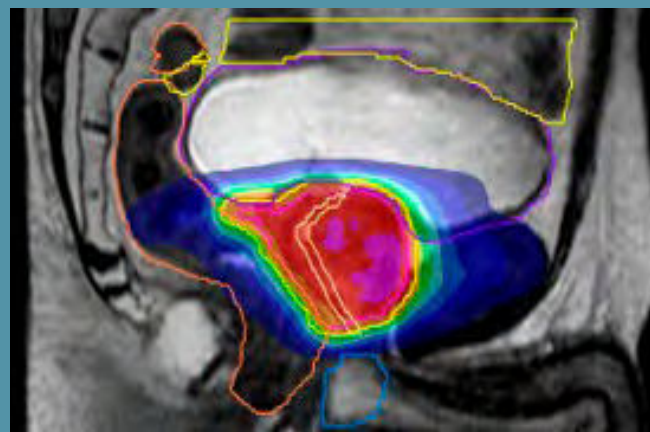
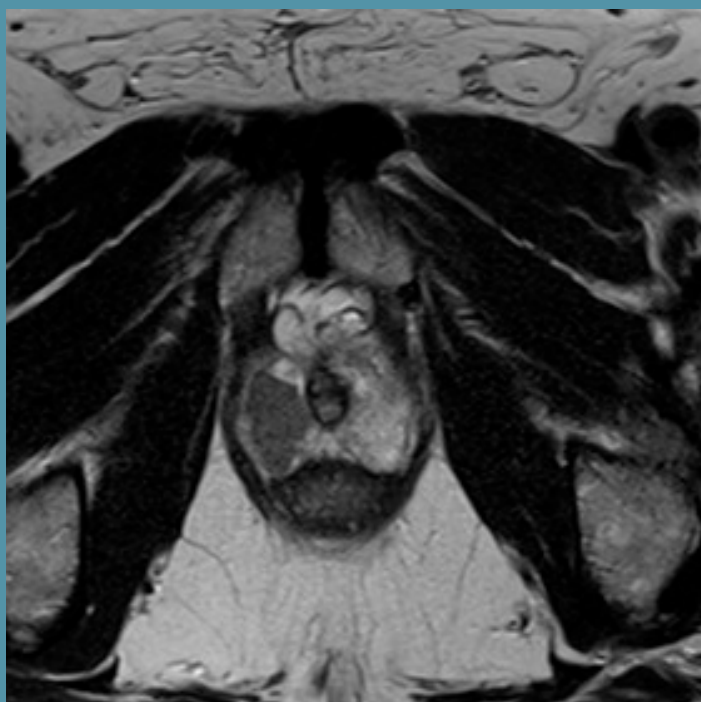
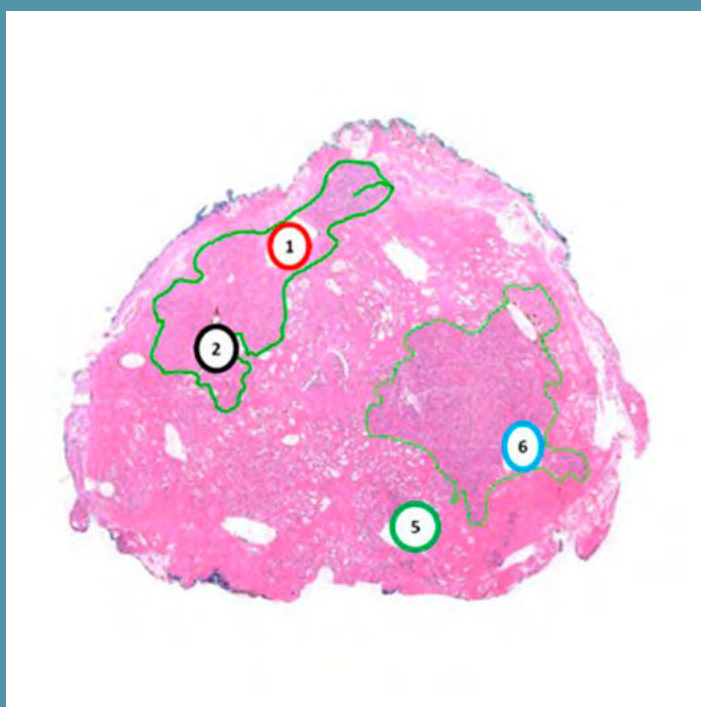


National Prostate Cancer Audit State of the Nation Report 2026

An audit of care received by people diagnosed or treated with prostate cancer between 1 September 2022 and 31 March 2025 in England and Wales. In addition, a description of national time trends in diagnoses, treatments, and survival outcomes between 1 January 2015 and 31 December 2025 in England and 1 September 2022 and 31 December 2024 in Wales.

Published October 2026



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The Royal College of Surgeons of England is an independent professional body committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care. As part of this it supports audit and the evaluation of clinical effectiveness for surgery. Registered Charity no: 212808.



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.



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.



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.



This work uses data that have been provided by patients and collected by the NHS as part of their care and support. For patients diagnosed in England, the data are 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.



NHS Wales recently implemented Cancer Dataset Forms with the latest implementation date being January 2025. These have been designed to improve the data capture and reporting capabilities of NHS Wales. This implementation has impacted the data quality within NHS Wales. 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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Contents

1. Introduction	1
1.1 PI 4: Percentage of men with newly diagnosed hormone-sensitive metastatic disease receiving systemic treatment intensification	2
2. Infographic	3
3. Recommendations	4
4. Results for England and Wales	7
4.1 New diagnoses	7
4.2 Radical treatment	7
4.3 Data completeness	7
4.4 Performance indicator results	8
5. Research and development spotlight	10
5.1 Survival outcomes in men with newly diagnosed metastatic prostate cancer	10
5.1.1 Background	10
5.1.2 Results	10
5.1.3 Summary	10
5.1.4 Recommendations	10
5.2 Three-year risk of post-prostatectomy radiotherapy	10
5.3 Focal therapy for the treatment of localised prostate cancer	11
6. Commentary	12

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 fourth publication of the NPCA State of the Nation Report in 2026 continues to reflect the move to the annual National Cancer Audit Collaborating Centre (NATCAN) reporting cycle.

We use [data routinely collected](#) by the NHS, using the nationally mandated flow of data from hospitals to the National Disease Registration Service (NDRS) in NHS England and the National Cancer Team, NHS Wales Performance and Improvement.

We present results from seven key performance indicators (PIs) in the management of prostate cancer (Table 1), as well as the variation in performance among providers in England and Wales (Table 2). Furthermore, we outline five recommendations for providers to help improve their performance, showcase [provider-level data](#) and describe results from our outlier process. We also aim to align the PIs with our [Quality Improvement Plan](#), last published in November 2025 and reviewed annually.

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 2026 webpage](#).

Welsh Data Issues

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. We are working with NHS Wales to resolve/understand issues relating to:

- Data completeness (particularly Gleason score)
- Linkage of main cancer registration dataset to supporting datasets
- Decreased number of radical prostatectomies recorded
- Decreased number of men recorded as receiving radical prostate radiotherapy
- PI 2 (overtreatment) - denominator is lower than expected
- PI 3 (undertreatment) - one SMDT is substantially lower than the other SMDTs
- PI 5 (emergency readmissions) - denominator is lower than expected

Table 1. Performance Indicators (PIs) included*

	England [*]	Wales [#]
PI 1: Percentage of men with metastatic disease at diagnosis	Yes (01/23 – 12/23)	Yes (01/24 – 12/24)
PI 2: Percentage of men with low-risk (CPG 1) localised cancer undergoing radical prostate cancer treatment	Yes (01/23 – 12/23)	Yes (01/24 – 12/24)
PI 3: Percentage of men with high-risk/locally advanced disease undergoing radical prostate cancer treatment	Yes (01/23 – 12/23)	Yes (01/24 – 12/24)
PI 5: Percentage of men who had an emergency readmission within 90 days of radical prostate cancer surgery	Yes (04/24 – 03/25)	Yes (04/24 – 03/25)
PI 6: Percentage of men experiencing at least one genitourinary (GU) complication requiring a procedural/surgical intervention within 2 years of radical prostatectomy**	Yes (09/22 – 08/23)	Yes (09/22 – 08/23)
PI 7: Percentage 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 (09/22 – 08/23)	Yes (09/22 – 08/23)
PI 8: Percentage of men experiencing at least one GU complication requiring a procedural/surgical intervention within 2 years of radical prostate radiotherapy**	Yes (09/22 – 08/23)	Yes (09/22 – 08/23)
* See methodology supplement for the exact definitions of each performance indicator [*] England data: Rapid Cancer Registration Dataset (RCRD) for PI5 and National Cancer Registration Dataset (NCRD) for all other PIs [#] Welsh data: Cancer Network Information System Cymru (CaNIS) and Cancer Dataset Form (CDF) ** Subject to NPCA Outlier Policy Acronyms: CPG = Cambridge Prognostic Group.		

1.1 PI 4: Percentage of men with newly diagnosed hormone-sensitive metastatic disease receiving systemic treatment intensification

Last year's NPCA State of the Nation Report 2025 included a systemic anti-cancer therapy (SACT) PI ("PI 4: Percentage of men with newly diagnosed hormone-sensitive metastatic disease receiving systemic treatment intensification"). During engagement with NHS trusts identified as potential negative outliers in the [2025 outlier process](#) and a [quality improvement \(QI\) intervention](#), issues regarding the accuracy of oral hormonal SACT data quality and completeness were raised. In particular, this centred around the submission and reporting of SACT medications widely used in the treatment of metastatic prostate cancer, such as androgen receptor pathway inhibitors (ARPIs) including: Abiraterone, Apalutamide, and

Enzalutamide. To explore this anomaly further, we engaged with the Medicines Value and Access (MVA) function, NHS England and undertook a pilot study using aggregate-level data from the Cancer Drugs Fund (Blueteq). The results of this work revealed systemic underreporting of ARPI usage across NHS trusts in England between 2018-2024. Therefore, because of the uncertainty relating to the accuracy of the currently available data, the NPCA have decided not to report this PI in this year's report. However, we will continue to investigate the capture of systemic therapy for inclusion in future reports. Data relating to the number of men with newly diagnosed hormone-sensitive metastatic disease starting SACT within 16 weeks of diagnosis in England between 2019-2025 is presented in [Table A1](#), although this is likely to be significantly underreported. Quarterly data, based on RCRD reporting, will continue to be published on the [NPCA Data Dashboard](#) in the interim.

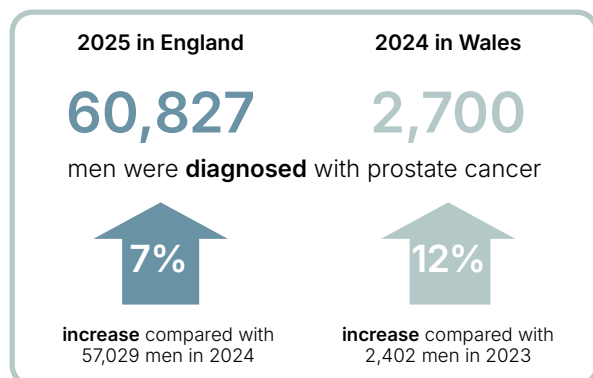
2. Infographic

Summary of results for people diagnosed or treated with prostate cancer in England and Wales between 1 January 2015 and 31 December 2025

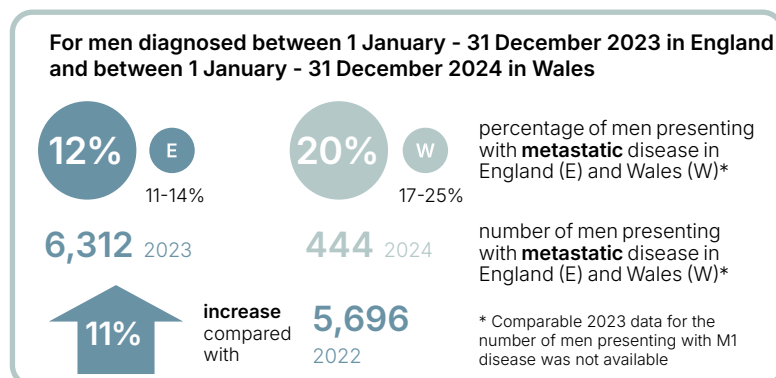
 The number within the circle represents the national percentage for the time period indicated. The numbers below represent the IQR by provider.

E = England
W = Wales

Diagnosis

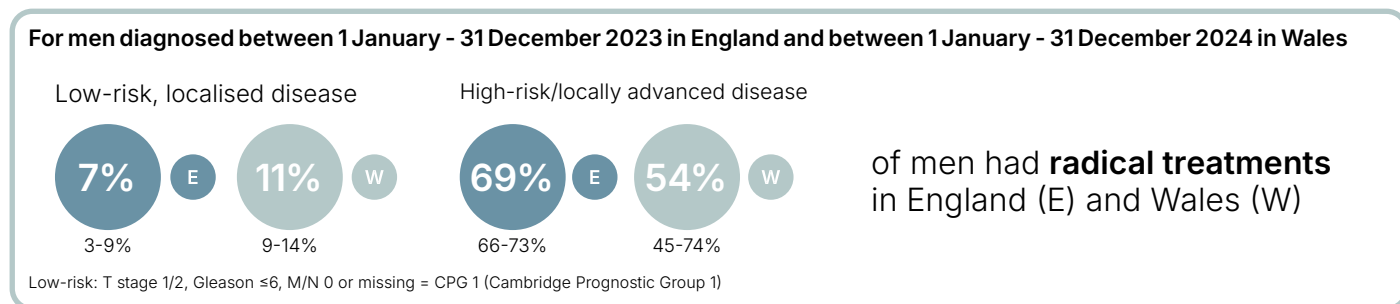


Disease presentation

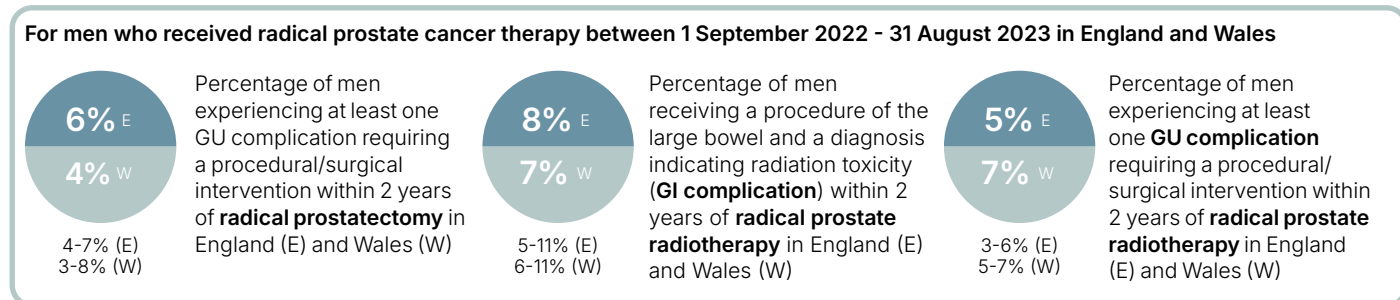
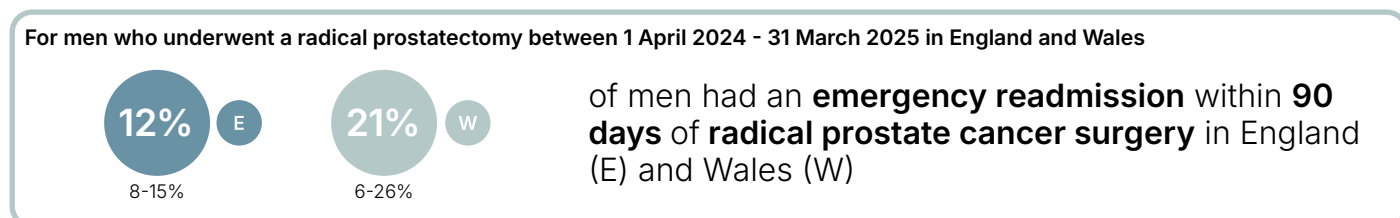


Treatment allocation

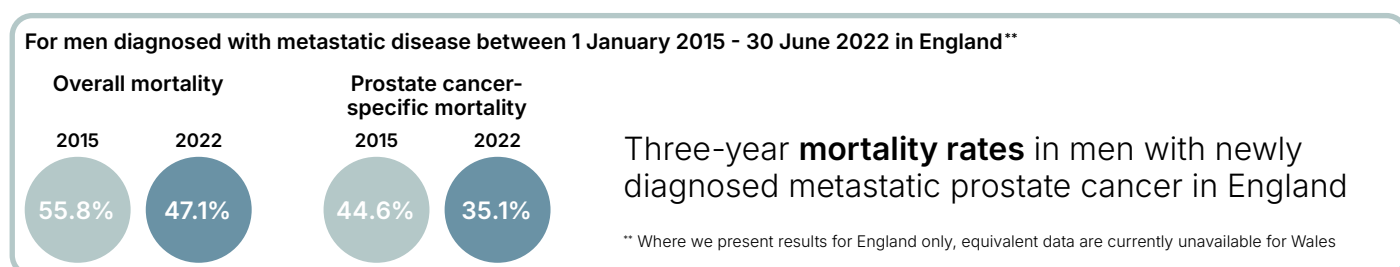
Note the relative proportions do not necessarily reflect changes in absolute numbers over time



Treatment outcomes



Survival outcomes



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.

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. Continue to advocate active surveillance for men with low-risk prostate cancer by: - documenting whether men eligible for active surveillance are offered it and reasons for treating, where appropriate - performing a detailed case-note review to determine why low-risk men are not undergoing active surveillance in specialist multidisciplinary teams (sMDTs) with a higher-than-expected percentage of men receiving radical treatment for low-risk disease - using the findings of the case-note review, centres should design local quality improvement interventions to decrease overtreatment rates	England: Cancer Alliances working with NHS trusts Wales: health boards	7% of men diagnosed with low-risk localised disease in England and 11% in Wales underwent radical treatment within 12 months of diagnosis	Goal #2: To reduce potential overtreatment	NICE Guideline [NG131] , 2019 1.3.8 For people with CPG 1 localised prostate cancer: - offer active surveillance - consider radical prostatectomy or radical radiotherapy if active surveillance is not suitable or acceptable to the person.
2. Investigate why men with high-risk/locally advanced disease are not considered for radical treatment and aim to reduce that percentage, if appropriate, by: - documenting by sMDTs whether men eligible for radical treatment are offered it and reasons for not treating, where appropriate - performing a detailed case-note review to determine why high-risk men are not receiving radical treatment in sMDTs with a lower-than-expected percentage of men receiving radical treatment for high-risk disease - 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 local quality improvement interventions to reduce potential undertreatment	England: Cancer Alliances working with NHS trusts Wales: health boards	69% of men diagnosed with high-risk/locally advanced disease in England and 54% in Wales underwent radical treatment within 12 months of diagnosis	Goal #3: To reduce potential undertreatment	NICE Guideline [NG131] , 2019 1.3.11 Do not offer active surveillance to people with high-risk localised and locally advanced 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 and locally advanced prostate cancer. NPCA Data Dashboard

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
3. Review variation between providers in rates of 90-day readmission rates and GU/GI complications 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 (IQR) between providers for emergency readmission within 90 days of surgery is 8-15% (England) and 6-26% (Wales); for GU complications post radical prostatectomy is 4-7% (England) and 3-8% (Wales); for GI complications post radical radiotherapy is 5-11% (England) and 6-11% (Wales); for GU complications post radical radiotherapy is 3-6% (England) and 5-7% (Wales)	Goal #4: To reduce short-term complications after radical prostate cancer surgery Goal #5: To reduce medium-term complications after radical prostate cancer surgery and radiotherapy	EAU - EANM - ESTRO - ESUR - ISUP - SIOG Guidelines on Prostate Cancer [2025] 6.2.2.4 Acute and chronic complications of radical prostatectomy. Royal College of Radiologists Guidance: "Radiotherapy target volume definition and peer review" . NPCA Prostate Radiotherapy Masterclass Part 1 & 2 .
4. Decisions regarding 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 men's health status and not deny men investigations or treatment based on chronological age alone - involving men and their families in shared decision-making, clearly explaining potential outcomes and aligning treatment decisions with their preferences, values, and quality of life goals - checking that standardised clinical pathways for prostate cancer treatment are shared across the sMDT, ensuring that every man receives evidence-based care regardless of their socio-demographic characteristics	England: Cancer Alliances working with NHS trusts Wales: health boards	In England, three-year mortality rates for men with newly diagnosed metastatic prostate cancer fell from 55.8% (overall) and 44.6% (prostate cancer-specific) in 2015 to 47.1% (overall) and 35.1% (prostate cancer-specific) in 2022 respectively	Goal #1: To improve timely diagnosis and treatment of high-risk prostate cancer Goal #3: To reduce potential undertreatment	EAU - EANM - ESTRO - ESUR - ISUP - SIOG Guidelines on Prostate Cancer [2025] 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 Offer people with metastatic prostate cancer tailored information and access to specialist urology and palliative care teams to address their specific needs. NPCA Quality Improvement Intervention 2026 – Educational Webinar: "The Use of Systemic Anti-Cancer Treatment in Metastatic Prostate Cancer"

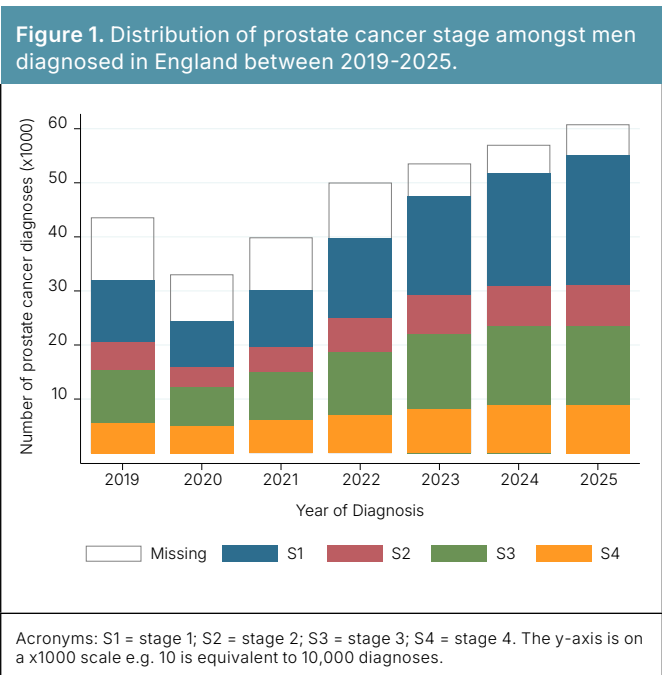
Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Data Quality Recommendation				
5. Aim to achieve greater completeness of key data items at the point of collection by NHS organisations in England and Wales, particularly tumour, node and metastasis (TNM) staging, prostate-specific antigen (PSA) and Gleason score variables by: • appointing a clinical data lead within sMDTs 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 79% Wales 76% PSA: England 62% Wales 98% Gleason score: England 82% Wales 54%	Applies to all QI goals: improved data completeness underpins all clinical recommendations and QI goals and allows all performance indicators and QI goals to be better assessed	The Cancer Outcome and Services Dataset (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) Data Quality and Insights Hub. 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.
All recommendations reinforce priorities identified in previous NPCA State of the Nation Reports reflecting their importance. The clinical recommendations are consistent with previous year's recommendations as not enough time has passed to be able to assess whether improvement has taken place following publication of previous NPCA State of the Nation Reports.				

4. Results for England and Wales

Results are derived from the more up-to-date Rapid Cancer Registration Dataset (RCRD), capturing men diagnosed between 1 January to 31 December 2025 for England and 1 January to 31 December 2024 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 2025 increased by 7% compared to 2024 (60,827 versus 57,029, [Table A2](#)). Previously in 2023, the number of men newly diagnosed, as per the RCRD, was 53,583, highlighting an ongoing year-on-year increase. In Wales, the number of men newly diagnosed with prostate cancer in 2024 increased by 12% compared to 2023 (2,700 versus 2,402, [Table A3](#)). For the first time since NPCA data collection began, the number of men newly diagnosed with prostate cancer exceeded 60,000 in England in 2025 alone, with rates predicted to continue to rise in both England and Wales in coming years. The distribution of disease stage in England has also changed between 2019 and 2025 (Figure 1). The increase in the number of men diagnosed with stage 1 disease likely reflects an increased uptake in early PSA testing and better capture of 'missing' stage data over time, causing an apparent relative decrease in the percentages of men presenting with metastatic disease. Currently, we do not know the risk category of men diagnosed in Wales in 2025, but this will be described in future reports.



4.2 Radical treatment

In England, the number of men undergoing a radical prostatectomy in 2025 increased by 7% (10,218 versus 9,552, [Table A4](#)). The number of men undergoing radical radiotherapy in 2025 is predicted to be similar compared to 2024, but only 10 months of data is currently captured ([Table A5](#)).

In Wales, the number of men with a record of radical surgery or radical prostate radiotherapy in 2024 decreased compared to 2023. The number of men with a record of radical prostatectomy fell by 22% (245 versus 315, [Table A6](#)) and the number of men with a record of radical prostate radiotherapy fell by 35% (606 versus 935, [Table A7](#)). We recommend caution in interpreting these results due to the identification of issues related to data quality and completeness in Wales – please refer to the '[Welsh Data Issues](#)' section in the Introduction for further details.

In England, the use of conventional radiotherapy fractionation schedules (traditionally 74 Gy in 37 fractions or similar) continues to decline. Instead, a greater proportion of departments have now joined other major clinical oncology departments in using hypofractionated radiotherapy (typically 60 Gy in 20 fractions), ultrahypofractionated radiotherapy (typically 36 Gy in 6 fractions), and stereotactic body radiation therapy (SBRT, typically 36.25 Gy in 5 fractions) schedules ([Table A8](#) – note only 10 months of data is currently captured for 2025). It is anticipated that the use of these latter methods of delivery will increase. We will continue to monitor this and with it, some of the potential urinary toxicities that are associated with it.

4.3 Data completeness

Data completeness of key items such as PSA, Gleason score and complete TNM staging remain a concern, with only 62%, 82%, and 79% of these data points being available in England for 2023 ([Table A9](#)), and 98%, 54%, and 76% in Wales for 2024 respectively ([Table A10](#)).

Patient and diagnostic characteristics are presented in [Table A11](#) for men diagnosed with prostate cancer in England between 1 January and 31 December 2023 and in Wales between 1 January and 31 December 2024.

Treatment characteristics for men receiving radical radiotherapy or prostatectomy in England over the period of 1 January to 31 December 2023 and in Wales over the period of 1 January to 31 December 2024 are presented in [Table A12](#).

4.4 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 National

Cancer Registration Dataset (NCRD) for England, and the Cancer Network Information System Cymru (CaNISC) and Cancer Dataset Form (CDF) 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	% (IQR; provider n)	No. of men	No. of events	% (IQR; provider n)
Time period for men diagnosed	1 Jan 2023 – 31 Dec 2023			1 Jan 2024 – 31 Dec 2024		
PI 1: Percentage of men with metastatic disease at diagnosis [#]	51,389	6,312	12 (11-14%; n=45)	2,220	444	20 (17-25%; n=4)
PI 2: Percentage of men with low-risk ¹ (CPG 1) localised cancer undergoing radical prostate cancer treatment [#]	6,000	418	7 (3-9%; n=44)	262	30	11 (9-14%; n=4)
PI 3: Percentage of men with high-risk/locally advanced ² disease undergoing radical prostate cancer treatment [#]	20,296	13,983	69 (66-73%; n=46)	829	451	54 (45-74%; n=4)
Men who underwent a radical prostatectomy between 1 Apr 2024 – 31 Mar 2025						
PI 5: Percentage of men who had an emergency readmission within 90 days of radical prostate cancer surgery ^{*,*}	9,725*	1,137	12 (8-15%; n=51)	218	46	21 (6-26%; n=6)
Men who received radical prostate cancer therapy between 1 Sep 2022 – 31 Aug 2023						
PI 6: Percentage of men experiencing at least one GU complication ³ requiring a procedural/surgical intervention within 2 years of radical prostatectomy [^]	7,844	464	6 (4-7%; n=49)	216	9	4 (3-8%; n=4)
PI 7: Percentage of men receiving a procedure of the large bowel and a diagnosis indicating radiation toxicity (GI complication) within 2 years of radical prostate radiotherapy [^]	17,597	1,430	8 (5-11%; n=49)	947	69	7 (6-11%; n=3)
PI 8: Percentage of men experiencing at least one GU complication ³ requiring a procedural/surgical intervention within 2 years of radical prostate radiotherapy [^]	17,597	895	5 (3-6%; n=49)	947	67	7 (5-7%; n=3)
[#] Provider: Specialist Multidisciplinary Team (sMDT); [*] Provider: treatment centre. [*] 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 82% for England and 54% for Wales, and for T-stage/category, Node category, Metastatic category (TNM) it was 79% for England and 76% for Wales Acronyms: IQR = interquartile range; GU = genitourinary; GI = gastrointestinal. All indicators are adjusted for relevant patient and disease characteristics with the exception of PI 1 which is unadjusted, details of adjustment are provided in the methodology supplement						

Key messages

In England, 12% of men diagnosed with prostate cancer in 2023 presented with metastatic disease, remaining stable compared to 12% in 2022. However, whilst the relative percentages remained stable, the absolute numbers of men diagnosed with both metastatic (from 5,696 in 2022 to 6,312 in 2023, reflecting an 11% increase) and non-metastatic (from 35,306 in 2022 to 41,798 in 2023) prostate cancer increased in 2023 compared to 2022 in England. Metastatic status was missing for 16% of men in England.

In England, an increase in prostate cancer incidence was observed across all risk sub-groups of men with non-metastatic and metastatic disease in 2023 compared to 2022, reflecting higher rates of prostate cancer diagnoses across all stages, in particular men diagnosed with low-risk (stage 1) disease ([Table A10](#)).

In Wales, between 1 January 2024 and 31 December 2024, the percentage of men diagnosed with prostate cancer presenting with metastatic disease was 20% (444 out of 2,220) (Table 2). Metastatic status was missing for 18% of men in Wales.

Key messages

The percentage of men with low-risk disease potentially receiving overtreatment remained stable in England but rose slightly for Wales. There continues to be significant variation in the utilisation of radical treatment for low-risk disease at sMDT level.

The percentage of men with a Cambridge Prognostic Group (CPG) risk score of 1 undergoing radical treatment was 7% in England and 11% in Wales (compared to 7% respectively in 2022). However, there was variation between sMDTs, the interquartile range (IQR) was 3-9% (n=44) in England and 9-14% (n=4) in Wales.

Key messages

The percentage of men potentially receiving undertreatment remained stable in England but fell significantly for Wales. There continues to be significant variation in the utilisation of radical treatment for high-risk/locally advanced disease at sMDT level.

The percentage of men with high-risk or locally advanced disease undergoing radical treatment was 69% in England and 54% in Wales (compared to 69% and 68% respectively in 2022). However, there was variation between sMDTs, the IQR was 66-73% (n=46) in England and 45-

74% (n=4) in Wales. The reasons underlying this significant variation remain unclear.

The percentage of men requiring an emergency readmission within 90 days of undergoing a radical prostatectomy remained stable in England (12%) but rose slightly for Wales (21% compared to 14%) compared to the previous year.

Key messages

The percentage of men experiencing at least one GU complication requiring a procedural/surgical intervention within 2 years of radical prostatectomy remained stable in England and fell slightly for Wales. The percentage of men experiencing a GI or GU complication within 2 years of radical radiotherapy in England remained stable compared to the previous year.

The percentage of men who experience a GU complication within 2 years of a radical prostatectomy was 6% (IQR 4-7%; n=49) in England (compared to 6% the previous year), and 4% (IQR 3-8%; n=4) in Wales (compared to 11% the previous year). The performance of two trusts fell below the 99.8% (3 standard deviations from the national average) 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 policy](#).

The percentage of men who experience a GI complication within 2 years of undergoing radical radiotherapy was 8% (IQR 5-11%; n=49) in England (compared to 8% the previous year), and 7% (IQR 6-11%; n=3) in Wales (compared to 6% the previous year). The performance of three trusts fell below the 99.8% (3 standard deviations from the national average) performance limit and that of three trusts fell below the 95% (2 standard deviations from the national average) for two consecutive years and were subject to our [outlier policy](#).

The percentage of men who experience a GU complication within 2 years of undergoing radical radiotherapy was 5% (IQR 3-6%; n=49) in England (compared to 6% the previous year), and 7% (IQR 5-7%; n=3) in Wales (compared to 6% the previous year). The performance of two trusts fell below the 99.8% (3 standard deviations from the national average) performance limit and were subject to our [outlier policy](#).

Variation between providers for all PIs is presented via funnel plots in the [NPCA Data Dashboard](#).

5. Research and development spotlight

5.1 Survival outcomes in men with newly diagnosed metastatic prostate cancer

5.1.1 Background

For the first time, we report trends in survival outcomes in men with newly diagnosed metastatic prostate cancer in England. The treatment landscape for metastatic prostate cancer has evolved substantially over the past decade with the increasing use of systemic treatment intensification including the use of chemotherapy and androgen receptor pathway inhibitors (ARPIs).

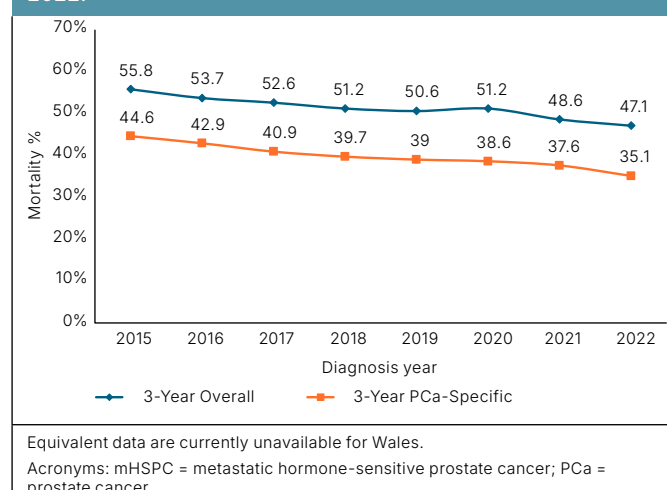
5.1.2 Results

A total of 45,339 men were newly diagnosed with metastatic hormone-sensitive prostate cancer (mHSPC) between 1 January 2015 and 30 June 2022. Three-year overall mortality fell from 55.8% for men diagnosed in 2015 to 47.1% for those diagnosed in 2022, representing an absolute reduction of 8.7% (Figure 2). Year-on-year improvements in both overall and prostate cancer-specific mortality were observed across the study period, although this trend plateaued for men diagnosed in 2020, possibly reflecting the impact of the COVID-19 pandemic.

Read more: Improved survival in newly diagnosed metastatic prostate cancer: a National Prostate Cancer Audit study, British Journal of Urology International (10.1111/bju.70432).

Using the same national data, the overall 5-year mortality for men diagnosed with metastatic prostate cancer without complications was 67.8%, rising to 89.3% for those presenting with complications¹.

Figure 2. Three-year overall (blue) and prostate cancer-specific (orange) mortality in men with newly diagnosed mHSPC in England between 1 January 2015 and 30 June 2022.



5.1.3 Summary

- A near 10% decrease in 3-year prostate cancer-specific mortality likely reflects the increasing adoption of systemic treatment intensification in the metastatic hormone-sensitive setting during this period.
- This change likely represents adoption of new approaches from derived evidence provided by large-scale, randomised clinical trials.

5.1.4 Recommendations

Increased uptake in the use of systemic treatment intensification for treatment of metastatic disease is likely to have significant survival benefits in a real-world setting. The [NPCA Quality Improvement Intervention](#), launched in October 2025, continues to address this.

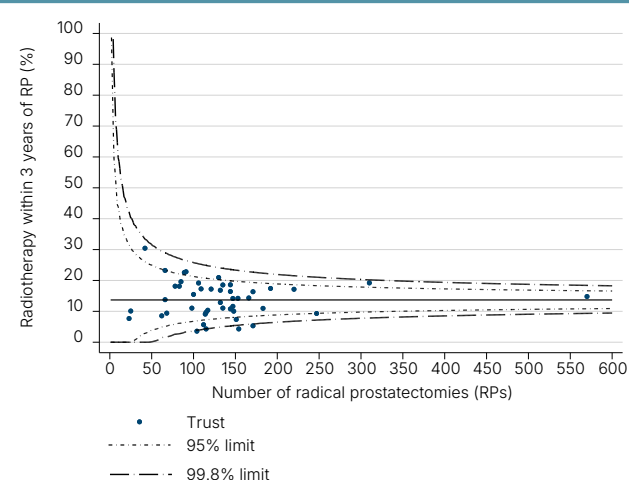
5.2 Three-year risk of post-prostatectomy radiotherapy

For the first time, we report the percentage of men receiving post-prostatectomy ('salvage') radiotherapy within 3 years of radical prostatectomy in England in 2021. Previous NPCA research demonstrated that the 5-year risk of the use of post-prostatectomy radiotherapy in England between 2014-2018 was significantly increased by the presence of high-risk clinical features at baseline including: PSA >20ng/ml, T3a and above, and International Society of Urological Pathology (ISUP) Grade Group 4 and above². On average, the 3-year risk of post-prostatectomy radiotherapy was 14% across England. However, there was variation (IQR 10-18% (n=46)) between NHS trusts after adjusting for age, comorbidities, risk category, and socioeconomic status (Figure 3). Therefore, the factors and reasons behind the variation need to be further investigated and better understood. The NPCA will continue to refine this process for inclusion as a future PI in subsequent NPCA State of the Nation Reports.

1 Nathan A, Parry MG, Cook A et al. Characteristics and outcomes of men presenting with complication of metastatic prostate cancer. *BJU Int* 2026;137:840-848.

2 Parry MG, Maffei D, Nathan A et al. 5 Year Risk of Post-Prostatectomy Radiotherapy in England: A National Population Level Study. *J Urol* 2026;215(5S):e899.

Figure 3. Adjusted funnel plot for the percentage of men receiving post-prostatectomy radiotherapy within 3 years of radical prostatectomy in England between January and December 2021.



Equivalent data are currently unavailable for Wales.

capture cases undertaken within an NHS setting and therefore does not include those HIFU cases performed in the private sector. Provisional data analyses show a wide variation in the availability of HIFU nationally, with few specialist centres treating more than 10 cases per year (Table 3).

We have previously published 5-year outcome data of men treated with HIFU since 2010 which showed, as expected, that treatment failure varied significantly with Gleason score³. Subsequent data, of men treated between 2014 and 2018 with complete 5-year follow-up, have shown similar results: Gleason score 3+3 (repeat HIFU: 7%; radical treatment: 10%; both: 7%), Gleason score 3+4 (repeat HIFU: 8%; radical treatment: 10%; both: 8%) and Gleason score 4+3 (repeat HIFU: 10%; radical treatment: 17%; both: 4%). We plan to report on more contemporary data in subsequent NPCA State of the Nation Reports with a view to comparing across treatment providers.

5.3 Focal therapy for the treatment of localised prostate cancer

For the first time, we report the use of high-intensity focused ultrasound (HIFU), an emerging focal therapy for localised prostate cancer, in England between 2018-2024. The NPCA is only able to

Table 3. NHS trusts in England offering high-volume HIFU services between 2018-2024.

Year	NHS Trust					All other NHS Trusts	Total
	Royal United Hospitals Bath NHS Foundation Trust	University Hospital Southampton NHS Foundation Trust	Hampshire Hospitals NHS Foundation Trust	University College London Hospitals NHS Foundation Trust	Imperial College Healthcare NHS Trust		
2018	0	27	21	75	67	10	200
2019	0	10	17	109	45	6	187
2020	0	19	13	91	64	6	193
2021	0	23	26	101	57	5	212
2022	0	34	24	128	103	1	290
2023	0	35	33	165	126	12	371
2024	30	19	14	143	94	12	312
Total	30	167	148	812	556	60	1,773

Counts represent numbers of cases of HIFU per patient.

Equivalent data are currently unavailable for Wales.

Acronyms: HIFU = high-intensity focused ultrasound.

6. Commentary

This fourth State of the Nation Report from the NPCA offers a concise overview of care for men diagnosed and treated for prostate cancer between 1 September 2022 and 31 March 2025 in England and Wales. The report's findings are intended to assess temporal trends and the status quo to guide improvements in service availability and patient outcomes and to serve as a resource for researchers, patient charities and support groups.

We discuss seven previously defined performance indicators and showcase new NPCA research and development spotlights including: survival outcomes for men with newly diagnosed metastatic prostate cancer, 3-year risk of post-prostatectomy radiotherapy, and the availability of focal therapies, including HIFU, in England.

The key findings include an ongoing increase in the overall number of prostate cancer diagnoses in 2025 compared to previous years, particularly in the numbers of men diagnosed with low risk, stage 1 disease. Together with the increasing numbers of men receiving treatment for prostate cancer and ongoing talks regarding the introduction of a targeted national prostate cancer screening programme for high-risk subgroups, this will likely lead to a rise in the burden of diagnosis, investigations and clinical workload within NHS trusts and organisations.

Those NHS trusts and organisations identified as negative outliers through our [outlier policy](#) were alerted and provided the opportunity to investigate further and formally respond. Please refer to [Outlier Communications](#) for further details.

For the first time, we report survival outcomes for men with newly diagnosed metastatic prostate cancer in England between 2015-2022. We found that overall and prostate cancer-specific mortality has gradually decreased year-on-year, with the exception of overall mortality in 2020 (likely as a

result of the COVID-19 pandemic). This is likely to be as a result of an increase in the use of systemic treatment intensification over time, which has been the focus of an [NPCA Quality Improvement Intervention](#). Nevertheless, factors relating to health inequalities including age, levels of socioeconomic deprivation and ethnicity continue to play a significant role in influencing treatment decisions⁴ and survival outcomes in men with prostate cancer. Further work is required to understand occurrence of variation and thereby facilitate plans for better treatment targeting where possible.

We also report the three-year risk of post-prostatectomy radiotherapy and the availability of HIFU in England. Both demonstrate wide variation in their delivery and availability respectively and we are conducting further analyses to investigate the factors behind this with the aims of developing these into PIs to include in future NPCA State of the Nation Reports.

Other future work will include investigating how to best predict men who progress to requiring radical treatment after active surveillance, examining rates of GI and GU complications from ultra-hypofractionated radiotherapy and outcomes from men with low-volume metastatic (M1a) disease undergoing palliative radiotherapy. We will also explore non-prostate cancer-related outcomes, including cardiovascular disease and bone health in men with metastatic disease receiving ADT and systemic treatment intensification⁵.

Looking ahead, the NPCA will continue to gather and report data which will facilitate enhanced prostate cancer care for men in England and Wales, focusing on more frequent and up-to-date reporting through our quarterly reports (available through the [NPCA Data Dashboard](#)) and collaborating closely with professional bodies and national data collection centres to drive quality improvement.

4 [Dodkins J, Cook A, Mayne E 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.](#)

5 [Liu JKH, Nathan A, Dodkins J et al. Future Directions of the National Prostate Cancer Audit. Clin Oncol 2026;52:104069](#)