NATCAN
National Cancer Audit Collaborating Centre

National Cancer Audit Collaborating Centre

Quality Improvement Goals and Performance Indicators – January 2025

V1.1: Updated QI Goals for the NLCA added to the document

Citation for this document:
Quality Improvement Goals and Performance Indicators 2024 London:
National Cancer Audit Collaborating Centre, Royal College of Surgeons of England, 2024.

Prepared by Verity Walker, Centre Project Manager.

Summary of the NATCAN Quality Improvement Goals and Performance Indicators published September 2024. More information and the full Quality Improvement Plans for each audit can be found here:

National Bowel Cancer Audit (NBOCA)
National Kidney Cancer Audit (NKCA)
National Audit of Metastatic Breast Cancer (NAoMe)
National Non-Hodgkin Lymphoma Audit (NNHLA)
National Oesophago-gastric Cancer Audit (NOGCA)
National Ovarian Cancer Audit (NOCA)
National Prostate Cancer Audit (NPCA)
National Pancreatic Cancer Audit (NPaCA)
National Audit of Primary Breast Cancer (NAoPri)

The updated Quality Improvement Plan for National Lung Cancer Audit (NLCA) was published in January 2025.

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) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). NATCAN delivers national cancer audits in non-Hodgkin lymphoma, bowel, breast (primary and metastatic), oesophago-gastric, ovarian, kidney, lung, pancreatic and prostate cancers. HQIP is led by a consortium of the Academy of Medical Royal Colleges and the Royal College of Nursing. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical, and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies. https://www.hqip.org.uk/national-programmes

Introduction

The National Cancer Audit Collaborating Centre

The National Cancer Audit Collaborating Centre (NATCAN) is a new national centre of excellence which aims to strengthen NHS cancer services by looking at treatments and patient outcomes across England and Wales. It was set up on 1st October 2022 to deliver six new national cancer audits, including kidney, ovarian, pancreatic, breast (two separate audits in primary and metastatic disease) and non-Hodgkin Lymphoma. Existing audits in prostate, lung, bowel, and oesophago-gastric cancers moved into NATCAN in 2023. The centre is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government.

The aim of the ten NATCAN Audits is to:

1. Provide regular and timely evidence to cancer services of where patterns of care in England and Wales may vary.
2. Support NHS services to increase the consistency of access to treatments and help guide quality improvement initiatives.
3. Stimulate improvements in cancer detection, treatment and outcomes for patients, including survival rates.

Quality Improvement Plans

Each audit in NATCAN carried out a Scoping Exercise to define the scope and care pathway of their cancer site and identified five key quality improvement goals. The Quality Improvement Plans aim to define ten performance indicators, and how they map to the quality improvement goals, national guidelines, and standards. These performance indicators will be used by the audits to monitor progress towards improvement goals and to stimulate improvements in cancer care.

The Quality Improvement Plans describe the approach taken to develop quality improvement goals and performance indicators. In addition, the plans aim to set out the improvement methods and activities that will support implementation, including strategies for reporting and disseminating results, in addition to describing the approaches to evaluation.

The Quality Improvement Plans were developed in consultation with key stakeholders, including people with lived experience of cancer, and will be reviewed on an annual basis.

This document outlines five Quality Improvement Goals and associated Performance Indicators. The performance indicators are published in annual State of the Nation reports (these may be fewer than ten) and, where appropriate, in quarterly reports. The publication of indicators is aligned with data availability and the completion of robust, methodological development work including appropriate risk-adjustment models.

NBOCA Quality improvement goals & performance indicators

The Quality Improvement Plan can be found here.

Quality Improvement goal	Performance indicators and local target^	National Guidance/Standards
Improving the diagnostic pathway	**More than 95% of patients seen by Clinical Nurse Specialist (CNS)**	ACPGBI Guidelines (2017) "Patients with colorectal cancer should meet and have access to a CNS as 'Key Worker' for advice and support from the time of their initial diagnosis."
	More than 90% of patients to have mismatch repair (MMR) or microsatellite instability (MSI) tested at or around diagnosis*#	NICE Clinical Guidelines [DG27] (2017) "Offer testing to all people with colorectal cancer, when first diagnosed, using immunohistochemistry for MMR proteins or MSI testing to identify tumours with deficient DNA mismatch repair, and to guide further sequential testing for Lynch syndrome"
	More than 70% data completeness of seven items for risk adjustment (age, sex, ASA grade, pathological TNM stage (tumour, node, metastasis staging) and site of cancer) in patients undergoing major surgery†	
Improving perioperative care	**Annual rectal cancer resection volume greater than 20 cases per centre[R]**	NICE Clinical guideline [NG151] (2020) "Providers performing major resection for rectal cancer should perform at least 10 of these operations each year." NBOCA results show that most providers in England and Wales perform at least 20 cases of rectal cancer surgery per year. Therefore, a target of 10 cases per year would not have a large impact on current practice.
	Less than 6% risk-adjusted 90-day mortality after bowel cancer resection	ACPGBI Guidelines (2017) "Colorectal units should expect to achieve an operative mortality of less than 20% for emergency surgery and less than 5% for elective surgery for colorectal cancer."
	Less than 10% risk-adjusted 30-day unplanned return to theatre after bowel cancer resection	ACPGBI Guidelines (2017) "Colorectal units should audit their leak rate for colorectal cancer surgery."
	Less than 15% risk-adjusted 30-day unplanned readmission after bowel cancer resection	NHS England utilises unplanned readmission as a marker of quality of care.
	Less than 35% risk-adjusted proportion of patients with unclosed diverting ileostomy 18-months after anterior resection	ACPGBI Guidelines (2017) "The permanent stoma rate following rectal cancer resection of colorectal units should be audited."
	More than 50% of bowel cancer resections via a minimally invasive approach†	
Improving oncological care	**More than 50% of patients with Stage 3 colon cancer receiving adjuvant chemotherapy**	NICE Clinical guideline [NG151] (2020) "For people with stage 3 colon cancer (pT1-4, pN1-2, M0) offer adjuvant chemotherapy." ACPGBI Guidelines (2017)

		"Adjuvant chemotherapy should be considered in older patients with stage 3 colorectal cancer, with appropriate tailoring of treatment."
	Less than 33% of patients experiencing severe acute toxicity during/after adjuvant chemotherapy for stage 3 colon cancer**	National guidelines not available. NBOCA team developed coding framework to identify severe acute toxicity from systemic anti-cancer therapy using hospital administrative data.
	10% to 60% of rectal cancer patients undergoing major resection receiving neoadjuvant treatment	NICE Clinical guideline [NG151] (2020) "Offer preoperative radiotherapy or chemoradiotherapy to people with rectal cancer that is cT1-T2, cN1-N2, M0, or cT3-T4, any cN, M0."
	Greater than 70% risk-adjusted 2-year overall survival rate after bowel cancer resection	NHS England utilises long-term survival from cancer as a marker of quality of care.
	Recruitment to at least one National Institute for Health and Care (NIHR) portfolio trial in rectal organ preservation[R#]	
Improving management of stage four disease	More than 95% of patients with synchronous liver metastases discussed at specialist liver MDT[#]	
	More than 80% of patients with stage 4 disease at diagnosis who have genetic tumour profiling (KRAS, NRAS, BRAF)[#*]	NICE Clinical guideline [NG151] (2020) Test for RAS and BRAF V600E mutations in all people with metastatic colorectal cancer suitable for systemic anti-cancer treatment.
Improving end of life care	Risk-adjusted 30-day mortality after palliative systemic treatment in patients with stage 4 disease	
	More than 95% of patients referred to palliative care or enhanced supportive care clinic within last year life[#]	

[^]Details of the five Quality Improvement Goals and the associated ten Performance Indicators are outlined in the table above. The Audit publishes the performance indicators in its annual State of the Nation report and, where appropriate, in quarterly reports. The publication of indicators is aligned with data availability and the completion of robust, methodological development work including appropriate risk-adjustment models.

*Only applicable for patients with histological confirmation of bowel cancer

[#] To be introduced once methodological development work is complete

† Contextualising measure

[R] Only applicable to centres undertaking rectal cancer surgery

** Severe acute toxicity defined as toxicity requiring an overnight stay, from administration of the first cycle of chemotherapy up until 8 weeks after administration of the last cycle of chemotherapy

NKCA Quality improvement goals & performance indicators

The Quality Improvement plan can be found here.

Quality improvement goal	Performance indicators*	National Guidance/standards
To increase regional equity in timely access to evidence-based kidney cancer services	Percentage of people with kidney cancer with the data completeness measure recorded for MDT meeting Percentage of people with kidney cancer who are consented for a clinical trial (England only) Percentage of people who are treated within 31 days of a decision-to-treat/Percentage of people who are treated within 62 days of an urgent referral	Scottish QPI4 Accord QPI 5; GIRFT; Scottish QPI14 NHS England
To increase the use of renal tumour biopsy	Percentage of people with a small renal mass (≤4cm) who have a biopsy (England only) Percentage of people who have a biopsy to confirm histological diagnosis before non-surgical treatment	GIRFT Kidney Cancer UK Consensus Statement; Scottish QPI2
To expedite treatment for people with localised RCC at potentially high risk for recurrence (i.e. cT3+, 10cm+, cN1 tumours)	Percentage of people with a T3+ and/or 10cm+ and/or N1 and M0 renal cell carcinoma (RCC) who have a radical nephrectomy within 31 days of diagnosis	GIRFT
To increase use of surgery, if medically appropriate, for initially localised RCC at high risk of progression, while reducing the use of unnecessary radical surgery for low-risk RCC	Percentage of people with T1b-3NxM0 RCC (T2-3NxM0 RCC for Wales) who have surgery Percentage of people with T1aN0M0 RCC who undergo nephron sparing treatment	Accord QPI2 Scottish QPI7
To increase use of evidence based SACT treatment in eligible patients without increasing severe toxicity	Percentage of people presenting with M1 RCC who have initial SACT within 12 months of diagnosis Percentage of people who die within 30 days of starting SACT treatment	Accord QPI 4; Scottish QPI9 Scottish QPI15

* The NKCA will publish initial performance indicators in the first State of the Nation Report in September 2024. Additional indicators will be reported in quarterly reports and future State of the Nation reports. The publication of indicators is aligned with data availability and completion of robust, methodological development work including appropriate risk-adjustment models.

NLCA Quality improvement goals & performance indicators

The Quality Improvement plan can be found here.

Quality improvement goal	Performance indicators*	National Guidance/standards
Improve early diagnosis of lung cancer	Proportion of patients diagnosed with Stage I or II lung cancer	The NHS Long Term Plan seeks to diagnose at least 75% of (all) cancers at stage I/II by 2028
	Proportion of patients with pathological diagnosis (PS 0–1)	https://www.nice.org.uk/guidance/ng122/chapter/Diagnosis-and-staging. NICE 2019 Quality Standard QS (statement 6) https://www.nice.org.uk/guidance/ng122
	Proportion of patients diagnosed with lung cancer via emergency presentation	NICE 2019 Quality Standard QS (statement 5) https://www.nice.org.uk/guidance/ng122
Increase the proportion of patients who receive treatment with curative intent	Proportion of patients with NSCLC who had curative treatment, stratified for people with Stage I-II (PS 0–2) and Stage IIIA (PS 0–2)	NICE 2019 Quality Standard QS (statement 5) https://www.nice.org.uk/guidance/ng122
	Proportion of patients with NSCLC who had surgery	NICE 2019 Quality Standard QS (statement 1) https://www.nice.org.uk/guidance/ng122
Increase the proportion of people with lung cancer receiving Systemic Anti-Cancer Therapy (SACT) and reduce unwarranted variation in access to SACT	Proportion of patients with NSCLC (IIIB–IV, PS 0–1) who had systemic anti-cancer therapy	NICE has algorithms for the treatment of squamous and non-squamous stage 3B and 4 NSCLC.
	Proportion of patients with SCLC receiving chemotherapy within 2 weeks of diagnosis	https://www.nice.org.uk/guidance/ng122. Recommends that people with limited-stage SCLC should be offered cisplatin-based combination chemotherapy and that people with extensive-stage SCLC should be offered a platinum-based combination chemotherapy.
Improve the quality of the patient pathway	Median time from diagnosis to treatment (days)	National Optimal Lung Cancer Pathway (NOLCP) https://rmpartners.nhs.uk/wp-content/uploads/2024/09/national-optimal-lung-cancer-pathway_v4_01jan2024.pdf
	Proportion of patients seen by lung CNS	NICE 2019 Quality Standard QS (statement 3) https://www.nice.org.uk/guidance/ng122
Improve and reduce variation in lung cancer outcomes	One year survival	

NAoMe Quality improvement goals & performance indicators

The Quality Improvement plan can be found here.

Quality improvement goal	Performance indicator/s*	National Guidance/Standards
Improve the movement of patients through the care pathway.	Percentage of patients with newly diagnosed metastatic breast cancer (MBC) discussed in a multi-disciplinary team (MDT).	NICE Quality Standard 12 - Quality Statement 5, EUSOMA/ABC , WHO Global Breast Cancer Initiative Implementation Framework - Breast cancer outcomes are improved when care is directed by a multi-disciplinary team. MDT discussion ensures optimal treatment is selected for each patient based on guidelines and patient related factors.
	Percentage of patients with recurrent MBC who had a metastatic lesion biopsied to inform care.	NICE Quality Standard 12 - Quality Statement 4, NICE CG81 recommendation 1.1, EUSOMA/ABC - Confirmation of a diagnosis of metastatic breast cancer may be required. Tumour biology is also desirable to understand all treatments and outcomes. Tumour biology in recurrent breast cancer may differ to that of the primary tumour, or the primary tumour biology may be unknown. If feasible it should be reassessed in recurrent disease where receptor status may have therapeutic indications.
Reduce unwarranted variation in access and timeliness to systemic anti-cancer treatment.	Percentage of patients with ER positive MBC who received CDK 4/6 inhibitors as first line treatment.	EUSOMA/ABC- Endocrine therapy should be first line for ER positive/HER2-negative disease. The addition of a CDK4/6 inhibitor to endocrine therapy has been shown to substantially improve progression-free and overall survival in the first- and second-line treatment of MBC compared to endocrine therapy alone.
	Percentage of patients with HER2 positive MBC who received anti-HER2 therapy as first line treatment.	EUSOMA/ABC- Anti-HER2 therapy should be offered as a first line to all patients with HER2-positive MBC.
	Percentage of patients who received chemotherapy.	EUSOMA/ABC- Chemotherapy can be utilised for many indications in MBC dependant on tumour biology. Knowledge of patterns of chemotherapy use will be a useful comparator for other systemic treatment modalities.
Reduce unwarranted variation in access and timeliness to palliative treatments.	Percentage of patients with bone metastases who received a bisphosphonate or denosumab.	NICE CG81 recommendation 1.5, EUSOMA/ABC- Management of bone metastases should involve a bone-modifying agent. Bone-modifying agents reduce the risk of developing skeletal-related events, delay the median time to a skeletal-related event and the onset of pain attributable to bone disease, and are cost-effective.
	Percentage of MBC patients who received radiotherapy.	NICE CG81 recommendation 1.5, EUSOMA/ABC- Radiotherapy can be utilised in MBC following surgical resection of a breast tumour or to target sites of distant metastases including within brain and bone. Effective control of metastatic disease via radiotherapy can improve quality of life.
Improve access to nursing support.	Percentage of patients with clinical nurse specialist (CNS) contact recorded as "Yes".	NICE Quality Standard 12 - Quality Statement 6, NICE CG81 recommendation 1.4, EUSOMA/ABC, WHO Global Breast Cancer Initiative Implementation Framework- Assigning key workers to people with locally advanced or metastatic breast cancer leads to better health outcomes. A key worker promotes continuity of care, offering information and support for the person with breast cancer throughout their care. They can improve the patient experience and ensure patient views are taken into account.
Improve and reduce variation in metastatic breast cancer outcomes.	Percentage of patients with death recorded within 30 days of a chemotherapy cycle.	National Confidential Enquiry into Patient and Outcome Death (NCEPOD) and National Patient Safety Agency reports have highlighted the need for improvements in the quality and safety of systemic anti-cancer therapy. Information on treatment-related death following chemotherapy can be used to inform iatrogenic risk and identify potentially futile treatment. (This is a recognised outcome measure for NHS England).

	Percentage of patients who survived at least 1, 3 or 5 years after diagnosis.	Survival is a key primary outcome in breast cancer research and can be used as an overall marker for treatment success.

* The NAoMe will publish the performance indicators (these may be fewer than ten) in the first State of the Nation Report in September 2024. Additional indicators (up to a maximum of ten) will be reported in quarterly reports and future State of the Nation reports. The publication of indicators is aligned with data availability and completion of robust, methodological development work including appropriate risk-adjustment models.

NNHLA Quality improvement goals & performance indicators

The Quality Improvement plan can be found here.

Quality improvement goal	Performance indicators*	National Guidance/standards
Improving timely diagnosis and treatment	Proportion of people diagnosed with NHL discussed at a lymphoma/haematology MDT within 4 weeks of diagnosis.	BSH guidelines for DLBCL and Follicular Lymphoma and NICE guideline for improving the outcomes of haematological cancers (NG47): recommendation 1.3.4
	Proportion of people with high-grade lymphoma (Burkitt Lymphoma (BL), DLBCL or high grade T-cell lymphoma) who start chemotherapy within 62 days of referral	https://www.england.nhs.uk/long-read/changes-to-cancer-waiting-times-standards-from-1-october-2023/
	Proportion of people with high-grade lymphoma (BL, DLBCL or high grade T-cell) who start radiotherapy within 8 weeks of end of first line chemotherapy.	https://www.england.nhs.uk/long-read/changes-to-cancer-waiting-times-standards-from-1-october-2023/
Reducing variation in NHL management among NHS providers	Proportion of people diagnosed with NHL seen by a clinical nurse specialist	NICE guideline for improving the outcomes of haematological cancers (NG47): recommendation 1.3.15
	Proportion of people with NHL receiving radiotherapy, reported by sub-type.	Aligns with the NICE quality standard for haematological cancer (QS150). NICE guideline for the diagnosis and management of NHL (NG52): recommendations 1.3.1, 1.6.1, 1.7.1, and 1.8.1
Treatment appropriate to the subtype of NHL	Proportion of people with BL or DLBCL undergoing treatment who have MYC testing.	NICE guideline for the diagnosis and management of NHL (NG52): recommendations 1.1.5 and 1.1.6
	First-line chemotherapy treatment regimens received by people with high-grade lymphoma (BL, DLBCL or high grade T-cell lymphoma).	NICE guideline for the diagnosis and management of NHL (NG52): recommendations 1.6, 1.7 and 1.8
	Time to treatment for relapse amongst follicular lymphoma, other B-cell lymphomas (incl. chronic lymphocytic leukaemia (CLL), marginal zone lymphoma) and T-cell lymphomas which are not high grade.	N/A
Improving safety and reducing toxicity of NHL therapy	Proportion of people diagnosed with NHL with severe acute toxicity after SACT, reported by sub-type.	NICE guideline for the diagnosis and management of NHL (NG52): Recommendations 1.9.1, 1.11.1 and 1.11.2)
Improving overall survival	Proportion of people diagnosed with NHL who are consented for a clinical trial/research study, reported by sub-type	BSH guidelines for Follicular Lymphoma and DLBCL
	Overall 2-year survival of people with high grade lymphoma (BL, DLBCL or high grade T-cell).	N/A

* Not all 11 indicators can be reported initially. More indicators will be reported when data availability allows and after completion of robust, methodological development work including appropriate risk-adjustment models.

NOGCA Quality improvement goals & performance indicators

The Quality Improvement plan can be found here.

Quality Improvement Goal	Performance Indicators*	National Guidance/Standards
Reduce rates of emergency and late-stage diagnosis of OG cancer	Percentage of people with a diagnosis of OG cancer who are diagnosed after an emergency admission	NHS Long Term Plan: the proportion of cancers diagnosed at stages 1 & 2 will rise to three-quarters of cancer patients (2028). Wales Cancer Network, A Cancer Improvement Plan for NHS Wales: reducing emergency presentation and 1st presentation with advanced disease
	Percentage of people with a diagnosis of OG cancer who are diagnosed at stage 4 or with unknown stage	
Reduce the percentage of patients with OG cancer waiting more than 62 days from referral to first treatment	Median time (days) and IQR from urgent suspected cancer GP referral to first treatment for OG cancer	NHS England: ≥85% patients begin treatment within 62 days of referral. NHS Wales: ≥75% patients begin treatment within 62 days of suspected cancer.
Increase the percentage of people with OG cancer who have access to a clinical nurse specialist (CNS)	Percentage of people with a diagnosis of OG cancer who were seen by a CNS	NICE Quality Statement (QS176) 1. Adults with OG cancer should have access to an OG CNS
Improve outcomes of potentially curative treatment for people with OG cancer	Percentage of people undergoing curative surgical resection for OG cancer who had adequate lymph nodes examined after surgery	AUGIS Provision of Services for Upper GI Surgery (2016) outcome standards: 1. ≥15 lymph nodes removed and examined 2. Longitudinal resection margin positivity rate for oesophagectomies <5% 3. Circumferential resection margin positivity rate for oesophagectomies <30% 4. Margin positivity rate for gastric resection <5%
	Percentage of people undergoing curative surgical resection for OG cancer who had positive surgical resection margin rates (risk adjusted)	
	Adjusted 90-day mortality rate after curative treatment (any treatment modality)	N/A
	Adjusted 1-year and 2-year mortality rates after curative treatment (any treatment modality)	
Improve completion and reduce complications of palliative chemotherapy for people with OG cancer	Percentage of people beginning palliative chemotherapy for OG cancer who complete their chemotherapy regimen as planned	N/A
	Percentage of people undergoing palliative chemotherapy for OG cancer who have a hospital admission for severe acute toxicity during or within 8 weeks of any chemotherapy administration	

*Details of the five Quality Improvement Goals and the associated ten Performance Indicators are outlined in the table above. Where appropriate, the performance indicators will be presented for specific patient groups as well as for the whole patient population. The Audit will publish the performance indicators in its annual State of the Nation report and, where appropriate, in quarterly reports. The publication of indicators is aligned with data availability and the completion of robust, methodological development work including appropriate risk-adjustment models

NOCA Quality improvement goals & performance indicators

The Quality Improvement plan can be found here.

Quality improvement goal	Performance indicators*	National Guidance/standards
Increase the proportion of patients receiving timely diagnosis and treatment decisions.	Proportion of patients with ovarian cancer who had an emergency admission within 28 days prior to diagnosis.	Patients can be diagnosed late with advanced disease and a poor performance status due to delays in presenting for medical care, delays in primary care, delays between primary and secondary care or delays in secondary care. The OCAFP showed that women diagnosed via an emergency presentation were 4 times more likely to die within two months of diagnosis than those diagnosed via the two-week wait referral system.
Increase the proportion of patients receiving molecular diagnostics.	Proportion of patients with epithelial ovarian cancer on histology receiving germline panel testing. Proportion of patients with advanced stage (stage III/IV or unstaged) high grade epithelial ovarian cancer on histology receiving HRD testing (BRCA 1/2 and/or genomic instability).	Patients with BRCA mutations have a substantial progression-free survival benefit when receiving PARP-inhibitors. Testing is also recommended by the BGCS. Additionally, it offers the opportunity for cascade testing of family members, allowing for preventative treatment for both breast and ovarian cancer. NICE guidelines on managing familial and genetic risk were published in March 2024.
Increase the proportion of patients receiving surgery.	Proportion of patients with stage II-IV or unstaged ovarian cancer who receive any cytoreductive surgery.	Surgical treatment is the cornerstone of ovarian cancer management. NICE guidelines recommend maximal cytoreductive surgery for advanced ovarian cancer. That involves the removal of all identifiable disease. The OCAFP shows that on average only 51% of women with FIGO Stage II-IV and unstaged ovarian cancer will receive cytoreductive surgery in England in the nine months following diagnosis.
Increase the proportion of patients receiving chemotherapy.	Proportion of patients with epithelial, stage II or above or unstaged, ovarian cancer who receive platinum-based chemotherapy.	First line chemotherapy treatment in ovarian cancer should include a platinum based compound, either in combination or as a single agent. Carboplatin is the platinum agent most commonly used, alone or in combination with paclitaxel, when the potential benefits outweigh the potential toxicity that paclitaxel is associated with.

	Proportion of patients with stage II-IV or unstaged ovarian cancer who receive any type of treatment (surgery and/or chemotherapy).	The OCAFP showed that 20.3% of patients did not have any treatment recorded between 1 month prior and 9 months following diagnosis. Those patients were also more likely to die within 2 months following diagnosis (56.9%). This could have been because patients presented with advanced disease, high burden of comorbidity or poor performance status, have limited treatment options.
Improve rates of survival and reduce variation in survival.	Proportion of patients with ovarian cancer who are alive 1 year after the diagnosis.	Significant variation in 1-year survival across Cancer Alliances was highlighted in the OCFAP. The 1-year survival was estimated to be 69% (which lags behind similar countries). That means that almost 1 in 3 women will die within 12 months following diagnosis and 14% within 2 months.

* The NOCA will publish initial performance indicators (this may be less than seven) in the first State of the Nation Report in September 2024. Additional indicators (maybe up to a maximum of ten) will be reported in quarterly reports and future State of the nation reports. The publication of indicators is aligned with data availability and completion of robust, methodological development work including appropriate risk-adjustment models.

NPCA Quality improvement goals & performance indicators

The Quality Improvement plan can be found here.

Quality improvement goal	Performance indicator	National guidance/standards
To improve timely diagnosis and treatment of high-risk prostate cancer	Percentage of men diagnosed with M1 disease	NICE Guideline [NG12], 2023: Suspected cancer: recognition and referral
To reduce potential over-treatment	Percentage of men with low-risk localised cancer undergoing radical prostate cancer treatment	NICE Quality Standard [QS91], 2015 QS2: men with low-risk prostate cancer for whom radical treatment is suitable are also offered the option of active surveillance. NICE Guideline [NG131], 2019 1.3.8 Offer a choice between active surveillance, radical prostatectomy or radical radiotherapy to people with low-risk localised prostate cancer for whom radical treatment is suitable.
To reduce potential under-treatment	Percentage of men with high-risk, locally advanced disease undergoing radical prostate cancer treatment Percentage of men with metastatic disease who receive additional therapies (androgen receptor targeted agents [ARTA], Docetaxel)^	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 radical radiotherapy in combination with androgen deprivation therapy (ADT) to people with high-risk localised prostate cancer when it is likely the person's cancer can be controlled in the long term.* *recommendations should be considered in the context of each man's fitness to receive treatment NICE Guideline [NG131], 2019 1.5.6: Offer docetaxel chemotherapy to people with newly diagnosed metastatic prostate cancer who do not have significant comorbidities
To reduce short-term complications after radical prostate cancer surgery	Percentage of men who had an emergency readmission within 90 days of radical prostate cancer surgery	NICE Guideline [NG131], 2019 1.3.3: Warn people undergoing radical treatment for prostate cancer of the likely effects of the treatment on their urinary function. NICE Guideline [NG131], 2019 1.3.5: People with prostate cancer who are candidates for radical treatment should have the opportunity to discuss the range of treatment modalities and their serious side effects in relation to their treatment options with a specialist surgical oncologist and a specialist clinical oncologist.
To reduce medium-term complications after radical prostate cancer surgery and radiotherapy	Percentage of men experiencing at least one GU complication requiring a procedural/surgical intervention within 2 years of radical prostate cancer surgery	Royal College of Radiologists. *Radiotherapy target volume definition and peer review.* 2nd edition.

Quality improvement goal	Performance indicator	National guidance/standards
	Percentage of men receiving a procedure of the large bowel and a diagnosis indicating radiation toxicity (GI complication) up to 2 years following radical prostate radiotherapy	NICE Guideline [NG131], 2019 1.3.3: Warn people undergoing radical treatment for prostate cancer of the likely effects of the treatment on their urinary function. NICE Guideline [NG131], 2019 1.3.5: People with prostate cancer who are candidates for radical treatment should have the opportunity to discuss the range of treatment modalities and their serious side effects in relation to their treatment options with a specialist surgical oncologist and a specialist clinical oncologist. NICE Guideline [NG131], 2014 1.3.44: Carry out full investigations, including flexible sigmoidoscopy, in people who have symptoms of radiation-induced enteropathy to exclude inflammatory bowel disease or malignancy of the large bowel and to ascertain the nature of the radiation injury.

^ This is a new indicator subject to further methodological development prior to being reported in our State of the Nation reports.

NPaCA Quality improvement goals & performance indicators

The Quality Improvement plan can be found here.

Quality improvement goal	Performance indicators*	National Guidance/standards
Increase the percentage of people who have diagnostic procedures and a process of diagnosis consistent with national recommendations for pancreatic cancer	Percentage of people with a diagnosis of pancreatic cancer who had a FDG-PET/CT prior to surgery Percentage of people with a diagnosis of pancreatic cancer who had a record of being discussed at an MDT meeting Percentage of people with a diagnosis of pancreatic cancer undergoing surgery (no neo-adjuvant chemotherapy) who had a biliary stent prior to Whipple procedure	NICE Quality Statements (QS 177 - Pancreatic cancer): 1. "Adults with suspected pancreatic cancer have their diagnosis and care agreed by a specialist pancreatic cancer multidisciplinary team (MDT)" (QS1) 2. "Adults with localised pancreatic cancer on CT have staging using FDG-PET/CT before they have surgery, radiotherapy, or systemic therapy" (QS2)
Optimise diagnostic and treatment pathways to reduce the time between referral and start of disease-targeted treatment	Time from referral to first treatment (days) *Note: within this we will look at component parts of the pathway: median time (IQR) from referral to diagnosis and from diagnosis to first treatment, and percentages achieving cancer waiting time targets, including percentage of people treated within 62 days of urgent suspected cancer GP referral (England)*	NHS England has three core measures for cancer waiting times: 28-day Faster Diagnosis Standard, 62-day referral to treatment standard and 31-day decision to treat to treatment standard. Furthermore, there is an NHS England Best Practice Timed Diagnostic Pathway for HPB cancer that sets out a target 21 days from referral to diagnosis. Wales has a Suspected Cancer Pathway of 62 days from point of suspicion to start of treatment.
Increase the percentage of people with pancreatic cancer (who are fit enough for treatment) who receive disease-targeted treatment (surgery, chemotherapy, radiotherapy - both curative and palliative)	Percentage of people with non-metastatic (stage 1-3) pancreatic cancer who received disease-targeted treatment** Percentage of people with metastatic (stage 4) pancreatic cancer who received disease-targeted treatment** Percentage of people with pancreatic cancer receiving CT/RT alongside surgery (Percentage who received CT/RT before any pancreatic surgery and percentage who received CT/RT after Whipple procedure)	Pancreatic Cancer UK reports that only 3 out of 10 people with pancreatic cancer receive active treatment. Furthermore, expert clinical input believes current clinical practice has moved beyond the NICE guidelines for pancreatic cancer published in 2018, with greater use of CT/RT in practice than is recommended in the guidelines.
Increase the percentage of people with pancreatic cancer who receive supportive care (care that helps the person to live as well as possible with	Percentage of people with a diagnosis of pancreatic cancer who were seen by a CNS Percentage of people with a diagnosis of pancreatic cancer who were prescribed pancreatic enzyme replacement therapy (PERT)	NICE Quality Statement (QS 177 - Pancreatic cancer): 1. "Adults with unresectable pancreatic cancer are prescribed enteric-coated pancreatin" (QS4) 2. "Effective interventions to address psychological needs" (QS5), but no guidance is currently available. The PCUK Optimal Care

their cancer and its treatment) in line with national recommendations		Pathway Policy Report recommends an HPB CNS should be responsible for coordinating access to psycho-social support.
Improve outcomes for people diagnosed with pancreatic cancer	30-, 90-day, 1- and 2-year survival rates after diagnosis, by intent and treatment modality	N/A

* The NPaCA will publish initial performance indicators in the first State of the Nation Report in September 2024. Additional indicators will be reported in quarterly reports and future State of the Nation reports. The publication of indicators is aligned with data availability and completion of robust, methodological development work including appropriate risk-adjustment models. **"Disease-targeted treatment" includes surgery, chemotherapy and radiotherapy, and includes treatments with curative and palliative intent; this may include both treatments targeting the disease and symptom management.

NAoPri Quality improvement goals & performance indicators

The Quality Improvement plan can be found here.

Quality improvement goal	Performance indicator/s	National Guidance/standards
Improve the movement of patients through the care pathway	Percentage of patients who underwent triple diagnostic assessment (TDA) in a single hospital visit.	*NICE Quality Standard 12 - Quality Statement 1:* Timely diagnosis. People with suspected breast cancer referred to specialist services are offered the triple diagnostic assessment in a single hospital visit.
	Percentage of patients who had contact with a Clinical Nurse Specialist (CNS) recorded after diagnosis.	*NICE NG101 recommendation 1.2 Providing information and psychological support.* All patients with breast cancer should have a named Clinical Nurse Specialist to support them through diagnosis, treatment, and follow-up.
Reduce unwarranted variation for patients undergoing surgery.	Percentage of patients who had i) breast-conserving surgery or ii) mastectomy within 12 months of diagnosis.	*NICE NG101, ESMO and SIOG guidelines.* Surgery is the choice of primary treatment for non-invasive and early invasive breast cancer in most patients.
Reduce unwarranted variation for patients having non-surgical oncological treatments.	Percentage of patients who received neo-adjuvant chemotherapy.	*NICE NG101 recommendation 1.11 Primary systemic therapy.* This guidance suggests offering neo-adjuvant chemotherapy to patients with ER-negative, ER positive and HER2-positive breast cancer as an option to reduce tumour size if it is otherwise indicated.
	Percentage of patients who received adjuvant radiotherapy following i) breast-conserving surgery and ii) mastectomy (stratified by recurrence risk).	*NICE NG101 recommendation 1.10 Radiotherapy after breast-conserving surgery* - All women with invasive breast cancer treated with breast-conserving surgery should be offered adjuvant radiotherapy unless they have a very low risk of recurrence. Consider adjuvant radiotherapy for women with non-invasive breast cancer treated with breast-conserving surgery. *NICE NG101 recommendation 1.10 Radiotherapy after mastectomy* – Patients with high-risk of recurrence should be offered adjuvant radiotherapy, but not those with low-risk of recurrence.
	Percentage of patients who received adjuvant chemotherapy.	*NICE NG101 recommendations 1.6 Adjuvant therapy planning and 1.8 Adjuvant chemotherapy for invasive breast cancer* - Adjuvant chemotherapy should be considered based on assessment of predictive and prognostic factors, and possible risks and benefits of the treatment.
Improve access to breast reconstruction after mastectomy.	Percentage of patients recorded as having had an immediate reconstruction following a mastectomy.	*NICE NG101 recommendation 1.5 Breast Reconstruction* - All patients undergoing mastectomy for breast cancer should be offered breast reconstruction.
Improve and reduce unwarranted variation in primary breast cancer outcomes.	Percentage of patients who had a re-excision surgery within 12 months of their initial surgical procedure.	*NICE NG101 recommendation 1.3 Surgery to the breast* - Further surgery should be considered if margins are not clear (<1mm).
	Percentage of patients who had an overnight hospital admission for treatment-related toxicity within 30 days of a systemic anti-cancer therapy (SACT) cycle.	*National Confidential Enquiry into Patient and Outcome Death (NCEPOD) and National Patient Safety Agency reports* have highlighted the need for improvements in the quality and safety of systemic anti-cancer therapy.

	Percentage of patients who survived at least 1, 3 or 5 years from the date of breast cancer diagnosis.	Survival is a key primary outcome in breast cancer research and can be used as an overall marker for treatment success.

* The NAoPri will publish the performance indicators (these may be fewer than ten) in the first State of the Nation Report in September 2024. Additional indicators (up to a maximum of ten) will be reported in quarterly reports and future State of the Nation reports. The publication of indicators is aligned with data availability and completion of robust, methodological development work including appropriate risk-adjustment models.