NPCA Quality Improvement Action Plan Template_ Annual Report 2019[1,2]

NPCA
National Prostate Cancer Audit

Recommendation	Suggested actions	Responsible person	Progress
1 Trusts should work to maintain or improve the quality of data submitted to the National Prostate Cancer Audit (NPCA), including detailed clinical data to allow the most accurate risk adjustment to be carried out. TNM stage, PSA and Gleason score should be recorded in at least 90% of cases.	• Appoint a clinical data lead. • Use the CancerStats website to review data quality in real time. • Raise the profile of performance data across the wider multidisciplinary team (MDT) at governance meetings or by sharing data. • Integrate data collection into MDT meetings. • Integrate clinical validation into the COSD submission process.	• MDT leads • MDT members • MDT coordinators • Audit staff • Cancer managers	
2 All MDTs should appoint a 'clinical data lead' with protected time to allow promotion of data quality, governance and quality improvement (to be measured through future rounds of organisational audit).	• Agree protected time for one clinical MDT member. • Support the clinical validation of data. • Feedback monthly data quality reports to the wider MDT. • Establish links with local commissioner and invite them to view the Trust's NPCA data. • Network with other data leads to share best practice. • Attend local/regional/national meetings to understand context and share best practice.	• MDT leads • Cancer managers	
3 All patients should be seen by a Clinical Nurse Specialist (CNS) (NICE Quality Standard 2015: QS5).[3]	• Ensure that the CNS establishment is appropriate to the prostate cancer workload. • Ensure that all nursing posts are staffed. • Ensure that clear referral pathways exist. • Review the activities of the nursing team and reduce their administrative burden. • Involve nurses in the validation of data submissions.	• MDT leads • CNS • Cancer managers • Commissioners	

4 All men should have a multiparametric MRI (mpMRI) prior to prostate biopsy (NICE 2019: 1.2.2).[4]	• Ensure that mpMRI and prostate biopsy data are submitted to the audit. • Review patient pathways and access to investigations. • Review individual clinician practices.	• MDT leads • Clinicians	
5 Specialist MDTs with a higher than expected proportion of men receiving radical treatment for low-risk disease should perform a detailed case-note review to determine why patients are not undergoing active surveillance and being potentially over-treated (NICE 2019: 1.3.7). [4]	• Ensure that data on all treatments are appropriately coded for in Hospital Episode Statistics (HES) and the Radiation Therapy Data Set (RTDS). • Review treatment policies for prostate cancer patients; review the pathway from diagnosis to treatment to ensure that it is as expeditious as possible.	• Specialist MDT leads • MDT leads • Clinicians • Commissioners	
6 Specialist MDTs with a lower than expected proportion of men receiving radical treatment for high-risk or locally advanced disease should perform a detailed case-note review to determine why patients are being potentially under-treated (NICE 2019: 1.3.14). [4]	• Ensure that data on all treatments are appropriately coded for in Hospital Episode Statistics (HES) and the Radiation Therapy Data Set (RTDS). • Review treatment policies for prostate cancer patients; review the pathway from diagnosis to treatment to ensure that it is as expeditious as possible.	• Specialist MDT leads • MDT leads • Clinicians • Commissioners	
7 Specialist MDTs should ensure that men with newly diagnosed metastatic disease are offered docetaxel chemotherapy (NICE 2019: 1.5.6). [4]	• Ensure that docetaxel data in SACT are submitted to the audit. • Review patient pathways and access to oncology services. • Review individual clinician practices.	• Specialist MDT leads • MDT leads • Clinicians	
8 Specialist MDTs with a lower than expected proportion of men receiving a brachytherapy boost for men receiving radical radiotherapy for high-risk/locally	• Ensure that data on radiotherapy/brachytherapy are appropriately coded for in the Radiation Therapy Data Set (RTDS).	• Specialist MDT leads • MDT leads	

advanced disease should consider brachytherapy in combination with radiotherapy (NICE 2019: 1.3.22). [4]	• Review treatment policies for radiotherapy candidates and referral pathways for brachytherapy boost treatment.	• Radiation oncologists • Commissioners	
9 Radiotherapy centres should ensure that men receiving radical radiotherapy for intermediate- or high-risk/locally advanced disease receive a hypofractionated regimen (NICE 2019: 1.3.7). [4]	• Ensure that data on radiotherapy are appropriately coded for in the Radiation Therapy Data Set (RTDS). • Review radiotherapy centre and individual clinician practices.	• Specialist MDT leads • MDT leads • Radiation oncologists • Commissioners	
10 Surgical centres with a higher than expected proportion of men being readmitted within 90 days should perform a detailed case-note review to determine why patients are being readmitted more often than other centres.	• Review surgical practices for prostate cancer patients; review the pathway from surgery to 90 days after treatment to ensure that patients are optimally managed.	• Specialist MDT leads • MDT leads • Surgeons • Commissioners	
11 Surgical centres with a higher than expected proportion of men requiring a genitourinary procedure within 2 years should perform a detailed case-note review to determine why patients are experiencing higher than average genitourinary toxicity.	• Review surgical practices for prostate cancer patients; review the pathway from surgery to 2 years after treatment to ensure that patients are optimally managed. • Offer appropriate counselling and management for men experiencing treatment-related adverse effects. This includes access to specialist erectile dysfunction and continence services (NICE 2019: 1.3.33/36).[4]	• Specialist MDT leads • MDT leads • Surgeons • Commissioners	
12 Radiotherapy centres with a higher than expected proportion of men requiring a gastrointestinal procedure within 2 years disease should perform a detailed case-note review to determine why patients are experiencing higher than average gastrointestinal toxicity.	• Review radiotherapy practices for prostate cancer patients; review the pathway from radiotherapy to 2 years after treatment to ensure that patients are optimally managed. • Offer appropriate counselling and management for men experiencing treatment-related adverse effects. This includes access to a team	• Specialist MDT leads • MDT leads • Radiation oncologists • Commissioners	

	of professionals with expertise in radiation-induced enteropathy (NICE 2019: 1.3.39).[4]		

The NPCA welcome your feedback on this quality improvement template to be used in conjunction with the NPCA Annual Report 2019 provider level results [1,2] and quality improvement resources[5] presented on our website.

Please contact the NPCA team npca@rcseng.ac.uk if you have any questions related to your results, data collection, the outlier process or service improvement.

References

1. NPCA Annual Report 2019 https://www.npca.org.uk/reports/npca-annual-report-2019/
2. Individual provider-level results from the NPCA https://www.npca.org.uk/provider-results/
3. NICE Quality Standards 2015 https://www.nice.org.uk/guidance/qs91/chapter/List-of-quality-statements
4. NICE Prostate Cancer: Diagnosis & Management 2019 https://www.nice.org.uk/guidance/NG131
5. NPCA Quality Improvement resources https://www.npca.org.uk/resources/quality-improvement-resources/