NPCA
National Prostate Cancer Audit

Local Action Plan for taking on NPCA 2022 Annual Report Recommendations	
The provider should complete the following details to allow for ease of review	
Audit title & aim:	National Prostate Cancer Audit (NPCA) To assess the process of care and its outcomes in men diagnosed with prostate cancer.
NHS organisation:	
Audit lead:	
Action plan lead:	

When making your action plan, make sure to keep the objectives SMART – Specific, Measurable, Assignable, Realistic, Time-related

Key 1 (for the action status)
1. Awaiting plan of action 2. Action in progress 3. Action fully implemented 4. No plan to action recommendation (state reason) **5.** Other (provide information)

Key 2 (for the action priority)
High: requires urgent attention (local audit) Medium: requires prompt action (consider local audit) Low: requires no immediate action (or local audit)

			Action activities			
No.	**Recommendation**	**Action required?**	**Responsible individual(s)**	**Agreed deadline**	**Status (Key 1)**	**Priority (Key 2)**
R1	Aim to achieve high completeness of key data items at the point of collection by NHS organisations in	*Suggested actions:* • *Appoint a clinical data lead with protected time for reviewing and checking the team's data returns and for*				

	England, particularly TNM staging variables. 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.	*championing improvements in the completeness of key data items.* • *Review the completeness of key data items including TNM staging information, PSA, Gleason and Performance status submitted to the National Cancer Registration and Analysis Service (NB: the CancerStats website can be used review the quality data quality in real time).* • *Raise the profile of data completeness across the wider multidisciplinary team (MDT) at governance meetings or by sharing data.* • *Feedback monthly data quality reports to the wider MDT.* • *Integrate data collection into MDT meetings with the aim of achieving 90% completeness of key data items (TNM staging information, PSA, Gleason and Performance status).*				
R2	Review recording of whether lymphadenectomy was carried out, working with data specialists.	*Suggested actions:* • *Review the number of lymphadenectomy procedures performed at your health board and ensure this correlates with the number of lymphadenectomy procedures recorded via your IT system.* • *Prostate cancer teams should agree and implement a standardised process of capturing data items on lymphadenectomy.* • *Raise the profile of the recording of lymphadenectomy across the wider multidisciplinary team (MDT) at governance meetings or by sharing data.* • *Feedback monthly data quality reports to the wider MDT.*				
R3	Seek advice from a doctor if any of the following new symptoms are experienced following diagnosis or treatment: urinary symptoms, erectile problems, blood in their urine or unexplained back pain, as early diagnosis improves outcomes.	*Suggested actions:* • *Ensure patients are counselled regarding complications associated with prostate cancer and treatment, including giving relevant PIS.* • *Ensure that each patient is given the contact details of the CNS team to facilitate reporting of any new symptoms.*				

R4	Ensure that a family history of prostate, breast or ovarian cancer is reported to a healthcare provider as it should precipitate a genetic counselling referral.	*Suggested actions:* • *Prostate cancer teams should agree and implement a standardised process of capturing data items on family history of prostate, breast or ovarian cancer.* • *Ensure your MDT team know who in their organisation is responsible for genetic counselling referrals.* • *Raise the profile of the recording of family history across the wider multidisciplinary team (MDT) at governance meetings or by sharing data.*				
R5	Undertake internal audit and review of prostate radiotherapy treatment delivery processes and outcomes. In England, participation in the RT Operational Delivery Networks may support this.	*Suggested actions:* • *Audit outcomes of RT treatment delivery in the radical setting e.g. incidence of GI/GU toxicity +/- PROMS.* • *Review the radiotherapy treatment delivery processes at your trust including target volume delineation, margins, dosimetric constraints, online imaging and patient setup.* • *Within the wider RT MDT, identify areas of practice which should be improved to optimise RT treatment delivery processes.*				
R6	Initiate routine integration of radiotherapy peer review as standard for radical prostate cancer cases	*Suggested actions:* • *Set up a regular peer review meeting in your trust to review contouring and treatment plans for radical prostate cancer cases.* • *Have standardised systems to define when, who and how peer review will be conducted and that expectations are clear*[i]*.* • *Develop a system for prospective review and feedback to ensure optimisation of quality of treatment delivery.*				
R7	Consider establishing specialist gastrointestinal services to offer expert advice to people with bowel-related side effects of radiotherapy.	*Suggested actions:* • *Support the identification of these side effects through dissemination of relevant patient information and consideration of initiation of PROMs collection.* • *Identify a member of the MDT who could lead on the development of a late effects associated with prostate cancer RT clinic*[ii]*.* • *Ensure best practice guidance for management of bowel related side effects are disseminated to the wider MDT to*				

		ensure optimised identification and referral to specialist services.				
R8	Consider initiation of routine hospital level PROMS programmes as part of post treatment follow up to support the identification of late effects of RT treatment e.g. bowel or urinary.	*Suggested actions:* • *Development and embedding of PROMs collection as part of routine follow up and assessment.* • *PROMs can help to 1) identify an individual patient's symptoms and function 2) aggregation of data from patient populations can support benchmarking of providers*[iii]*.*				
R9	Support radiotherapy centres to integrate IMRT into standard radiotherapy practice for primary radical RT	*Suggested actions:* • *As per NICE guidance, patients having radical external beam radiotherapy for localised prostate cancer should be offered radiotherapy using IMRT.* • *Any trusts not utilising IMRT, should explore how to integrate this treatment modality into prostate cancer radiotherapy practice at their trust.*				
R10	Ensure that men who are offered prostate cancer treatment are made 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.	*Suggested actions:* • *Ensure patients are given standardised sMDT approved PIS regarding early and late treatment-related side effects at first appointment.* • *Opportunity to discuss concerns prior to treatment and during consent.* • *Aim to allocate each patient a clinical nurse specialist to discuss potential side effects of treatment in more detail if required.*				
R11	Empower patients to ask to be referred to specialist support services if they are experiencing physical or psychological side effects during, or following, prostate cancer treatment.	*Suggested actions:* • *Ensure patients are given standardised sMDT approved PIS regarding physical or psychological side effects of prostate cancer treatment at first appointment.* • *Ensure that patients have the opportunity to express if they are experiencing physical or psychological side effects during, or following, prostate cancer treatment* • *These should be offered early and on an ongoing basis, in keeping with national recommendations.* • *Review which specialist support services are available at your provider and circulate this to the wider MDT.*				

R12	Make available sources of further information and support 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.	*Suggested actions:* • *Allocate a MDT member to lead on improving patient access to information and support. This information can be provided a clinic setting and clinical nurse specialists can support with this.* • *Ensure patients are given standardised sMDT approved PIS at first appointment. 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.*				
R13	Continue to advocate active surveillance in the first instance for men with low-risk prostate cancer.	*Suggested actions:* • *Ensure documentation of whether patients eligible for active surveillance are offered it and reasons for not allocating, if appropriate.* • *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.*				
R14	Discuss with your clinical specialist the option of disease monitoring with active surveillance in the first instance.	*Suggested actions:* • *Ensure patients are given standardised sMDT approved PIS regarding active surveillance at first appointment.* • *Ensure that patients have the opportunity to discuss treatment options and decisions regarding their management during appointments.*				
R15	Investigate why men with high-risk/locally advanced disease are not considered for radical local treatment.	*Suggested actions:* • *Ensure documentation of whether patients eligible for radical treatment are offered it and reasons for not allocating, if appropriate.* • *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.				
R16	Discuss with your clinical specialist the radical treatment options available for men with high-risk/locally advanced disease.	*Suggested actions:* • *Ensure patients are given standardised sMDT approved PIS regarding radical treatment options at first appointment.* • *Ensure that patients have the opportunity to discuss treatment options and decisions regarding their management during appointments.*				
R17	Review of the NPCA indicators for providers should be undertaken within the region and nationally and fed through to providers	*Suggested actions:* • *Review variation in diagnostic, treatment and support services for your organisation and compare these to within your integrated care board or alliance and nationally.* • *Perform a local audit to assess service provision within your organisation.* • *Pay particular attention to variations in service provision (diagnostics, treatment and support services) and treatment outcomes.* • *Where variation is apparent, agree quality improvement action plans and present these to the Trusts and Health Boards, which should put in place follow-up procedures to monitor the implementation of practice changes to address problems identified.*				
R18	Ensure that radiotherapy and surgical treatment centres continue to integrate and upgrade evidence-based treatments and support services for patients.	*Suggested actions:* • *Review radiotherapy and surgical practices for prostate cancer patients; review the pathway from radiotherapy or surgery after treatment to ensure that patients are optimally managed.* • *Offer appropriate supportive services for prostate cancer patients including counselling and management for men experiencing treatment-related adverse effects.*				
CR1	Review the diagnostic and treatment activity for your region during 2020	*Suggested actions:*				

	and 2021 illustrating how your service responded during this time and to support decision making in response to current changes in demand.	• *For your organisation, review the diagnostic and treatment activity for prostate cancer during 2020/21 and compare this to the national results.* • *Use the NHS England Cancer Delivery plan for tackling the Covid 19 backlog, February 2022, [iv] to help guide recovery of prostate cancer services.*				
CR2	Monitor adherence to the recommended diagnostic pathway for suspected prostate cancer.	*Suggested actions:* • *Review the pathway from diagnosis to treatment to ensure that relevant staging investigations are performed according to risk profile and current international and national guidance (i.e. NICE and BAUS).*				
CR3	Continue to increase the use of hypofractionated radiotherapy.	*Suggested actions:* • *Ensure that data on radiotherapy are appropriately coded for in the Radiation Therapy Data Set (RTDS).* • *Review radiotherapy centre and individual clinician practices.*				
CR4	Offer enzalutamide (or apalutamide) with androgen deprivation therapy (or abiraterone for patients intolerant of enzalutamide) to people with newly diagnosed metastatic disease instead of docetaxel, where appropriate.	*Suggested actions:* • *Assess performance status and co-morbidities prior to offering anti-cancer treatment.* • *Prostate cancer teams should agree and implement a standardised process of capturing data items on systemic therapy to ensure that all systemic therapy data in SACT are submitted to the audit accurately.*				

The NPCA welcome your feedback on this quality improvement template to be used in conjunction with the NPCA Annual Report 2022 provider level results and quality improvement resources presented on our website.

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

References

1. NPCA Annual Report 2022
2. Individual provider-level results from the NPCA https://www.npca.org.uk/provider-results/
3. NICE Quality Standards https://www.nice.org.uk/guidance/qs91
4. NICE Prostate Cancer: Diagnosis & Management https://www.nice.org.uk/guidance/ng131

5. NPCA Quality Improvement resources https://www.npca.org.uk/resources/quality-improvement-resources/
6. Radiotherapy target volume definition and peer review, second edition RCR guidance: https://www.rcr.ac.uk/system/files/publication/field_publication_files/radiotherapy-peer-review-2022.pdf
7. Pelvic Radiation Disease Association Pelvic Radiation Disease Best Practice Pathway https://www.prda.org.uk/
8. How to collect patient-reported outcome measures in routine cancer care: https://www.ipaac.eu/news-detail/en/58-patient-reported-outcome-measures-cancer-care/
9. NHS England Delivery plan for tackling the Covid-19 backlog: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf

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[i] Radiotherapy target volume definition and peer review, second edition RCR guidance. Accessed at: https://www.rcr.ac.uk/system/files/publication/field_publication_files/radiotherapy-peer-review-2022.pdf

[ii] Pelvic Radiation Disease Association Pelvic Radiation Disease Best Practice Pathway https://www.prda.org.uk/

[iii] How to collect patient-reported outcome measures in routine cancer care. Accessed at: https://www.ipaac.eu/news-detail/en/58-patient-reported-outcome-measures-cancer-care/

[iv] NHS England Delivery plan for tackling the covid 19 backlog. Accessed at https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf