

# NPCA

National Prostate Cancer Audit

## National Prostate Cancer Audit

### Scoping Document

November 2023

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**NATCAN**

National Cancer Audit  
Collaborating Centre



Royal College  
of Surgeons  
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ADVANCING SURGICAL CARE

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**HQIP**

Healthcare Quality  
Improvement Partnership

The National Cancer Audit Collaborating Centre (NATCAN) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). NATCAN delivers national cancer audits in non-Hodgkin lymphoma, bowel, breast (primary and metastatic), oesophago-gastric, ovarian, kidney, lung, pancreatic and prostate cancers. 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.

<https://www.hqip.org.uk/national-programmes>

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## Executive Summary

The National Prostate Cancer Audit (NPCA) joined the National Cancer Audit Collaborating Centre (NATCAN) in July 2023 and will continue to support access to the most appropriate treatments for patients depending on stage of disease, reduce variation amongst providers and improve patient experience of care. The scope of the NPCA is directly informed by national standards, professional guidance and active patient involvement. The NPCA's performance indicators, which measure provider performance in these areas, reflect this.

The move into NATCAN offers multiple opportunities for cross-audit innovations, including the development of new performance indicators, new and improved ways of delivering outputs to patients and public, and understanding and innovative mechanisms of quality improvement. It will also see the release of clinical and policy relevant "State of the Nation" annual reports.

The focus on research into the causes of variation observed at all stages of the patient pathway will remain and the NPCA will continue to actively coordinate and collaborate with other national initiatives creating a unique environment that brings together input from clinicians, methodologists, and patients with collaborative working relationships and data providers. Finally, access to complete and timely data remains of paramount importance to the audit's success in driving quality improvement, and will be a renewed focus of the NPCA.

## 1. Background and purposes of the document

This document outlines in Section 1 the background of the National Prostate Cancer Audit (NPCA), its recent move into the new National Cancer Audit Collaborating Centre (NATCAN), and the purposes of the recent scoping meeting and this document. Section 2 describes the current scope and design of NPCA and Section 3 outlines the proposed scope and design of NPCA within NATCAN, about which we have received stakeholder feedback. Sections 2 and 3 are both structured in terms of (1) scope and performance indicators, (2) data provision, (3) reporting, (4) quality improvement, (5) engagement with patients and the public.

### 1.1 Future contracting of NPCA

The contract for the National Prostate Cancer Audit (NPCA) at the Royal College of Surgeons of England (RCS England) came to an end on 30<sup>th</sup> June 2023. On 1<sup>st</sup> July 2023, the NPCA moved into the [National Cancer Audit Collaborating Centre \(NATCAN\)](#) at the Clinical Effectiveness Unit (CEU) of the Royal College of Surgeons of England under a contract variation.

### 1.2 NPCA team and partnership

[NPCA](#) is a clinical-methodological partnership based at the Clinical Effectiveness Unit of the Royal College of Surgeons of England. Clinical leadership is provided by the British Association of Urological Surgeons (BAUS) and British Uro-Oncology Group (BUG). This is supported by annual meetings of the stakeholders in the Clinical Reference Group, including clinicians from across the patient pathway, patients, charity representatives and commissioners. A standalone Patient and Public Involvement Forum provides advisory support, ensuring the patient perspective is central to the direction and delivery of the Audit. These trusted long-term relationships ensure the clinical relevance of NPCA work, engagement with clinicians and impact on quality improvement initiatives.

### 1.3 The National Cancer Audit Collaborating Centre (NATCAN)

[NATCAN](#) is a new national centre of excellence to strengthen NHS cancer services by looking at treatments and patient outcomes across the country. The new centre is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government with funding in place for an initial period of three years.

Since 1st October 2022, this collaborating centre has been based within the [CEU](#), the academic partnership between RCS England and the London School of Hygiene & Tropical Medicine: it is recognised as a national centre of expertise in analytic methodology and the development of administrative and logistic infrastructure for collating and handling large-scale data for assessment of health-care performance.

Prior to October 2022, the [CEU](#) was already the sole provider of national cancer audits in the NHS in England and Wales, incorporating audits in [prostate](#), [lung](#), [bowel](#), and [oesophago-gastric](#) cancers, and completed an audit of [breast cancer in older patients in 2022](#). These audits have helped provide a wider understanding of cancer treatments across England and Wales and have improved services and infrastructure leading to improved outcomes for patients. They have also promoted quality improvement (QI) initiatives within NHS cancer services and identified areas of best practice.

NATCAN will deliver national cancer audits in six new cancer areas: ovarian, pancreatic, kidney, breast (two separate audits in primary and metastatic disease) and non-Hodgkin Lymphoma. The aim of these audits is to:

1. Provide regular and timely evidence to cancer services of where patterns of care in England and Wales may vary.
2. Support NHS services to increase the consistency of access to treatments and help guide quality improvement initiatives.
3. Stimulate improvements in cancer detection, treatment and outcomes and experience of care for patients, including survival rates.

#### 1.4 NPCA within NATCAN

The main changes to the contracted deliverables when NPCA moved into NATCAN were:

- Production of an annual 10 page “State-of-the-Nation” report with a maximum of 5 national recommendations
- Set out a maximum of 10 performance indicators
- Greater focus on quality improvement (QI)
- More frequent and timely reporting

Within NATCAN, NPCA will retain its own Project Team comprising methodologists, clinicians and a project manager, its own Clinical Reference Group of stakeholders and its own Patient and Public Involvement Forum. Governance will be at Centre level with an overarching Board and Executive Team across NATCAN. NATCAN will also have a Director of Operations, Clinical Director, Technical Advisory Group and Quality Improvement Team working across the Centre.

#### 1.5 Role of the scoping meeting (18<sup>th</sup> May 2023)

A scoping meeting was held in May 2023 to ensure that the proposed future scope and design of NPCA within NATCAN considers the needs of stakeholders whilst driving local and national quality improvement in services and outcomes for prostate cancer patients. The specific aims of the meeting were to:

- Assess the current performance indicators
- Update the suite of performance indicators
- Determine which data sources provide required information
- Review and update the healthcare quality improvement plan

## 2. Current NPCA approach

### 2.1 Current scope of NPCA and performance indicators

Prostate cancer is one of the commonest solid cancers (~45,000 cases annually in the UK). There are concerns about over-diagnosis and over-treatment in men with low-risk disease, while men with locally

advanced disease may not always get optimal radical treatment<sup>1</sup>. Furthermore, significant numbers of men present with metastatic disease and there is variation in access and use of diagnostic and treatment options in this group. Finally, the NPCA has been conducted in a period of major change in clinical practice<sup>2</sup>.

The NPCA aims to guide changes in practice so that they will save lives and improve quality of life, through supporting five key quality improvement goals which centre on:

- Maintaining use of active surveillance to treat men with low-risk prostate cancer, thus reducing potential over-treatment.
- Increasing use of multimodality therapy for men with high-risk or locally advanced prostate cancer, thus reducing potential under-treatment.
- Improving safety and reducing toxicity of prostate cancer therapy.
- Reducing variation in prostate cancer management among NHS providers.
- Improving experience of care among men with prostate cancer.

The NPCA reports on:

- Differences among prostate cancer centres in the treatment they provide, and in patient outcomes derived from national linked clinical datasets, and where possible, from patient-reported outcome measures.
- The regional organisation of prostate cancer services.
- Patient-reported experience of care, especially about how treatment decisions were made and the involvement of a clinical nurse specialist.

In addition, the NPCA carries out a programme of work, consisting of methodological development (to ensure that the audit is methodologically robust), investigations of determinants of variation in treatment and outcomes (to ensure that the audit's recommendations are clinically relevant), and mapping of the structure and arrangement of prostate cancer services (to investigate the impact of the cancer service structure on the care provided), that directly informs the NPCA's quality improvement activities and initiatives. The audit also provides a large data repository with linkage to clinical outcomes from treatment available through Hospital Episode Statistics (HES). This invaluable resource enables tracking of cancer treatment outcomes and survivorship stratified for geography, ethnicity and socio-economic status.

## 2.2 NPCA data provision: to date

The National Disease Registration Service (NDRS) and the Wales Cancer Network (WCN) provide clinical data to the NPCA:

- NDRS collects patient-level clinical data from all English NHS providers through a range of national electronic data feeds. The NPCA receives cancer registry data annually and from the start of 2021, quarterly extracts of Rapid Cancer Registry Data (RCRD), linked at patient level to items of several national, routinely collected datasets, including the Cancer Outcomes and Services dataset (COSD), the Hospital Episode Statistics (HES) data sets, the Radiotherapy Data Set (RTDS), and the Systemic Anti-Cancer Treatment (SACT) data set.
- The data collection process in Wales differs from England. Similar data is captured through a national system and uploaded to the Wales Cancer Network, only after sign-off by a designated clinician. The NPCA also receives these data annually, linked to the Patient Episode Database for Wales.

Additionally, when financially feasible, the NPCA has collected patient-reported outcome and experience measures from all men in England and Wales who had received (or who were candidates for) radical

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<sup>1</sup> <https://www.nice.org.uk/guidance/cg175/evidence/full-guideline-191710765.more>

<sup>2</sup> Aggarwal a, Nossiter J, Parry M, et al. Public reporting of outcomes in radiation oncology: the National Prostate Cancer Audit. *Lancet Oncol.* 2021 May;22(5):e207-e215. doi: 10.1016/S1470-2045(20)30558-1

treatment 18 months after the date of their prostate cancer diagnosis. These patient-reported data were linked to the clinical data, described above.

Finally, an organisational survey is carried out every two to three years to gather information about the regional organisation of prostate cancer services, the availability of diagnostic/therapeutic facilities and support services, creating a unique national data source. The most recent organisational audit was completed in 2022.

### 2.3 NPCA reporting: to date

The scope of the NPCA to date is directly informed by explicit standards derived from a range of sources providing national guidance. It includes:

- The diagnostic and staging process of patients newly diagnosed with prostate cancer in England and Wales, including the use of multiparametric MR imaging before biopsy and the type of biopsy.
- The initial treatments received.
- Safety and toxicity outcomes of prostate cancer therapy following treatment.
- Patient-reported experience with care and functional outcomes and health-related quality of life.

Informed by this scope, the NPCA produces Annual Reports that include, for all prostate cancer service providers in England and Wales, performance indicators that are defined in detail in the NPCA's Methodology Supplement. These indicators were developed and evaluated according to four explicit criteria, including validity, statistical power, technical feasibility, and fairness. These provider-level indicators are presented using funnel plots, allowing a statistical approach to identify "potential outliers", also adjusting for difference in case mix.

In a series of Short Reports, the NPCA also provided results of in-depth analyses on specific topics that are priorities among the Audit's stakeholders, including new risk stratification approaches and management of men with locally advanced and metastatic disease, substratified for geography, ethnicity and social class.

The results of methodological development and the investigations to inform the NPCA's quality improvement activities and initiatives are published serially in peer-reviewed publications.

### 2.4 Current Quality Improvement (QI) Plan

The Quality Improvement Plan of the NPCA follows as closely as possible the priorities of the current scope, described in section 2.1.

The agreed key improvement goals are:

- to reduce inequity in access to evidence based prostate cancer services
- to increase the use of multiparametric MRI before prostate biopsy, including refining the standards of reporting
- to reduce the risk of post-biopsy complications
- to improve the access to guidance based staging stratification
- to reduce over-treatment and under-treatment (as defined earlier)
- to reduce the risk of short and long-term adverse events
- to reduce the rate of salvage treatment after primary radical treatment
- to increase the rate of cancer cure
- to improve functional outcomes and health-related quality of life following treatment
- to improve the overall experience of care for men with prostate cancer, in particular the availability of specialist cancer nurses and the involvement of patients in decisions about their treatment

The NPCA's website and social media provide a detailed overview of relevant activities aiming to achieve these goals as well as links to a wider set of resources. The key features are:

- Annual national [quality improvement workshops](#), with clinicians, commissioners, and patients, providing a forum for further developing and implementing improved treatments.
- [Quality improvement case studies within the annual reports](#), highlighting learning points from outliers and selected providers which will act as a core resource for supporting quality improvement activity.
- Updates on presentations of NPCA reports to [national and international communities](#) (e.g. BAUS Oncology and BUG Annual meetings, international conferences).
- Links to [quality improvement resources](#), giving access to available methods and tools and to national quality improvement programmes.
- [Quality improvement blogs](#), written by members of the NPCA team and patient representatives, explaining how NPCA data is collected and analysed and how its results can be used to guide quality improvement initiatives.

In addition, the [annual meetings of the British Association of Urological Surgeons and the British Uro-oncology Group](#) provide [keynote slots](#) where the findings and recommendations of the NPCA's Annual Reports are presented.

The [latest Annual Report](#), published in January 2023, covered the management of men newly diagnosed with prostate cancer between 1<sup>st</sup> April 2020 and 31<sup>st</sup> March 2021 in England and Wales (with some indicators reported for men undergoing radical treatment between 1<sup>st</sup> October 2018 to 31<sup>st</sup> September 2019) suggests little change in [medium-term treatment outcomes](#) (for gastrointestinal and genitourinary complication after radical treatment) compared to previous years.

However, there is a [lag between quality improvement initiatives and their effects manifesting in clinical practice](#) and therefore it will take time before the impact of the NPCA's quality improvement initiatives can be truly evaluated. It is also essential to consider [the impact of other factors](#) influencing diagnosis and therapy in prostate cancer (e.g., publication of trial results on diagnosis and treatment of locally advanced and advanced disease, a surge in cases diagnosed in response to national awareness campaigns, and most prominently the diagnostic and treatment deficits during the COVID-19 pandemic)<sup>3</sup>.

## 2.5 Current engagement with patients and the public

The NPCA has an active [Patient and Public Involvement \(PPI\) Forum](#) that meets twice yearly. Twelve men with varying characteristics and lived experiences act as a consultative group, advising on all aspects of the audit. During PPI meetings, we have discussed the NPCA's strategic direction and how it is delivered. Updates on outputs are presented and we ask advice on recommendations.

The NPCA also has strong and supportive relationships with [Prostate Cancer UK](#), a patient representative organisation, and [Tackle Prostate Cancer](#), a patient-led organisation, enabling us to draw upon their expertise and existing structures, particularly their patient information networks.

Since the first virtual meeting of the PPI Forum in April 2020, members of the NPCA PPI Forum have had an invaluable impact on the NPCA to date including:

- Improving the content and style of the [Patient Summaries and infographics](#) of the NPCA's Annual Reports and providing feedback which shaped the development of the patient slide sets.
- A review of the [NPCA website](#) to ensure it is accessible and useful for a wide range of audiences. Their opinions are regularly sought to maintain its relevance.
- Participating in [NPCA QI workshops](#) and sharing their views in interviews.
- [Co-development and/or co-authorship](#) of scientific papers that explore NPCA results in more detail.

<sup>3</sup> <https://bjui-journals.onlinelibrary.wiley.com/doi/abs/10.1111/bju.15699>

### 3. Proposed future approach

#### 3.1. Proposed future scope and performance indicators

Prostate cancer care is constantly evolving, and it is important that the NPCA's performance indicators, informed by national and international guidance, reflect this. The data, collected by our data partners and accessible to the NPCA team, need to follow the changes in care with respect to:

- use of multiparametric MRI in the diagnostic process
- type of biopsy used and whether it is "informed" by MRI
- completeness of pathology investigations available for analysis
- active surveillance protocols
- staging investigations and type of imaging modality used (e.g., PET imaging, bone scan, PSMA-PET), derived from a novel linkage to the Diagnostic Imaging Dataset
- adoption of novel staging categories derived from imaging (e.g., PIRADS score) and risk stratification groups (e.g., Cambridge Prognostic Groups)
- details of radical treatment that men receive, including surgical treatment (e.g., nerve-sparing), type and regimen of radiotherapy (e.g., ultrahypofractionation) and extent (e.g. pelvic lymph node irradiation)
- details of salvage treatments after primary curative surgical and radiotherapy treatment, due to regular clinical trial results leading to changes in SOC, and how these are implemented nationally
- treatment of men with primary (oligo)metastatic disease, especially the treatment of the primary tumour, the use of docetaxel and other agents as well as new hormonal treatment, including enzalutamide and abiraterone among others. An important limitation of the currently available data is the lack of information about primary hormone therapy, its duration and the long-term side effects
- safety and adverse events from evolving practices of care in uro-oncology in certain centres (e.g. rectal spacers)
- Cancer recurrence and survival outcomes
- Shaping pathological and radiological reporting standards nationally

Second, the performance indicators related to outcomes reported by the NPCA only cover the side-effects of treatment (e.g., urinary continence, sexual function, bowel function).

A key priority is the development of new indicators reflecting local recurrence or disease progression, and the treatments following these events. We have a collaboration with an NIHR-funded-project that started in 2022 (NIHR132459) to help address this. Whilst this work is ongoing, we will look to assess variation in rates of salvage therapy, including local and systemic treatments, across hospitals after primary curative prostate cancer treatment.

Third, the NPCA has used patient-reported outcomes measures (PROMs) to monitor outcomes of radical treatment. In the NPCA Quality Improvement event on treatment-related toxicity that took place in December 2019, it was generally accepted that PROMs should be the primary source of information to monitor the side-effects of treatment. Ongoing collection of PROMs is essential for understanding outcomes from prostate cancer treatment, has been shown to discriminate hospital level care quality and would give patients a greater voice and provide authoritative outcome information that cannot be obtained in any other way.

Fourth, our work with the NPCA PPI Forum has highlighted the need to focus on support services available for men diagnosed with prostate cancer. The NPCA organisational audit only records whether these services are available, but not how they are used nor whether they provide the support that men need. Patient-reported experience measures (PREMs) are an important approach to fill this gap. The NPCA has reported



provider-level results which demonstrate the potential of feeding back results based on PREMs to the providers of prostate cancer services. We also found that the value of PREMs can be enhanced if the relevant items in the current version of the NPCA's patient survey, now mainly derived from the National Cancer Patient Experience Survey, are updated or replaced by more appropriate items that better capture the full range of the patient experience.

In addition to improving aspects of the initial management following diagnosis, we also propose expanding the scope of the audit to management of men with local recurrence or progression to metastatic disease. This is a fundamentally important clinical area with considerable variation in clinical practice between providers. Our ongoing methodological work will allow us to identify men with cancer recurrence (explained earlier) and monitor the follow-up treatments they receive, so that relevant performance indicators can be fed back to providers, facilitating quality improvement activities that will reduce variation and improve outcomes. Scoping work looking at the feasibility of monitoring for obstructive uropathy and its treatment in men with metastatic disease is nearing completion.

The routine data the NPCA receives (e.g., HES) can also be linked to clinical trial data, enabling the combination of 'real world data' with trial data to identify side effects. For example, looking at increased incidence of fractures in patients diagnosed with metastatic prostate cancer.

### 3.2 Data provision in the future NPCA within NATCAN

The COVID-19 pandemic has changed the data landscape. Regular data feeds from the English NCRAS were interrupted because of difficulties deriving key staging items from the hospital information systems. However, the need to monitor the impact of the COVID-19 pandemic on clinical practice has created new options using the Rapid Cancer Registration Dataset (RCRD). By continuing to use the RCRD, we are able to provide feedback to prostate cancer services more frequently (e.g., quarterly or 6-monthly) and in a more timely way (e.g., with a delay between date of diagnosis and reporting of only 6 months). Unfortunately, the RCRD does not include Gleason data and TNM staging is less complete so we are unable to report on the basis of risk group. We are currently using historic data that contains both RCRD and full cancer registry data to assess the impact of these data limitations.

For patients in Wales, NPCA will continue to use national cancer data from the Cancer Network Information System Cymru (CaNISC), which is in the process of being replaced by Cancer Information System for Wales. As the replacement work is ongoing, it is unclear exactly what data will be available, or how frequent and timely it will be.

NATCAN has requested a single resource of linked datasets for all cancer audits. However, NPCA data for the upcoming year (2023/2024) has been requested through an extension of the current contractual arrangements. NATCAN staff are working to build relationships with NDRS as well as hospital staff to support them to improve their data. Reporting of data items will be used as an incentive for providers to improve data quality. Development work will be needed to balance the improved timeliness of reporting using RCRD against reduced case ascertainment and data completeness.

A Secure Research Environment (SRE) for cancer data is being developed in NHS England which would be particularly beneficial if it gave quicker access to the data. However, the SRE would need to hold Welsh cancer data because the statistical analysis will require a single dataset that combines data from both countries.

For accurate and timely benchmarking it is essential that the NDRS and Welsh cancer data that is being used by NPCA:

- (i) includes all of the data items required to risk-stratify patient subgroups and to measure and risk-adjust performance indicators (such as age, ethnicity, socioeconomic status and geography)

- (ii) is timely
- (iii) has a high-level of case-ascertainment
- (iv) has high levels of data completeness
- (v) is accurate

### **Timeliness versus case-ascertainment and data completeness**

Gold standard cancer registration data is considered to have 100% case ascertainment but has a lag of around 20-22 months from diagnosis to release of the data. Rapid cancer registration data is much more timely but not as complete<sup>4</sup>. Widespread recognition of the critical need for timely access to up to date Gold Standard data for audit impact and relevance to the community is currently lacking. In addition, the absence of Gleason Score in RCRD used to risk stratify patients and report up to date NPCA performance indicators is a fundamental roadblock to adoption of RCRD as primary source of timely data for NPCA reporting. Either using resources to decrease the time lag of gold standard data to no more than 12 months or improvements in the case-ascertainment and data completeness of RCRD would ensure NPCA impacts on the quality of care received by prostate cancer patients.

### **3.3 Proposed future reporting**

The four priorities for reporting for the audit will be providing:

1. More timely, more frequent reporting on the provider dashboards of the website. Development work will be carried out to improve the data visualisation of the provider dashboards, showing change over time and increasing interactivity.
2. More concise “state of the nation” annual reports limited to 10 performance indicators and 5 national recommendations, as specified in the NATCAN contract. These reports will be responsive to arising clinical issues and the areas identified in the QI initiatives of the audit.
3. Outlier reporting included every year based on data within the State of the Nation reports.
4. Peer-reviewed publications of the results of methodological development, clinical epidemiological investigations of determinants of variation, mapping of the structure of prostate cancer services, and assessments of the impact of the NPCA’s quality improvement activities and initiatives.

The “state of the nation” annual reports will use the “gold-standard” cancer registration datasets, which are currently only released on an annual basis. The provider dashboards will be updated quarterly using rapid cancer registration data. More frequent reporting will be limited to information available in the RCRD which currently does not include Gleason Score. Thus, indicators on the basis of risk group are not currently possible.

At a NATCAN-level, we are liaising with external web designers who have experience in handling complex quantitative information. Special attention will be paid to the appropriate representation of the uncertainty in indicator values (i.e., the “signal-to-noise” ratio) so that organisations are not erroneously labelled as either positive or negative outliers. This is a key element especially for quarterly reporting given that numbers of patients and relevant events will be smaller than in the conventional state of the nation reports.

### **3.4 Proposed quality improvement implementation**

The NPCA sees itself as a driving force for improving standards, providing objective evidence of availability and performance of prostate cancer services in England and Wales as well as using this evidence to initiate, guide and support quality improvement initiatives. The team could initiate the sharing of more detailed analyses enabling Trusts/Cancer Alliances/Health Boards to contextualise their data prior to comparisons so that QI initiatives be more targeted to the patient population. Examples where NPCA data (e.g., through a formal outlier process of selected performance indicators) have led to changes in practice will be made available on the NPCA website.

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<sup>4</sup> [NPCA-comparison-of-standard-and-rapid-cancer-registry-data\\_19.12.21.pdf](#)

Annual NPCA QI workshops will continue around key themes identified by NPCA analyses and aimed at all members of the prostate cancer clinical care community.

Based on our experience since the NPCA started in 2013, quality improvement initiatives aimed at increasing awareness of audit outputs and engagement with them by individual Cancer Alliances, Trusts and Health Boards will be developed in collaboration with the community so as to embed the audit into routine practice. These could include:

- Sharing learnings from high performing Trusts/Health Boards
- Feedback from Trusts/Health Boards identified as outliers
- Benchmarking and performance champions to develop and disseminate QI programmes
- Improvements to procedures for distribution of audit resources

We will actively coordinate and collaborate with other national initiatives, including the CQC's National Clinical Audit Benchmarking ([NCAB](#)) project, GIRFT Urology Surgery workstream, and several programmes carried out within NHS England where NPCA findings directly influence policy/priority changes, the English National Cancer Registry, NHS Wales – Welsh Cancer Intelligence and Surveillance Unit as well as national and international professional bodies (i.e., BAUS, BUG and Royal College of Radiologists).

The NPCA aims to have a leading role in this multi-agency collaboration, creating a unique environment that brings together input from clinicians, methodologists, and patients with collaborative working relationships and data providers. The patient input is coordinated through our PPI Forum, the established relationships with Tackle Prostate Cancer, Prostate Cancer UK and other groups.

As mentioned above, the move into NATCAN offers opportunities for cross-audit innovations. In addition to reporting innovations such as bespoke data dashboards enabling providers to access their most recently uploaded data (from rapid cancer registration data), important quality improvement projects will be implemented such as:

1. Projects that aim to “close the audit cycle” using rapid cancer registration data, a first at national level. These will be designed by the NATCAN's QI Team and supported by experts from the University of Leeds (Professor Robbie Foy and Dr Sarah Alderson) who have extensive experience in methods to change professional and organisational behaviour.
2. Initiatives/interventions which demonstrate impact (through attaining the QI goals set by the Team).

### 3.5 Future engagement with patients and the public

NPCA will continue its close collaborative working with patients through its existing Patient and Public Involvement (PPI) Forum, with the chair a member of the clinical advisory group. The Patient and Public Involvement Forum is working to recruit carers and ensure it has diverse representation (geographical, ethnic, age, stage of disease).

Changes to the scope and design of NPCA, and further development of the provider dashboards, will require input from the PPI forum to ensure that the needs of the patient and the public are met. A key focus in the future will be to ensure that all NPCA findings are made available to the public, including those published in peer-reviewed publications.