West of Scotland Cancer Network

Urological Cancer
Managed Clinical Network

Audit Report

Prostate Cancer
Quality Performance Indicators

Clinical Audit Data: 01 July 2020 to 30 June 2021

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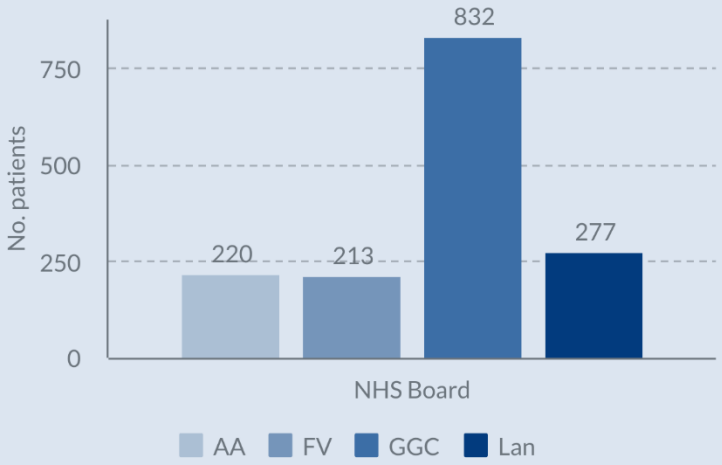
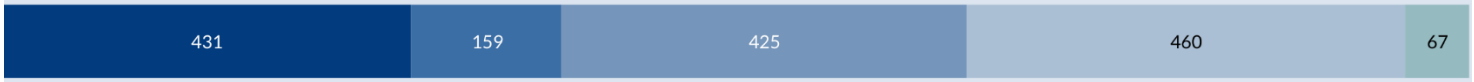
Prostate Cancer QPI Overview

Patients diagnosed July 2020 - June 2021

Number of patients	1542
Median Age of Patients:	71
Age standardised net survival:	
1 year survival	96%
5 year survival	84%

Where are patients diagnosed





I II III IV Not Available

Stage of Disease at Presentation

Performance (%)

Target Performance 2020-21 Change from 2019-20

	Target	Performance	Change
QPI 2: Radiological Staging	95%	99%	↑
QPI 4: MDT Meeting (i)	95%	97%	→
QPI 4: MDT Meeting (ii)	95%	98%	↑
QPI 5: Surgical Margins	<20%	23%	↑
QPI6: Volume of Cases per Surgeon	50	2 met 1 not met	
QPI 7: Hormone Therapy and Docetaxel Chemotherapy (i)	95%	96%	→
QPI 7: Hormone Therapy and Docetaxel Chemotherapy (ii)	40%	1%	↓
QPI 8: Post Surgical Incontinence	50%	0%	→
QPI 11: Management of Active Surveillance	95%	40%	→
QPI 13: Clinical Trials and Research Study Access	15%	6%	↑
QPI 14: Diagnostic Pre-biopsy MRI (i)	95%	98%	↑
QPI 14: Diagnostic Pre-biopsy MRI (ii)	95%	95%	↑
QPI 15: Low Burden Metastatic Disease (i)	95%	86%	↑
QPI 15: Low Burden Metastatic Disease (ii)	60%	39%	↓

Key Achievements:

- Excellent radiological staging (QPI 2)
- Timely MDT discussion with improvements for patients with metastatic disease (QPI 4i & ii)
- Improvements in performance against new measures on diagnostic pre-biopsy MRI (QPI 14) and assessment of metastatic disease burden (QPI 15i)

Areas for Improvement:

- Exploration of trend for higher proportion of surgical patients with positive margins over the last two years
- Finalisation of the regional active surveillance protocol
- Review of QPI definitions, particularly for QPI 7ii and 11 at upcoming Formal Review

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 2020 and 30 June 2021. Results are measured against the Prostate Cancer Quality Performance Indicators[1] (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 2nd 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 in August 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 2020/21 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						
	Target	Year	AA	FV	GGC	LAN	WoSCAN
QPI 2: Radiological Staging – Proportion of patients with high risk prostate cancer undergoing radical treatment who have had MRI and bone scan staging.	**95%**	2020 - 21	96.2%	98.2%	99.6%	96.1%	98.5%
		2019 - 20	98.4%	98.1%	97.5%	98.6%	97.9%
		2018 - 19	95.8%	93.1%	99.3%	95.9%	97.4%
QPI 4(i): Multi-Disciplinary Team Meeting (MDT). Proportion of patients with non-metastatic prostate cancer (TanyNanyM0) discussed at the MDT before definitive treatment.	**95%**	2020 - 21	94.0%	96.0%	97.7%	96.9%	96.9%
		2019 - 20	94.3%	98.8%	96.8%	95.5%	96.5%
		2018 - 19	96.0%	97.8%	94.7%	98.1%	96.0%
QPI 4(ii): Multi-Disciplinary Team Meeting (MDT). Proportion of patients with metastatic prostate cancer (TanyNanyM1) discussed at the MDT within 6 weeks of commencing treatment.	**95%**	2020 - 21	95.4%	98.1%	98.4%	97.3%	97.7%
		2019 - 20	85.4%	96.0%	93.7%	92.6%	92.8%
		2018 - 19	94.7%	94.3%	92.6%	96.3%	93.9%
QPI 5: Surgical Margins* – Proportion of patients with pathologically confirmed, organ confirmed (stage pT2) prostate cancer who undergo radical prostatectomy in which tumour is present at the margin, i.e. positive surgical margin.	**< 20%**	2020 - 21	-	-	23.4%	-	23.4%
		2019 - 20	-	-	22.3%	-	22.3%
		2018 - 19	-	-	14.3%	-	14.3%
QPI 6: Volume of Cases per Surgeon* – Number of radical prostatectomy procedures performed by a surgeon over a one year period.	**50 minimum**	2020 - 21	-	-	2 met 1 not met	-	2 met 1 not met
		2019 - 20	-	-	2 met 1 not met	-	2 met 1 not met
		2018 - 19	-	-	2 met 2 not met	-	2 met 2 not met

QPI	Target	Year	AA	FV	GGC	LAN	WoSCAN
QPI 7(i): Hormone Therapy & Docetaxel Chemotherapy – Proportion of patients with metastatic prostate cancer who are treated with immediate hormone therapy (31 days)	**95%**	2020 - 21	100.0%	89.8%	95.8%	95.9%	95.8%
		2019 - 20	100.0%	84.0%	98.8%	95.7%	96.1%
		2018 - 19	94.3%	88.5%	94.5%	98.8%	94.6%
QPI 7(ii): Hormone Therapy & Docetaxel Chemotherapy – Proportion of patients with metastatic prostate cancer who are treated with immediate hormone therapy (31 days) and docetaxel chemotherapy.	**70%**	2020 - 21	0%	0%	0%	2.2%	0.6%
		2019 - 20	4.5%	10.7%	13.6%	11.3%	11.7%
		2018 - 19					
QPI 8: Post-Surgical Incontinence*/ -** Proportion of prostate cancer 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%**	2020 - 21	-	-	0.0%	-	0.0%
		2019 - 20	-	-	0.0%	-	0.0%
		2018 - 19					
QPI 11: Management of Active Surveillance -** Proportion of men with prostate cancer under active surveillance who undergo bpMRI or mpMRI within 12-18 months of diagnosis.	**95%**	2020 - 21	60.5%	32.6%	38.9%	14.3%	40.0%
		2019 - 20	38.7%	65.9%	31.5%	39.1%	40.5%
		2018 - 19					
QPI 13: Clinical Trials and Research Study Access - Proportion of patients diagnosed with prostate cancer who are consented for a clinical trial / research study	**15%**	2021	2.0%	5.3%	7.6%	3.5%	5.7%
		2020	0.4%	1.7%	4.0%	1.8%	2.7%
		2019	8.0%	8.6%	11.7%	8.1%	10.0%
QPI 14i): Diagnostic Pre-biopsy MRI - Proportion of patients with prostate cancer who undergo biopsy that have a pre-biopsy bpMRI or mpMRI as their first line diagnostic investigation.	**95%**	2020 - 21	92.6%	96.6%	100.0%	97.5%	97.7%
		2019 - 20	97.1%	75.6%	97.7%	85.4%	90.2%
		2018 - 19					
QPI 14ii): Diagnostic Pre-biopsy MRI - Proportion 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.	**95%**	2020 - 21	95.1%	97.8%	94.1%	95.1%	94.9%
		2019 - 20	96.3%	96.9%	87.0%	88.2%	90.0%
		2018 - 19					

QPI	Target	Year	AA	FV	GGC	LAN	WoSCAN
QPI 15i): Low Burden Metastatic Disease - Proportion of patients with metastatic prostate cancer in whom burden of disease is assessed.	**95%**	2020 - 21	100.0%	100.0%	71.5%	100.0%	85.7%
		2019 - 20	100.0%	100.0%	63.4%	72.5%	75.2%
		2018 - 19					
QPI 15ii): Low Burden Metastatic Disease - Proportion of patients with metastatic prostate cancer who have a low metastatic burden that receive radiotherapy.	**60%**	2020 - 21	34.8%	12.5%	54.3%	39.1%	38.8%
		2019 - 20	30.8%	20.0%	61.5%	30.0%	42.7%
		2018 - 19					

**QPI Reported by Board of Surgery*

*** QPI Reported one year in arrears – patients diagnosed 2019-2020*

Conclusions and Actions Required

Overall WoS results from the 9th year of Prostate Cancer QPI analysis are reassuring and demonstrate the high standard of care provided for prostate cancer patients across the West of Scotland. NHS Boards have found some of the targets for these QPIs challenging to meet, most notably the surgical margins measure (QPI 5) which shows an increase in the proportion of patients with positive margins following surgery in the last two reporting years. Encouragingly, improvements can be seen in a number of areas in the last year including timely MDT discussions (QPI 4i & ii), diagnostic pre-biopsy MRI (QPI 14) and the assessment of metastatic burden (QPI 15i), while recent improvements in the collection of patient recorded outcomes following surgery (QPI 8) will result in improved performance in the QPI in future years. There are some of measures where the QPI definitions would benefit from review in light of current best practice, including QPI 7ii and QPI 11; these will be considered at the upcoming Formal Review.

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, which 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:

- WoSCAN to seek reassurance from NHSGGC lead clinician regarding recent increases in the proportion of prostate cancer patients with positive surgical margins.

- MCN to finalise the regional stand-alone active surveillance protocol incorporating any changes agreed as part of the Formal Review.

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 2020 and 30 June 2021. This year's data is measured against the Prostate Cancer Quality Performance Indicators[1] (QPIs) for the ninth consecutive year. 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 a second review of the prostate QPIs was completed at the beginning of 2020 with the third review due to commence in 2022 after the publication of these data.

2. Background

Four NHS Boards across the WoS serve the 2.5 million population[2]. From this population, on average 1,635 men were diagnosed with prostate cancer annually between 2016 and 2020 in WoS and 3,741 annually in Scotland[3]. Figures were lower in 2020 than in the previous years due to the impact of the COVID-19 pandemic.

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
Glasgow	(i) Glasgow Royal Infirmary, Stobhill Hospital (ii) Queen Elizabeth University Hospital, New Victoria Infirmary, Gartnavel General Hospital (iii) 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

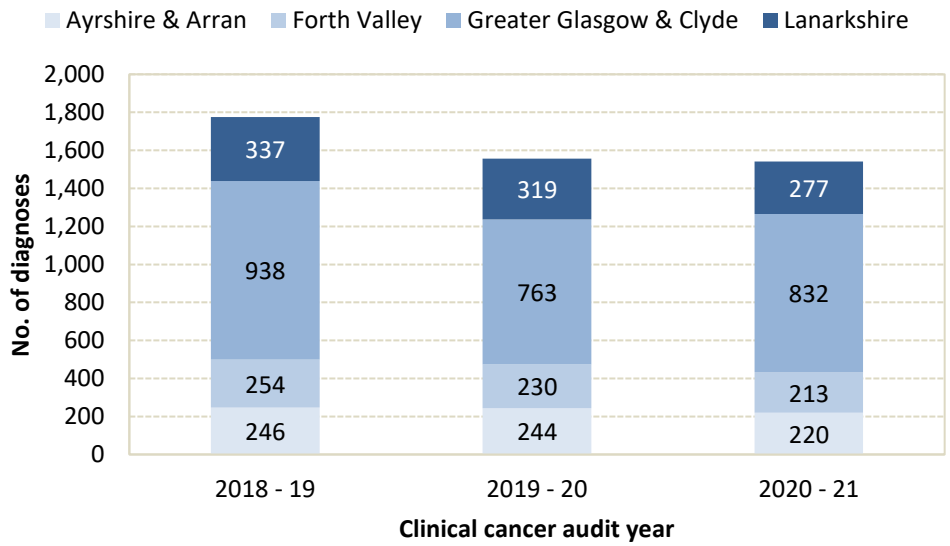
Prostate cancer is the most common cancer in males with 3394 cases diagnosed in Scotland in 2020[3]. These account for 22.6% of cancer diagnoses in males in Scotland in 2020[3]. It is ranked as the third most commonly diagnosed cancer in Scotland after lung and breast cancer[3].

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; however numbers fell to 3,394 in 2020, a likely consequence of the early lockdown restrictions implemented due to the COVID-19 pandemic[3]. Age standardised net survival from prostate cancer at 1 and 5 years was 97.0% and 85.7% respectively for patients diagnosed during the period 2015-2019, with evidence of a gradual improvement in both survival measures since 1995-99[4].

2.2 West of Scotland Context

1,542 cases of prostate cancer were recorded through audit as diagnosed in the WoS between 1st July 2020 and 30th June 2021. As the largest health board in WoS[2], 54.0% (832) 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 2018/19 – 2020/21



Year	AA	FV	GGC	Lan	WoSCAN
2018 – 19	246	254	938	337	**1,775**
2019 - 20	244	230	763	319	**1,556**
2020 - 21	220	213	832	277	**1,542**

Patient Profile

In 2020-21, the majority of prostate cancer cases (58.6%) 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 and 2020 - 21

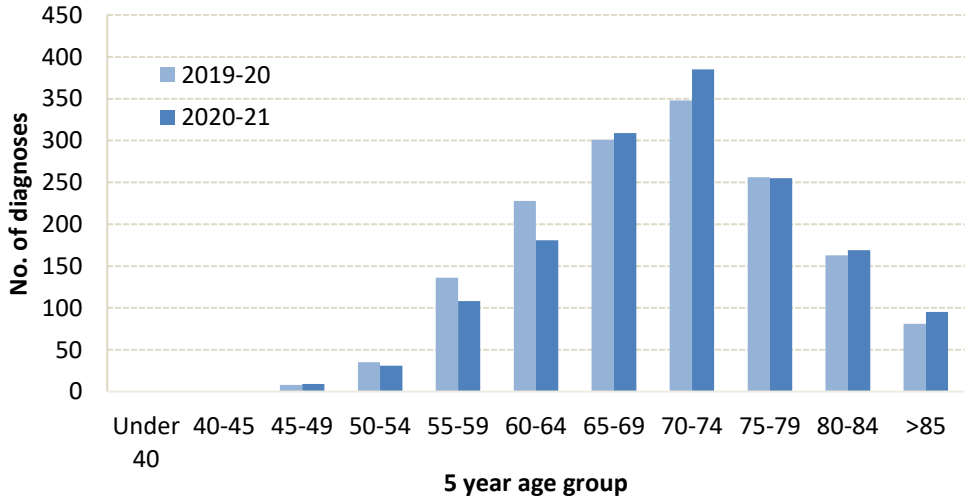
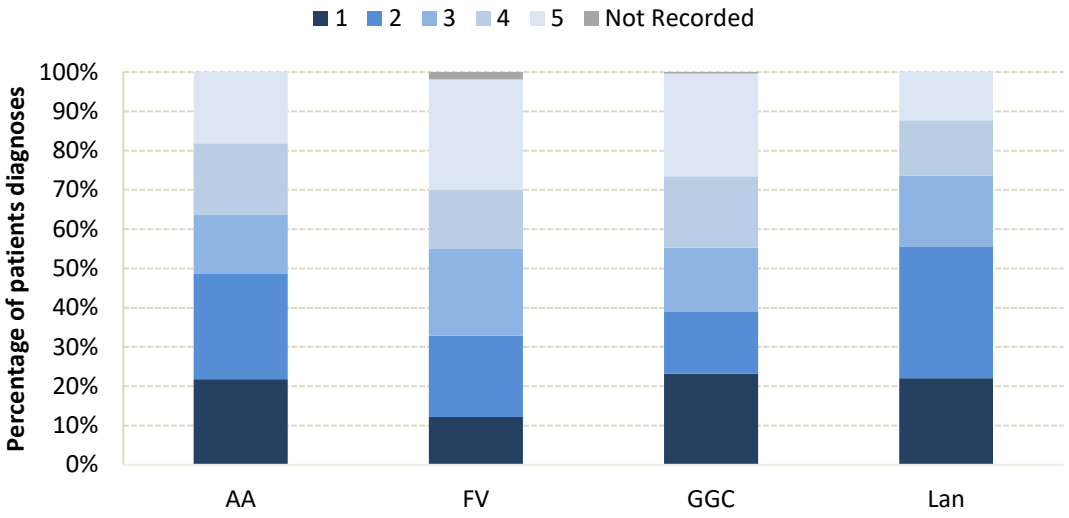


Figure 3 shows the Scottish Index of Multiple Deprivation (SIMD) 2020 quintiles for patients diagnosed with prostate cancer; with 1 equating to the most deprived postcodes and 5 equating to the least deprived.

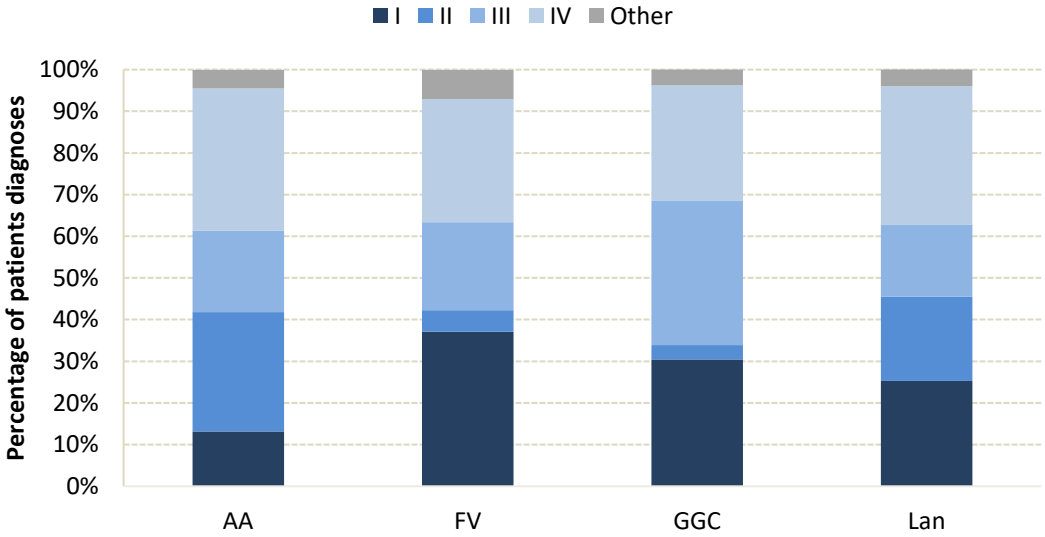
Fig 3: Proportion of patients diagnosed with prostate cancer in WoS Deprivation Category 2020- 21



Tumour Stage at Diagnosis

Figure 4 shows the distribution of prostate cancers by clinical stage, indicating the predominance of advanced stage disease with 57.4% of prostate tumours presenting at stage III or greater.

Fig 4: Proportion of patients diagnosed with prostate cancer in WoS by stage 2020 - 21



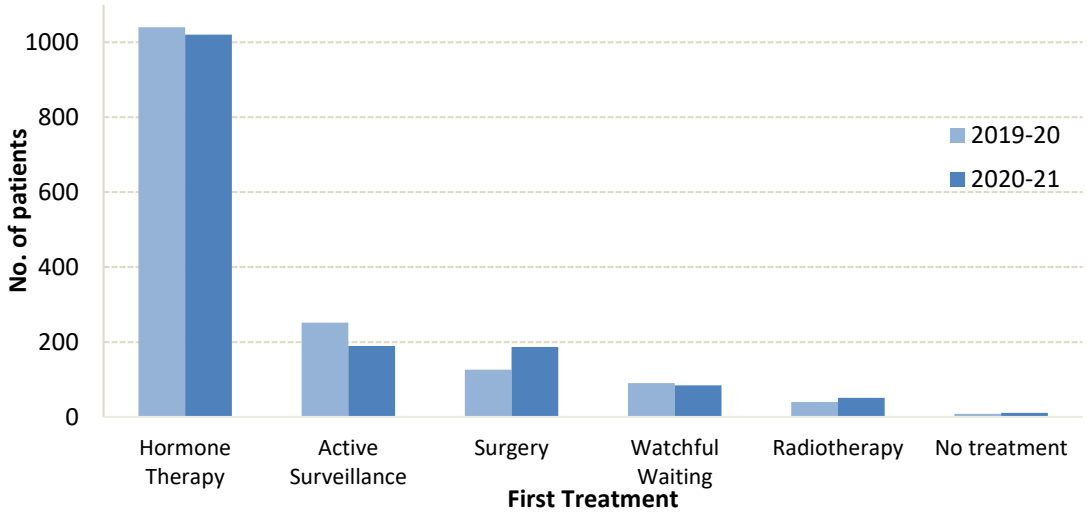
**Other includes inapplicable, not recorded, and unable to stage*

	AA		FV		GGC		Lan		WoSCAN	
Stage	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
I	29	13.2%	79	37.1%	253	30.4%	70	25.3%	431	28.0%
II	63	28.6%	11	5.2%	29	3.5%	56	20.2%	159	10.3%
III	43	19.5%	45	21.1%	289	34.7%	48	17.3%	425	27.6%
IV	75	34.1%	63	29.6%	230	27.6%	92	33.2%	460	29.8%
Inapplicable	3	1.4%	0	0%	20	2.4%	6	2.2%	29	1.9%
NR	0	0%	11	5.2%	6	0.7%	2	0.7%	19	1.2%
Unable to stage	7	3.2%	4	1.9%	5	0.6%	3	1.1%	19	1.2%
Total	220		213		832		277		1542	

Prostate Cancer Treatment

The type of first treatment that patients diagnosed in WoSCAN in 2020–21 received is summarised in Figure 5, with the majority of patients (66.1%) 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 is higher than indicated below. In 2020-21, 243 patients had a radical prostatectomy.

Fig 5: First treatment type for patients diagnosed in WoS 2019-20 & 2020-21



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. Where the number of cases meeting the denominator is between one and four, performance 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. Any commentary provided by NHS Boards relating to the impacted indicators will however be included as a record of continuous improvement. Specific regional and NHS Board actions have been identified to address issues highlighted through the data analysis.

QPI 2: Radiological Staging

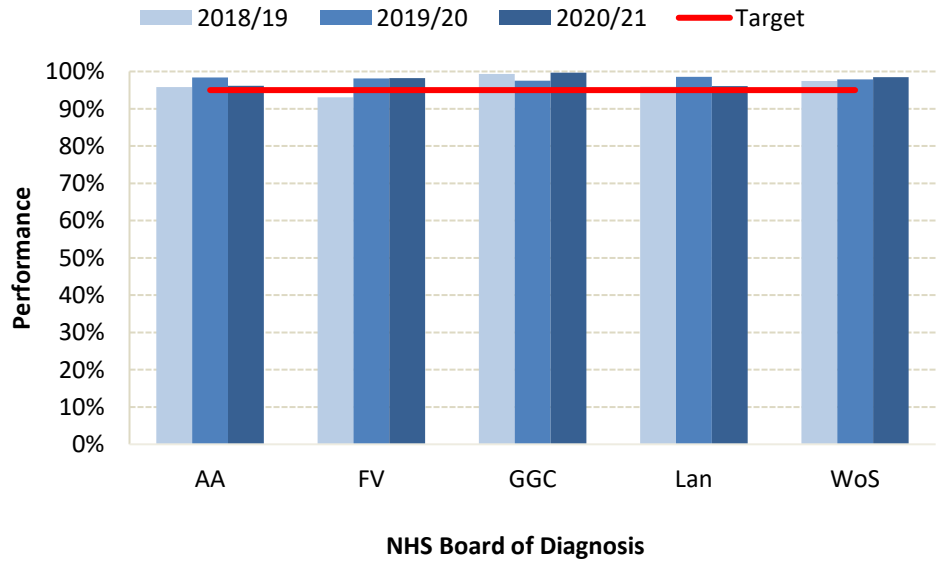
Several factors have been shown to predict the risk of recurrence of prostate cancers and these have been used to classify localised prostate cancer into the risk groups below. QPI 2, based on the radiological staging of prostate cancer, refers to patients within these specific risk categories.

Localised Prostate Cancer Risk Categories[1]

Low Risk	Clinical Stage T1 – T2a **and** Gleason Score ≤ 6 **and** PSA at diagnosis < 10 ng/mL
Intermediate Risk	Clinical Stage T2b **or** Gleason Score 7 **or** PSA at diagnosis 10 – 20 ng/mL
High Risk	Clinical Stage ≥T2c **or** Gleason Score 8 – 10 **or** PSA at diagnosis > 20 ng/mL

It is important that patients are staged using Magnetic Resonance Imaging (MRI) and bone scan[1]. 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.

QPI Title:	Patients with high risk prostate cancer, who are suitable for radical treatment, should be evaluated for locally advanced, nodal or bony metastatic disease.
Numerator:	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).
Denominator:	All patients with high risk prostate cancer undergoing radical treatment.
Exclusions:	• Patients unable to undergo an MRI scan • Patients who decline MRI • Patients with T2c tumours (with no other high risk factors)
Target:	**95%**



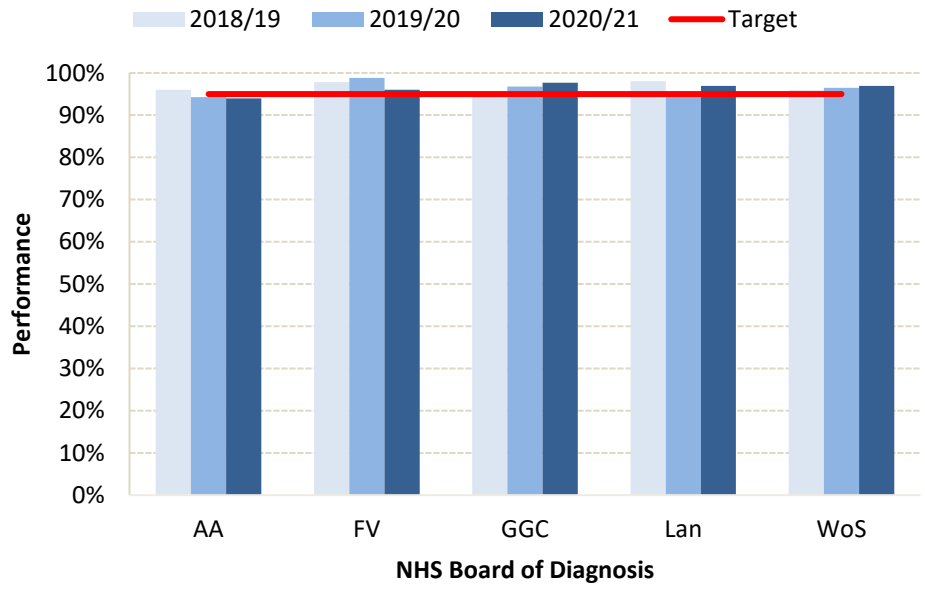
Board / Area	Performance (%)	Numerator	Denominator
AA	96.2%	50	52
FV	98.2%	54	55
GGC	99.6%	282	283
Lan	96.1%	73	76
WoS	**98.5%**	**459**	**466**

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[1].

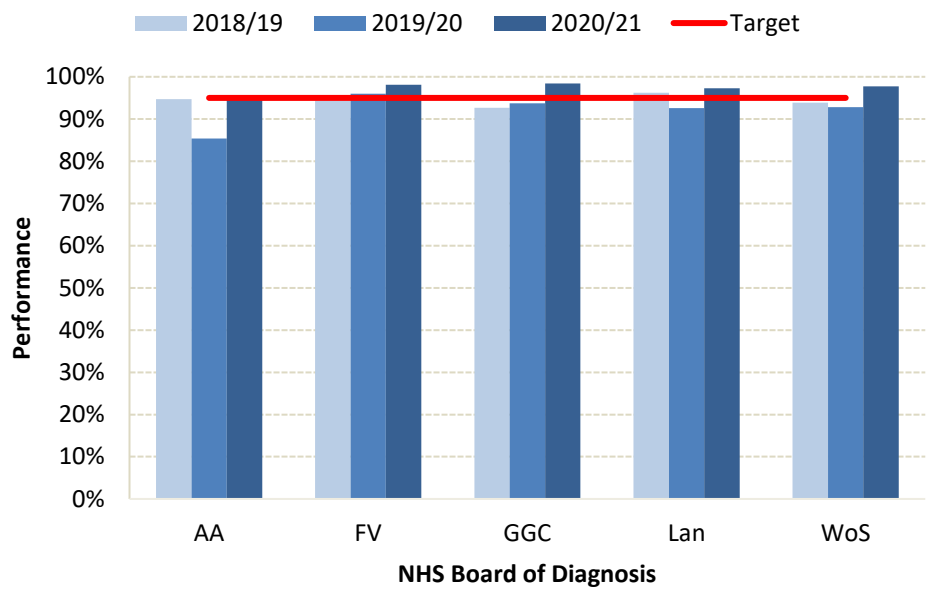
QPI Title:	Patients should be discussed by a multidisciplinary team prior to definitive treatment.
Specification (i)	Non-metastatic prostate cancer (TanyNanyM0)
Numerator:	Number of patients with non-metastatic prostate cancer (TanyNanyM0) discussed at the MDT before definitive treatment.
Denominator: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



Board / Area	Performance (%)	Numerator	Denominator
AA	94.0%	142	151
FV	96.0%	144	150
GGC	97.7%	603	617
Lan	96.9%	190	196
WoS	**96.9%**	**1079**	**1114**

For QPI 4(i), all boards except NHS Ayrshire & Arran met the target. Within NHS Ayrshire & Arran the 9 patients not meeting this QPI were started on hormone therapy prior to MDT discussion and were not considered fit enough for further treatment or refused 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:	**95%**



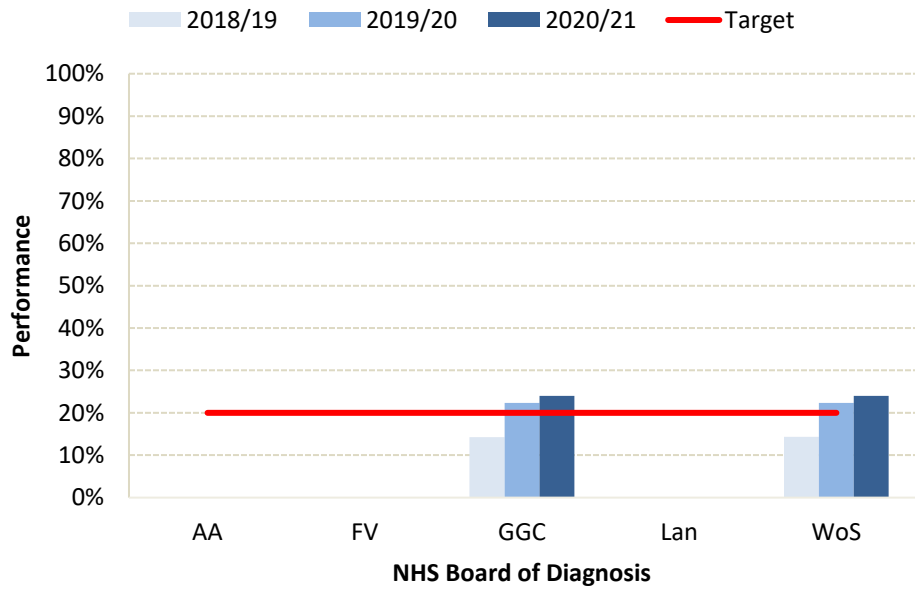
Board / Area	Performance (%)	Numerator	Denominator
AA	95.4%	62	65
FV	98.1%	51	52
GGC	98.4%	190	193
Lan	97.3%	72	74
WoS	**97.7%**	**375**	**384**

This specification was met at a regional level and by all NHS Boards, with a notable improvement in performance compared with previous years. In previous years the majority of patients not meeting this QPI were discussed at MDT but more than six weeks after commencing hormone therapy so it is encouraging that the timeliness of MDT discussions have improved in 2020-21 for patients with metastatic disease across all Boards.

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%**



Board / Area	Performance (%)	Numerator	Denominator
AA	*	0	0
FV	*	0	0
GGC	23.4%	30	128
Lan	*	0	0
WoS	**23.4%**	**30**	**128**

Note that 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 23.4%.

Nerve-sparing procedures which aim to preserve function are offered to appropriate patients to improve both post-surgical outcomes and survivorship, in line with evolving clinical practice across the world. The clinical team cite no evidence of correlation between positive surgical margin and detectable PSA or biochemical relapse for patients during this audit period despite worsening performance against this QPI. NHSGGC are currently recruiting patients into the Neurosafe PROOF clinical trial which is looking at how frozen sections can be used to minimise positive surgical margins when performing nerve sparing surgery, the results of which are anticipated to result in reductions in the numbers of patients with positive surgical margins. However, the small number of patients recruited is unlikely to impact on the overall positive surgical margin results in isolation and the increase in the proportion of patients with positive surgical margins in the past two years will be highlighted to the lead clinician for NHSGGC for additional assurances.

Action required:

- **WoSCAN to seek reassurance from NHSGGC lead clinician regarding recent increases in the proportion of prostate cancer patients with positive surgical margins.**

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[1].

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[1].

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:	**Minimum of 50 procedures per surgeon in a 1 year period.**

.

The number of radical prostatectomies performed per surgeon 2020/21.

	No. of Operating Surgeons	No. of Procedures	No. of Surgeons Meeting Target
GGC	3	244	2
WoS	**3**	**244**	**2**

All patients receiving surgery for prostate cancer are now referred to, and operated on, by the regional robotics team in NHSGGC.

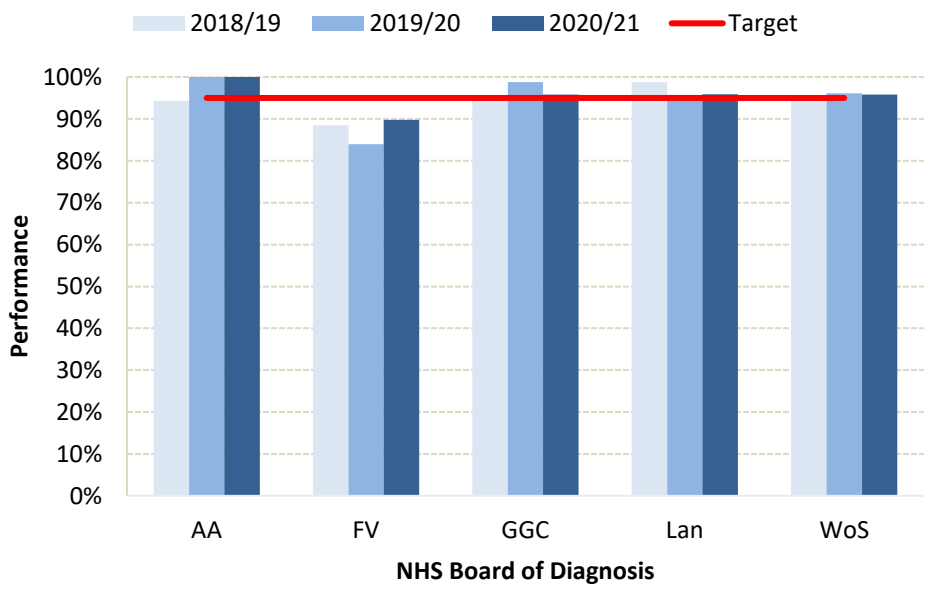
Within NHSGGC one surgeon performed only 45 procedures, this was due to interruptions to surgical schedules during the audit period as a result of the COVID-19 pandemic. It is anticipated that all three surgeons would perform over 50 surgeries a year under normal circumstances.

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[5] 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[1].

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[1].

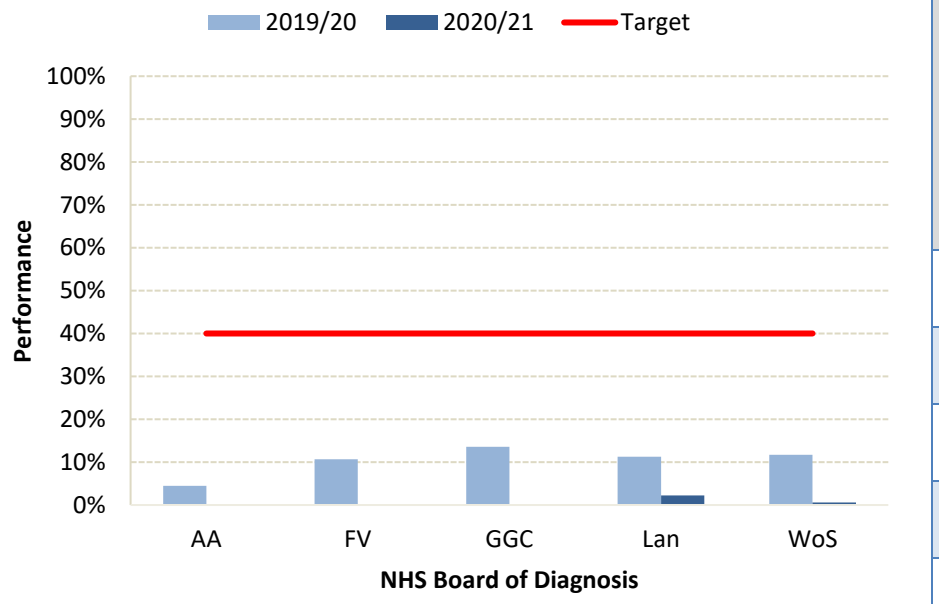
QPI Title:	Patients with metastatic prostate cancer should undergo immediate hormone therapy and chemotherapy where appropriate.
Specification (i)	Immediate hormone therapy
Numerator:	Number of patients presenting with metastatic prostate cancer (TanyNanyM1) treated with immediate hormone therapy.
Denominator:	All patients presenting with metastatic prostate cancer (TanyNanyM1).
Exclusions:	• Patients documented to have refused immediate hormone therapy • Patients enrolled in clinical trials
Target:	**95%**



Board / Area	Performance (%)	Numerator	Denominator
AA	100%	65	65
FV	89.8%	44	49
GGC	95.8%	183	191
Lan	95.9%	71	74
WoS	**95.8%**	**363**	**379**

Specification (i) was met at a regional level in 2020-21 and by all NHS Boards except NHS Forth Valley. NHS Forth Valley have reviewed the five patients not meeting the QPI, the majority of patients had delays to hormone therapy due to extended diagnostic pathways. This was primarily due to patients requiring additional imaging. NHS Forth Valley performance against this measure will be reviewed by the MCN at the next reporting cycle.

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:	• Patients documented to have declined immediate hormone therapy • Patients documented to have declined chemotherapy • Patients enrolled in clinical trials • Patients receiving ARTA (Androgen Receptor Targeted Agent) treatment
Target:	**40%**



Board / Area	Performance (%)	Numerator	Denominator
AA	0%	0	32
FV	0%	0	20
GGC	0%	0	79
Lan	2.2%	1	45
WoS	**0.6%**	**1**	**176**

None of the boards within WoS met this target in 2020-21. 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 decreased in 2019-20 in WoSCAN and across Scotland with further declines to near zero in WoSCAN in 2020-21.

In April 2020, Docetaxel prescribing was suspended because of the increased COVID-19 exposure risk in line with the Covid-19 National Cancer Medicines Advisory Group advice (NCMAG001) which approved routine off label use of oral Abiraterone in low risk newly diagnosed metastatic hormone sensitive prostate cancer patients who would otherwise be offered Docetaxel.

The definition of this QPI will be reviewed in light of recent changes in practice in the Formal Review currently underway and it is anticipated that the measure will be amended to reflect changes in clinical practice, particularly as the interim guidance has not been extended.

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[1]. 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:	• Patients who undergo salvage prostatectomy • Patients who receive adjuvant radiotherapy within 12 months of surgery
Target:	**50%**

Audit Period	2019-20			2020-21		
Board	**Performance (%)**	**Numerator**	**Denominator**	**Performance (%)**	**Numerator**	**Denominator**
AA	*	0	0	*	0	0
FV	*	0	0	*	0	0
GGC	0%	0	156	0%	0	153
Lan	*	0	0	*	0	0
WoS	**0%**	**0**	**156**	**0%**	**0**	**153**

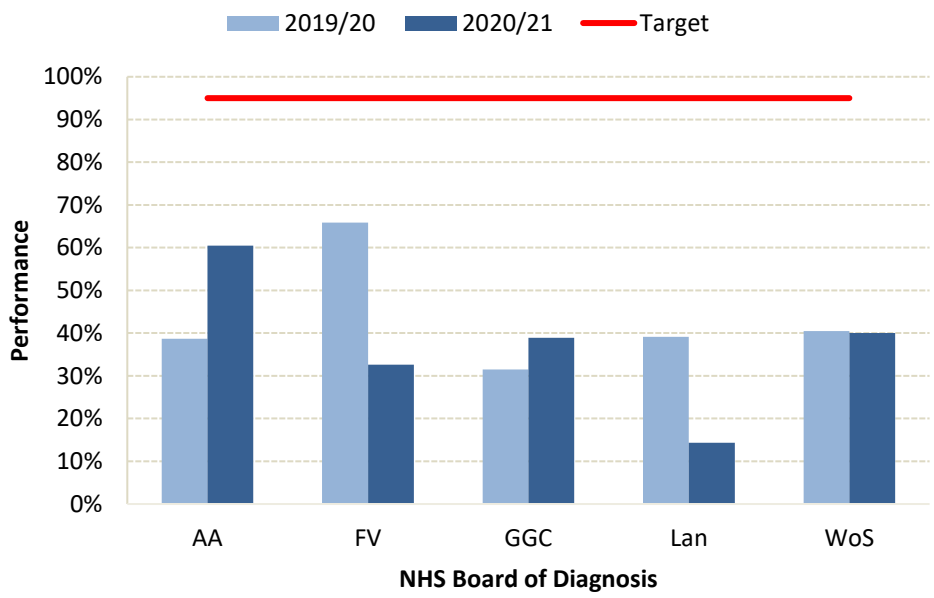
This is a new QPI that requires patients to complete a PROMs tool both pre-operatively and post operatively. As the indicator looks at the use of the PROMs tool 12-18 months post surgery then the QPI is reported one year in arrears, as such data analysed here are for patients diagnosed in 2018-2019 and 2019-20.

All radical prostatectomies for patients diagnosed within WoSCAN were undertaken in NHSGGC. Pre-treatment EPIC-26 questionnaires have been issued to all patients being considered for radical treatment since early 2020 with a completion rate between 75 and 80% among patients who proceed to surgery. Unfortunately changes to follow-up arrangements as a result of COVID-19, with telephone clinics becoming standard, mean that follow-up questionnaires were not issued as planned to patients diagnosed in 2019-20. Follow-up questionnaires are now being posted out to patients a year after surgery and it is hoped that this will result in the QPI target being met in future years.

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[1].

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:	• Patients unable to undergo an MRI scan • Patients who decline MRI
Target:	**95%**



Board / Area	Performance (%)	Numerator	Denominator
AA	60.5%	23	38
FV	32.6%	14	43
GGC	38.9%	37	95
Lan	14.3%	2	14
WoS	**40.0%**	**76**	**190**

This QPI is reported one year in arrears so data presented are for patients diagnosed in 2019-20. None of the WoSCAN NHS Boards met this revised QPI for patients diagnosed in 2019-20. Review of these results indicated that the majority (92%) of these patients did have an MRI but for many the imaging was outwith the 12-18 month window. Across all NHS Boards most patients not meeting this QPI had MRI imaging approximately 12 months after their initial MRI but less than 12 months after pathological diagnosis; this is considered to be clinically appropriate. In addition there were a small number of patients that had imaging earlier due to a change in symptoms.

A review of the measurement definitions for this QPI will be undertaken as part of the Formal Review of prostate cancer QPIs currently underway. If the QPI were to measure if patients were required to have surveillance imaging at any time within 18 months of diagnosis then performance would be 83% across WoS for the 2020-21 audit period which is more than double the current performance.

All NHS Boards within the WoS noted small numbers of patients had surveillance MRI more than 18 months after diagnosis (16 patients across the region) with NHS Ayrshire & Arran, NHSGGC and NHS Lanarkshire noting that the COVID-19 pandemic has resulted in delays to imaging for some of these patients. In addition, small numbers of patients (16 patients) had no surveillance MRI which were attributed to the pandemic in the most part.

With all NHS Boards reinforcing the requirements of the active surveillance pathway to clinicians, the agreement of a stand-alone active surveillance protocol for WoSCAN in March 2022 (which is currently being finalised for publication) and as the impact of COVID-19 pandemic on surveillance MRIs recedes, improvements in timely surveillance MRI imaging are anticipated in future. Furthermore, in NHS Lanarkshire the planned introduction of the nurse led active surveillance follow up clinics should further improve timeous surveillance scanning for appropriate patients.

Action Required:

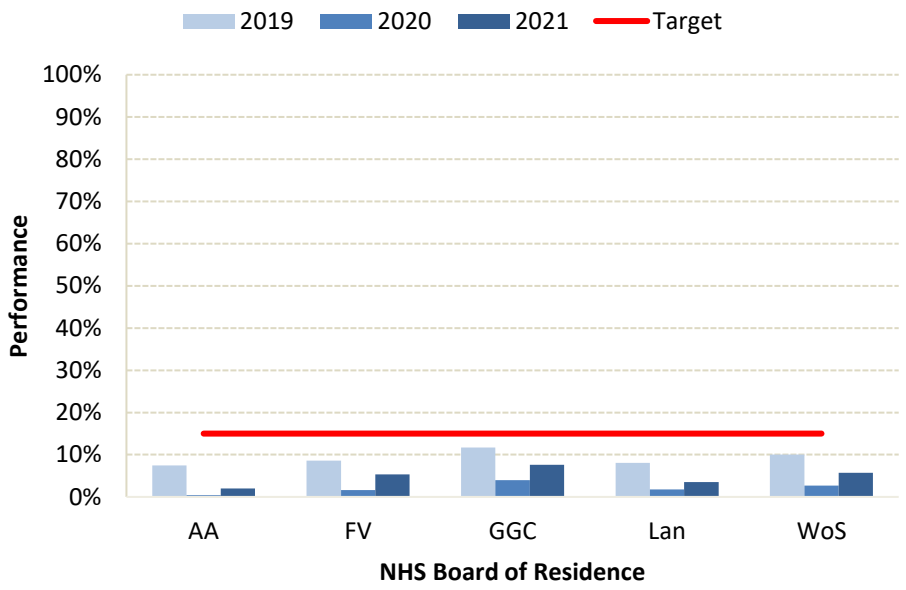
- **MCN to finalise the regional stand-alone active surveillance protocol incorporating any changes agreed as part of the Formal Review.**

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[1]. Clinicians are therefore encouraged to enter patients into well designed trials and to collect longer term follow up data.

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[1].

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:	**15%**



Board / Area	Performance (%)	Numerator	Denominator
AA	2.0%	5	248
FV	5.3%	13	243
GGC	7.6%	67	879
Lan	3.5%	12	340
WoS	**5.7%**	**97**	**1710**

No boards in the WoS achieved the 15% target for patients consented for clinical trials or research studies with 5.7% of prostate cancer patients living in WoS being recruited into clinical trials or research studies in 2021. Performance shows a slight increase from 2020, when recruitment into trials has been significantly influenced by the COVID-19 pandemic which caused all trial recruitment to be suspended in March 2020.

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 2021

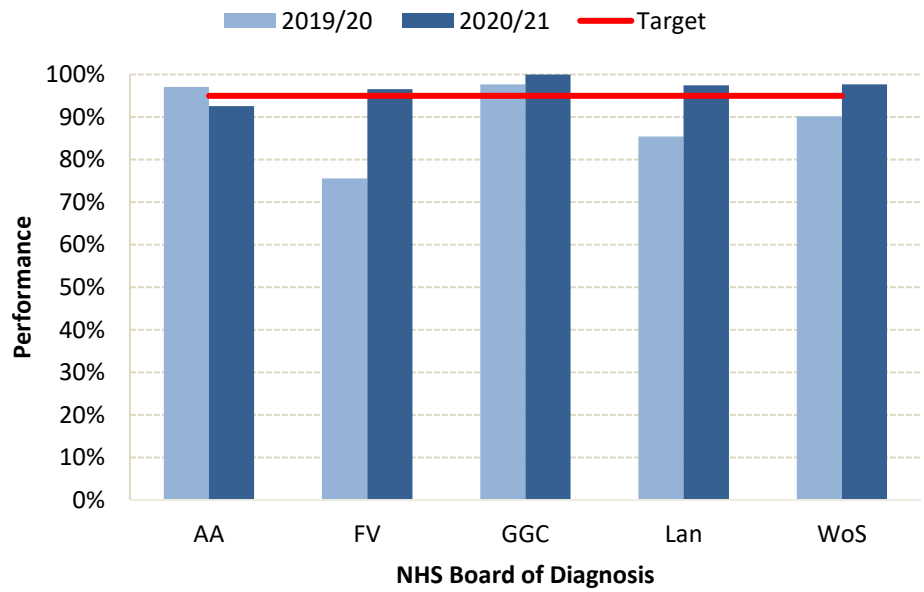
Project Title	2021	
	Consented	Recruited
Bayer 20510	**1**	**0**
Clinical Study of the ProSpace™ Balloon System	2	2
ECMC EXPLOR BIOMARKER	7	7
NEPTUNES	14	14
Phase I/IIa study to evaluate CCS1477 in advanced tumours v1.0	3	3
Phase 1b/2 trial of BXCL701 with Pembro in patients with SCNC; NEPC	1	1
PIVOTALboost	6	6
TALAPRO-2	13	2
The PACE Trial (Prostate Advances in Comparative Evidence)	7	7
TrueNTH Global Registry	43	43
Total	**97**	**85**

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[1].

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:	• Patients unable to undergo an MRI scan • Patients who decline MRI • Patients who have undergone TURP • Patients who have undergone laser enucleation • Patients with locally advanced (Clinical T3 and above) and / or M1 disease.
Target:	**95%**

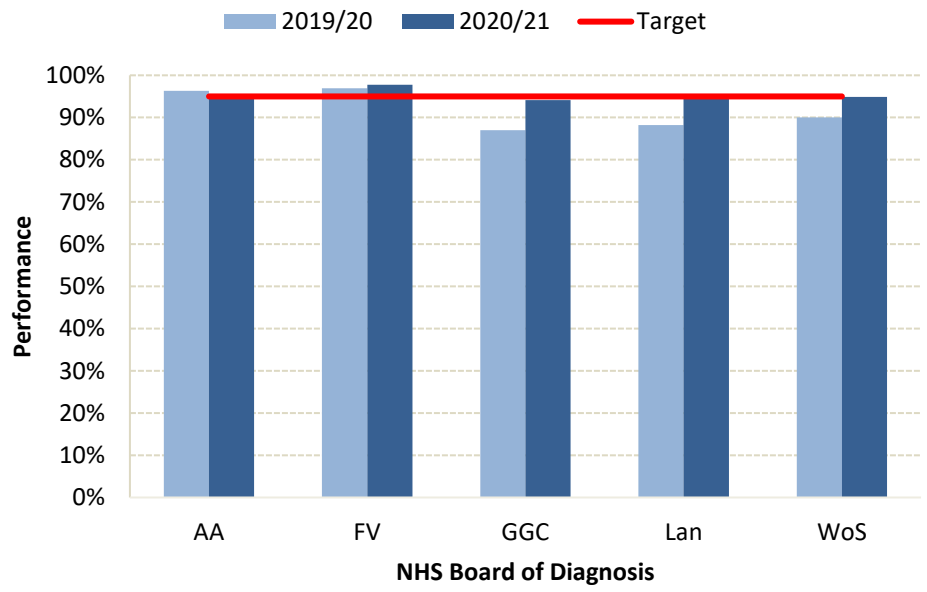


Board / Area	Performance (%)	Numerator	Denominator
AA	92.6%	87	94
FV	96.6%	84	87
GGC	100%	264	264
Lan	97.5%	118	121
WoS	**97.7%**	**553**	**566**

Within the West of Scotland 97.7% of patients that had a TRUS biopsy had an MRI as their first diagnostic investigation, meeting the target of 95%; a considerable improvement in performance since the first year of recording in 2019-20. Only one NHS Board, NHS Ayrshire & Arran, did not meet the target; review of patients not meeting the QPI within the Board indicated that all patients had high PSA and were considered to have T3 or 4 prostate cancer on initial clinical examination and therefore went

straight to TRUS biopsy, although they were subsequently staged by the MDT with T2 disease so included within this measure.

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:	**95%**



Board / Area	Performance (%)	Numerator	Denominator
AA	95.1%	116	122
FV	97.8%	133	136
GGC	94.1%	557	592
Lan	95.1%	174	183
WoS	**94.9%**	**980**	**1033**

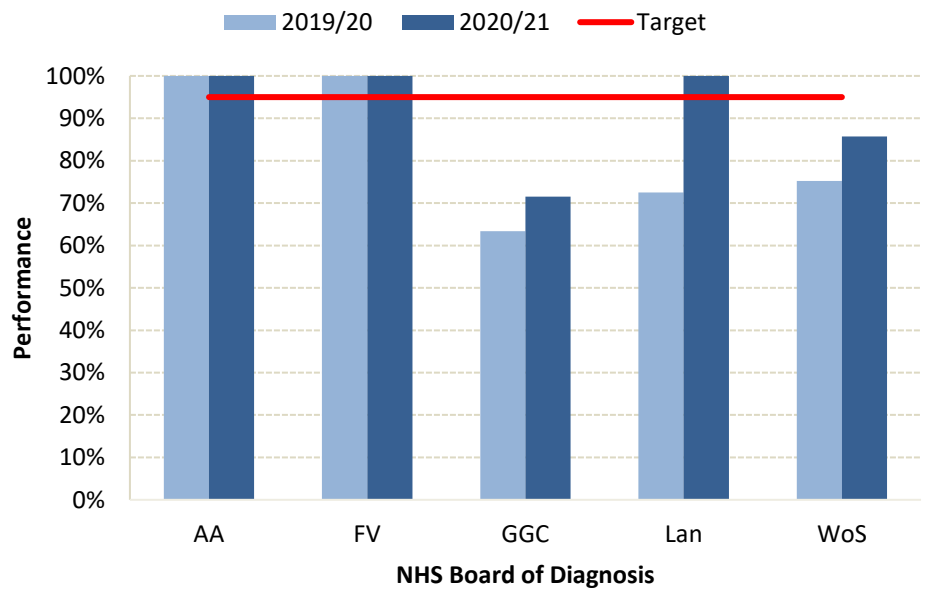
Within the West of Scotland 94.9% of patients that had pre-biopsy MRI had imaging reported using a PI-RADS / Likert system of grading, very close to the target of 95%; an improvement in performance since the first year of recording this indicator in 2019-20.

Review of patients not meeting this QPI in NHSGGC indicated that for 5 of these the score was not assessable due to imaging artefacts. In the majority of the remaining cases (25) patients had T3 or T4 disease with obvious and extensive tumour present. Radiologists will be reminded of the requirement to report PI-RADS score for all prostate MRIs.

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 ≥ 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.

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:	**95%**

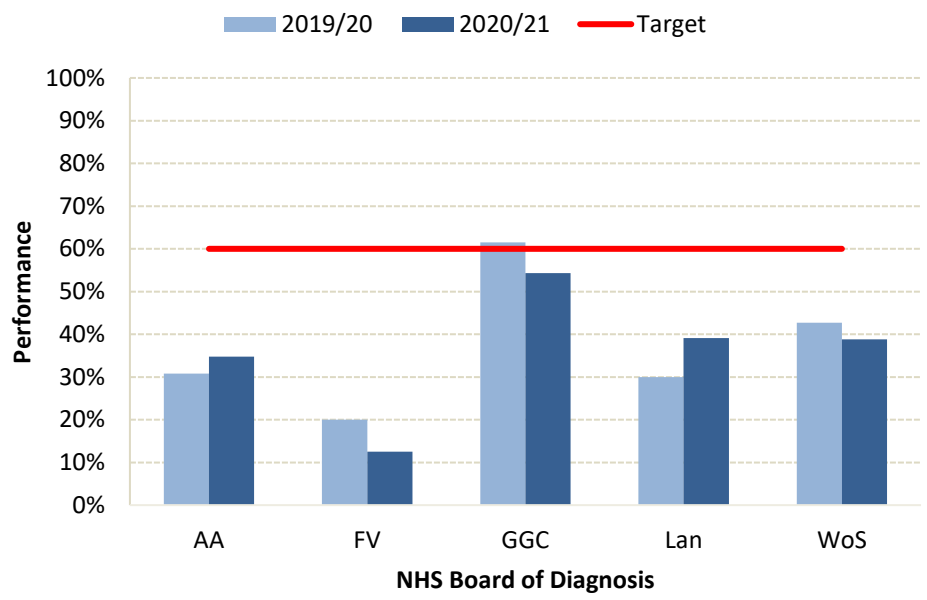


Board / Area	Performance (%)	Numerator	Denominator
AA	100%	65	65
FV	100%	52	52
GGC	71.5%	138	193
Lan	100%	74	74
WoS	**85.7%**	**329**	**384**

Within the West of Scotland 85.7% of patients with metastatic disease had their burden of disease assessed, below the target of 95%; however this target was met with 100% performance in NHS Ayrshire & Arran, NHS Forth Valley and NHS Lanarkshire with improvements in performance noted in NHS Lanarkshire, NHSGGC and at a regional level.

Within NHSGGC disease burden was not assessed for 55 patients. Around a quarter of these patients clearly or probably had low burden disease, and so may have been suitable for radiotherapy; the majority of the remainder had widespread bone metastases. The Glasgow and Clyde MDTs were merged from spring 2022 and this combined GGC MDT has been reminded to document disease burden for all metastatic patients which is anticipated to improve performance in future years.

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:	**60%**



Board / Area	Performance (%)	Numerator	Denominator
AA	34.8%	8	23
FV	12.5%	3	24
GGC	54.3%	25	46
Lan	39.1%	9	23
WoS	**38.8%**	**45**	**116**

Within the West of Scotland 38.8% of patients that had low metastatic burden received radiotherapy, below the target of 60%. While numbers of patients included within this QPI are relatively small, making comparisons between NHS Boards difficult, performance against this measure was higher in NHSGGC than in other NHS Boards over both years of reporting.

Cases not meeting the target were reviewed and the majority of patients not meeting this QPI were not considered suitable for radiotherapy due to fitness levels and co-morbidities; many were considered more suitable for hormone therapy. Review of patients not meeting the QPI in NHS Forth Valley indicated that for 15 of the 20 patients not having radiotherapy, this decision was made by an oncologist; the other 5 were not suitable for radiotherapy. Within NHSGGC three of the 21 patients not meeting this QPI were awaiting radiotherapy treatment at the time of reporting, if these patients did receive their radiotherapy treatment the QPI would be met by the Board.

The prostate cancer CMG was updated in early 2021 to include treatment options for patients with low and high burden metastatic disease and a presentation on the treatment pathways for metastatic cancer patients was made at the MCN education day in May 2022 which should improve performance against this QPI. Review of results of this QPI in future years will enable assessment of whether there is scope for improvements in performance against this QPI or whether the target is unrealistic in light of patient fitness and co-morbidities in this group of patients.

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

NHS AA	NHS Ayrshire & Arran
CNS	Clinical Nurse Specialist
CT	Computed tomography
eCASE	Electronic Cancer Audit Support Environment
NHS FV	NHS Forth Valley
HIS	Healthcare Improvement Scotland
NHS LAN	NHS Lanarkshire
LHRH	Luteinizing Hormone Releasing Hormone. Hormone therapy.
MCN	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.*
MDT(s)	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.**
NCQSG	National Cancer Quality Steering Group
NHSGGC	NHS Greater Glasgow and Clyde
QPI(s)	Quality Performance Indicator(s)
RCAG	Regional Cancer Advisory Group
SMR01	General / Acute Inpatient and Day Case
TNM	Tumour, Nodes, Metastases (staging system)
TURP	Transurethral Resection of the Prostate
TRUS	Transrectal ultrasound biopsy
WoS	West of Scotland
WoSCAN	West of Scotland Cancer Network

Sources:
* www.woscan.scot.nhs.uk
** 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/Prostate/Prostate-Cancer-Core-Dataset-V4-1-Final.pdf

2. Mid-2021 Population Estimates Scotland | National Records of Scotland (nrscotland.gov.uk)

3. Cancer incidence in Scotland - to December 2020 - Cancer incidence in Scotland - Publications - Public Health Scotland

4. Cancer survival statistics - People diagnosed with cancer during 2015 to 2019 - Cancer survival statistics - Publications - Public Health Scotland

5. MacMillan Cancer Support, Hormone Therapy for Prostate Cancer, June 2018. Available at: Hormonal therapy for prostate cancer - Macmillan Cancer Support

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Appendix 1: Meta Data

<table>
<tr><td>Report Title</td><td>Cancer Audit Report: Prostate Cancer Quality Performance Indicators</td></tr>
<tr><td>Time Period</td><td>Patients diagnosed between 01 July 2020 to 30 June 2021</td></tr>
<tr><td>Data Source</td><td>Cancer Audit Support Environment (eCASE). A secure centralised web-based database which holds cancer audit information in Scotland.</td></tr>
<tr><td>Data extraction date</td><td>2200 hrs on 16 May 2022</td></tr>
<tr><td>Methodology</td><td>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.

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.

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.</td></tr>
<tr><td>Data Quality</td><td>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.

<table>
<tr><th></th><th>Ayrshire & Arran</th><th>Forth Valley</th><th>GGC</th><th>Lanarkshire</th><th>WoS</th></tr>
<tr><td>Cases from audit</td><td>220</td><td>213</td><td>832</td><td>277</td><td>1542</td></tr>
<tr><td>Cases from ISD (2016-20)</td><td>248</td><td>243</td><td>879</td><td>340</td><td>1710</td></tr>
<tr><td>Case ascertainment</td><td>88.7%</td><td>87.7%</td><td>94.7%</td><td>81.5%</td><td>90.2%</td></tr>
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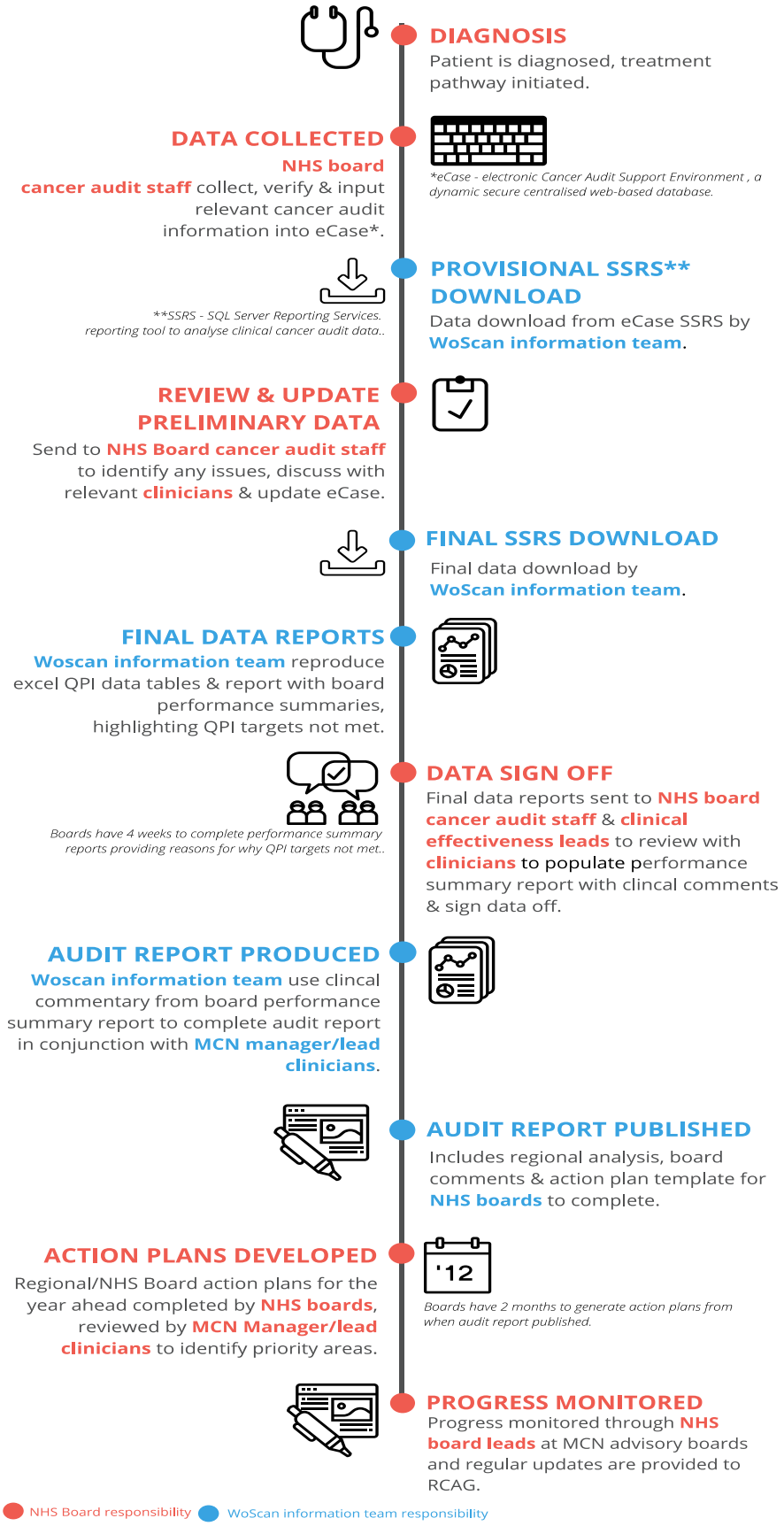
Appendix 2: Cancer Audit Timeline



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

Area:	MCN
Action Plan Lead:	
Date:	

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

QPI No.	Action Required	MCN Action Taken	Timescales		Lead	Progress/Action Status	Status (see Key)
			Start	End			
	Ensure actions mirror those detailed in Audit Report.	*Detail specific actions that will be taken by the NHS Board.*	*Insert date*	*Insert date*	*Insert name of responsible lead for each specific action.*	*Provide detail of action in progress, change in practices, problems encountered or reasons why no action taken.*	*Insert No. from key above*.
5	WoSCAN to seek reassurance from NHSGGC lead clinician regarding recent increases in the proportion of prostate cancer patients with positive surgical margins.						
11	MCN to finalise the regional stand-alone active surveillance protocol incorporating any changes agreed as part of the Formal Review.						