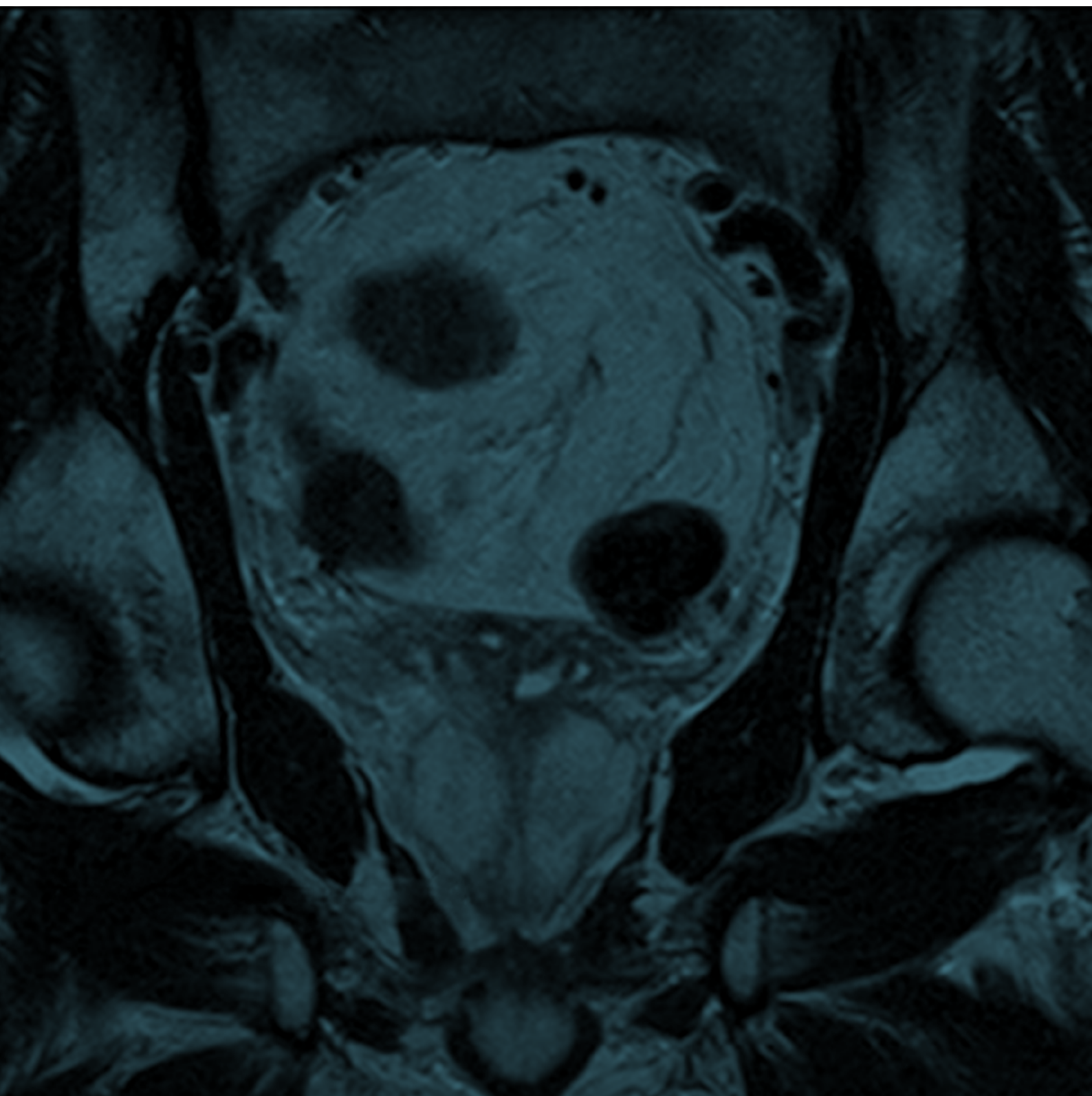


Annual Report 2019

Executive Summary



National Prostate Cancer Audit

Sixth Year Annual Report – Results of the NPCA Prospective Audit in England and Wales for men diagnosed 1 April 2017 – March 2018

London: The Royal College of Surgeons of England, 2020.



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, 2019.

In partnership with:



THE BRITISH ASSOCIATION
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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:



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, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. HQIP holds the contract to manage and develop the National Clinical Audit Programme, comprising more than 30 clinical audits that cover 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 audits, also funded by the Health Department of the Scottish Government, DHSSPS Northern Ireland and the Channel Islands.

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Executive Summary

Background

The aim of the NPCA is to assess the process of care and its outcomes in men diagnosed with prostate cancer in England and Wales. The NPCA determines whether the care received by men diagnosed with prostate cancer in England and Wales is consistent with current recommended practice and provides information to support healthcare providers, commissioners, regulators, patient groups and patients in helping improve care for patients. This is the first national audit which is able to report on process and outcome measures from all aspects of the care pathway for men with prostate cancer.

Data collection and analysis

This report presents results from the prospective audit for men diagnosed with, or treated for, prostate cancer between 1st April 2017 and 31st March 2018 in England and Wales.¹ The basis of the audit are routine data sources which include: Cancer Registry data, Cancer Outcomes and Services Dataset (COSD), Hospital Episode Statistics (HES), the Office for National Statistics (ONS), the Radiotherapy Data Set (RTDS) and the Systemic Anti-Cancer Therapy (SACT) database in England, and CaNISC, Patient Episode Database for Wales (PEDW) and ONS in Wales.

We report on specific information relating to diagnosis, staging and treatment, as well as core performance indicators, in order to compare diagnostic specialist MDTs and/or treatment centres. This is the first time we report on the use of docetaxel, brachytherapy boost (high-dose rate and low-dose rate) and radiotherapy hypofractionation.

We report on 9 performance indicators:

1. Proportion of men diagnosed with metastatic disease at first presentation.
2. Proportion of men with low-risk localised prostate cancer undergoing radical prostate cancer therapy.
3. Proportion of men with high-risk/locally advanced disease receiving radical prostate cancer therapy.
4. Proportion of men with newly diagnosed metastatic disease who receive docetaxel in combination with androgen deprivation therapy (ADT).
5. Proportion of men having radical radiotherapy for intermediate- or high-risk/locally advanced disease receiving a hypofractionated regimen.
6. Proportion of men having radical radiotherapy for high-risk/locally advanced disease receiving a brachytherapy boost.

7. Proportion of patients who had an emergency readmission within 90 days of radical prostate cancer surgery.
8. Proportion of patients experiencing at least one severe genitourinary (GU) complication within 2 years of radical prostatectomy.
9. Proportion of patients experiencing at least one severe gastrointestinal (GI) complication within 2 years of radical external beam radiotherapy.

NICE Quality Standards, 2015²

1. QS 1: men with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.
2. QS2: men with low-risk prostate cancer for whom radical treatment is suitable are also offered the option of active surveillance.
3. QS3: men with intermediate- or high-risk/locally advanced localised prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and ADT in combination.
4. QS4: men with adverse effects of prostate cancer treatment are referred to specialist services.
5. QS5: men with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer MDT.

Although the NPCA started prior to the publication of the NICE Quality Standards, the Audit provides results that can be used to evaluate to what extent prostate cancer care providers meet most of these standards.

Last year we reported results from the NPCA patient survey which asked about how men were informed about their treatment options, how treatment decisions were made and to what extent they had access to a named clinical nurse specialist (CNS) (QS1). Further patient surveys are planned for 2020 and current information with respect to CNS provision can be found in section 3.6. We also present results for indicators of possible over-treatment in men with low-risk disease and potential under-treatment in men with high-risk/locally advanced disease which can be found in section 3.4 (QS2 and QS3).

The results from our annual organisational survey³ indicate whether providers of cancer services have specialist services on-site and can be found in section 3.6 (QS4).

¹ Medium-term indicators require longer follow-up (up to two years' post-treatment) so the reporting time period for severe GU or GI complications is 1st January to 31st December 2016.

² Prostate Cancer, NICE Quality Standard [QS91], 2015.

³ <https://www.npca.org.uk/reports/npca-organisational-audit-2019/>

Currently data with respect to hormone-relapse and recurrence are not available from routine national datasets and so an assessment of treatment options for these men is not possible (QS5).

In addition to the results linked directly to the NICE Quality Standards, the NPCA reports on aspects of care that capture ongoing developments in the way men with prostate cancer are being assessed and treated. The Audit also provides evidence on the adoption of newer technologies (e.g. use of multiparametric MRI scanning before the prostate biopsy and the type of biopsy used) and treatments (robotic-assisted prostatectomy and intensity-modulated radiotherapy), as well as the impact on patient outcomes.

Further to the publication of updated NICE guidelines in May 2019⁴ we report, for the first time, the uptake of docetaxel in men with newly presenting metastatic disease, the use of hypofractionated radiotherapy and the use of brachytherapy boost in men with high-risk/locally advanced prostate cancer.

How to use this report and the NPCA website

The information presented here compares prostate cancer services locally and nationally. We recommend that this be a starting point for reflection on the reasons behind variation in practice and outcomes, and that this report be used to identify areas for potential quality improvement.

A breakdown of results at the level of each Trust and specialist MDT are provided in the appendices and a full breakdown of the organisational survey is also available on our website.⁵ Users of this report should take time to identify areas for improvement in data completeness, service availability and patient outcomes. We also encourage clinical leads to attend our Quality Improvement workshop later this year and these results will be the basis for discussion and improvement planning. We welcome feedback on how the audit outputs can be made more useful.

It is also important to highlight that treatment outcome results are published as part of the Clinical Outcomes Programme (COP) and the National Clinical Audit Benchmarking (NCAB) to enable dissemination of our findings to clinicians, stakeholders, patients and the wider public. We also encourage that users of this report also access these resources to drive quality improvement.

Patients can use these results to start conversations with their care providers and a lay summary of the report will be published early next year. Previous lay summaries of our Annual Reports can be found on our website at:

www.npca.org.uk

⁴ Prostate cancer: diagnosis and management. NICE Guideline [NG131], 2019.

⁵ <https://www.npca.org.uk/reports/npca-organisational-audit-2019/>

Key Messages

Data quality

1. Completeness of key variables remains low in England (multiparametric MRI and prostate biopsy type). New data items for multiparametric MRI and prostate biopsy type will be introduced into COSD from April next year. We encourage all prostate MDTs in England to use these data items so that they can provide reliable results about key parts of the diagnostic pathway.

Service organisation

2. Multiparametric MRI is available at 98% of the diagnostic Trusts in England and Wales. Its use is increasing, with a concomitant increase in its use prior to biopsy.
3. Trans-perineal biopsy is performed in 77% of the diagnosing Trusts in England and Wales and its use has increased since 2018.
4. Nurse specialists are available in 98% of diagnostic Trusts.
5. The availability of support services is very good. 98% of specialist MDTs have sexual function and continence services available and all have psychological counselling available. However, less than half of radiotherapy centres have a specialist gastrointestinal service.
6. The majority of radiotherapy centres use rotational IMRT with cone beam CT (and not fiducial markers or kilovoltage (KV) imaging).
7. According to the organisational survey, there is a consensus across oncology centres about when to administer docetaxel for newly diagnosed hormone sensitive disease, with the majority of centres supporting its use in high and low volume M1 disease.
8. There is substantial variation in neo-adjuvant and adjuvant ADT treatment duration across the country for low-risk and all high-risk disease.

Prospective audit

9. The proportion of men presenting with metastatic disease at diagnosis is stable.
10. The potential “over-treatment” of men with low-risk disease has remained low at 4%.
11. The potential “under-treatment” of men with high-risk/locally advanced disease has decreased slightly (32%).
12. This is the first time the NPCA have reported on the use of primary docetaxel use in metastatic disease (27%).

13. This is the first time the NPCA has reported the use of hypofractionated radiotherapy. We report its use at 91% in intermediate-risk cases and 59% in high-risk/locally advanced cases, with substantial national variation in the latter.
14. This is the first time the NPCA have reported on the use of brachytherapy boost. We report its use at 5% in high-risk/locally advanced cases, the majority of which are restricted to a few specialist MDTs.
15. Genitourinary complications following radical prostatectomy have improved. Approximately one in ten men experience at least one severe genitourinary complication within two years of their prostatectomy.
16. The rate of bowel dysfunction following radical radiotherapy is stable and consistent with that reported last year. One in ten men experience a severe gastrointestinal complication within two years of their radiotherapy.

Recommendations

For prostate cancer teams (local and specialist MDTs) within NHS Trusts/Health Boards

- Where appropriate, every man should get a multiparametric MRI prior to initial prostate biopsy (R1).
- Where appropriate, increase the use of trans-perineal prostate biopsy to maximise diagnostic accuracy (specifically anterior tissue), whilst balancing against resource constraints and the risk of side effects (R2).
- NHS Organisations in England should aim to achieve high completeness of key data items capturing performance status, mpMRI and prostate biopsy type submitted to the national cancer registration service and use the updated Cancer Outcomes Services Dataset (COSD) from April 2020. A clinician responsible for reviewing and checking their team’s data returns should be identified, mirroring the approach in Wales where data completeness remains high (R3).
- Continue to advocate active surveillance in the first instance for men with low-risk prostate cancer (R4).
- Investigate why men with high-risk/locally advanced disease are not considered for radical treatment (R5).
- Where appropriate, offer primary docetaxel to people with newly diagnosed metastatic disease (R6).
- Radiotherapy centres should continue to increase the use of hypofractionated radiotherapy, especially in intermediate-risk disease (R7).

- Consider establishing radiotherapy centre specialist gastrointestinal services to offer advice to people with bowel-related side effects of radiotherapy (R8).
- Consider brachytherapy in combination with external beam radiotherapy for patients with intermediate- or high-risk prostate cancer (R9).
- Ensure access to nurse specialists and their services for patients with prostate cancer (R10).

For patients

- Seek advice from a doctor if you experience any of the following: urinary symptoms, erectile problems, blood in your urine or unexplained back pain (R11).
- Men with a family history of prostate, breast or ovarian cancer should have a higher vigilance for seeking advice from their GP (R12).
- Men who are referred to a specialist for suspected prostate cancer should have a multiparametric MRI scan before having a biopsy (R13).
- Men with low-risk prostate cancer ensure should be offered disease monitoring in the first instance as treatment is only needed if your cancer progresses (R14). This protects men against the side-effects of treatment, discussed below.
- Men newly diagnosed with metastatic disease should be offered chemotherapy according to new prostate cancer guidelines (R15).
- Ensure men who are offered prostate cancer treatment are aware of the 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 (R16).
- 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 (R17).
- Sources of further information and support should be 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 (R18).

For commissioners and health care regulators

Review and identify regional performance indicators for prostate cancer. Pay particular attention to variations in service provision for neo-adjuvant and adjuvant ADT treatment duration for low-risk and all high-risk disease. Where variation is apparent, agree quality improvement action plans and present these to the Trust Board and/or CCG. Trust Boards and CCGs should follow-up implementation progress (R19).

Table 1. NPCA Annual Report 2019: Recommendations, key findings and related national guidance

No.	Recommendation	Audience	Annual Report 2019 findings underlying recommendation	Annual Report 2018 results	National guidance
R1	Where appropriate, every man should get a multiparametric MRI prior to initial prostate biopsy.	Prostate cancer teams	98% of NHS Organisations in England and Wales are able to perform mpMRI onsite (Results 3.6). If a multiparametric MRI was used, 87% were performed pre-biopsy in England and 67% in Wales. (Results 3.3 and Table 2).	Increase compared with previous year - 80% of men in England and 41% in Wales.	NICE Guideline [NG131], 2019 <i>1.2.2 Offer multiparametric MRI as the first-line investigation for people with suspected clinically localised prostate cancer.</i>
R2	Where appropriate, increase the use of trans-perineal prostate biopsy to maximise diagnostic accuracy (specifically anterior tissue), whilst balancing against resource constraints and the risk of side effects.	Prostate cancer teams	17% of men in England and 7% of men in Wales had a trans-perineal prostate biopsy. 75% of NHS Organisations in England and Wales are able to perform trans-perineal prostate biopsy (Results 3.6).	Increase compared with previous year - 12% of men in England and 4% in Wales.	National guidance currently unavailable.
R3	NHS Organisations in England should aim to achieve high completeness of key data items capturing performance status, mpMRI and prostate biopsy type submitted to the national cancer registration service and use the updated Cancer Outcomes Services Dataset (COSD) from April 2020. A clinician responsible for reviewing and checking their team's data returns should be identified, mirroring the approach in Wales where data completeness remains high.	Prostate cancer teams	Data completeness in England: Performance status (52%) mpMRI performed (51%) Biopsy performed (52%) Data completeness in Wales: Performance status (100%) mpMRI performed (98%) Biopsy performed (100%) (Results 3.2, Table 1, Table 2).	Minimal change in England compared with previous year: Performance status (51%) mpMRI (51%)	<i>The Cancer Outcome and Services Data set (COSD) has been the national standard for reporting cancer in the NHS in England since January 2013. Feedback reports for the data submitted are available through the CancerStats website.</i>
R4	Continue to advocate active surveillance in the first instance for men with low-risk prostate cancer.	Prostate cancer teams	4% of men diagnosed with low-risk localised cancer in England Wales underwent radical prostate cancer therapy within 12 months of diagnosis. There were no specialist MDTs with significantly higher levels of 'potential over-treatment' compared with the national average after case-mix adjustment. (Results 3.4, Performance indicator 2, Figure 2).	No change compared with previous year - 4% of men in England and Wales.	NICE Quality Standard [QS91], 2015 <i>QS2: men with low-risk prostate cancer for whom radical treatment is suitable are also offered the option of active surveillance.</i> NICE Guideline [NG131], 2019 <i>1.3.7 Offer a choice between active surveillance, radical prostatectomy or radical radiotherapy to people with low-risk localised prostate cancer for whom radical treatment is suitable.</i>

No.	Recommendation	Audience	Annual Report 2019 findings underlying recommendation	Annual Report 2018 results	National guidance
R5	Investigate why men with high-risk/locally advanced disease are not considered for radical treatment.	Prostate cancer teams	68% of men diagnosed with locally-advanced prostate cancer underwent radical treatment within 12 months of diagnosis in England and Wales equating to 32% of men being potentially undertreated. 'Potential under-treatment' by NHS provider varied (15% to 56%) and there were four specialist-MDTs which had significantly higher levels compared with the national average following adjustment for case-mix. (Results 3.4, Performance indicator 3, Figure 3).	Slight reduction compared with previous year – 67% of men in England and Wales.	NICE Guideline [NG131], 2019 <i>1.3.13 Do not offer active surveillance to people with high-risk localised prostate cancer.</i> NICE Guideline [NG131], 2019 <i>1.3.14 Offer radical prostatectomy or radical radiotherapy to people with high-risk localised prostate cancer when it is likely the person's cancer can be controlled in the long term.</i>
R6	Where appropriate, offer primary docetaxel to people with newly diagnosed metastatic disease.	Prostate cancer teams	27% of men received primary docetaxel in combination with standard ADT (ranging from 0% to 39% by NHS provider in England). (Results 3.4, Performance indicator 4, Figure 4).	N/A*	NICE Guideline [NG131], 2019 <i>1.5.6 Offer docetaxel chemotherapy to people with newly diagnosed metastatic prostate cancer who do not have significant comorbidities</i>
R7	Radiotherapy centres should continue to increase the use of hypofractionated radiotherapy, especially in intermediate-risk disease.	Prostate cancer teams	91% of men receiving radical radiotherapy for intermediate-risk disease received a hypofractionated regimen (ranging from 12% to 100% by NHS provider in England).	N/A*	NICE Guideline [NG131], 2019 <i>1.3.17 For people having radical external beam radiotherapy for localised prostate cancer: offer hypofractionated radiotherapy (60 Gy in 20 fractions) using IMRT, unless contraindicated</i>
R8	Consider establishing radiotherapy centre specialist gastrointestinal services to offer advice to people with bowel-related side effects of radiotherapy.	Prostate cancer teams	37.5% of radiotherapy centres have a specialist gastrointestinal service (33/56 centres). (Results 3.6, Organisational Audit)	N/A*	NICE Guideline [NG131], 2019 <i>1.3.39 Offer people with signs or symptoms of radiation-induced enteropathy care from a team of professionals with expertise in radiation-induced enteropathy (who may include oncologists, gastroenterologists, bowel surgeons, dietitians and specialist nurses).</i>
R9	Consider brachytherapy in combination with external beam radiotherapy for patients with intermediate- or high-risk prostate cancer.	Prostate cancer teams	5% of men receiving radical radiotherapy for high-risk/locally advanced disease received a brachytherapy boost. There were seven specialist MDTs which saw a substantially higher proportion of men receiving this multimodal approach than the others (between 14% and 40%). (Results 3.4, Performance indicator 6, Figure 7).	N/A*	NICE Guideline [NG131], 2019 <i>1.3.22 Consider brachytherapy in combination with external beam radiotherapy for people with intermediate- and high-risk localised prostate cancer.</i>

No.	Recommendation	Audience	Annual Report 2019 findings underlying recommendation	Annual Report 2018 results	National guidance
R10	Ensure access to nurse specialists and their services for patients with prostate cancer.	Prostate cancer teams	98% of Trusts/Health Boards had a CNS but the type of CNS varied across the country. 91% had a CNS dedicated to prostate cancer with 65% having a general urology nurse specialist (Figure 11). Approximately one third of Trusts had either an oncology CNS (33%) or an advanced prostate cancer CNS (31%). (Results 3.6, Organisational Audit)	Organisational audit results were previously reported in the 2014 Annual Report. 97% of providers in England and 90% in Wales had a CNS.	NICE Quality Standard [QS91], 2015 <i>QS 1 Men with prostate cancer should have a discussion about treatment options and adverse effects with a named nurse specialist.</i>
R11	Seek advice from a doctor if you experience any of the following: urinary symptoms, erectile problems, blood in your urine or unexplained back pain.	Patients	Overall 16% of men in England Wales were diagnosed with metastatic disease at presentation (ranging from 10% to 26% by specialist MDT). (Results 3.4, Performance indicator 1, Figure 1).	No change compared with previous year – 16% of men in England and Wales	NHS Long Term Plan for Cancer 2019 <i>‘...build on work to raise greater awareness of symptoms of cancer, lower the threshold for referral by GPs, accelerate diagnosis and treatment.’</i> Cancer delivery plan for Wales 2016 - 2020 <i>‘... develop a programme of awareness campaigns for cancer’</i>
R12	Men with a family history of prostate, breast or ovarian cancer should have a higher vigilance for seeking advice from their GP.	Patients	Overall 16% of men in England Wales were diagnosed with metastatic disease at presentation (ranging from 10% to 26% by specialist MDT). (Results 3.4, Performance indicator 1, Figure 1).	No change compared with previous year – 16% of men in England and Wales	NHS Long Term Plan for Cancer 2019 <i>‘...build on work to raise greater awareness of symptoms of cancer, lower the threshold for referral by GPs, accelerate diagnosis and treatment.’</i> Cancer delivery plan for Wales 2016 - 2020 <i>‘...develop a programme of awareness campaigns for cancer’</i>
R13	Men who are referred to a specialist for suspected prostate cancer should have a multiparametric MRI scan before having a biopsy.	Patients	If a multiparametric MRI was used, 87% were performed pre-biopsy in England and 67% in Wales. (Results 3.3 and Table 2). 98% of NHS Organisations in England and Wales are able to perform mpMRI onsite (Results 3.6).	Increase compared with previous year - 80% of men in England and 41% in Wales.	NICE Guideline [NG131], 2019 <i>1.2.2 Offer multiparametric MRI as the first-line investigation for people with suspected clinically localised prostate cancer.</i> <i>1.2.1 Do not routinely offer multiparametric MRI to people with prostate cancer who are not going to be able to have radical treatment.</i>
R14	Men with low-risk prostate cancer should be offered disease monitoring in the first instance as treatment is only needed if your cancer progresses.	Patients	4% of men diagnosed with low-risk localised cancer in England Wales underwent radical prostate cancer therapy within 12 months of diagnosis. There were no specialist MDTs with significantly higher levels of ‘potential over-treatment’ compared with the national average after case-mix adjustment.	No change compared with previous year - 4% of men in England and Wales.	NICE Quality Standard [QS91], 2015 <i>QS2: men with low-risk prostate cancer for whom radical treatment is suitable are also offered the option of active surveillance.</i> NICE Guideline [NG131], 2019 <i>1.3.7 Offer a choice between active surveillance, radical prostatectomy or radical radiotherapy to people with low-risk localised prostate cancer for whom radical treatment is suitable.</i>

/Table 1 continued

No.	Recommendation	Audience	Annual Report 2019 findings underlying recommendation	Annual Report 2018 results	National guidance
R15	Men newly diagnosed with metastatic disease should be offered chemotherapy according to new prostate cancer guidelines.	Patients	27% of men received primary docetaxel in combination with standard ADT (ranging from 0% to 39% by NHS provider in England). (Results 3.4, Performance indicator 4, Figure 4).	N/A	NICE Guideline [NG131], 2019 <i>1.3.24 Discuss the option of docetaxel chemotherapy with people who have newly diagnosed non-metastatic prostate cancer and are starting long-term ADT, have no significant comorbidities and have high-risk disease.</i>
R16	Ensure men who are offered prostate cancer treatment are aware of the 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.	Patients, Commissioners and health care regulators	9% of men experienced at least one severe genitourinary (GU) complication within two years after radical prostatectomy. Following adjustment, two surgical centres had significantly worse rates of severe bowel toxicity compared with other NHS providers in England and Wales. (Results 3.4, Performance indicator 8, Figure 9). 10% of men experienced at least one severe bowel complication within two years after radical radiotherapy. Following adjustment, three centres had significantly worse rates of severe bowel toxicity compared with other NHS providers in England and Wales. (Results 3.4, Performance indicator 9, Figure 10).	Small improvement in GU complications compared with previous report – 10% of men in England and Wales. No change in GI complications compared with previous report – 10% of men in England and Wales.	NICE Guideline [NG131], 2019 <i>1.1.12 Tell people with prostate cancer and their partners or carers about the effects of prostate cancer and the treatment options on their: sexual function physical appearance continence other aspects of masculinity.</i> <i>Support people and their partners or carers in making treatment decisions, taking into account the effects on quality of life as well as survival.</i> NICE Quality Standard [QS91], 2015 <i>QS4: men with adverse effects of prostate cancer treatment are referred to specialist services.</i>
R17	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.	Patients, Commissioners and health care regulators	Support services were found to be widely available in England and Wales. 98% of specialist MDTs had sexual function and continence services with all specialist MDTs having psychological counselling services. However, less than half of radiotherapy centres have a specialist gastrointestinal service. (Results 3.6).	Organisational audit results were previously reported in the 2014 Annual Report. The provision of support services has increased since this time - 50% of providers in England and 60% in Wales provided the full array of support services including cancer advisory centres, sexual function and	NICE Guideline [NG131], 2019 <i>1.1.11 Ensure that mechanisms are in place so people with prostate cancer and their primary care providers have access to specialist services throughout the course of their disease.</i>
R18	Sources of further information and support should be 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	Patients	Recommendation in light of R13 and R14.	N/A	NICE Guideline [NG131], 2019 <i>1.1.3 Offer people with prostate cancer advice on how to get information and support from websites, local and national cancer information services, and from cancer support groups.</i> <i>1.1.4 Choose or recommend information resources for people with prostate cancer that are clear, reliable and up to date. Ask for feedback from people with prostate cancer and their carers to identify the highest quality information resources.</i>

/Table 1 continued

No.	Recommendation	Audience	Annual Report 2019 findings underlying recommendation	Annual Report 2018 results	National guidance
R19	Review and identify regional performance indicators for prostate cancer. Pay particular attention to variations in service provision for neo-adjuvant and adjuvant ADT treatment duration for low-risk and all high-risk disease. Where variation is apparent, agree quality improvement action plans and present these to the Trust Board and/or CCG. Trust Boards and CCGs should follow-up implementation progress.	Commissioners and health care regulators	Recommendation in light of R1 – R13.	N/A	N/A

*Further to the recent publication of updated NICE guidance comparative data for these performance indicators will be published in future reports

DIAGNOSIS AND STAGING

42,668

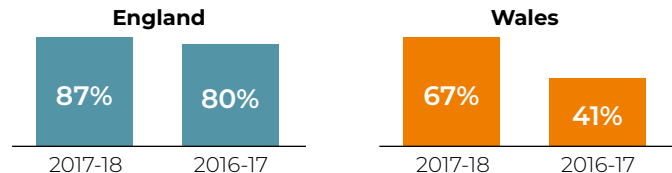
men were diagnosed with prostate cancer in England and Wales between 1st April 2017 and 31st March 2018



16% of men presented with metastatic disease – no change from 16/17



Of the men having a **multiparametric MRI**, more are having this carried out **pre-biopsy**



the use of **transperineal biopsy** is increasing

17% in 17/18 compared with **12%** in 16/17

7% in 17/18 compared with **4%** in 16/17

TREATMENT ALLOCATION

Low-risk, localised disease

4% of men had radical treatments and were potentially **'over-treated'** - no change from 16/17

Intermediate-risk disease

91% of men having radical radiotherapy in England had a hypofractionated regimen*

* data currently unavailable in Wales

High-risk/locally advanced disease

32% of men did not have radical treatments and were potentially **'under-treated'** - **33%** of men in 16/17

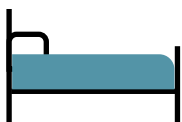
In England **5%** of men having radical radiotherapy also had a brachytherapy boost*

Metastatic disease

27% of men had primary docetaxel chemotherapy in England*

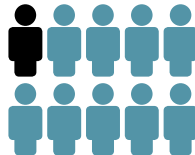
TREATMENT OUTCOMES

14%



of men diagnosed 17/18 were **readmitted** within 3 months following surgery

This short-term outcome is stable compared with 16/17



Medium term outcomes are also stable – no change for men undergoing treatment in 2016 compared with 2015

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

NURSE SPECIALISTS

98%

of trusts/health boards have clinical nurse specialists (CNS)



91%

have a **dedicated prostate cancer CNS**

SUPPORT SERVICES



100% of specialist MDTs have **psychological counselling** available

98% have **sexual function** and **continence services**