NPCA
National Prostate Cancer Audit

NATCAN
National Cancer Audit Collaborating Centre

National Prostate Cancer Audit State of the Nation Report 2025

An audit of care received by people diagnosed or treated with prostate cancer from 1 September 2021 to 31 March 2024 in England and Wales. In addition, a description of national time trends in diagnoses and treatments from 1 January 2019 to 31 December 2024 in England and 1 January 2022 to 31 December 2023 in Wales.

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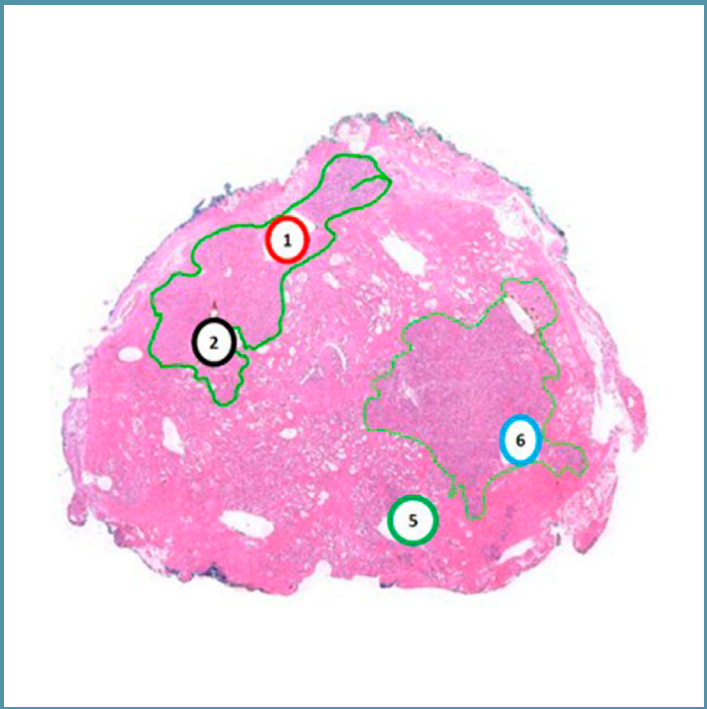

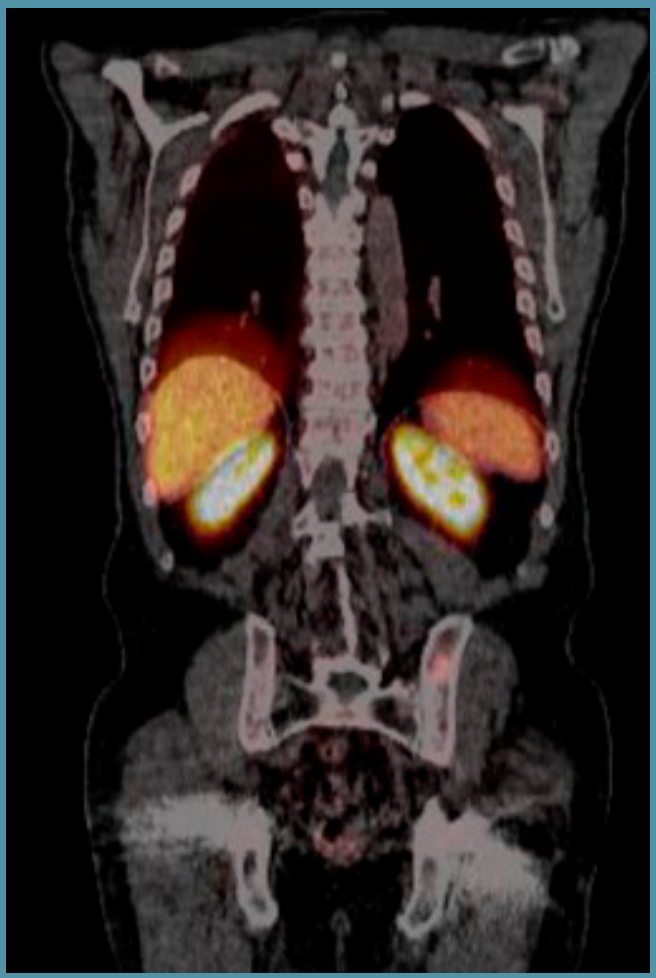

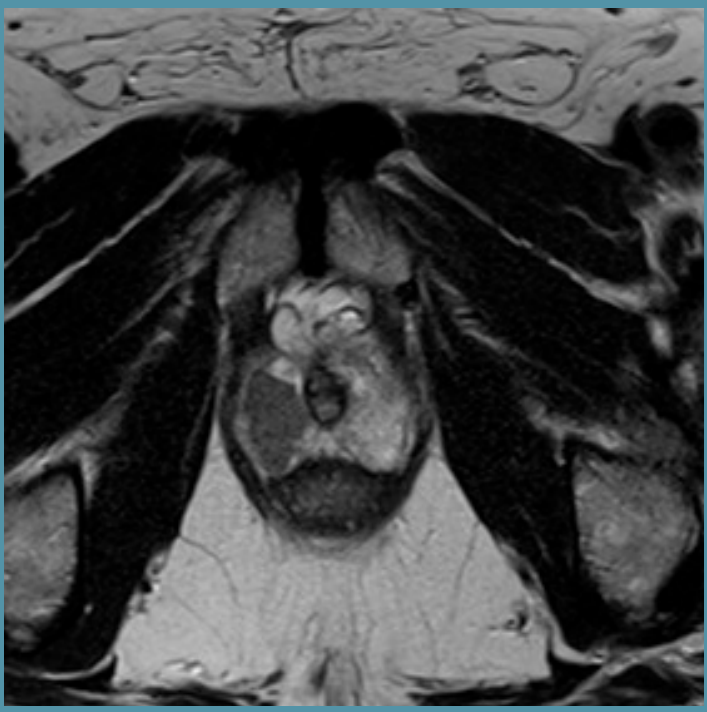

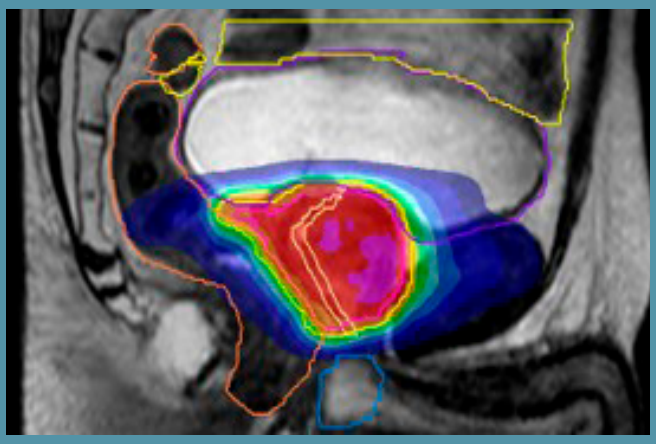

NPCA

National Prostate Cancer Audit

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Royal College of Surgeons of England
ADVANCING SURGICAL CARE

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

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The British Association of Urological Surgeons (BAUS) was founded in 1945 and exists to promote the highest standards of practice in urology, for the benefit of patients, by fostering education, research and clinical excellence. BAUS is a registered charity and qualified medical practitioners practising in the field of urological surgery are eligible to apply for membership. Registered Charity no: 1127044

BUG

The British Uro-oncology Group (BUG) was formed in 2004 to meet the needs of clinical and medical oncologists specialising in the field of urology. As the only dedicated professional association for uro-oncologists, its overriding aim is to provide a networking and support forum for discussion and exchange of research and policy ideas. Registered Charity no: 1116828

NDRS
NATIONAL DISEASE REGISTRATION SERVICE

This work uses data that has been provided by patients and collected by the NHS as part of their care and support. For patients diagnosed in England, the data is collated, maintained and quality assured by the National Disease Registration Service (NDRS), which is part of NHS England. Access to the data was facilitated by the NHS England Data Access Request Service.

GIG CYMRU NHS WALES
Rhwydwaith Canser Cymru
Wales Cancer Network

NHS Wales is implementing a new cancer informatics system. As a result, the quality and completeness of data from Wales is likely to have been impacted due to implementation of this new system across multiple NHS organisations (Health Boards), which has resulted in data being supplied by both old and new systems. Additionally, and reflecting the uncertainty of data quality, the data submitted to the audit may not have undergone routine clinical validation prior to submission to the Wales Cancer Network (WCN), Public Health Wales.

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1. Introduction

The National Prostate Cancer Audit (NPCA) evaluates patterns of care and outcomes and reports on diagnosis, treatment and outcomes for men diagnosed with prostate cancer in England and Wales. As much as possible, we compare practice and outcomes against national guidance and quality standards, including those from the National Institute for Health and Care Excellence (NICE) to help NHS organisations benchmark their prostate cancer care against measurable standards and to identify unwarranted variation in measures of processes and outcomes. This second publication of the NPCA State of the Nation report in 2025 reflects the move to the National Cancer Audit Collaborating Centre (NATCAN) reporting cycle.

The NPCA derives its indicators using information that is routinely collected by the NHS as part of the care and support given to men diagnosed with prostate cancer, rather than data collected specifically for the Audit[1]. For men diagnosed or treated in England, the data are collated, maintained and quality assured by NHS England's National Disease Registration Service (NDRS). For men diagnosed or treated in Wales, data are provided by Wales Cancer Network (WCN)[2] using the Cancer Network Information System Cymru (CaNISC) or Cancer Dataset Form (CDF).

We use the National Cancer Registration Dataset (NCRD) for England, which is considered the 'gold standard' because it draws data from various sources. It also benefits from enhanced data processing by cancer registration officers and follow-up from NHS hospital trusts. NCRD data is currently available for patients diagnosed up to December 2022. The Rapid Cancer Registration Dataset (RCRD) includes proxy tumour registrations, providing more up-to-date data but with less accuracy than the NCRD. The RCRD is used in the NPCA Data Dashboard, updated quarterly, and in section 4 of this report. Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-21.

We present results from **eight key performance indicators** (PIs) in the management of prostate cancer, as well as the variation in performance among providers in England and Wales (**Table 2**). Furthermore, we outline **recommendations for providers** to help improve their performance, showcase provider-level data and describe results from our outlier process.

For the first time, we report the proportion of men with metastatic disease who receive systemic treatment intensification (PI4a and PI4b) and report the proportion of genitourinary complications occurring after radiotherapy to the prostate, with or without pelvic lymph nodal radiation (PI8). These new performance indicators align with our Quality Improvement (QI) Plan, published in September 2024 and reviewed yearly. PI8 is a new indicator presented for the first time in this report, the NPCA QI Plan will be updated on its next release to reflect this new indicator.

Please refer to the NPCA methodology supplement for comprehensive details regarding this report's data sources and methodology. Additional supplementary materials, including a glossary of technical terms, an appendix, an action plan template, a patient and public-friendly summary, details of our outlier process and each NHS provider's results for data completeness and performance indicators, are available on the NPCA State of the Nation report 2025 webpage.

1 The audits in NATCAN do not 'collect' clinical data. The cancer audits utilise the nationally mandated flows of data from hospitals to the National Disease Registration Service (NDRS) in NHSE and the Wales Cancer Network in Public Health Wales, thereby minimising the burden of data collection on provider team.

2 NHS Wales is part way through a cancer informatics implementation programme which is designed to improve the data capture and reporting capabilities of NHS Wales. This ongoing implementation is impacting the data quality within NHS Wales in the short term with multiple systems being used and different implementation dates across cancer sites and organisations resulting in a complex data landscape. NHS Wales has committed to continue to submit audit data annually until data submissions are sourced exclusively from the new cancer informatics solution. This will be from 2027 onwards that NHS Wales will be able to supply quarterly data using this new integrated, and more accessible digital platform.

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Table 1. Performance Indicators Included*		
	England^	**Wales#**
PI1: Proportion of men diagnosed with metastatic disease	Yes (01/22 – 12/22)	Yes (04/23 – 12/23)
PI2: Proportion of men with low-risk (CPG 1) localised cancer undergoing radical prostate cancer treatment	Yes (01/22 – 12/22)	Yes (04/23 – 12/23)
PI3: Proportion of men with high-risk/locally advanced disease undergoing radical prostate cancer treatment	Yes (01/22 – 12/22)	Yes {04/23 – 12/23)
PI4: Proportion of men with newly diagnosed hormone-sensitive metastatic disease receiving systemic treatment intensification (under 75 years old and 75 years and older)	Yes (01/22 – 12/22)	No(data unavailable)
PI5: Proportion of men who had an emergency readmission within 90 days of radical prostate cancer surgery	Yes (04/23 – 03/24)	Yes (04/23 – 03/24)
PI6: Proportion of men experiencing at least one genitourinary (GU) complication requiring a procedural/surgical intervention within 2 years of radical prostatectomy	Yes (09/21 – 08/22)	Yes (09/21 – 08/22)
PI7: Proportion of men receiving a procedure of the large bowel and a diagnosis indicating radiation toxicity (gastrointestinal [GI] complication) within 2 years of radical prostate radiotherapy	Yes (09/21 – 08/22)	Yes (09/21 – 08/22)
PI8: Proportion of men experiencing at least one GU complication requiring a procedural/ surgical intervention within 2 years of radical prostate radiotherapy	Yes (09/21 – 08/22)	Yes (09/21 – 08/22)

* See methodology supplement for the exact definitions of each performance indicator
^ England data: National Cancer Registration Dataset (NCRD)
# Welsh data: Cancer Network Information System Cymru (CaNISC)

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2. Infographic

Summary of results for people diagnosed or treated with prostate cancer in England and Wales (2021-2024)

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% The number within the circle represents the national percentage for the time period indicated. The numbers below represent the range by provider.

Diagnosis & staging

2024 in England

58,218

men were **diagnosed** with prostate cancer

9%

increase compared with 53,462 men in 2023

2023 in Wales

2,402

6%

decrease compared with 2,551 men in 2022

Disease presentation

For men diagnosed between January - December 2022 in England and between April - December 2023 in Wales*

12% E 5-19%

20% W 17-22%

of men presented with **metastatic** disease in England (E) and Wales (W)

5,696 2022 men were diagnosed with metastatic disease in England

8%

decrease compared with **6,161** 2021

Treatment allocation

For men diagnosed between January - December 2022 in England and between April - December 2023 in Wales

Low-risk*, localised disease

7% E 2-40%

7% W 3-10%

High-risk/locally advanced disease

69% E 46-87%

68% W 48-87%

of men had **radical treatments** in England (E) and Wales (W)

Low-risk: T stage 1/2, Gleason ≤6, M/N 0 or missing = CPG 1 (Cambridge Prognostic Group 1)

For men diagnosed with metastatic disease between January - December 2022 in England**

Under 75 years

66% 39-87%

75 years and older

29% 11-57%

of men **received systemic treatment intensification** within 12 months of diagnosis

** We present results for England only as equivalent data are currently unavailable for Wales

Treatment outcomes

For men undergoing surgery between April 2023 - March 2024 in England and Wales

12% E 5-25%

14% W 0-33%

of men were **readmitted** within 3 months **following surgery** in England (E) and Wales (W)

For men undergoing radical treatment between September 2021 - August 2022 in England and Wales

6% E
11% W
0-21% E
0-13% W

Proportion of men experiencing at least one GU complication requiring a procedural/ surgical intervention within 2 years of **radical prostatectomy** in England (E) and Wales (W)

8% E
6% W
0-16% E
4-8% W

Proportion of men receiving a procedure of the large bowel and a diagnosis indicating radiation toxicity (GI complication) within 2 years of **radical prostate radiotherapy** in England (E) and Wales (W)

6% E
6% W
2-17% E
4-8% W

Proportion of men experiencing at least one GU complication requiring a procedural/ surgical intervention within 2 years of **radical prostate radiotherapy** in England (E) and Wales (W)

The NPCA makes use of the most recently available data for each performance indicator. For disease presentation and treatment allocation, this corresponds to different time periods in England and Wales.
* Data available for Wales does not include a full 12 months and therefore we are unable to compare it with the preceding year.

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3. Recommendations

The following recommendations are developed in collaboration with the NPCA Clinical Reference Group and based on key findings in this report. The recommendations are intended for healthcare providers and commissioners in England and Wales, including trusts, Cancer Alliances, and health boards. The NPCA local quality improvement action plan contains suggested actions to address the recommendations described below.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. Investigate why men with high-risk, locally advanced disease are not considered for radical treatment and aim to reduce that proportion, if appropriate, by: • documenting whether patients eligible for radical treatment are offered standard of care, and if not, documenting reasons for not using combination ADT or receiving radical therapy • performing a detailed case-note review to determine if specialist Multidisciplinary Teams (sMDTs) are recommending radical treatment, and if so, the reasons behind why it was not given • assessing fitness for treatment regardless of chronological age and considering referral to oncogeriatric services, if appropriate • using the findings of the case-note review, centres should design behavioural change interventions which will increase treatment rates	England: Cancer Alliances working with NHS trusts Wales: health boards	69% (sMDT range 46-87%) of men diagnosed with high-risk/locally-advanced prostate cancer in England and 68% (48-87%) of men in Wales underwent radical treatment within 12 months of diagnosis	QI goal 1: To improve timely diagnosis and treatment of high-risk prostate cancer QI goal 3: To reduce potential under-treatment	NICE Guideline [NG131], 2019 1.3.11 Do not offer active surveillance to people with high-risk localised prostate cancer. NICE Guideline [NG131], 2019 1.3.12, 1.3.21. Offer radical prostatectomy or alternatively radical radiotherapy in combination with androgen deprivation therapy (ADT) to men with high-risk localised prostate cancer.
2. Review variation between providers in rates of GU/ GI complications and 90-day readmission rates by: • ensuring proactive onward referral to specialist services for the management of side effects • using the NPCA quarterly report feedback to evaluate quality improvement relating to readmissions	England: Cancer Alliances working with NHS trusts Wales: health boards	Variation between providers for GU complications post radical prostatectomy is: 0%-21% (England) and 0%-13% (Wales); for GI complications post radical radiotherapy is 0%-16% (England) and 4%-8% (Wales); for emergency readmission within 90 days of surgery is: 5%-25% (England) and 0%-33% (Wales)	QI goal 4: To reduce short-term complications after radical prostate cancer surgery	Royal College of Radiologists Guidance: "Radiotherapy target volume definition and peer review". NPCA Prostate Radiotherapy Masterclass Part 1 & 2. EAU - EANM - ESTRO - ESUR - ISUP - SIOG Guideline [2024] 6.2.2.4 Acute and chronic complications of radical prostatectomy.

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Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
3. Decisions regarding diagnosis and treatment should consider life expectancy and co-morbidity, balancing the treatment benefits and risks, to ensure equitable care by: • using individualised assessment, such as comprehensive geriatric assessment (CGA) tools, to accurately measure patients' health status and not deny a patient investigations or treatment based on chronological age alone • involving patients and their families in shared decision-making, clearly explaining potential outcomes and aligning treatment decisions with the patient's preferences, values, and quality of life goals • checking that standardised clinical pathways for prostate cancer treatment are shared across the MDT, ensuring that every patient receives evidence-based care regardless of their socio-demographic characteristics	England: Cancer Alliances working with NHS trusts Wales: health boards	In England, 29% (11-57%) of men aged 75 and above presenting with metastatic disease received systemic treatment intensification compared to 66% (39-87%) men aged below 75.	QI goal 3: To reduce potential under-treatment	EAU - EANM - ESTRO - ESUR - ISUP - SIOG Guideline [2024] 6.1.3 Heterogeneity in performance increases with advancing age, so it is important to use measures other than just age or performance status when considering treatment options. NICE Guideline [NG131], 2019 1.5.1 Offer people with metastatic prostate cancer tailored information and access to specialist urology and palliative care teams to address their specific needs. NPCA Oncogeriatric Perspective.
4. To better understand why men with newly diagnosed hormone-sensitive metastatic prostate cancer are not being treated with systemic treatment intensification therapy • documentation of whether patients eligible for treatment intensification using systemic therapy are offered it and if not, to record the reasons for not treating • using the NPCA quarterly report feedback to evaluate quality improvement relating to treatment intensification use in newly diagnosed hormone-sensitive metastatic prostate cancer	England: Cancer Alliances working with NHS trusts Wales: health boards	In England, 47% of men received systemic treatment intensification therapy within 12 months of diagnosis	QI goal 3: To reduce potential under-treatment	EAU Recommendation for the first-line treatment of newly diagnosed hormone-sensitive metastatic disease "Offer ADT combined with abiraterone acetate plus prednisone or ADT plus apalutamide or enzalutamide to patients with M1 disease who are fit for the regimen."
Data Quality Recommendation				
5. Aim to achieve greater completeness of key data items at the point of collection by NHS organisations in England and Wales, particularly tumour, node and metastasis (TNM) staging, PSA and Gleason score variables by: • appointing a clinical data lead with protected time for reviewing and checking the team's data returns and for championing improvements in data completeness • integrating routine documentation of staging, PSA and Gleason information into MDT meetings • using the NPCA quarterly report feedback to evaluate quality improvement relating to data completeness	England: Cancer Alliances working with NHS trusts Wales: health boards	Data completeness in NCRD: TNM: England 70% (6-96%) Wales 62% (46-93%) Gleason: England 81% (11-96%) Wales 87% (80-97%)	Applies to all QI goals: improved data completeness underpins all clinical recommendations and QI goals and allows all QI goals to be better assessed	The Cancer Outcome and Services Data set (COSD) has been the national standard for reporting cancer in the NHS in England since January 2013. Feedback reports for the data submitted are available through the National Disease Registration Service (NDRS) CancerStats2 website. COSD is the main source for the Rapid Cancer Registration Dataset. The Cancer Network Information System Cymru (CaNISC) collects, analyses and releases information about cancer in Wales.

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4. Results for England and Wales

Results are derived from the more up-to-date Rapid Cancer Registration Dataset (RCRD), capturing men diagnosed in 2024 for England and 2023 for Wales. NHS Wales is undergoing the implementation of a new cancer informatics system, which may affect the data quality and completeness for Wales in this audit.

4.1 New diagnoses

In England, the number of men newly diagnosed with prostate cancer in 2024 increased by 9% compared to 2023 (58,218 versus 53,462, **Table S1**). Previously, in 2022, the number of men newly diagnosed, as per the RCRD, was 49,974, highlighting a persistent year-on-year increase. In Wales, the number of men newly diagnosed with prostate cancer in 2023 decreased by 6% compared to 2022 (2,402 versus 2,551, **Table S2**). Assuming a similar number of men were diagnosed with prostate cancer in Wales in 2024, the number of men diagnosed in England and Wales may exceed 60,000 per year for the first time since NPCA data collection began. Currently, we do not know the risk category of the men diagnosed in England in 2024 or Wales in 2023, but this will be described in future reports.

4.2 Radical treatment

In England, the number of men undergoing a radical prostatectomy in 2024 increased by 13% compared to 2023 (9,590 versus 8,524, **Table S3**). The number of men undergoing radical radiotherapy in 2024 increased by 13% compared to 2023 (20,782 versus 18,385, **Table S4**).

Despite a decline in overall diagnoses in Wales in 2023 compared to 2022, the number of men undergoing radical treatment increased. The number of men undergoing a radical prostatectomy rose by 23% (314 versus 255, **Table S5**), and the number of men undergoing radical radiotherapy rose by 13% (935 versus 830, **Table S6**).

The use of conventional radiotherapy fractionation schedules (typically 74 Gy in 37 fractions or similar) continues to decline. Instead, a greater proportion of hypofractionated radiotherapy (typically 60 Gy in 20 fractions), stereotactic body radiation therapy (SBRT, typically 36.25 Gy in 5 fractions), and ultrahypofractionated radiotherapy (typically 36 Gy in 6 fractions) schedules were employed (**Table S7**).

4.3 Systemic therapy

The number of men with newly diagnosed hormone-sensitive metastatic prostate cancer treated with additional systemic therapy in England remained similar (2,843 in 2023 versus 2,968 in 2022). Compared to 2023, in 2024 (up to 30th September), the use of Docetaxel, as the additional systemic therapy of choice, continued to decrease from 27% to 22%. The use of Abiraterone moderately increased (4% to 9%) although remained low in comparison with Apalatumide and Enzalutamide, which remained the same (32% and 37% respectively up to 30th September 2024, **Table S8**).

4.4 Data completeness

Data completeness of key items such as Gleason Score and complete TNM staging remains a concern, with only 81% and 70% of these data points being available in England for 2022 and 87% and 62% respectively in Wales for 2023 (**Tables S9** and **S10**).

*Patient and diagnostic characteristics are presented in **Table S11** for men diagnosed with prostate cancer in England between 1 January and 31 December 2022 and in Wales between 1 April and 31 December 2023.*

*Treatment characteristics for men receiving radical radiotherapy or prostatectomy in England over the period of 1 January and 31 December 2024 and in Wales over the period of 1 January and 31 December 2023 are presented in **Table S12**.*

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4.5 Performance indicator results

In England and Wales, we report performance indicators across different periods to report the most recent data available for each indicator in each country (**Table 2**). We utilise both the more accurate National Cancer Registration Dataset (NCRD) for England and the Cancer Network Information System Cymru for Wales as well as the Rapid Cancer Registration Dataset (RCRD) for England which provides more up-to-date data but with less accuracy than the NCRD.

Table 2. England and Wales performance indicators table

	England			Wales		
	No. of men	No. of events	% (range; provider n)	No. of men	No. of events	% (range; provider n)
Time period for men diagnosed	**1 Jan 2022 – 31 Dec 2022**			**1 Apr 2023 – 31 Dec 2023**		
PI1: Proportion of men diagnosed with metastatic disease[#]	45,599	5,696	**12** (5-19%; n=45)	1,600	316	**20** (17-22%; n=4)
PI2: Proportion of men with low-risk[1] (CPG 1) localised cancer undergoing radical prostate cancer treatment[#]	5,453	383	**7** (2-40%; n=45)	256	18	**7** (3-10%; n=4)
PI3: Proportion of men with high-risk/locally advanced[2] disease undergoing radical prostate cancer treatment[#]	17,966	12,333	**69** (46-87%; n=46)	539	365	**68** (48-87%; n=4)
PI4a: Proportion of men under 75 years old with newly diagnosed hormone-sensitive metastatic disease receiving systemic treatment intensification within 12 months of diagnosis[#,$]	2,728	1,803	**66** (39-87%; n=39)	-	-	-
PI4b: Proportion of men 75 years and older with newly diagnosed hormone-sensitive metastatic disease receiving systemic treatment intensification within 12 months of diagnosis[#,$]	2,951	867	**29** (11-57%; n=40)	-	-	-
Men who underwent a radical prostatectomy between 1 Apr 2023 – 31 Mar 2024						
PI5: Proportion of men who had an emergency readmission within 90 days of radical prostate cancer surgery[^,*]	8,868*	1,060	**12** (5-25%; n=49)	220	30	**14** (0-33%; n=5)
Men who received radical prostate cancer therapy between 1 Sep 2021 – 31 Aug 2022						
PI6: Proportion of men experiencing at least one GU complication[3] requiring a procedural/ surgical intervention within 2 years of radical prostatectomy[^]	6,357	395	**6** (0-21%; n=49)	171	18	**11** (0-13%; n=4)
PI7: Proportion of men receiving a procedure of the large bowel and a diagnosis indicating radiation toxicity (GI complication) within 2 years of radical prostate radiotherapy[^]	13,329	1,092	**8** (0-16%; n=45)	629	38	**6** (4-8%; n=3)
PI8: Proportion of men experiencing at least one GU complication[3] requiring a procedural/ surgical intervention within 2 years of radical prostate radiotherapy[^]	13,364	752	**6** (2-17%; n=48)	629	38	**6** (4-8%; n=3)

[#]Provider: Specialist Multidisciplinary Team (sMDT); [^]Provider: treatment centre, [$]Data not available for Wales. *For England, this Performance Indicator (PI) uses the Rapid Cancer Registration Dataset (RCRD) whereas the other PIs use the National Cancer Registration Dataset (NCRD). [1]Our definition of 'low-risk' is Cambridge Prognostic Group (CPG) 1; [2]Our definition of 'high-risk or locally advanced' differs from CPG4/5 due to the inclusion of nodal disease (N1) in the NPCA definition. [3]Please see our methodology supplement for a list of complications.

Data completeness for Gleason score was 81% for England and 87% for Wales, and for T-stage/category, Node category, Metastatic category (TNM) it was 70% for England and 62% for Wales

Acronyms: GU = genitourinary; GI = gastrointestinal.

All indicators are adjusted for relevant patient and disease characteristics with the exception of PI1 which is unadjusted, details of adjustment are provided in the methodology supplement

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Key Messages

In England, 12% of men diagnosed with prostate cancer in 2022 presented with metastatic disease, compared to 17% in 2021. This decline reflects both an increase in non-metastatic prostate cancer diagnoses (from 28,223 in 2021 to 35,306 in 2022) and only a small decrease in the absolute number of men presenting with metastatic disease at first diagnosis (from 6,161 to 5,696). Metastatic status was missing for 24% of patients in England.

In England, an increase in prostate cancer incidence occurred across all risk sub-groups of patients with non-metastatic disease, a proportion of whom (13%) have low-risk disease (**Table S11**).

In Wales, between 1st April 2023 and 31st December 2023, this proportion was 20% (316 out of 1,600 men diagnosed overall) (Table 2). Metastatic status was missing for 33% of patients in Wales.

The proportion of men potentially receiving over- and under-treatment remains stable year-on-year. However, there continues to be wide variation in the utilisation of appropriate treatment at sMDT level.

The proportion of men with a Cambridge Prognostic Group (CPG) risk score of 1 undergoing radical treatment was 7% in England and Wales. However, there was substantial variation between sMDTs, ranging from 2-40% (n=45) in England and 3-10% in Wales (n=4).

The proportion of men with high-risk or locally advanced disease undergoing radical treatment was 69% in England and 68% in Wales. However, there was substantial variation between sMDTs, ranging from 46-87% (n=46) in England and 48-87% in Wales (n=4).

For the first time, we assess the proportion of men who experience a GU complication within two years of receiving radical radiotherapy. The proportion was 6% in both England (range 2-17%, n=48) and Wales (4-8%, n=3) (**Table 2**).

The proportion of men who experience a GU complication within two years of undergoing a radical prostatectomy was 6% (range 0-21%, n=49) in England and 11% (0-13%, n=4) in Wales. The performance of two trusts fell below the 99.8% (3 standard deviations from the national average) performance limit and that of one trust fell below the 95% (2 standard deviations from the national average) for two consecutive years and were subject to our outlier process.

The proportion of men who experience a GI complication within two years of receiving radical therapy reduced in England in 2022 (8%, range 0-16%, n=45) compared to 2021 and from 8% to 6% in Wales. The performance of three trusts fell below the 99.8% performance limit and that of two trusts fell below the 95% (2 standard deviations from the national average) for two consecutive years and were subject to our outlier process. The data for three trusts were reviewed and clarified. After this review the data for these trusts were removed as per our outlier policy. Variation between providers for PI6 and PI7 are presented via funnel plots in the Data Dashboard.

The proportion of men requiring an emergency readmission within 90 days of undergoing a radical prostatectomy, experiencing a GU complication within two years of a radical prostatectomy or developing radiation toxicity within two years of radical radiotherapy has remained similar compared to the previous year.

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4.6 The use of systemic therapy in metastatic prostate cancer

4.6.1 Background

For the first time, we report the proportion of men diagnosed with metastatic prostate cancer who receive systemic treatment intensification. Historically, treatment for newly diagnosed metastatic hormone-sensitive prostate cancer (mHSPC) involved androgen deprivation therapy (ADT) alone. However, landmark trials have shown that men with mHSPC treated with intensification therapies, such as docetaxel[3] or androgen receptor pathway inhibitors (ARPIs) like abiraterone[4], apalutamide[5], or enzalutamide[6], experience better overall survival compared to those treated with ADT alone.

National clinical guidelines advise treatment intensification for all men with mHSPC. However, it remains unclear whether men in England are receiving the recommended treatment.

Notes:

We present results for England only as equivalent data are currently unavailable for Wales. Data from this report relating to the use of systemic therapy in metastatic prostate cancer are under review as hormone treatments are known to be less well recorded in the SACT dataset. This performance indicator is undergoing further methodological refinement and subject to a quality improvement programme.

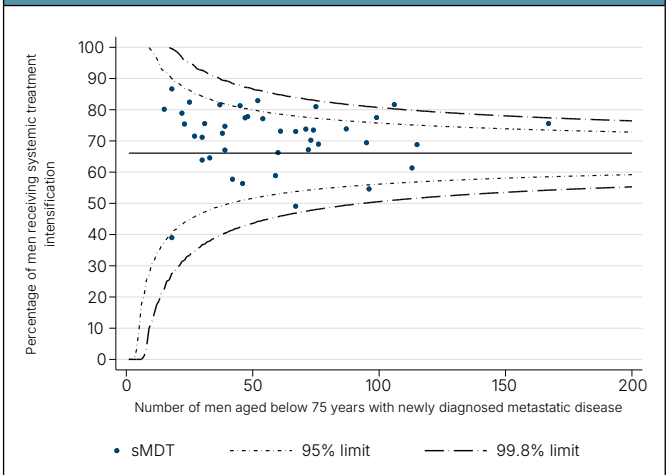
4.6.2 Findings

Among men newly diagnosed with mHSPC in 2022 in England, 47% (2,670 out of 5,679) received systemic treatment intensification therapy within 12 months of diagnosis. The proportion of patients receiving treatment intensification differed by age category. Men aged below 75 were more likely to receive treatment (66%, sMDT range 39-87%) than men aged 75 and above (29%, 11-57%, **Table 2**). There was also considerable variation by sMDT. This variation remained even after adjustment for age, number of comorbidities, performance status and frailty level.

The proportion of men below 75 who received treatment intensification therapy increased slightly between 2018 (62%) and 2022 (66%)[7]. During initial investigation of this performance indicator, five sMDTs were found to be below the 99.8% limit (3 standard deviations from the national average). Following our outlier process, data issues were identified and results for these sMDTs have subsequently been removed (**Figure 1**).

Additionally, the proportion of men aged 75 and above who received treatment intensification has improved between 2018 (14%) and 2022 (29%)[7]. This may be due to the increasing amount of high-quality randomised trial data showing a significant survival advantage to adding treatment intensification. During initial investigation of this performance indicator, four sMDTs were found to be below the 99.8% limit (3 standard deviations from the national average). Following our outlier process, data issues were identified and results for these sMDTs have subsequently been removed (**Figure 2**). In addition, this performance indicator is the focus of the NPCA Quality Improvement Intervention, launching in October 2025, which will aim to understand and improve the variation in performance between different sMDTs.

Figure 1. Adjusted funnel plot for the proportion of men aged below 75 years with newly diagnosed metastatic hormone-sensitive prostate cancer (mHSPC) who received treatment intensification therapy between 1st January 2022 and 31st December 2022, at sMDT level, in England.



We present results for England only as equivalent data are currently unavailable for Wales.

3 James ND, Sydes MR, Clarke NW, Mason MD, Dearnaley DP, Spears MR, et al. Addition of docetaxel, zoledronic acid, or both to first-line long-term hormone therapy in prostate cancer (STAMPEDE): survival results from an adaptive, multiarm, multistage, platform randomised controlled trial. Lancet. 2016;387(10024):1163-77.

4 James ND, de Bono JS, Spears MR, Clarke NW, Mason MD, Dearnaley DP, et al. Abiraterone for Prostate Cancer Not Previously Treated with Hormone Therapy. N Engl J Med. 2017;377(4):338-51.

5 Chi KN, Agarwal N, Bjartell A, Chung BH, Pereira de Santana Gomes AJ, Given R, et al. Apalutamide for Metastatic, Castration-Sensitive Prostate Cancer. N Engl J Med. 2019;381(1):13-24.

6 Davis ID, Martin AJ, Stockler MR, Begbie S, Chi KN, Chowdhury S, et al. Enzalutamide with Standard First-Line Therapy in Metastatic Prostate Cancer. N Engl J Med. 2019;381(2):121-31.

7 Dodkins J, Cook A, Mayne E, Parry M, Parry MG, Boyle J, et al. Are evidence-based guidelines translating into clinical practice? A national population-based study of the use of treatment intensification in metastatic hormone-sensitive prostate cancer (mHSPC) in England. Eur J Cancer. 2025;220:115335.

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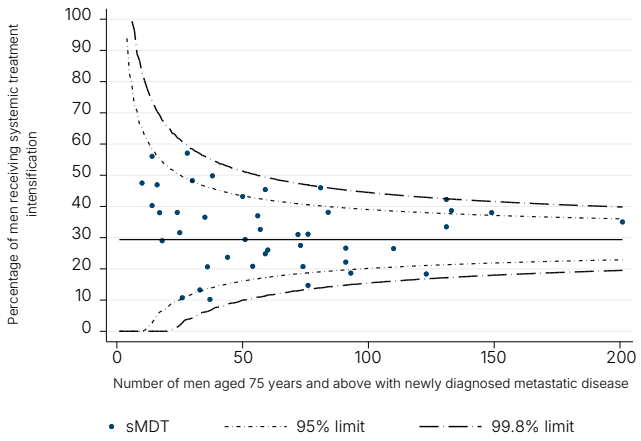
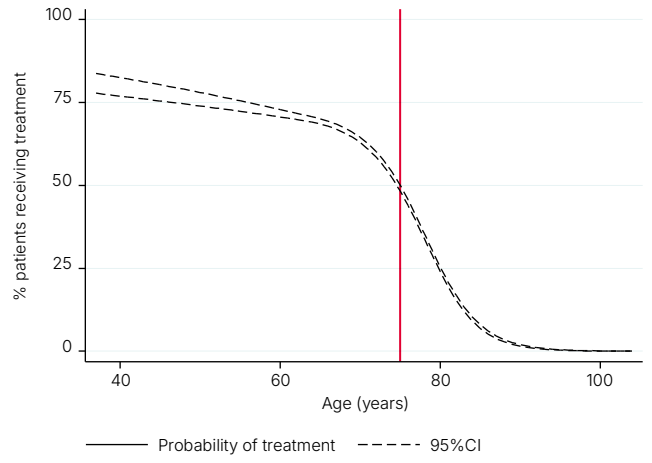
Figure 2. Adjusted funnel plot for the proportion of men aged 75 years and above with mHSPC who received treatment intensification therapy between 1st January 2022 and 31st December 2022 in England.



4.6.3 Determinants of receiving treatment intensification

Previous research conducted by the NPCA team on men diagnosed with mHSPC in England over a longer period between 2018 and 2022, described further how older men are less likely to receive treatment intensification (**Figure 3**). Among men aged 75 years or younger, 59.8% received treatment intensification, compared to only 16.8% of men older than 75 over the five-year period[8]. Between the ages of 70 and 80 there was a sharp decline in the use of treatment intensification[8].

Figure 3. The proportion of men with newly diagnosed metastatic hormone sensitive prostate cancer (mHSPC) who received treatment intensification therapy within six months of diagnosis between 1st January 2018 and 31st December 2022 in England according to age. The red vertical line on Figure 3 represents 75 years of age.



We present results for England only as equivalent data are currently unavailable for Wales.

In addition to being older, men with more comorbidities and men deemed to be more frail were less likely to receive treatment intensification. Among men with no comorbidities, 44.2% received treatment intensification compared to 13.9% with two or more comorbidities.

Furthermore, men from Black ethnic backgrounds or socioeconomically deprived neighbourhoods were less likely to receive treatment intensification. Of all Black men diagnosed with mHSPC, only 40.1% received treatment intensification, and they were less likely (adjusted risk ratio [aRR]: 0.76, 0.67-0.86) to receive treatment compared to White men when adjusted for age, co-morbidities, frailty and socioeconomic status. Only 35.1% of men from the most socioeconomically deprived neighbourhoods received treatment intensification, and they were less likely (aRR: 0.76, 0.71-0.81) to receive treatment intensification compared to men from the least deprived neighbourhoods.

4.6.4 Summary

1. Many men across England may not be receiving proven and recommended combination treatment strategies for their metastatic prostate cancer[8].

2. Men from Black ethnic groups are less likely to receive combination treatment compared to White ethnic groups.

3. Men from more deprived socioeconomic backgrounds are less likely to receive appropriate treatment compared to men from less deprived socioeconomic backgrounds.

4.6.5 Recommendations

1. Treatment decisions should be based on the overall health of the patient rather than solely on age.

2. Significant sMDT-level variation exists in the delivery of treatment: the factors behind this need to be better understood.

3. Audit and feedback with a subsequent re-audit should be considered, as it may help to increase the use of systemic therapies in men with metastatic prostate cancer. The NPCA Quality Improvement Intervention, due to launching in October 2025, will aim to address this.

8 Dodkins J, Cook A, Mayne E, Parry M, Parry MG, Boyle J, et al. Are evidence-based guidelines translating into clinical practice? A national population-based study of the use of treatment intensification in metastatic hormone-sensitive prostate cancer (mHSPC) in England. Eur J Cancer. 2025;220:115335.

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5. Commentary

This third State of the Nation report from the NPCA offers a concise overview of care for patients newly diagnosed with or treated with first line therapy for prostate cancer between 1st January 2019 and 31st December 2024 in England and Wales. The report's findings are intended to guide improvements in service availability and patient outcomes and can serve as a resource for patient charities and support groups.

We discuss six previously defined performance indicators, and for the first time, we introduce a seventh and eighth performance indicator, including one aimed at assessing the type of treatment provided to men with newly diagnosed metastatic prostate cancer.

The key findings include an increase in the overall number of prostate cancer diagnoses in 2024 compared to the previous years. The increase in the number of men diagnosed with prostate cancer, and the continued expected increase over the next years, will lead to a rise in the burden of diagnosis, investigations and clinical workload concerning the continued surveillance and treatment of prostate cancer. The overall number of men presenting with metastatic disease has not changed appreciably.

Looking ahead, the NPCA aims to continue enhancing prostate cancer care in England and Wales, focusing on more frequent reporting through our quarterly reports and collaborating closely with professional bodies to drive quality improvement. For the first time, we report the proportion of men with metastatic prostate cancer who receive systemic treatment intensification therapy in addition to ADT alone. We found a shortfall in the number of men who were treated with optimal treatment, and there were inequalities based on age, ethnicity and socioeconomic level of deprivation. We are launching a new quality improvement programme to address these shortfalls and potential data quality issues by working with both data and care providers. Our quarterly report dashboard will allow for a more up-to-date review of results compared to the results released in the State of the Nation report.

Currently, we are conducting preliminary work into the longer-term outcomes of men diagnosed with high-risk, clinically localised prostate cancer, in particular, those requiring salvage radiotherapy after radical prostatectomy. Provisional data analyses show that over 50% of men with T3b disease who undergo an initial radical prostatectomy may require salvage radiotherapy within five years. We plan to investigate how to best predict men who will require salvage treatments, including determination of the variation observed across the country: this will be reported in subsequent NPCA State of the Nation reports. In addition, we plan to use the same methodology to report on progression to radical treatment after active surveillance and focal therapy, as well as report on prostate cancer-related mortality.

Other future work will include investigating outcomes of men who present with complications at the time of their prostate cancer diagnosis, further examining the outcomes of secondary treatments for advanced prostate cancer, assessing long-term cure rates from surgery, and evaluating the results of modern active surveillance.

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