

**West of Scotland Cancer Network**

**Urological Cancer  
Managed Clinical Network**



# **Audit Report**

## **Prostate Cancer Quality Performance Indicators**

**Clinical Audit Data: 01 July 2019 to 30 June 2020**

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# Prostate Cancer QPI Overview

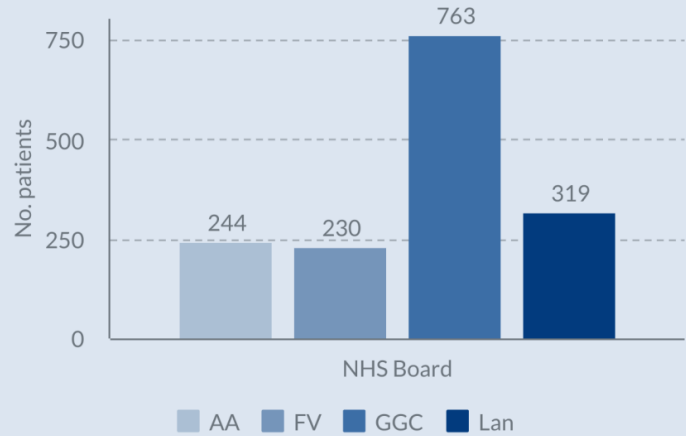
Patients diagnosed July 2019 - June 2020

Number of patients **1556**

Median Age of Patients: **70**

Age standardised net survival:  
 1 year survival **96%**  
 5 year survival **84%**

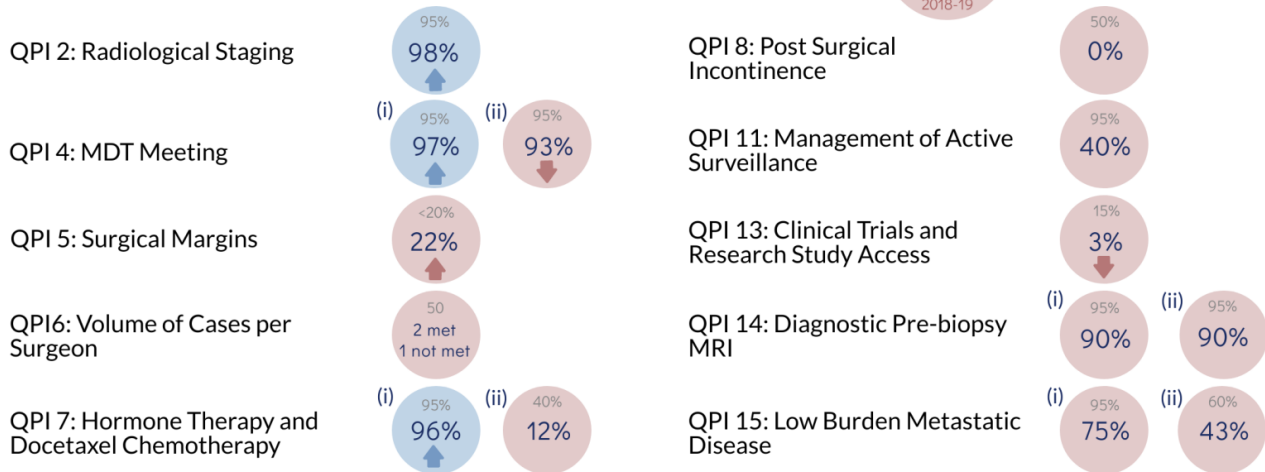
## Where are patients diagnosed



## Stage of Disease at Presentation

## Performance (%)

Target Performance 2019-20  
 Change from 2018-19



### Key Achievements:

- Excellent radiological staging (98%)
- Patients with non-metastatic disease are routinely discussed at MDT before treatment (97%)
- Improvements in patients with metastatic disease receiving immediate hormone therapy (96%)

### Areas for Improvement:

- Integration of MDTs within NHSGGC to streamline prostate cancer services
- To develop the active surveillance protocol for WoSCAN and reinforce the pathway to clinicians
- To raise awareness of updates to regional guidelines for assessing and treating metastatic prostate cancer

# Executive Summary

## Introduction

This report contains an assessment of the performance of West of Scotland (WoS) urological cancer services using clinical audit data relating to patients diagnosed with prostate cancer in the twelve months between 01 July 2019 and 30 June 2020. Results are measured against the Prostate Cancer Quality Performance Indicators<sup>1</sup> (QPIs), the original version of which were implemented for patients diagnosed on or after 01 July 2012.

In order to ensure the success of the Cancer QPIs in driving quality improvement in cancer care, QPIs will continue to be assessed for clinical effectiveness and relevance. The 2<sup>nd</sup> review of the prostate QPIs was completed at the beginning of 2020. QPIs are reviewed every 3 years with the next prostate review to be commenced after the publication of year 9 data in mid 2022. This clinically led review aims to identify potential refinements to the current QPIs and involves key clinicians from each of the Regional Cancer Networks.

## Methodology

Further detail on the audit and analysis methodology and data quality is available in the meta data within [Appendix 1](#).

## Results

A summary of the Prostate Cancer QPI 2019/20 clinical audit data is presented below, with a more detailed analysis of the results set out in the main report. Data are analysed in the most part by location of diagnosis or treatment (Hospital of Surgery), and illustrate NHS Board performance against each target and overall regional performance for each performance indicator.

## Summary of QPI Results

Key	
	Above Target Result
	Below Target Result
-	Indicates data based on less than 5 patients
	Indicates no comparable measure for previous years

Quality Performance Indicator (QPI)	Performance by NHS Board of diagnosis						
	QPI target	Year	AA	FV	GGC	LAN	WoSCAN
<b>QPI 2: Radiological Staging.</b> Proportion of patients with high risk prostate cancer undergoing radical treatment who have had Magnetic Resonance Imaging (MRI) and bone scan staging.	95%	2019 - 20	98.4%	98.1%	97.5%	98.6%	97.9%
		2018 - 19	95.8%	93.1%	99.3%	95.9%	97.4%
		2017 - 18					
<b>QPI 4(i): Multi-Disciplinary Team Meeting (MDT).</b> Proportion of patients with non-metastatic prostate cancer (TanyNanyM0) discussed at the MDT before definitive treatment.	95%	2019 - 20	94.3%	98.8%	96.8%	95.5%	96.5%
		2018 - 19	96.0%	97.8%	94.7%	98.1%	96.0%
		2017 - 18	-	98.3%	96.6%	91.6%	96.0%
<b>QPI 4(ii): Multi-Disciplinary Team Meeting (MDT).</b> Proportion of patients with metastatic prostate cancer (TanyNanyM1) discussed at the MDT within 6 weeks of commencing treatment.	95%	2019 - 20	85.4%	96.0%	93.7%	92.6%	92.8%
		2018 - 19	94.7%	94.3%	92.6%	96.3%	93.9%
		2017 - 18					
<b>QPI 5: Surgical Margins*.</b> Proportion of patients with pathologically confirmed, organ confirmed (stage pT2) prostate cancer who undergo radical prostatectomy in which tumour is present at the margin.	< 20%	2019 - 20	-	-	22.3%	-	22.3%
		2018 - 19	-	-	14.3%	-	14.3%
		2017 - 18	-	-	12.9%	100.0%	14.0%
<b>QPI 6: Volume of Cases per Surgeon.</b> Number of radical prostatectomy procedures performed by a surgeon over a one year period.	50 minimum	2019 - 20	-	-	2 met 1 not met	-	2 met 1 not met
		2018 - 19	-	-	2 met 6 not met	1 not met	2 met 7 not met
		2017 - 18	-	-	1 met 6 not met	1 not met	-

Quality Performance Indicator (QPI)	Performance by NHS Board of diagnosis						
	QPI target	Year	AA	FV	GGC	LAN	WoSCAN
<b>QPI 7(i): Hormone Therapy and Docetaxel Chemotherapy.</b> Proportion of patients with metastatic prostate cancer who are treated with immediate hormone therapy.	95%	2019 - 20	100.0%	84.0%	98.8%	95.7%	96.1%
		2018 - 19	94.3%	88.5%	94.5%	98.8%	94.6%
		2017 - 18	-	90.6%	91.7%	93.8%	92.1%
<b>QPI 7(ii): Hormone Therapy and Docetaxel Chemotherapy.</b> Proportion of patients with metastatic prostate cancer who are treated with immediate hormone therapy and docetaxel chemotherapy.	40%	2019 - 20	4.5%	10.7%	13.6%	11.3%	11.7%
		2018 - 19					
		2017 - 18					
<b>QPI 8: Post Surgical Incontinence<sup>*/**</sup>.</b> Proportion patients who undergo radical prostatectomy that have returned a PROMs tool both pre-operatively and post-operatively (12-18 months following surgery) for assessment of incontinence.	50%	2019 - 20	-	-	0.0%	-	0.0%
		2018 - 19					
		2017 - 18					
<b>QPI 11: Management of Active Surveillance<sup>**</sup>.</b> Proportion of men under active surveillance who undergo bpMRI or mpMRI within 12-18 months of diagnosis.	95%	2019 - 20	38.7%	65.9%	31.5%	39.1%	40.5%
		2018 - 19					
		2017 - 18					
<b>QPI 13: Clinical Trials and Research Study Access.</b> Proportion of patients who are consented for a clinical trial / research study	15%	2020	0.4%	1.7%	4.0%	1.8%	2.7%
		2019	7.4%	8.6%	11.7%	8.1%	10.0%
		2018	4.7%	12.2%	7.9%	3.3%	8.2%
<b>QPI 14(i): Diagnostic Pre-biopsy MRI.</b> Proportion of patients who undergo biopsy that have a pre-biopsy bpMRI or mpMRI as their first line diagnostic investigation.	95%	2019 - 20	97.1%	75.6%	97.7%	85.4%	90.2%
		2018 - 19					
		2017 - 18					
<b>QPI 14(ii): Diagnostic Pre-biopsy MRI.</b> Proportion of patients	95%	2019 - 20	96.3%	96.9%	87.0%	88.2%	90.0%

Quality Performance Indicator (QPI)	Performance by NHS Board of diagnosis						
	QPI target	Year	AA	FV	GGC	LAN	WoSCAN
who undergo biopsy that have a pre-biopsy bpMRI or mpMRI as their first line diagnostic investigation with imaging reported using a PI-RADS/ Likert system of grading.		2018 - 19					
		2017 - 18					
<b>QPI 15(i): Low Burden Metastatic Disease.</b> Proportion of patients with metastatic prostate cancer in whom burden of disease is assessed.	<b>95%</b>	2019 - 20	100.0%	100.0%	63.4%	72.5%	75.2%
		2018 - 19					
		2017 - 18					
<b>QPI 15(ii): Low Burden Metastatic Disease.</b> Proportion of patients with metastatic prostate cancer who have a low metastatic burden that receive radiotherapy.	<b>60%</b>	2019 - 20	30.8%	20.0%	61.5%	30.0%	42.7%
		2018 - 19					
		2017 - 18					

\*QPI Reported by Board of Surgery

\*\* QPI Reported one year in arrears – patients diagnosed 2018-2019

## Conclusions and Actions Required

Overall WoS results from the 8th year of Prostate Cancer QPI analysis are encouraging and demonstrate the high standard of care provided for prostate cancer patients across the West of Scotland. A number of new and amended QPIs have been added in this audit cycle and NHS Boards have found some of the targets for these QPIs challenging to meet. Some variance in performance does exist across the region and, as per the agreed Regional governance process, each NHS Board was asked to complete a Performance Summary Report, providing a documented response where performance was below the QPI target. NHS Boards provided detailed comments indicating valid clinical reasons, or in some cases patient choice or co-morbidities, have influenced patient management. Remaining actions are summarised below and outlined in the main report under the relevant section.

The MCN will actively take forward regional actions identified and NHS Boards are asked to develop local Action/Improvement Plans in response to the findings presented in the report. A summary of actions for each NHS Board has been included within the Action Plan templates in [Appendix 3](#).

### Actions required:

- NHSGGC (North Glasgow/Clyde) to progress integration of North and Clyde Urology Services and MDT.
- Urology MCN to review performance of QPI 7(ii) and benchmarking against other regions to better understand the impact of both the change in QPI definition and changes to treatment options and risks during the COVID-19 pandemic on performance against this QPI.
- All NHS Boards to reinforce the requirements of the active surveillance pathway to clinicians locally.
- MCN to develop a stand-alone active surveillance protocol for WoSCAN.
- MCN to highlight the importance of assessing the metastatic burden of patients and using this as a tool for making treatment decisions in line with treatment pathways within the recently updated CMG; including the addition of 'the assessment of metastatic disease' as a topic within the annual education event programme.

NHS Boards are asked to develop local Action/Improvement Plans in response to the findings presented in the report. **Completed Action Plans should be returned to WoSCAN within two months of publication of this report.**

Please note actions have been categorised into groupings (for example surgery, oncology, pathology or data capture) for internal management purposes to allow regional trends to be identified and co-ordinate regional actions across multiple tumour groups where appropriate.

Progress against these plans will be monitored by the MCN Advisory Board and any service or clinical issue which the Advisory Board considers not to have been adequately addressed will be escalated to the NHS Board Territorial Lead Cancer Clinician and Regional Lead Cancer Clinician. Additionally, progress will be reported annually to the Regional Cancer Advisory Group (RCAG) by NHS Board Territorial Lead Cancer Clinicians and MCN Clinical Leads, and nationally on a three-yearly basis to Healthcare Improvement Scotland as part of the governance processes set out in CEL 06 (2012).



## 1. Introduction

This report contains an assessment of the performance of West of Scotland (WoS) urological cancer services using clinical audit data relating to patients diagnosed with prostate cancer in the twelve months between 01 July 2019 and 30 June 2020. This year's data is measured against the Prostate Cancer Quality Performance Indicators<sup>1</sup> (QPIs) for the eighth consecutive year, the original version of which were implemented for patients diagnosed on or after 01 July 2012. The last three years are presented within this audit report for QPIs where results have remained comparable.

These audit data underpin much of the regional development/service improvement work of the Managed Clinical Network (MCN) and regular reporting of activity and performance is a fundamental requirement of an MCN to assure the quality of care delivered across the region.

In order to ensure the success of the Cancer QPIs in driving quality improvement in cancer care, QPIs will continue to be assessed for clinical effectiveness and relevance. The initial formal review of Prostate Cancer QPIs took place in 2016 and are valid for patients diagnosed on or after 1<sup>st</sup> July 2015. The second review of the prostate QPIs was completed at the beginning of 2020 with the third review due to commence mid-2022 after the publication of year 9 data.

## 2. Background

Four NHS Boards across the WoS serve the 2.5 million population<sup>2</sup>. From this population, on average 1,668 men were diagnosed with prostate cancer annually between 2015 and 2019 in WoS and 3,779 annually in Scotland<sup>3</sup>.

The configuration of the Multidisciplinary Teams (MDTs) in the region is set out below and each MDT convenes on a weekly basis.

MDT	Constituent Hospitals
Ayrshire & Arran (AA)	University Hospital Crosshouse, University Hospital Ayr
Pan Glasgow	(i) Glasgow Royal Infirmary, Stobhill Hospital
	(ii) Queen Elizabeth University Hospital, New Victoria Infirmary, Gartnavel General Hospital
Clyde	Royal Alexandra Hospital, Inverclyde Royal Hospital, Vale of Leven
Forth Valley (FV)	Forth Valley Royal Hospital
Lanarkshire (Lan)	University Hospital Monklands, University Hospital Wishaw, University Hospital Hairmyres

### 2.1 National Context

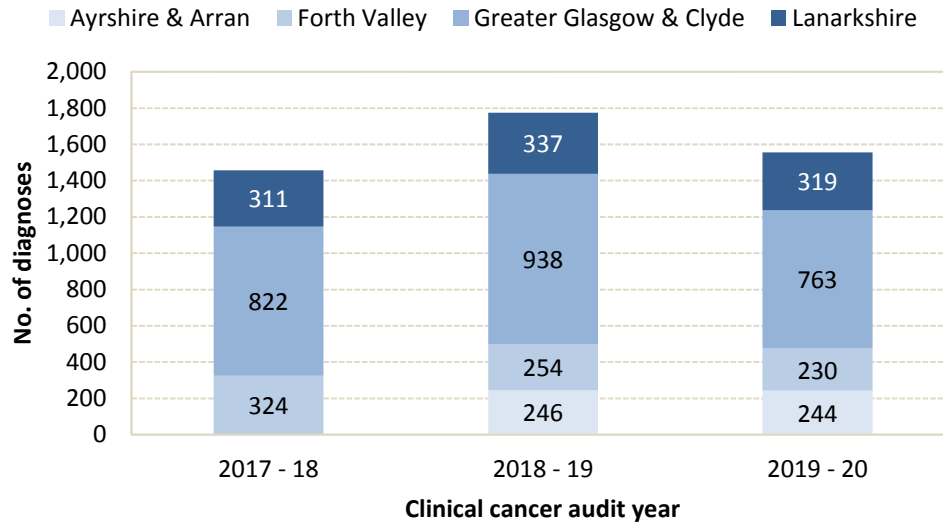
Prostate cancer is the most common cancer in males with 4,066 cases diagnosed in Scotland in 2019<sup>3</sup>. These account for 24.1% of cancer diagnoses in males in Scotland in 2019<sup>3</sup>. It is ranked as the fourth most commonly diagnosed cancer in Scotland after lung, breast and colorectal cancer<sup>3</sup>.

The incidence of prostate cancer increased by 30.9% in the ten years between 2009 and 2019, rising from 3,106 to 4,066 respectively<sup>3</sup>. Age standardised net survival from prostate cancer at 1 and 5 years was 96.1% and 84.3% respectively for patients diagnosed during the period 2013-2017<sup>4</sup>. There was no clear evidence for an improvement in net survival between 2008-12 and 2013-17.

## 2.2 West of Scotland Context

1,556 cases of prostate cancer were recorded through audit as diagnosed in the WoS between 1<sup>st</sup> July 2019 and 30<sup>th</sup> June 2020. As the largest health board<sup>2</sup> in WoS, 49.0 % (763) of all new cases of prostate cancers were diagnosed in NHS Greater Glasgow and Clyde.

**Fig 1: Number of patients diagnosed with prostate cancer in WoS 2017/18 – 2019/20**



Year	AA	FV	GGC	Lan	WoSCAN
2017 – 18	-	324	822	311	1,457
2018 – 19	246	254	938	337	1,775
2019 - 20	244	230	763	319	1,556

### Patient Profile

In 2019/20, the majority of prostate cancer cases (54.5%) in WoS occurred in men over the age of 70. There is a gradual increase in cases diagnosed after the age of 45, with a peak between age group 70 – 74 and a drop thereafter.

**Fig 2: Number of patients diagnosed with prostate cancer in WoS by age 2019/20**

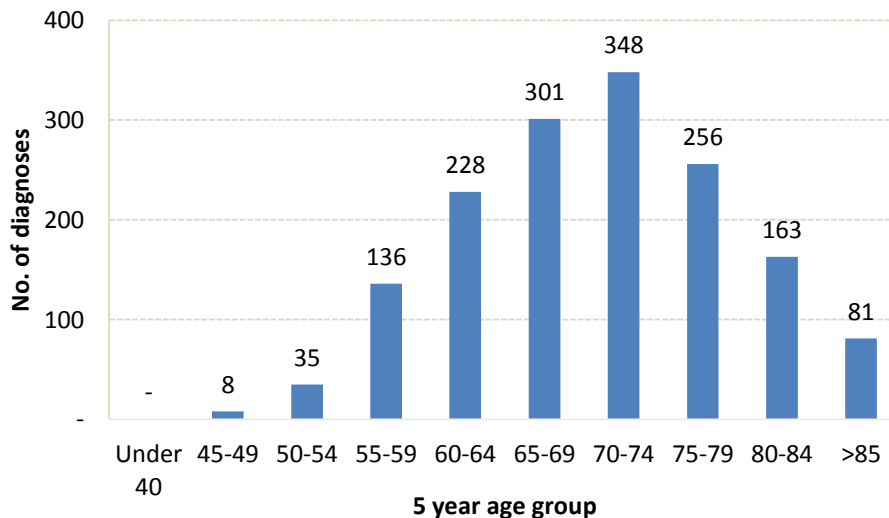
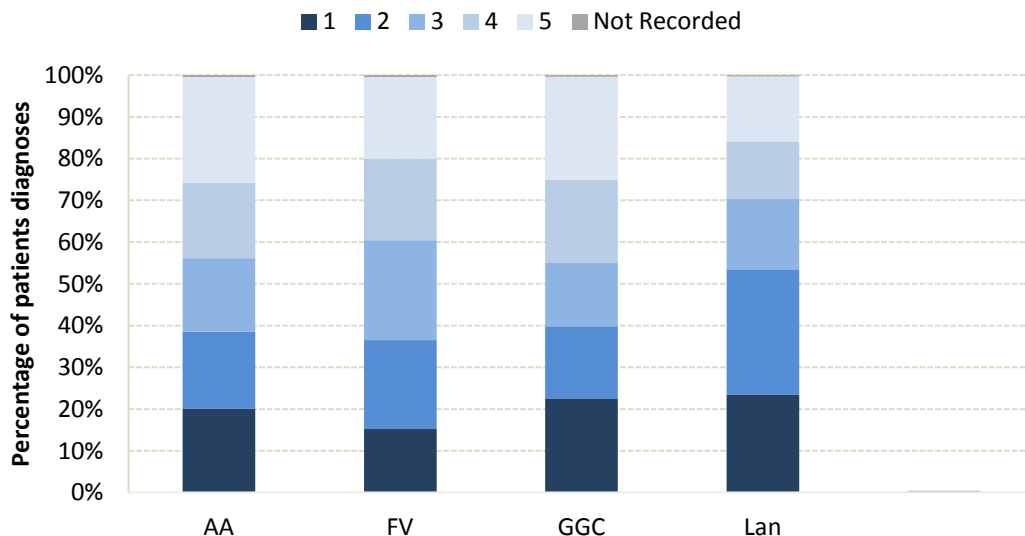


Figure 3 shows the Scottish Index of Multiple Deprivation (SIMD) 2020 quintiles for patients diagnosed with prostate cancer; with 1 equating to the most deprived postcodes and 5 equating to the least deprived.

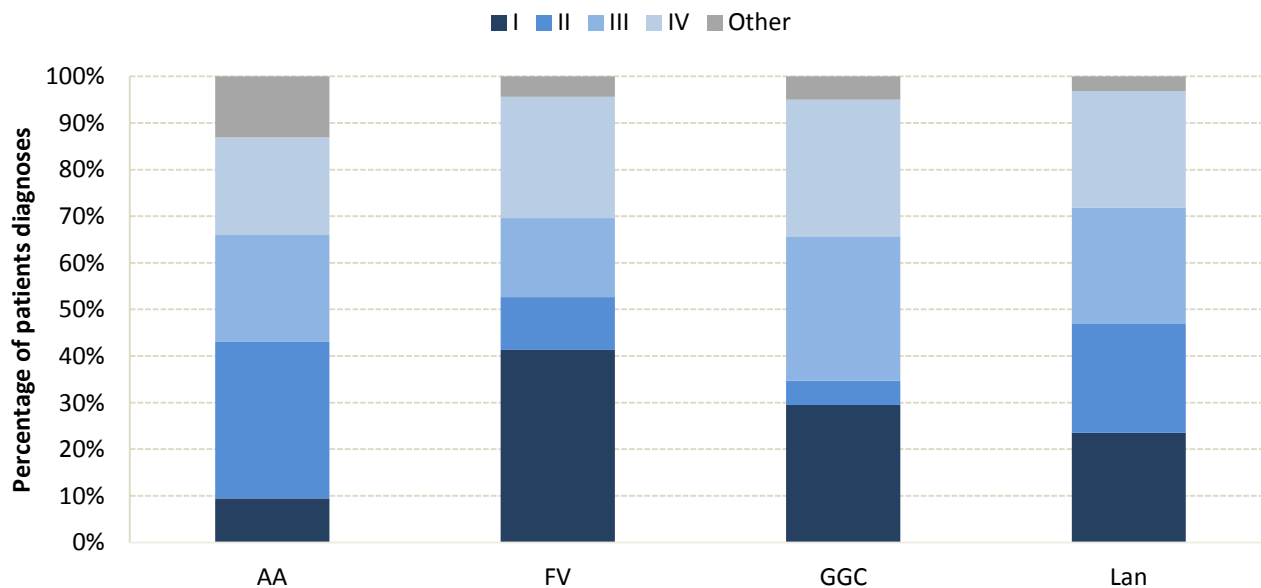
**Fig 3: Proportion of patients diagnosed with prostate cancer in WoS Deprivation Category 2019/20**



### Tumour Stage at Diagnosis

Figure 4 shows the distribution of prostate cancers by clinical stage, indicating the predominance of advanced stage disease with 53.0% of prostate tumours presenting at stage III or greater.

**Fig 4: Proportion of patients diagnosed with prostate cancer in WoS by stage 2019/20**



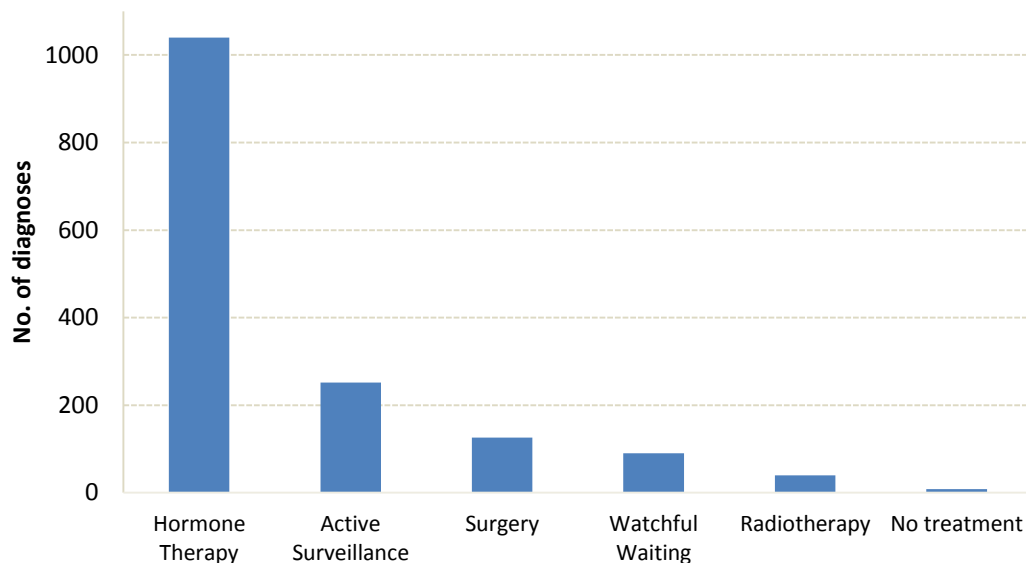
\*Other includes Inapplicable, Not recorded, unable to stage

Stage	AA		FV		GGC		Lan		WoSCAN	
	N	%	N	%	N	%	N	%	N	%
I	23	9.4%	95	41.3%	225	29.5%	75	23.5%	418	26.9%
II	82	33.6%	26	11.3%	40	5.2%	75	23.5%	223	14.3%
III	56	23.0%	39	17.0%	236	30.9%	79	24.8%	410	26.3%
IV	51	20.9%	60	26.1%	224	29.4%	80	25.1%	415	26.7%
Inapplicable	7	2.9%	4	1.7%	10	1.3%	6	1.9%	27	1.7%
NR	2	0.8%	2	0.9%	23	3.0%	3	0.9%	30	1.9%
Unable to stage	23	9.4%	4	1.7%	5	0.7%	1	0.3%	33	2.1%
<b>Total</b>	<b>244</b>		<b>230</b>		<b>763</b>		<b>319</b>		<b>1556</b>	

### Prostate Cancer Treatment

The type of first treatment that patients diagnosed in WoSCAN in 2019/20 received is summarised in Figure 5, with the majority of patients (66.8%) receiving hormone therapy as first treatment. Some patients having hormone therapy or active surveillance may have surgery at a later date and therefore the number of patients having surgery as first treatment is higher than indicated below. In 2019-20, 173 patients had a radical prostatectomy.

**Fig 5: First treatment type for patients diagnosed in WoS 2019/20**



### 3. Methodology

Further detail on the audit and analysis methodology and data quality is available in the meta data within [Appendix 1](#).

### 4. Results and Actions Required

Results of the analysis of Prostate Cancer QPIs are set out in the following sections. Data are presented by location of diagnosis or treatment, and illustrate NHS Board performance against each target and overall regional performance for each performance indicator.

Results are presented graphically and the accompanying tables also highlight any missing data and its possible effect on any of the measured outcomes for the current year of analysis. Where the number

of cases meeting the denominator criteria for any indicator is between one and four, the percentage calculation has not been shown on any associated charts or tables. This is to avoid any unwarranted variation associated with small numbers and to minimise the risk of disclosure. Any charts or tables impacted by this restricted data are denoted with a dash (-). An asterisk (\*) is used to specify a denominator of zero and to distinguish between this and a 0% performance. Any commentary provided by NHS Boards relating to the impacted indicators will however be included as a record of continuous improvement. Data for patients diagnosed in 2017-18 in NHS Ayrshire & Arran are not presented within this report as data were not complete at the time of reporting.

Specific regional and NHS Board actions have been identified to address issues highlighted through the data analysis.

## QPI 2: Radiological Staging

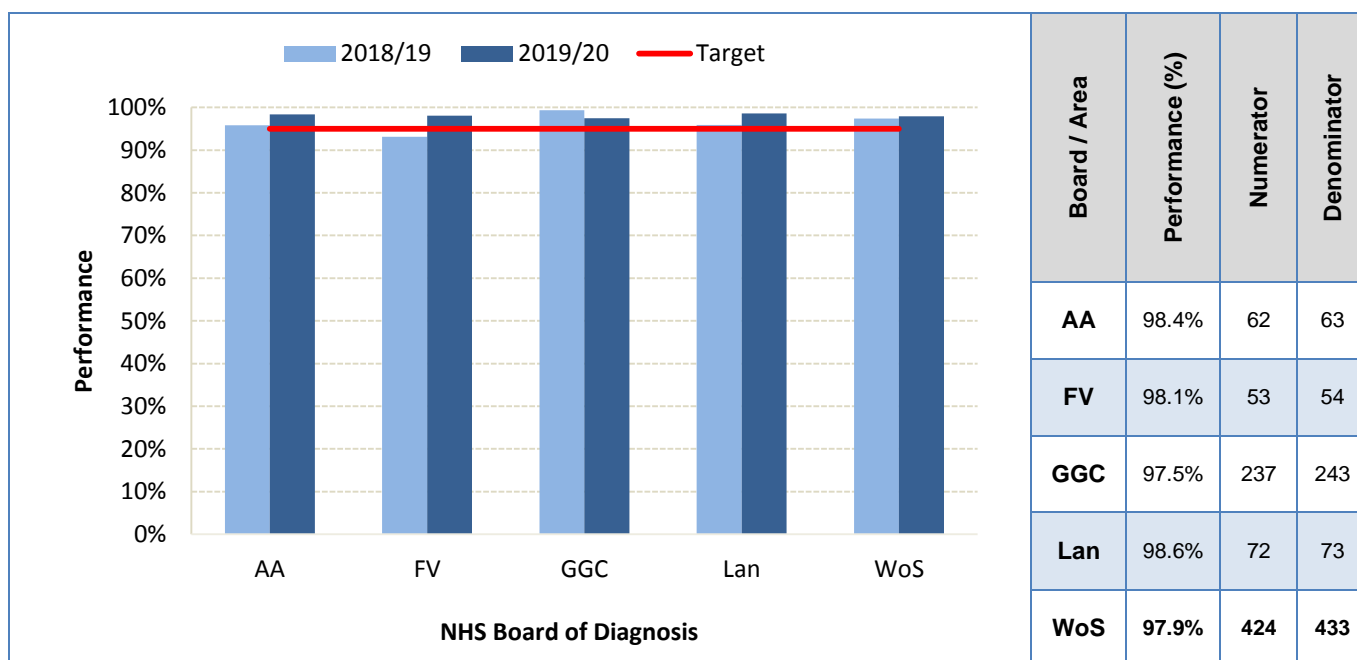
Several factors have been shown to predict the risk of recurrence of prostate cancers and these have been used to classify localised prostate cancer into the risk groups below. QPI 2, based on the radiological staging of prostate cancer, refers to patients within these specific risk categories.

### Localised Prostate Cancer Risk Categories<sup>1</sup>

<b>Low Risk</b>	Clinical Stage T1 – T2a <b>and</b> Gleason Score $\leq$ 6 <b>and</b> PSA at diagnosis < 10 ng/mL
<b>Intermediate Risk</b>	Clinical Stage T2b <b>or</b> Gleason Score 7 <b>or</b> PSA at diagnosis 10 – 20 ng/mL
<b>High Risk</b>	Clinical Stage $\geq$ T2c <b>or</b> Gleason Score 8 – 10 <b>or</b> PSA at diagnosis > 20 ng/mL

It is important that patients are staged using Magnetic Resonance Imaging (MRI) and bone scan<sup>1</sup>. Results from these imaging tests could alter the management of some patients and further evaluate whether or not a patient is suitable for radical treatment; patients found to have bone metastases may not be suitable for radical treatment.

<b>QPI Title:</b>	Patients with high risk prostate cancer, who are suitable for radical treatment, should be evaluated for locally advanced, nodal or bony metastatic disease.
<b>Numerator:</b>	Number of patients with high risk prostate cancer undergoing radical treatment who have an MRI of the prostate and isotope bone scan (or alternative whole body MRI evaluation).
<b>Denominator:</b>	All patients with high risk prostate cancer undergoing radical treatment.
<b>Exclusions:</b>	<ul style="list-style-type: none"> <li>• Patients unable to undergo an MRI scan</li> <li>• Patients who decline MRI</li> <li>• Patients with T2c tumours (with no other high risk factors)</li> </ul>
<b>Target:</b>	<b>95%</b>



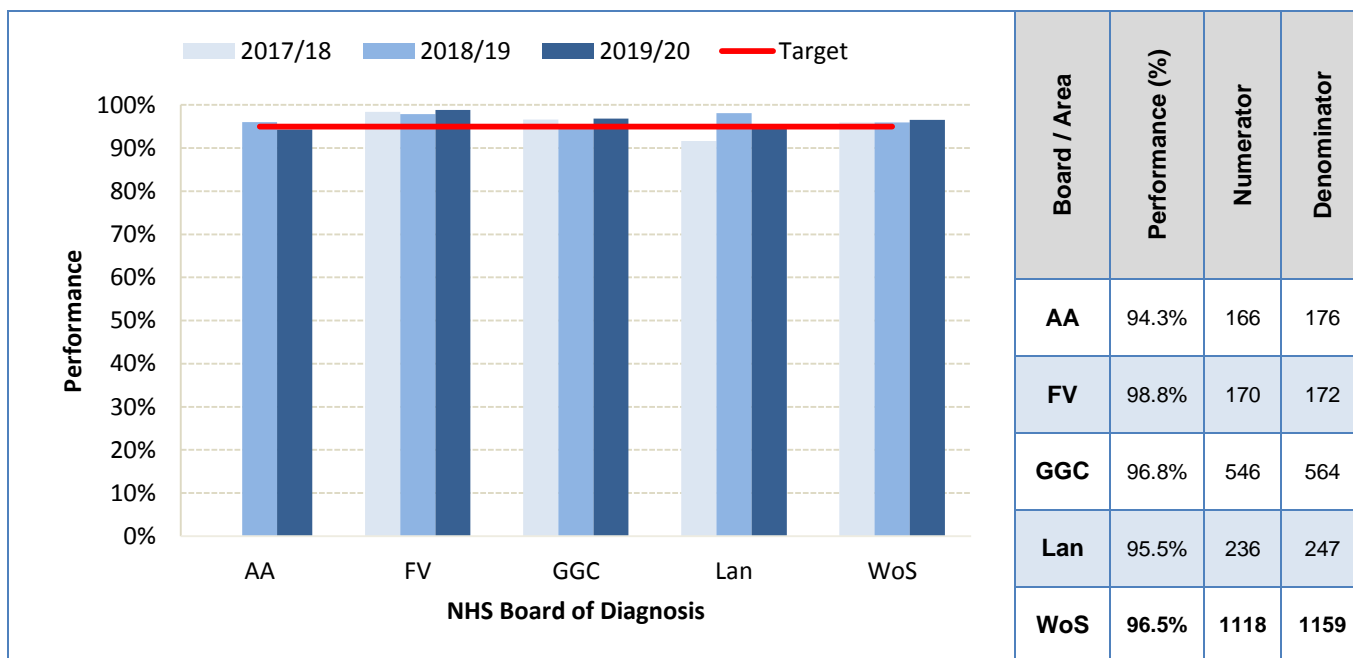
Results for this QPI indicate that high risk prostate cancer patients undergoing radical treatment are having appropriate imaging, with the QPI target being comfortably met across all WoS Boards as well as at a regional level.

## QPI 4: Multi-Disciplinary Team (MDT) Meeting

Evidence suggests that patients with cancer managed by a multidisciplinary team have a better outcome. There is also evidence that the multidisciplinary management of patients increases their overall satisfaction with their care. Discussion prior to definitive treatment decisions being made provides reassurance that patients are being managed appropriately<sup>1</sup>.

This QPI is split into two parts to account for patients with metastatic disease who often start hormone treatment immediately and therefore prior to MDT discussion. QPI 4(ii) stipulates that these cases should be discussed within 6 weeks of first treatment.

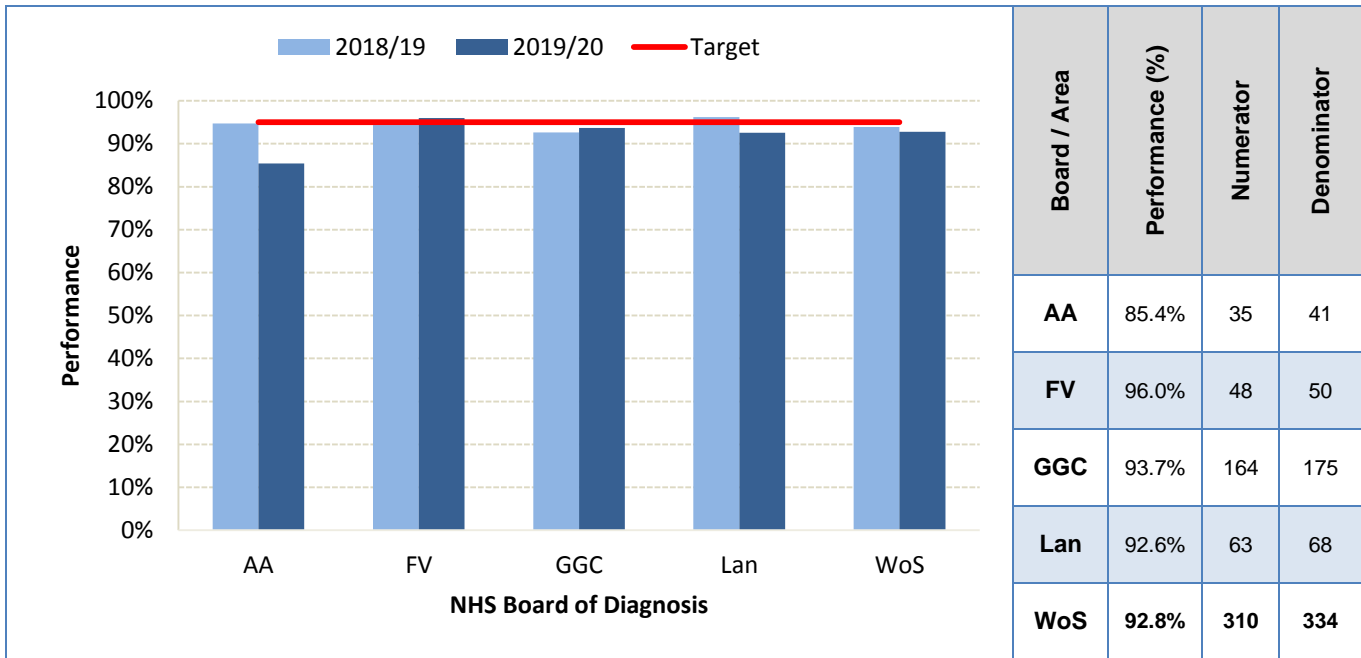
QPI Title:	Patients should be discussed by a multidisciplinary team prior to definitive treatment.
Specification (i)	Non-metastatic prostate cancer (TanyNanyM0)
Numerator:	Number of patients with non-metastatic prostate cancer (TanyNanyM0) discussed at the MDT before definitive treatment.
Denominator:	All patients with non-metastatic prostate cancer (TanyNanyM0).
Exclusions:	Patients who died before first treatment.
Target:	<b>95%</b>



For QPI 4 (i), all boards except NHS Ayrshire & Arran met the target. Within NHS Ayrshire & Arran the 10 patients not meeting this QPI were started on hormone therapy prior to MDT discussion and were not considered fit enough for further treatment when seen in clinic post MDT.



QPI Title:	Patients should be discussed by a multidisciplinary team prior to definitive treatment.
Specification (ii)	Metastatic prostate cancer (TanyNanyM1)
Numerator:	Number of patients with metastatic prostate cancer (TanyNanyM1) discussed at the MDT within 6 weeks of commencing treatment.
Denominator:	All patients with metastatic prostate cancer (TanyNanyM1).
Exclusions:	Patients who died before first treatment.
Target:	<b>95%</b>



This specification was not met at a regional level with only NHS Forth Valley meeting the 95% target. The majority of patients not meeting this QPI were discussed at MDT but more than six weeks after commencing hormone therapy. All patients not meeting this QPI were reviewed, in NHS Lanarkshire the QPI was not met for a range of valid clinical reasons however patients were considered to be on appropriate management. Within NHS Ayrshire & Arran radiology capacity was highlighted as the cause of delayed MDT discussion as patients with a clinical diagnosis of metastatic prostate cancer are commenced on immediate hormone therapy prior to diagnostic staging.

Within NHSGGC all patients not meeting the QPI were within Clyde sector. The majority of patients were discussed at MDT however this was more than 6 weeks after commencing hormone therapy. Six patients having delayed MDT discussion required biopsy and/or imaging prior to MDT, of these two had biopsy delayed by the COVID-19 pandemic and while the reasons for delay in a further 3 patients were unclear they coincided with the start of the COVID-19 pandemic. A plan is in place to combine Glasgow and Clyde MDTs; in the interim NHSGGC will establish rapid prostate access clinics in Clyde sector, and a joint Glasgow/Clyde TRUS list to tackle the primary cause of delay to discussion for these patients.

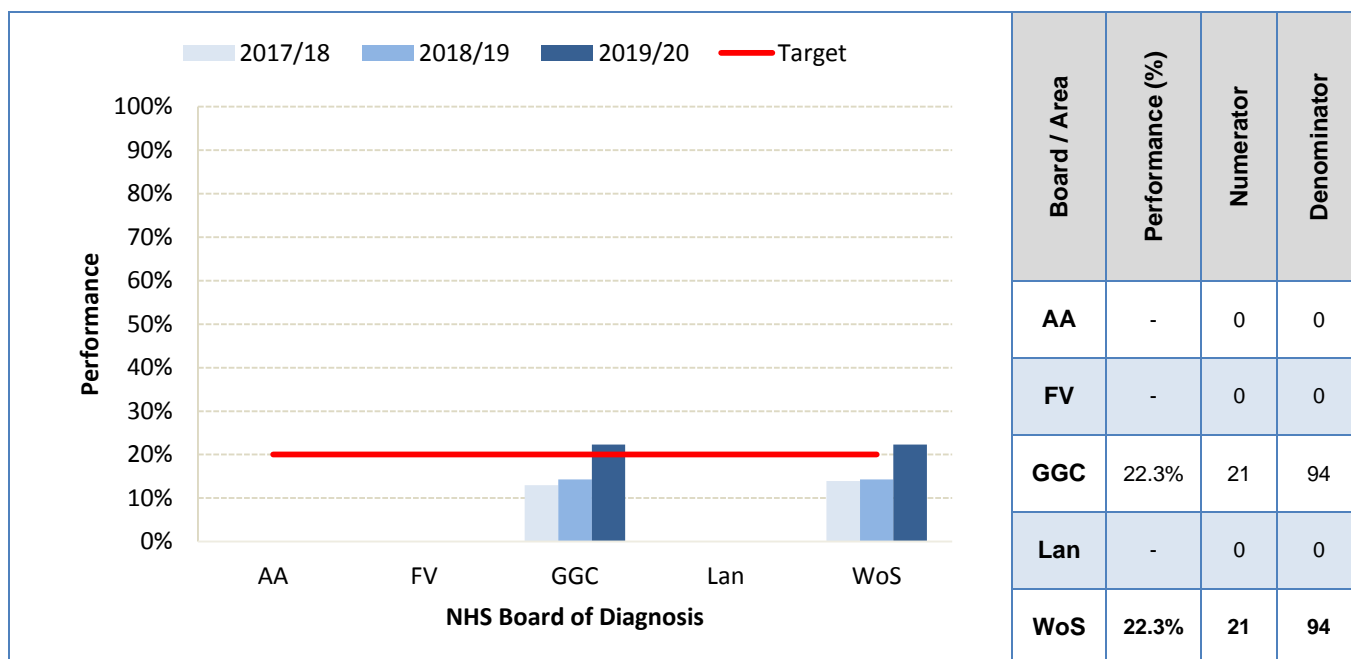
#### Actions Required:

- NHSGGC (North Glasgow/Clyde) to progress integration of North and Clyde Urology Services and MDT.

## QPI 5: Surgical Margins

Radical prostatectomy, the total removal of the prostate, is the primary curative surgical procedure for prostate cancer. Radical prostatectomy reduces the number of deaths and the risk of metastases in men with prostate cancer, however sometimes the tumour cannot be completely removed and the disease can recur.

QPI Title:	Organ confined prostate cancers which are surgically treated with radical prostatectomy should be completely excised.
Numerator:	Number of patients with stage pT2 prostate cancer who underwent radical prostatectomy in which tumour is present at the margin.
Denominator:	All patients with stage pT2 prostate cancer who underwent radical prostatectomy.
Exclusions:	None
Target:	< 20%



Note that from 2018-19 this QPI includes all surgeries undertaken within the audit period, including patients diagnosed prior to the audit period but undergoing surgery after a period of active surveillance. All patients receiving surgery for prostate cancer are now referred to, and operated on, by the regional robotics team in NHSGGC. NHSGGC did not meet the QPI target with a positive surgical margin rate of 22.3%.

Nerve-sparing procedures were not performed when robotic surgery commenced; as the surgical team have gained experience this procedure has been offered to an increasing group of patients. Review of the data shows a higher positive margin rate in certain nerve sparing procedures. This includes a cohort of Retzius sparing operations who had a higher proportion of potential positive margins. This operation is no longer offered and it is anticipated that overall positive margin rate will improve in future years. Within NHSGGC all patients are discussed in the planning meeting where their suitability for a robotically assisted nerve sparing procedure is agreed.

## QPI 6: Volume of Cases per Surgeon

It is preferable for radical prostatectomy to be performed in institutions that perform the procedure routinely. Studies have shown the rates of post-operative and late urinary complications following radical prostatectomy are significantly reduced if the procedure is performed in a high-volume hospital and by a surgeon who performs a large number of such procedures<sup>1</sup>.

The provision of radical prostatectomy surgery has changed across Scotland with the implementation of robotically-assisted surgery in three high-volume centres. Regional service redesign commenced in the WoS in April 2016 and all procedures are now robotically assisted and take place at Queen Elizabeth University Hospital (QEUH) in Glasgow. For robotic assisted radical prostatectomy it has been suggested that individual surgeons should undertake a minimum of 50-100 cases per annum<sup>1</sup>.

QPI Title:	Surgery should be performed by surgeons who perform the procedure routinely.
Specifications:	Number of radical prostatectomies performed by each surgeon in a given year.
Exclusions:	None
Target:	<b>Minimum of 50 procedures per surgeon in a 1 year period.</b>

**The number of radical prostatectomies performed per surgeon 2019/20.**

	No. of Operating Surgeons	No. of Procedures	No. of Surgeons Meeting Target
<b>GGC</b>	3	173	2
<b>WoS</b>	3	173	2

Note that this QPI was based on data from SMR01 in previous years. Some errors had previously been noted in the SMR01 data therefore the audit data reported for the first time this year is considered to provide a more accurate reflection of the surgical volumes undertaken by individual surgeons. All patients receiving surgery for prostate cancer are now referred to, and operated on, by the regional robotics team in NHSGGC.

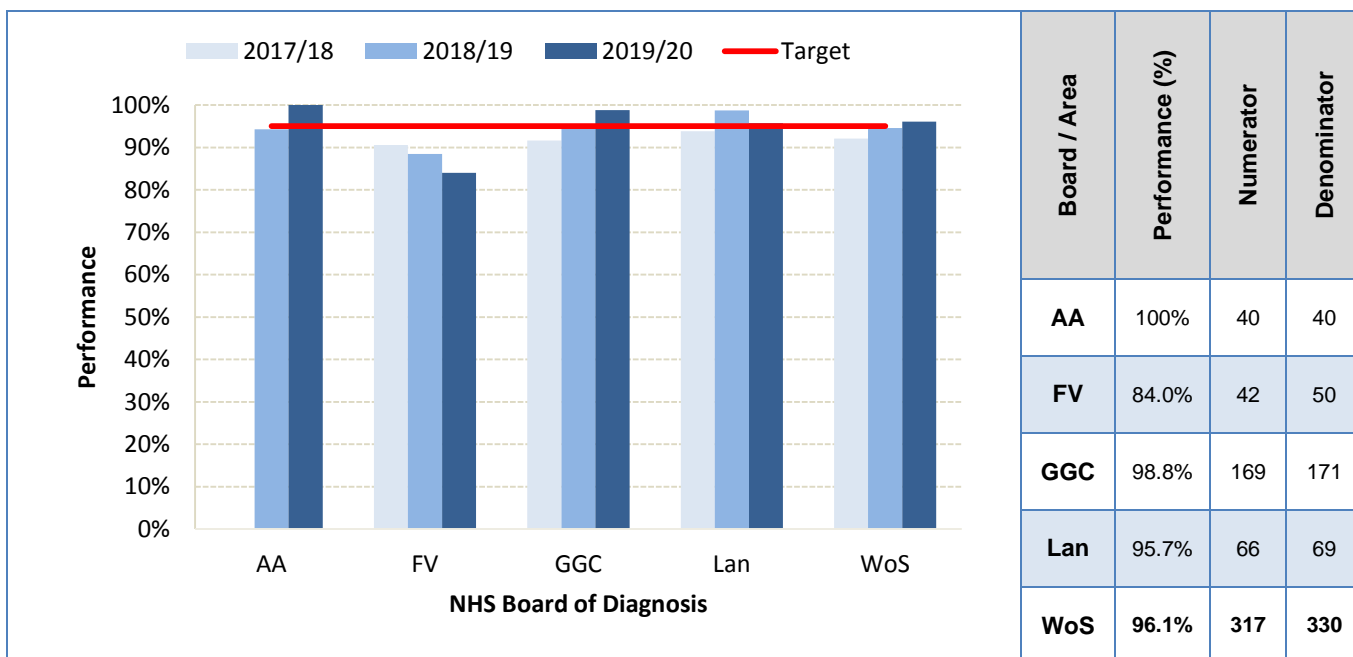
Within NHSGGC one surgeon performed only 20 procedures, this was due to access to a limited number of theatre sessions, and to the COVID-19 pandemic which temporarily halted, then slowed prostate surgery. Interim data for the 2020/21 indicate that this surgeon will meet, or be very close to the target at the next reporting cycle while the other surgeons have exceeded the target for this period.

## QPI 7: Hormone Therapy and Docetaxel Chemotherapy

The function of hormone therapy on prostate cancer is to stop testosterone feeding prostate cancer and encouraging growth<sup>5</sup>. Androgen Deprivation Therapy (ADT) blocks the production of androgens including testosterone, with the aim of slowing the growth of prostate cancer cells. There is evidence for symptom palliation and possible survival benefit in symptomatic metastatic patients, and for prolonged progression-free survival in asymptomatic patients with metastatic prostate cancer<sup>1</sup>.

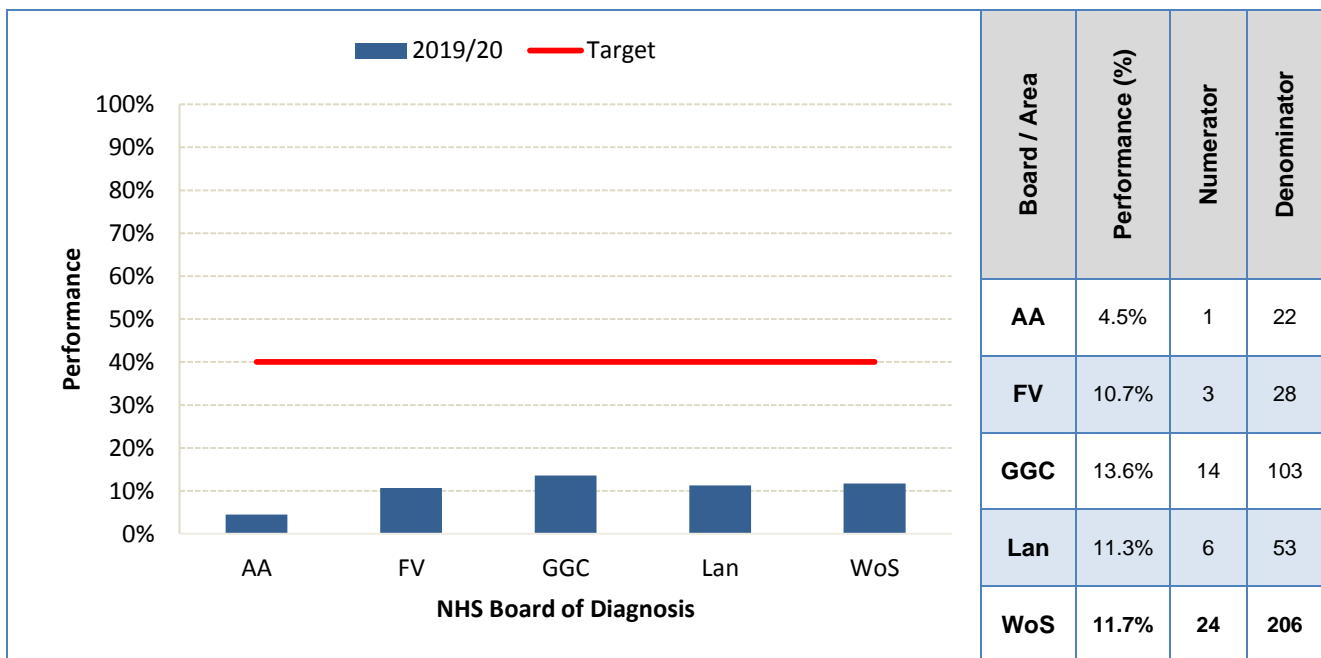
Docetaxel chemotherapy has shown evidence of improved survival when given in conjunction with hormone therapy and therefore should be offered to men who are suitably fit as part of their care<sup>1</sup>.

QPI Title:	Patients with metastatic prostate cancer should undergo immediate hormone therapy and chemotherapy where appropriate.
Specification (i)	Immediate hormone therapy
Numerator:	Number of patients presenting with metastatic prostate cancer (TanyNanyM1) treated with immediate hormone therapy.
Denominator:	All patients presenting with metastatic prostate cancer (TanyNanyM1).
Exclusions:	<ul style="list-style-type: none"> <li>• Patients documented to have refused immediate hormone therapy</li> <li>• Patients enrolled in clinical trials</li> </ul>
Target:	<b>95%</b>



Specification (i) was met at a regional level in 2019-20 and by all NHS Boards except NHS Forth Valley. NHS Forth Valley have reviewed the patients not meeting the QPI, and concluded clinically valid reasons for delay or differing management interventions.

QPI Title:	Patients with metastatic prostate cancer should undergo immediate hormone therapy and chemotherapy where appropriate.
Specification (ii)	Immediate hormone therapy and Docetaxel chemotherapy
Numerator:	Number of patients presenting with metastatic prostate cancer (TanyNanyM1) treated with immediate hormone therapy and Docetaxel chemotherapy.
Denominator:	All patients presenting with metastatic prostate cancer (TanyNanyM1).
Exclusions:	<ul style="list-style-type: none"> <li>• Patients documented to have declined immediate hormone therapy</li> <li>• Patients documented to have declined chemotherapy</li> <li>• Patients enrolled in clinical trials</li> <li>• Patients receiving ARTA (Androgen Receptor Targeted Agent) treatment</li> </ul>
Target:	<b>40%</b>



None of the boards within WoS met this target in 2019-20. Historically this QPI has been challenging to meet as chemotherapy is not a suitable treatment for a high proportion these patients due to patient fitness and comorbidities. Performance against this QPI has decreased in 2019-20 however results for 2019-20 are not comparable to those from previous years due to changes in the QPI definition (to exclude patients receiving androgen receptor targeted agent).

The reasons that individual patients did not receive Docetaxel chemotherapy have been reviewed across all WoSCAN Boards. As in previous years, the majority of the patient cohort is not suitable for chemotherapy treatment because of fitness, age or co-morbidities, with the increased COVID-19 risk being an additional factor in the 2019-20 data. Some additional patients died before treatment while small numbers also received chemotherapy more than 90 days after commencing hormone therapy.

On 20<sup>th</sup> April 2020, the National Cancer Medicines Advisory Group (NCMAG) approved the routine off-label use of oral Abiraterone in low risk newly diagnosed metastatic hormone sensitive prostate cancer patients who would otherwise be offered Docetaxel. This contributed to the decline in numbers of patients receiving Docetaxel during 2019-20.

This national advice remains unchanged and is valid until end of March 2022 but may be reviewed earlier if it is considered safe to re-introduce Docetaxel in this patient population or a licensed and SMC accepted alternative becomes available.

Review of the data in NHSGGC did not reveal any cases where chemotherapy would have been appropriate but was not given. Within NHSGGC, where patients received chemotherapy but were treated outwith the 90-day target, the target was exceeded by 17 days at the most.

The Urology MCN will review performance of this new measure and benchmarking against other regions to better understand the impact of both the change in QPI definition and changes to treatment options and risks during the COVID-19 pandemic on performance against this QPI.

**Actions Required:**

- Urology MCN to review performance of QPI 7(ii) and benchmarking against other regions to better understand the impact of both the change in QPI definition and changes to treatment options and risks during the COVID-19 pandemic on performance against this QPI.

## QPI 8: Post Surgical Incontinence

Urinary incontinence, especially over the long-term, is significant and is associated with poor quality of life, this therefore requires to be minimised in men undergoing surgery for prostate cancer<sup>1</sup>. Patient reported outcome measures (PROMs) are used to establish patient views on quality of life issues at various points within the care experience. Many men with prostate cancer experience significant quality of life issues post radical treatment including incontinence, sexual function, and bowel function. The use of a validated PROMs tool provides a reliable measure of health quality for these patients.

QPI Title:	Post surgical incontinence for patients with prostate cancer should be assessed using a validated PROMs (Patient Reported Outcome Measures) tool.
Numerator:	Number of patients with prostate cancer undergoing radical prostatectomy that have returned a PROMs tool both pre-operatively and post-operatively (12-18 months following surgery) for assessment of incontinence.
Denominator:	All patients with prostate cancer undergoing radical prostatectomy.
Exclusions:	<ul style="list-style-type: none"> <li>• Patients who undergo salvage prostatectomy</li> <li>• Patients who receive adjuvant radiotherapy within 12 months of surgery</li> </ul>
Target:	<b>50%</b>

Board	Performance (%)	Numerator	Denominator
AA	-	0	0
FV	-	0	0
GGC	0%	0	156
Lan	-	0	0
WoS	<b>0%</b>	<b>0</b>	<b>156</b>

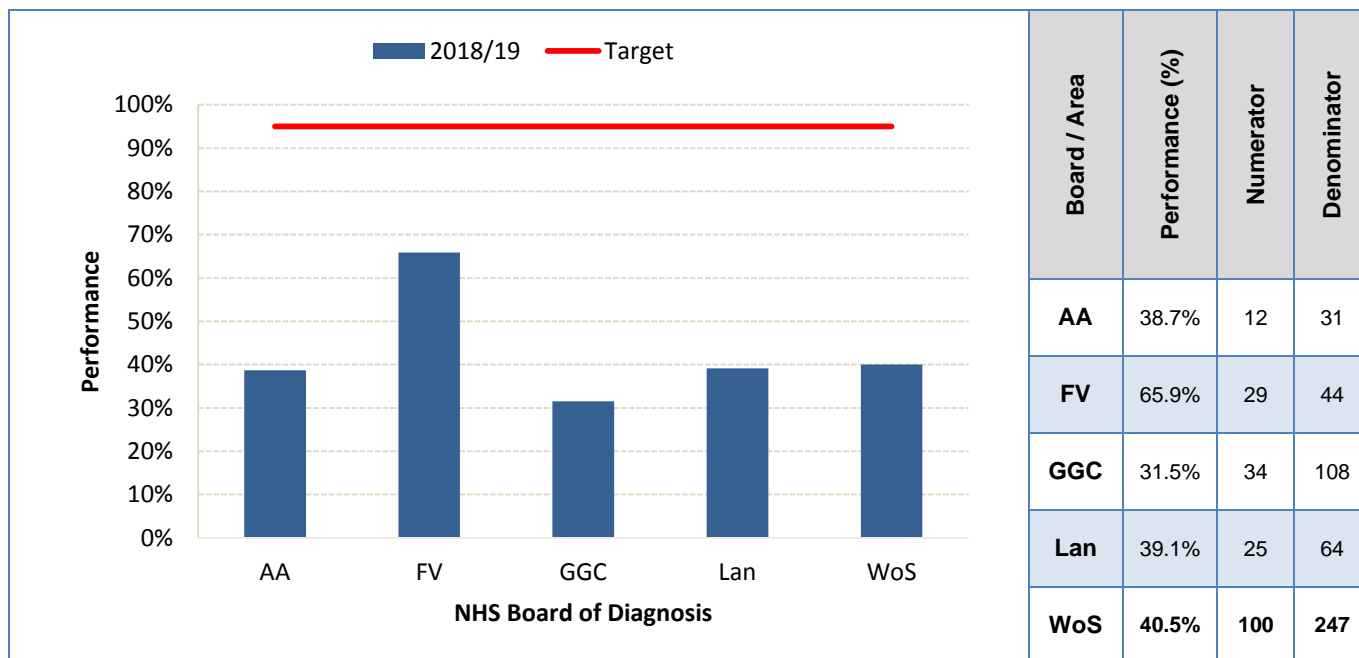
This is a new QPI that requires patients to complete a PROMs tool both pre-operatively and post operatively. As the indicator looks at the use of the PROMs tool 12-18 months post surgery then the QPI is reported one year in arrears, as such data analysed here are for patients diagnosed in 2018-2019.

All radical prostatectomies for patients diagnosed within WoSCAN were undertaken in NHSGGC. Data is unfortunately incomplete in all cases as EPIC-26 questionnaires were not in routine use prior to early 2020 and post operative questionnaires not routinely issued until January 2021; nearly all of this cohort had surgery prior to this time. In the remaining cases less than 18 months has elapsed since surgery so they are excluded from the analysis as the result cannot be determined. The majority of the patients diagnosed in 2019-20 and due to be reported next year will have had surgery following the introduction of the EPIC-26 forms and performance can be anticipated to improve, although an impact from the COVID-19 pandemic is also expected. Processes have also been put in place to ensure that audit staff are able to access information on when questionnaires are issued and returned.

## QPI 11: Management of Active Surveillance

Different treatment options are available for men with low risk prostate cancer including surgery, radiotherapy and also active surveillance. Active surveillance as a treatment option can reduce overtreatment and therefore reduce potential adverse effects from radical treatments as well as being beneficial in terms of healthcare costs. It is recommended that men who are undergoing active surveillance should have a multiparametric MRI (mpMRI) performed at the outset if not had one previously. Evidence suggests that a further mpMRI should also be undertaken 12 – 18 months later in order to identify any clinically significant cancer or re-stage prostate cancer after diagnosis<sup>1</sup>.

QPI Title:	Men under active surveillance for prostate cancer should undergo biparametric MRI (bpMRI) or multiparametric MRI (mpMRI) within 12- 18 months of diagnosis.
Numerator:	Number of patients with prostate cancer under active surveillance who undergo bpMRI or mpMRI within 12-18 months of diagnosis.
Denominator:	All patients with prostate cancer under active surveillance.
Exclusions:	<ul style="list-style-type: none"> <li>• Patients unable to undergo an MRI scan</li> <li>• Patients who decline MRI</li> </ul>
Target:	<b>95%</b>



Please note that this QPI is reported one year in arrears so data presented are for patients diagnosed in 2018-19. Due to changes to the QPI definition at formal review, results cannot be compared with those from previous years.

None of the WoSCAN NHS Boards met this revised QPI for patients diagnosed in 2018-19. Following review of the exceptions, it is noted that the majority of these patients did have an MRI but imaging was outwith the 12-18 month window. NHSGGC and NHS Ayrshire & Arran noted that a significant number of patients had MRI imaging less than 12 months after diagnosis with NHSGGC highlighting that MRI dates were often arranged 12 months after the diagnostic MRI rather than the subsequent biopsy date. All four NHS Boards within the WoS noted some patients had MRI more than 18 months after diagnosis with NHS Ayrshire & Arran and NHS Lanarkshire noting that the COVID-19 pandemic has resulted in delays to imaging.



A significant minority of patients had no surveillance MRI at the time of reporting, NHS Forth Valley noted that some of these patients had a rebiopsy instead of imaging. NHS Forth Valley has updated the pathway for patients on active surveillance since the reporting period to reflect current NICE recommendations for imaging to be undertaken prior to any biopsy and results in subsequent report periods are anticipated to reflect this and improve.

NHSGGC are considering introducing dedicated nurse-led active surveillance clinics, a new CNS is being recruited for Clyde sector which could facilitate this.

**Actions Required:**

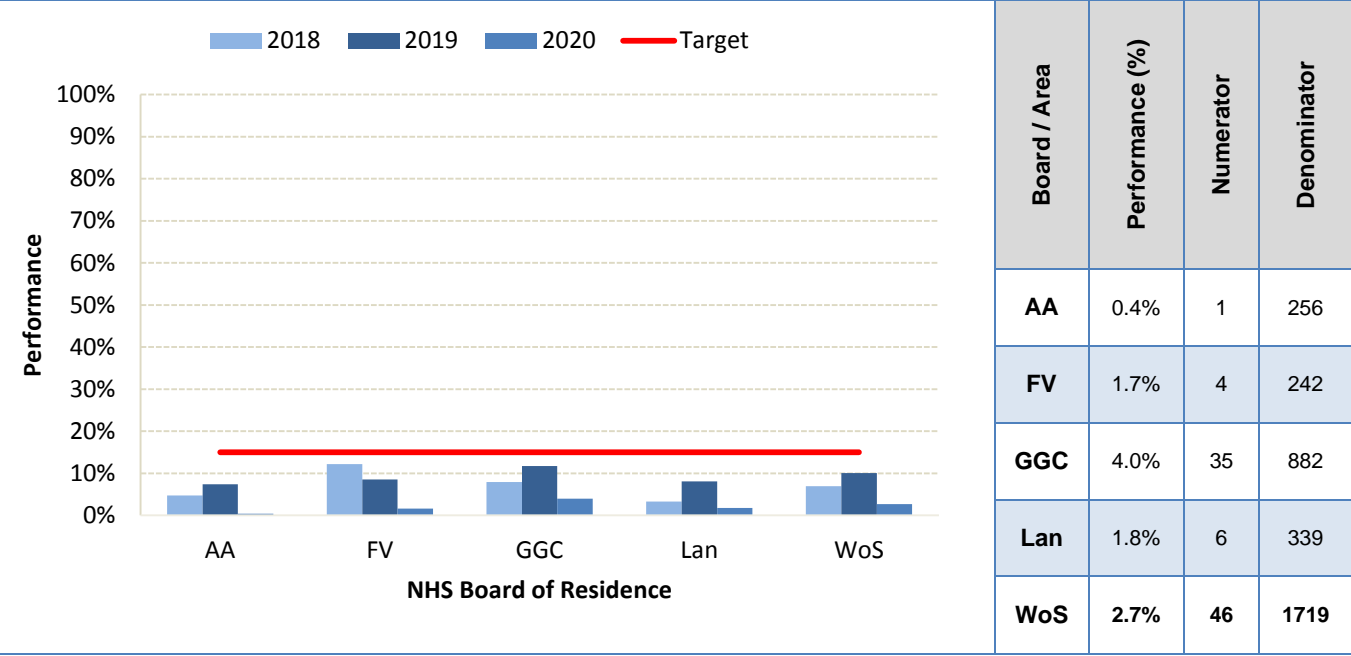
- All NHS Boards to reinforce the requirements of the active surveillance pathway to clinicians locally.
- MCN to develop a stand-alone active surveillance protocol for WoSCAN.

### QPI 13: Clinical Trial and Research Study Access

Clinical trials are necessary to demonstrate the efficacy of new therapies and other interventions. Evidence suggests improved patient outcomes when hospitals are actively recruiting patients into clinical trials<sup>1</sup>. Clinicians are therefore encouraged to enter patients into well designed trials and to collect longer term follow up data.

The measurement of this QPI focuses on those patients who have consented in order to reflect the intent to join a clinical trial and demonstrate the commitment to recruit patients. Often patients can be prevented from enrolling within a trial due to stratification of studies and precise inclusion criteria identified during the screening process. The clinical trials QPI is measured utilising Scottish Cancer Research Network (SCRN) data and Public Health Scotland incidence data, as is the methodology currently utilised by the Chief Scientist Office (CSO) and the National Cancer Research Institute (NCRI). The principal benefit of this approach is that this data is already collected utilising a robust mechanism<sup>1</sup>.

QPI 13:	All patients should be considered for participation in available clinical trials/research studies, wherever eligible.
Numerator:	Number of patients diagnosed with prostate cancer consented for a clinical/research study.
Denominator:	All patients with prostate cancer.
Exclusions:	No exclusions
Target:	<b>15%</b>



No boards in the WoS achieved the 15% target for patients consented for clinical trials or research studies with only 2.7% of patients living in WoS being recruited into clinical trials or research studies in 2020. Performance shows a decline from previous years as recruitment into trials has been significantly influenced by the COVID-19 pandemic which caused all trial recruitment to be suspended in March 2020, with few of the prostate cancer trials re-opening to recruitment within the audit period.

Prostate cancer ranges from very low risk localised disease requiring no intervention to metastatic disease with a short survival time. Many patients are not managed in a trial active arena due to the multidisciplinary approach to treatment. There are very few trials available for patients having imaging or undergoing surgery for prostate cancer. As a result of this, the majority of men diagnosed with prostate cancer are not eligible for available trials.

**Number of patients recruited and consented into Prostate clinical trials, 2020**

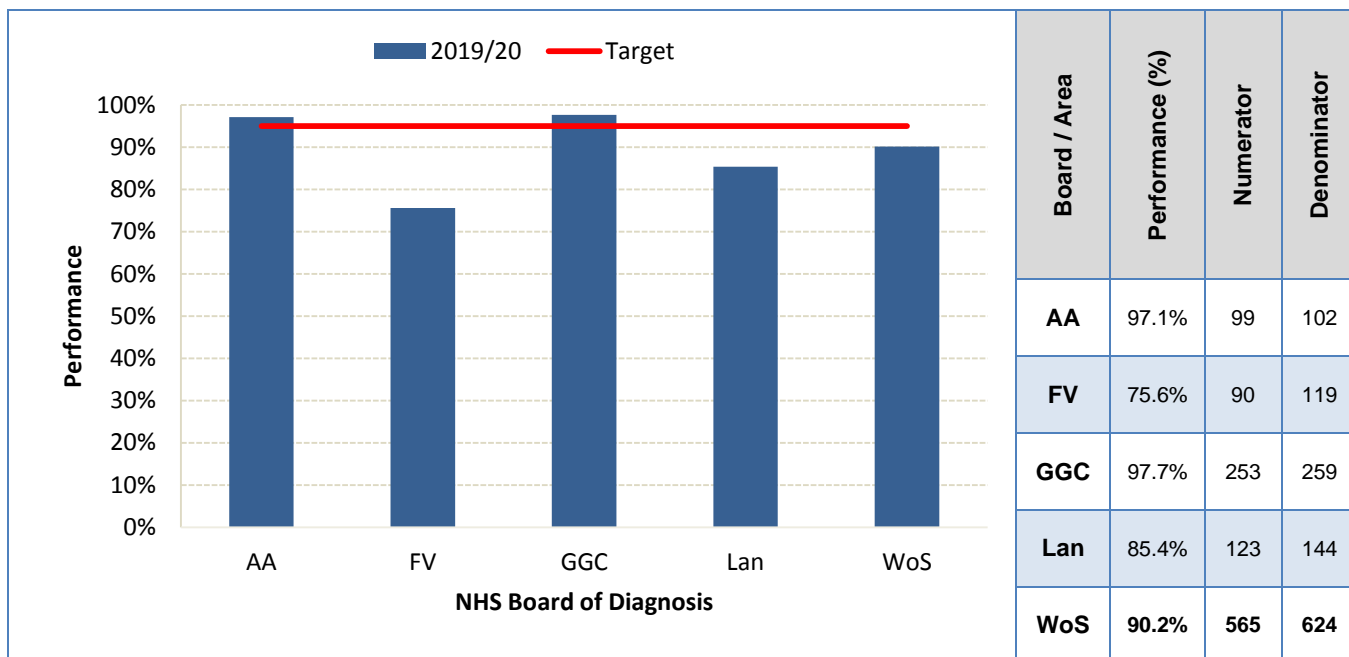
Project Title	2020	
	Consented	Recruited
Clinical Study of the ProSpace™ Balloon System	2	2
ECMC biomarker	9	9
GAP 4 INTERVAL - MCRPC v3.0	1	1
IMAGINE	0	0
NEPTUNES	11	2
NeuroSAFE proof	1	1
PARADIGM	2	2
PATCH: Prostate Adenocarcinoma - TransCutaneous Hormones	2	2
PIVOTALboost	3	3
TALAPRO-2	12	2
The PACE Trial (Prostate Advances in Comparative Evidence)	2	2
UK Genetic Prostate Cancer Study	1	1
<b>Total</b>	<b>46</b>	<b>27</b>

Source: SCRN data

## QPI 14: Diagnostic Pre-biopsy MRI

Evidence from the PROMIS trial suggests that performing multi-parametric MRI as a triage investigation can reduce the number of patients undergoing unnecessary biopsy by approximately one quarter. In addition, it can also improve the detection of clinically significant cancers compared with the standard TRUS (transrectal ultrasound) biopsy whilst reducing the over-diagnosis of insignificant cancers. In line with recommendations, patients with suspected clinically localised prostate cancer should be offered multi-parametric MRI as first line investigation, with results reported using a Likert scale. Use of a standardised Likert scoring system to detect clinically significant cancer provides guidance on whether a biopsy is recommended<sup>1</sup>.

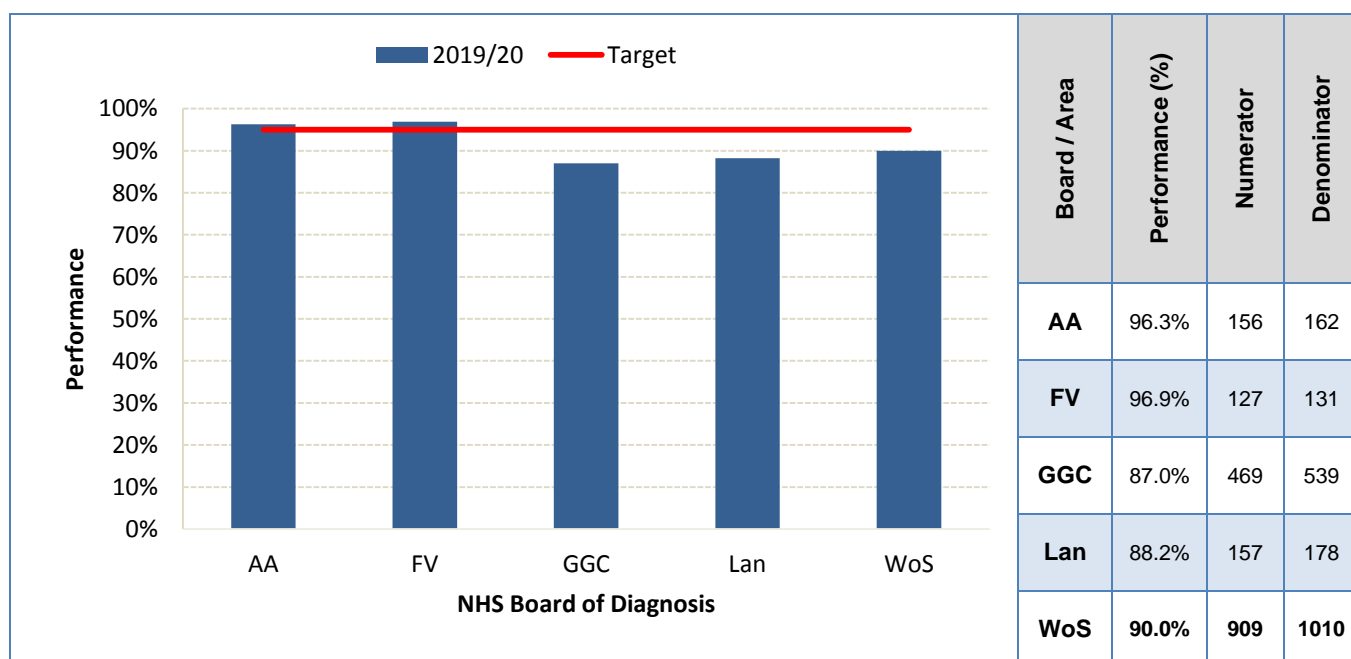
QPI Title:	Patients with prostate cancer who undergo biopsy should be evaluated initially with a pre-biopsy biparametric MRI (bpMRI) or multiparametric MRI (mpMRI) and reported using a PI-RADS/Likert system of grading
Specification (i):	Patients with prostate cancer who undergo biopsy that have a pre-biopsy bpMRI or mpMRI as their first line diagnostic investigation
Numerator:	Number of patients with prostate cancer who undergo biopsy that have a pre-biopsy bpMRI or mpMRI as their first line diagnostic investigation.
Denominator:	All patients with prostate cancer who undergo biopsy.
Exclusions:	<ul style="list-style-type: none"> <li>• Patients unable to undergo an MRI scan</li> <li>• Patients who decline MRI</li> <li>• Patients who have undergone TURP</li> <li>• Patients who have undergone laser enucleation</li> <li>• Patients with locally advanced (Clinical T3 and above) and / or M1 disease.</li> </ul>
Target:	<b>95%</b>



Within the West of Scotland 90.2% of patients that had a TRUS biopsy had an MRI as their first diagnostic investigation, below the target of 95%; however this target was met in NHS Ayrshire & Arran and NHSGGC. This is the first year this new QPI has been reported so there is no performance from previous years with which to compare the 2019-20 performance.

Patients not meeting this QPI were reviewed, NHS Lanarkshire noted difficulties in patients having an MRI prior to biopsy due to the COVID-19 pandemic. Within NHS Forth Valley the pathway has been updated to reflect current NICE recommendations for MRI to be undertaken before biopsy and results in subsequent report periods are anticipated to reflect this and improve.

QPI Title:	Patients with prostate cancer who undergo biopsy should be evaluated initially with a pre-biopsy biparametric MRI (bpMRI) or multiparametric MRI (mpMRI) and reported using a PI-RADS/Likert system of grading
Specification (ii):	Patients with prostate cancer who undergo biopsy that have a pre-biopsy bpMRI or mpMRI as their first line diagnostic investigation with imaging reported using a PI-RADS/ Likert system of grading.
Numerator:	Number of patients with prostate cancer who undergo biopsy that have a pre-biopsy bpMRI or mpMRI as their first line diagnostic investigation with imaging reported using a PI-RADS/Likert system of grading.
Denominator:	All patients with prostate cancer who undergo biopsy that have a pre-biopsy bpMRI or mpMRI as their first line diagnostic investigation.
Exclusions:	No Exclusions
Target:	<b>95%</b>



Within the West of Scotland 90.0% of patients that had pre-biopsy MRI had imaging reported using a PI-RADS / Likert system of grading, below the target of 95%; however this target was met in NHS Ayrshire & Arran and NHS Forth Valley. This is the first year this new QPI has been reported so there is no performance from previous years with which to compare the 2019-20 performance.

Review of patients not meeting this QPI in NHSGGC indicated that in 9 of these the score was not assessable as imaging artefacts degraded the diffusion-weighted sequences. In 8 cases reviewed, patients had a score documented for an earlier MRI but not on the scan immediately prior to biopsy which is captured by audit. This is in line with protocol, where a score will be documented on the initial scan, and on any subsequent change, but may not be where appearances are unchanged

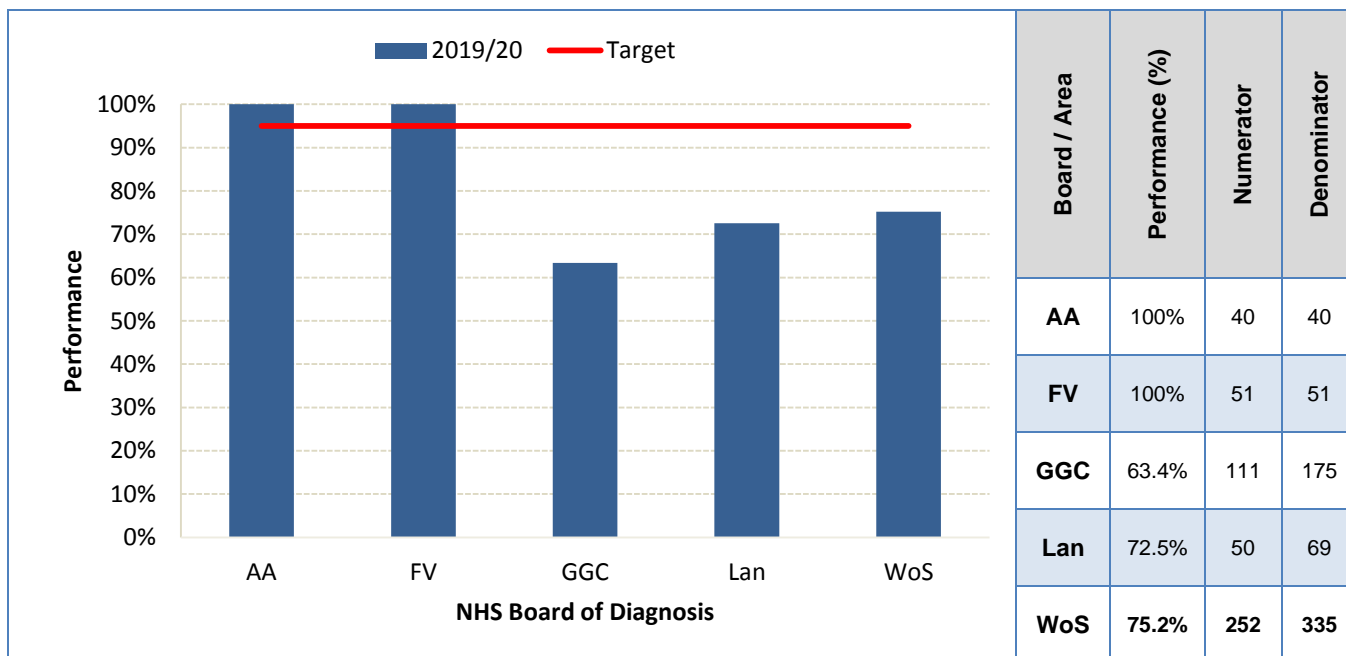
between scans. Changes to the dataset have since been made so that, in future, scores from previous imaging will be audited in cases where no changes have been recorded from previous imaging therefore patients will meet this QPI.

Where radiologists have omitted the PI-RADS or Likert grading score this will be highlighted in both NHSGGC and NHS Lanarkshire with the aim of improving performance against this new indicator in future years. Provisional analysis of data for July 2020 – December 2020 in NHS Lanarkshire indicate that the Board are now on target to meet this QPI for the next reporting period.

## QPI 15: Low Burden Metastatic Disease

Metastatic burden of disease should be assessed in order to guide treatment decisions in men with newly diagnosed metastatic prostate cancer. There is evidence to suggest that prostate radiotherapy treatment provides an overall survival benefit when given to men with newly diagnosed metastatic prostate cancer who have a low metastatic disease burden. High metastatic burden is those patients that have  $\geq$  four metastases, with one or more outside the vertebral bodies or pelvis, or visceral metastases, or both. Other assessable patients are considered to be low metastatic burden<sup>1</sup>.

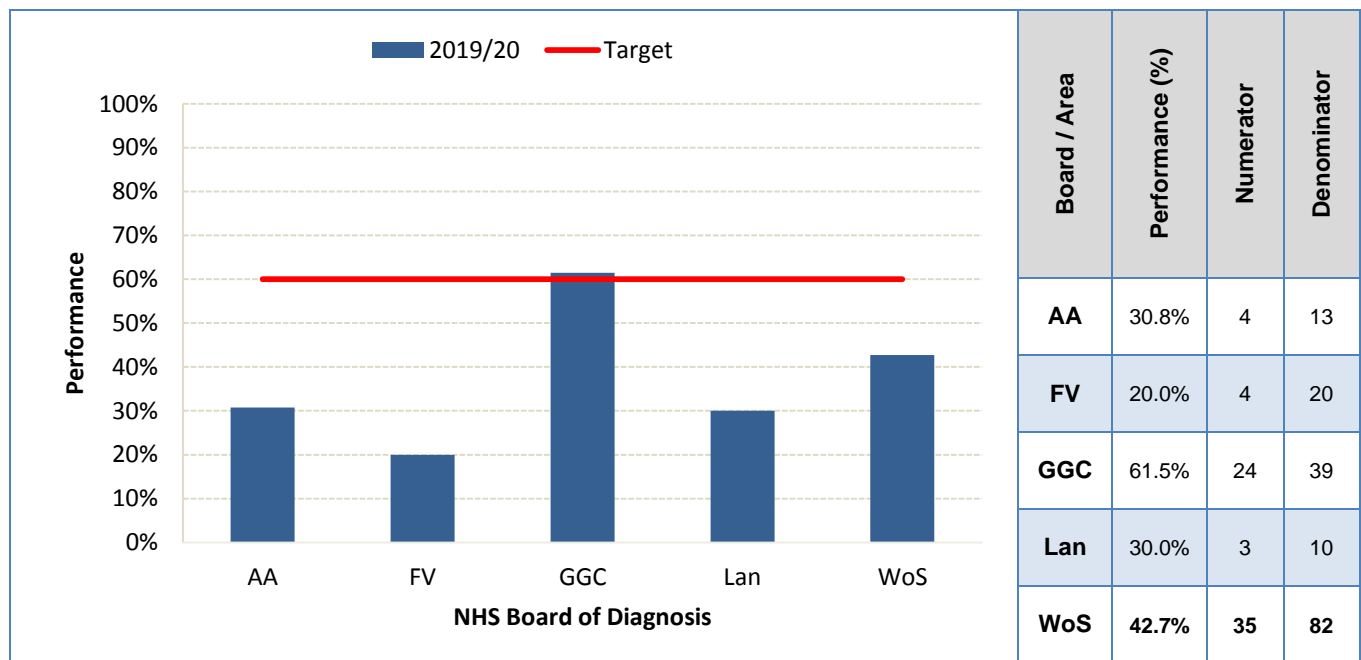
QPI Title:	Patients with metastatic prostate cancer should have their burden of disease assessed, and undergo radiotherapy where appropriate.
Specification (i):	Patients with metastatic prostate cancer in whom burden of disease is assessed.
Numerator:	Number of patients with metastatic prostate cancer in whom burden of disease is assessed.
Denominator:	All patients with metastatic prostate cancer.
Exclusions:	No Exclusions
Target:	<b>95%</b>



Within the West of Scotland 75.2% of patients with metastatic disease had their burden of disease assessed, below the target of 95%; however this target was met in NHS Ayrshire & Arran and NHS Forth Valley. This is the first year this new QPI has been reported so there is no performance from previous years with which to compare the 2019-20 results.

Recording of metastatic burden has been reviewed in NHSGGC and NHS Lanarkshire. The majority of patients not meeting the QPI within NHSGGC (38) were in Clyde sector. NHSGGC will reiterate the need to document metastatic burden at MDT in line with the Clinical Management Guideline and in the longer term are working towards merging the Pan Glasgow and Clyde MDTs to ensure equity of access to treatments for all patients, as identified under QPI 4. Similarly in NHS Lanarkshire clinical staff will be reminded to document the metastatic burden of disease at MDT discussion and it is anticipated that performance against this QPI will improve as this becomes standard practice.

QPI Title:	Patients with metastatic prostate cancer should have their burden of disease assessed, and undergo radiotherapy where appropriate.
Specification (ii):	Patients with metastatic prostate cancer who have a low metastatic burden that receive radiotherapy.
Numerator:	Number of patients with metastatic prostate cancer who have a low metastatic burden that receive radiotherapy
Denominator:	All patients with metastatic prostate cancer who have a low metastatic burden.
Exclusions:	Patients documented to have declined radiotherapy treatment.
Target:	<b>60%</b>



Within the West of Scotland 42.7% of patients that had low metastatic burden received radiotherapy, below the target of 60%; however this target was met in NHSGGC. This is the first year this new QPI has been reported so there is no performance from previous years with which to compare the 2019-20 performance.

Cases not meeting the target were reviewed and there were various reasons for not having radiotherapy. Within NHS Ayrshire & Arran patients were considered to be not fit for radiotherapy while in NHS Forth Valley no reason was recorded for the majority of patients not having radiotherapy. NHS Lanarkshire commented that each patient is assessed individually with a treatment plan agreed depending on various patient and tumour characteristics. While MDT discussion can highlight an individual's potential suitability, a face to face assessment will always be advisable before making a final decision on treatment.

The prostate cancer CMG was updated in early 2021 to include treatment options for low and high burden metastatic disease and these treatment options are now being discussed at the pan Glasgow MDT. Further education work around the treatment pathways for metastatic cancer patients will be undertaken by the MCN which should also improve performance against this QPI.



**Actions Required:**

- MCN to highlight the importance of assessing the metastatic burden of patients and using this as a tool for making treatment decisions in line with treatment pathways within the recently updated CMG; including the addition of 'the assessment of metastatic disease' as a topic within the annual education event programme.

## 5. Next Steps

The MCN will actively take forward regional actions identified and NHS Boards are asked to develop local Action/Improvement Plans in response to the findings presented in the report. A summary of actions for each NHS Board has been included within the Action Plan templates in [Appendix 3](#).

## **6. Acknowledgements**

This report has been prepared using clinical audit data provided by the following NHS Boards in the WoSCAN area:

NHS Ayrshire & Arran  
NHS Forth Valley  
NHS Greater Glasgow and Clyde  
NHS Lanarkshire

We would like to thank all members and active participants in the cancer network for their continued support of the MCN, and the many hospitals that are committed to making the audit succeed. We also acknowledge the efforts of the clinical effectiveness staff, nurses, and other service users for their work in ensuring the data are available to enable analysis to take place each year. Without their considerable efforts this level of progress would not be possible.

## 7. Glossary

<b>NHS AA</b>	NHS Ayrshire & Arran
<b>CNS</b>	Clinical Nurse Specialist
<b>CT</b>	Computed tomography
<b>eCASE</b>	Electronic Cancer Audit Support Environment
<b>NHS FV</b>	NHS Forth Valley
<b>HIS</b>	Healthcare Improvement Scotland
<b>NHS LAN</b>	NHS Lanarkshire
<b>LHRH</b>	Luteinizing Hormone Releasing Hormone. Hormone therapy.
<b>MCN</b>	Managed Clinical Network - Linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and NHS Board boundaries, to ensure equitable provision of high quality clinically effective services.*
<b>MDT(s)</b>	Multidisciplinary Team(s) - A Multidisciplinary Team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.**
<b>NCQSG</b>	National Cancer Quality Steering Group
<b>NHSGGC</b>	NHS Greater Glasgow and Clyde
<b>QPI(s)</b>	Quality Performance Indicator(s)
<b>RCAG</b>	Regional Cancer Advisory Group
<b>SMR01</b>	General / Acute Inpatient and Day Case
<b>TNM</b>	Tumour, Nodes, Metastases (staging system)
<b>TURP</b>	Transurethral Resection of the Prostate
<b>TRUS</b>	Transrectal ultrasound biopsy
<b>WoS</b>	West of Scotland
<b>WoSCAN</b>	West of Scotland Cancer Network

Sources:

\* [www.woscan.scot.nhs.uk](http://www.woscan.scot.nhs.uk)

\*\* [www.datadictionary.nhs.uk](http://www.datadictionary.nhs.uk)

## 8. References

1. Public Health Scotland (formerly Information Services Division). National Data Definitions for the Minimum Core Data Set for Prostate Cancer v4.1. Updated May 2020. Available at: <https://www.isdscotland.org/Health-Topics/Cancer/Cancer-Audit/docs/Prostrate/Prostate-Cancer-Core-Dataset-V4-1-Final.pdf>
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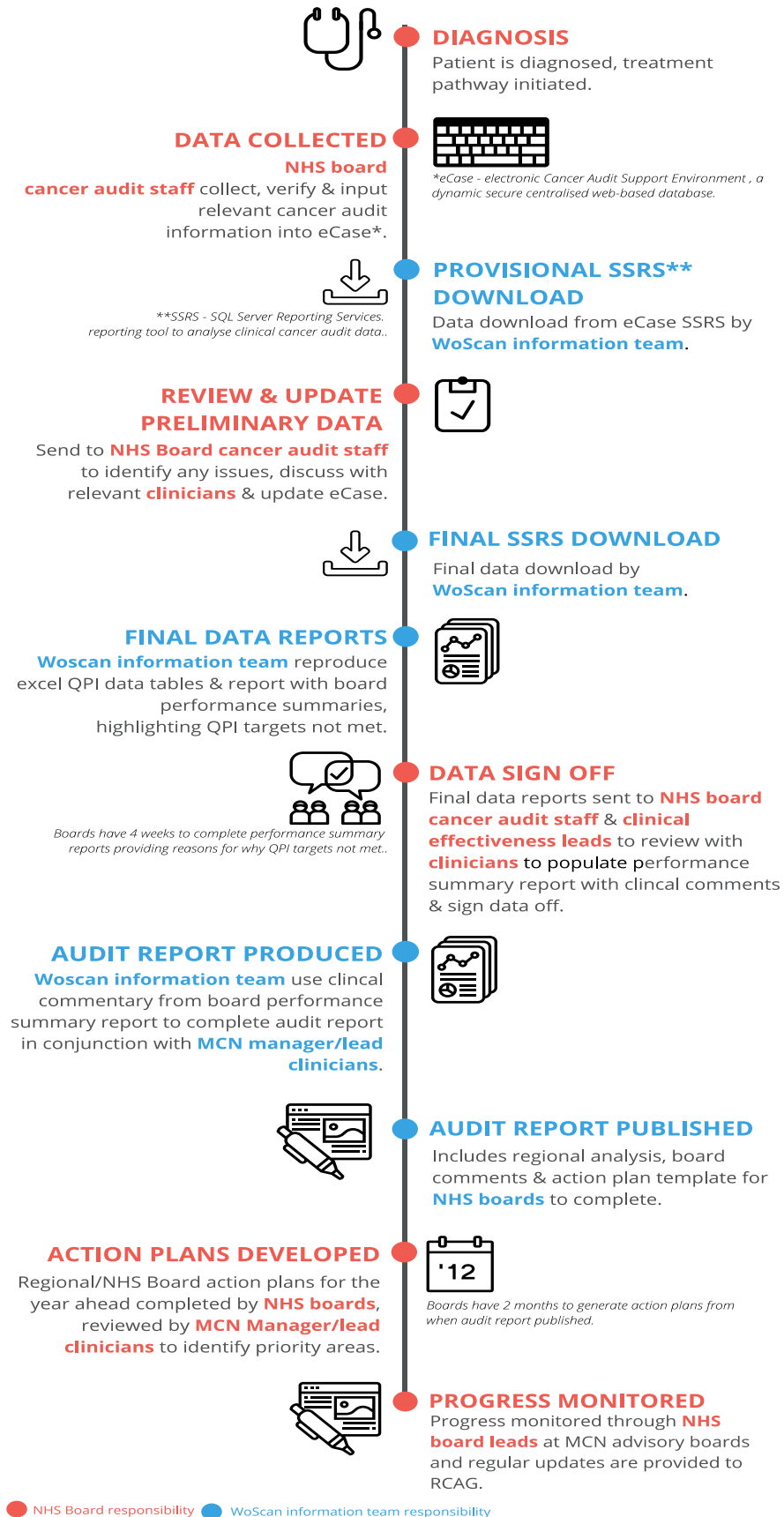
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## Appendix 1: Meta Data

Report Title	Cancer Audit Report: Prostate Cancer Quality Performance Indicators																												
Time Period	Patients diagnosed between 01 July 2019 to 30 June 2020																												
Data Source	Cancer Audit Support Environment (eCASE). A secure centralised web-based database which holds cancer audit information in Scotland.																												
Data extraction date	2200 hrs on 11 June 2021																												
Methodology	<p>Analysis was performed centrally for the region by the WoSCAN Information Team. The timescales agreed took into account the patient pathway to ensure that a complete treatment record was available for the majority of patients.</p> <p>Initial results were provided to Boards to check for inaccuracies, inconsistencies or obvious gaps and a subsequent download taken upon which final analysis was carried out.</p> <p>The final data analysis was disseminated for NHS Board verification in line with the regional audit governance process to ensure that the data was an accurate representation of service in each area. Please see info graphic in appendix 2 for a more detailed look at the reporting process.</p>																												
Data Quality	<p>Audit data completeness can be assessed by estimating the proportion of expected patients that have been identified through audit compared to the number reported by the National Cancer registry (provided by ISD, National Services Division); this is known as case ascertainment. Figures should only be used as a guide as it is not possible to compare the same exact cohort from each data source. Note that a 5 year average is taken for cancer registry cases to take account of annual fluctuations in incidence within NHS Boards.</p> <table border="1" data-bbox="370 1157 1338 1451"> <thead> <tr> <th></th> <th>Ayrshire &amp; Arran</th> <th>Forth Valley</th> <th>GGC</th> <th>Lanarkshire</th> <th>WoS</th> </tr> </thead> <tbody> <tr> <td>Cases from audit</td> <td>244</td> <td>230</td> <td>763</td> <td>319</td> <td>1556</td> </tr> <tr> <td>Cases from ISD (2015-19)*</td> <td>256</td> <td>242</td> <td>882</td> <td>339</td> <td>1719</td> </tr> <tr> <td>Case ascertainment</td> <td>95.3%</td> <td>95.0%</td> <td>86.5%</td> <td>94.1%</td> <td>90.5%</td> </tr> </tbody> </table>						Ayrshire & Arran	Forth Valley	GGC	Lanarkshire	WoS	Cases from audit	244	230	763	319	1556	Cases from ISD (2015-19)*	256	242	882	339	1719	Case ascertainment	95.3%	95.0%	86.5%	94.1%	90.5%
	Ayrshire & Arran	Forth Valley	GGC	Lanarkshire	WoS																								
Cases from audit	244	230	763	319	1556																								
Cases from ISD (2015-19)*	256	242	882	339	1719																								
Case ascertainment	95.3%	95.0%	86.5%	94.1%	90.5%																								

## Appendix 2: Cancer Audit Timeline





### Appendix 3: NHS Board Action Plans

A summary of actions for each NHS Board has been included within the following Action Plan templates. Completed Action Plans should be returned to WoSCAN within two months of publication of this report.

#### Prostate Cancer QPI Action / Improvement Plan

<b>Area:</b>	NHS Ayrshire & Arran
<b>Action Plan Lead:</b>	
<b>Date:</b>	

KEY (Status)	
<b>1</b>	Action fully implemented
<b>2</b>	Action agreed but not yet implemented
<b>3</b>	No action taken (please state reason)

QPI No.	Action Required	Health Board Action Taken	Timescales		Lead	Progress/Action Status	Status (see Key)
			Start	End			
	<i>Ensure actions mirror those detailed in Audit Report.</i>	<i>Detail specific actions that will be taken by the NHS Board.</i>	<i>Insert date</i>	<i>Insert date</i>	<i>Insert name of responsible lead for each specific action.</i>	<i>Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.</i>	<i>Insert No. from key above.</i>
11	All NHS Boards to reinforce the requirements of the active surveillance pathway to clinicians locally (action category: other)						

## Prostate Cancer QPI Action / Improvement Plan

<b>Area:</b>	NHS Forth Valley
<b>Action Plan Lead:</b>	
<b>Date:</b>	

KEY (Status)	
<b>1</b>	Action fully implemented
<b>2</b>	Action agreed but not yet implemented
<b>3</b>	No action taken (please state reason)

QPI No.	Action Required	Health Board Action Taken	Timescales		Lead	Progress/Action Status	Status (see Key)
			Start	End			
	<i>Ensure actions mirror those detailed in Audit Report.</i>	<i>Detail specific actions that will be taken by the NHS Board.</i>	<i>Insert date</i>	<i>Insert date</i>	<i>Insert name of responsible lead for each specific action.</i>	<i>Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.</i>	<i>Insert No. from key above.</i>
11	All NHS Boards to reinforce the requirements of the active surveillance pathway to clinicians locally (action category: other)						

## Prostate Cancer QPI Action / Improvement Plan

<b>Area:</b>	NHS GGC
<b>Action Plan Lead:</b>	
<b>Date:</b>	

<b>KEY (Status)</b>	
<b>1</b>	Action fully implemented
<b>2</b>	Action agreed but not yet implemented
<b>3</b>	No action taken (please state reason)

<b>QPI No.</b>	<b>Action Required</b>	<b>Health Board Action Taken</b>	<b>Timescales</b>		<b>Lead</b>	<b>Progress/Action Status</b>	<b>Status (see Key)</b>
			<b>Start</b>	<b>End</b>			
	<i>Ensure actions mirror those detailed in Audit Report.</i>	<i>Detail specific actions that will be taken by the NHS Board.</i>	<i>Insert date</i>	<i>Insert date</i>	<i>Insert name of responsible lead for each specific action.</i>	<i>Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.</i>	<i>Insert No. from key above.</i>
4	NHSGGC (North Glasgow/Clyde) to progress integration of North and Clyde Urology Services and MDT (action category: MDT)						
11	All NHS Boards to reinforce the requirements of the active surveillance pathway to clinicians locally (action category: other)						

## Prostate Cancer QPI Action / Improvement Plan

<b>Area:</b>	NHS Lanarkshire
<b>Action Plan Lead:</b>	
<b>Date:</b>	

<b>KEY (Status)</b>	
<b>1</b>	Action fully implemented
<b>2</b>	Action agreed but not yet implemented
<b>3</b>	No action taken (please state reason)

<b>QPI No.</b>	<b>Action Required</b>	<b>Health Board Action Taken</b>	<b>Timescales</b>		<b>Lead</b>	<b>Progress/Action Status</b>	<b>Status (see Key)</b>
			<b>Start</b>	<b>End</b>			
	<i>Ensure actions mirror those detailed in Audit Report.</i>	<i>Detail specific actions that will be taken by the NHS Board.</i>	<i>Insert date</i>	<i>Insert date</i>	<i>Insert name of responsible lead for each specific action.</i>	<i>Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.</i>	<i>Insert No. from key above.</i>
11	All NHS Boards to reinforce the requirements of the active surveillance pathway to clinicians locally (action category: other)						

## Prostate Cancer QPI Action / Improvement Plan

<b>Area:</b>	MCN
<b>Action Plan Lead:</b>	
<b>Date:</b>	

<b>KEY (Status)</b>	
<b>1</b>	Action fully implemented
<b>2</b>	Action agreed but not yet implemented
<b>3</b>	No action taken (please state reason)

QPI No.	Action Required	Health Board Action Taken	Timescales		Lead	Progress/Action Status	Status (see Key)
			Start	End			
	<i>Ensure actions mirror those detailed in Audit Report.</i>	<i>Detail specific actions that will be taken by the NHS Board.</i>	<i>Insert date</i>	<i>Insert date</i>	<i>Insert name of responsible lead for each specific action.</i>	<i>Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.</i>	<i>Insert No. from key above.</i>
7	Urology MCN to review performance of QPI 7(ii) and benchmarking against other regions to better understand the impact of both the change in QPI definition and changes to treatment options and risks during the COVID-19 pandemic on performance against this QPI (action category: oncology)						
11	MCN to develop a stand-alone active surveillance protocol for WoSCAN (action category: other)						
15	MCN to highlight the importance of assessing the metastatic burden of patients and using this as a tool for making treatment decisions in line with treatment pathways within the recently updated CMG; including the addition of 'the assessment of metastatic disease' as a topic within the annual education event programme (action category: treatment decision)						