also produce information for hospitals to compare their outcomes with other hospitals. The aim is to allow quality improvement to take place where it will be most helpful and will potentially improve outcomes for patients.

External Beam Radiotherapy (EBRT)

The use of high energy X-ray beams directed at the prostate to kill cancer cells. It is used to treat Localised Disease or Locally Advanced prostate cancer. It may be Hyperfractionated or Hypofractionated Radiotherapy-fractionated (see below).

Fistula

An abnormal opening between organs or other structures in the body. Fistulas are rare in prostate cancer treatment. If they occur they are usually in the pelvic area.

Functional Outcomes

How a patient's sexual function, urinary continence, bowel function and overall well-being is affected by treatment.

Gleason Score

The grade of the cells in the prostate tissue (how they look under the microscope) and the pattern of the cells. The Gleason score makes up part of the risk profile that helps to inform treatment decisions.

Hypofractionated Radiotherapy

Radiotherapy delivered using a regime of treatment during which a smaller number of high intensity radiotherapy treatments (fractions) are administered over a shorter period of time. It is used to treat intermediate risk Localised Disease prostate cancer.

Hyperfractionated Radiotherapy

Radiotherapy with a longer regime of treatment during which radiotherapy treatments (fractions) are administered at a lower dose and on more visits. It is used to treat Localised Disease or Locally Advanced prostate cancer, usually in combination with hormone treatment.

Localised Disease

When cancer is contained within the prostate gland and has not spread to any other parts of the body. Localised prostate cancer is classed into 3 risk groups depending on how likely it is that the cancer will grow quickly or spread. These risk groups depend on the following:

- the tumour distribution in the prostate (T stage)
- the grade of the cells in the prostate tissue (how they look under the microscope) (Gleason Score)
- the Prostate Specific Antigen blood test (PSA) blood test

Locally Advanced Disease

When cancer has spread to areas immediately outside the prostate. This may also be associated with early spread of cancer in to surrounding lymph nodes in the pelvic region close to the prostate gland itself.

Metastatic Disease

When cancer has spread away from the prostate to distant areas of the body, mainly to the bones and lymph nodes outside the pelvic region.

Multiparametric MRI (mpMRI)

A special type of Magnetic Resonance Imaging (MRI) scan that provides detailed images of the prostate.

National Institute for Health and Care Excellence (NICE)

An organisation responsible for providing national guidance on the promotion of good health, and the prevention and treatment of ill health.

Prostate Specific Antigen blood test (PSA)

PSA is a protein that is produced by prostatic tissue. The blood test determines the level of PSA in the blood. This indicates if further investigations are needed and makes up part of the risk profile that helps to inform treatment decisions.

Radical Treatment

Any treatment aimed at getting rid of the cancer in the prostate completely, for example surgery or external beam radiotherapy for prostate cancer.

Radiotherapy

The use of radiation to destroy cancer cells. There are different ways in which radiotherapy can be delivered, including external beam radiotherapy and brachytherapy.

Risk profiles:

Low risk prostate cancers

- are unlikely to grow or spread for many years and have all of the following:
 - a T stage of T₁ to T_{2a}
 - a Gleason score no higher than 6
 - a Prostate Specific Antigen blood test (PSA) level less than 10 ng/ml

Medium (intermediate) risk prostate cancers

- May grow or spread but many do not do so for some years. The Gleason score is the most important determinant of this.
 - a Gleason score of 7 (Gleason 3+4 behaves more indolently than Gleason 4+3)
 - a Prostate Specific Antigen blood test (PSA) level between 10 and 20 ng/ml

High-risk prostate cancers

- might grow or spread within a few years and have one of the following:
 - a T stage of T_{2c} or above
 - a Gleason score between 8 and 10
 - a high Prostate Specific Antigen blood test (PSA) level is usually but not always associated with this

Staging/stage

The anatomical extent of a cancer, in other words, how far it has spread within and around the prostate and in metastatic cases, where the disease is elsewhere in the body.

Trans-rectal Ultrasound (TRUS) Guided Biopsy

This involves using thin needles put into the prostate, after numbing the area with local anaesthetic, to take around 10-12 small samples of tissue. The biopsy is done using an ultrasound scanning probe placed in the rectum (back passage). The precise placement of these needles is enabled by the use of this ultrasound scanner.

Trans-perineal Biopsy

Taking biopsies of the prostate through the perineum (the area between the back of the scrotum and the rectum). This is performed under general anaesthetic.

Organisations

British Association of Urological Surgeons (BAUS)

A professional association for urological surgeons. Registered charity no: 1127044.

British Uro-oncology Group (BUG)

A professional association for clinical and medical oncologists specialising in the field of urology. Registered charity no: 1116828.

Clinical Outcomes Programme (COP)

An NHS initiative, managed by the Healthcare Quality Improvement Partnership (HQIP), to publish quality measures at the level of each individual consultant, team and unit using national clinical and administrative data.

Health Board

A local health organisation that is responsible for delivering all healthcare services within a regional area in Wales. Currently, there are seven Health Boards in Wales and six of these provide prostate cancer services.

Healthcare Quality Improvement Partnership (HQIP)

The Healthcare Quality Improvement Partnership (HQIP) aims to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP is led by a group of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices.

National Cancer Registration and Analytical Service (NCRAS)

A national body which collects, analyses and reports on cancer data for the NHS population in England.

NHS Trust

An NHS organisation (usually a hospital) that provides acute care services in England. A Trust can include one or more hospitals.

National Institute for Health and Care Excellence (NICE)

An organisation responsible for providing national guidance on the promotion of good health, and the prevention and treatment of ill health.

Royal College of Surgeons of England (RCS)

An independent professional body committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care. As part of this it supports audit and the evaluation of clinical effectiveness of surgery.

Wales Cancer Network

Wales Cancer Network (WCN) is an organisation that has evolved from the merger of the two Cancer Networks in Wales and the Cancer National Specialist Advisory Group (NSAG) and is designed to collect cancer-specific information in Wales.