NATCAN
National Cancer Audit
Collaborating Centre

National Cancer Audit Collaborating Centre
Recommendations – October 2025

NATCAN

National Cancer Audit
Collaborating Centre

Citation for this document:

Citation for this document:
Recommendations from State of the Nation Reports published October 2025 London:

National Cancer Audit Collaborating Centre, Royal College of Surgeons of England, 2025.

Prepared by Verity Walker, Centre Project Manager.

Summary of the Recommendations from the NATCAN audits published in September and October 2025. More information and the full Reports can be found here:

NAoMe:
https://www.natcan.org.uk/reports/naome-state-of-the-nation-report-2025/

NAoPri:
https://www.natcan.org.uk/reports/naopri-state-of-the-nation-report-2025/

NBOCA:
https://www.natcan.org.uk/reports/nboca-state-of-the-nation-report-2025/

NKCA:
https://www.natcan.org.uk/reports/nkca-state-of-the-nation-report-2025/

NNHLA:
https://www.natcan.org.uk/reports/nnhla-state-of-the-nation-report-2025/

NOCA:
https://www.natcan.org.uk/reports/noca-state-of-the-nation-report-2025/

NOGCA:
https://www.natcan.org.uk/reports/nogca-state-of-the-nation-report-september-2025/

NPaCA:
https://www.natcan.org.uk/reports/npaca-state-of-the-nation-report-2025/

NPCA:
https://www.natcan.org.uk/reports/npca-state-of-the-nation-report-2025/

The Royal College of Surgeons of England (RCS) 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.

Contents

1. NAoMe Recommendations 4
2. NAoPri Recommendations 6
3. NBOCA Recommendations 8
4. NKCA Recommendations 10
5. NNHLA Recommendations 12
6. NOCA Recommendations 15
7. NOGCA Recommendations 18
8. NPaCA Recommendations 20
9. NPCA Recommendations 22

1. NAoMe Recommendations

The SotN Report can be found here.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance / Standards / Resources
Clinical Recommendations				
1. Ensure the care for all people newly diagnosed with Metastatic Breast Cancer (MBC) (either *de novo* or recurrent) is discussed within a breast multidisciplinary team (MDT) meeting.	England: Breast care teams and clinical management in NHS trusts Wales: Breast care teams and clinical management in NHS health boards	58% (England) and 71% (Wales) of people with *de novo* MBC had a record that their care was discussed within an MDT. In England, the highest performing trusts discussed at least a four-fold higher proportion of their patients than the lowest performing trusts.	Goal #1 – Improve the movement of patients through the care pathway.	*NICE Quality Standard 12 - Quality Statement 5*. Breast cancer outcomes are improved when care is directed by an MDT.
2. Examine rates of treatment with CDK4/6 inhibitors within 12 months of diagnosis in people with ER+ HER2- MBC. Consider variation in care - especially in low-use centres – to try to identify underlying causes and opportunities for improved quality of care.	England: Cancer Alliances working with breast care teams and clinical management (incl. oncology teams) in NHS trusts Wales: Breast care teams and clinical management (incl. oncology teams) in NHS health boards	In England, in the breast units where CDK4/6 inhibitors were used most, over 50% of people received them, whereas in the units where they were used least, fewer than 10% did.	Goal #5 – Improve and reduce unwarranted variation in metastatic breast cancer outcomes.	*NICE Technology Appraisal Guidance (TA563), TA836, TA687* recommend use of CDK4/6 inhibitors for metastatic breast cancer.
3. Assess 30-day mortality rates following chemotherapy and, in trusts with rates outside the 95% control limits of the national average, conduct outcome reviews and evaluations of local prescribing practices to ensure appropriate consideration of chemotherapy risks and benefits.	England: Cancer Alliances working with breast care teams and clinical management (incl. oncology teams) in NHS trusts Wales: Breast care teams and clinical management (incl. oncology teams) in NHS health boards	In England, 30-day mortality rates for people with *de novo* MBC varied across units from 0-31% (national average: 10%). For people with recurrent MBC 30-day mortality rates ranged from 0-44% (England average: 19%)	Goal #5 – Improve and reduce unwarranted variation in metastatic breast cancer outcomes.	NICE Guideline NG101 Early and locally advanced breast cancer: diagnosis and management recommends assessment of the prognostic and predictive factors, and the possible risks and benefits of chemotherapy treatment.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance / Standards / Resources
Data Quality Recommendations				
4. Ensure accurate recording of date and type of breast cancer recurrence by: (a) Education, sharing the NAoMe Guide to collecting COSD data for breast cancer recurrence with NHS organisations in England; (b) Review and optimise the process of capturing and uploading to COSD (England) and the Cancer Data Form (CDF, Wales).	England: Breast care teams and clinical management in NHS trusts Wales: Breast care teams and clinical management in NHS health boards	The NAoMe recurrent MBC cohort is smaller than expected. Improvements in data quality for recurrence are vital for progress in the NAoMe.	Goals #1-5, as will facilitate identification of the correct cohort of people for the NAoMe.	The COSD is the main source for the rapid cancer registration dataset and an important component of the National Cancer Registration Dataset (NCRD). Improved completeness of this dataset is required to ensure accurate reporting. The Welsh Health Circular mandates high quality data submissions.
5. Confirm breast MDTs have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness should include full tumour characterisation (i.e., stage, grade, histology), ER and HER2, performance status, the NABCOP fitness assessment data items (for people aged 70+ years) and contact with clinical nurse specialists (CNS).	England: Cancer Alliances working with breast care teams and clinical management (incl. oncology teams) in NHS trusts Wales: Breast care teams and clinical management (incl. oncology teams) in NHS health boards	In England, performance status and CNS contact were less than 70% complete. In Wales, performance status was less than 35% complete. Improvements in the quality of these key data items should be a priority.	Goals #1-5.	The COSD is the main source for the rapid cancer registration dataset and an important component of the (NCRD). Improved completeness of this dataset is required to ensure accurate quarterly reporting. The Welsh Health Circular mandates high quality data submissions.
Note that due to differences in data and methodology between reports, direct comparisons between the 2024 and 2025 reports should not be used to infer about trends over time.				

2. NAoPri Recommendations

The SotN Report can be found here.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. Ensure that people with breast cancer have access to Triple Diagnostic Assessment (TDA) in a single visit and, if required, identify methods to increase the provision of this service.	England: Cancer Alliances working with breast care teams and clinical management in NHS trusts. Wales: Breast care teams and clinical management in NHS health boards.	We estimated that 68% of non-screen-detected cases (England, algorithm-based) and 51% (Wales) of people had TDA in a single visit.	Goal #1 – Improve the movement of patients through the care pathway.	*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.
2. Review the use of neo-adjuvant chemotherapy for people with triple negative and HER2+ early invasive breast cancer. Reduce the levels of unexplained regional variation, with particular emphasis in increasing use among those showing low rates and ensuring neo-adjuvant chemotherapy is offered to eligible patients in line with guideline recommendations	England: Cancer Alliances working with breast care teams and clinical management in NHS trusts. Wales: Breast care teams and clinical management in NHS health boards.	Among all 121 NHS breast units in England and Wales, rates of neo-adjuvant chemotherapy among triple negative or HER2+ patients with stage 2-3A disease were <40% for 23 units and >60% for 23 units.	Goal #3 – Reduce unwarranted variation for patients having non-surgical oncological treatments.	*NICE NG101 summary of recommendations:* Offer neo-adjuvant chemotherapy to people with invasive breast cancer as an option to reduce tumour size. *ABS Neo-adjuvant Chemotherapy: Multidisciplinary Guidance*
3. Review rates of immediate breast reconstruction (IBR) and, where rates are lower than expected, act to improve access by ensuring it is offered to all women as part of a balanced shared decision-making process, unless precluded by comorbidity or adjuvant therapies.	England: Cancer Alliances working with breast care teams and clinical management in NHS trusts. Wales: Breast care teams and clinical management in NHS health boards	In England and Wales, 23% of patients undergoing mastectomy had IBR. By Cancer Alliance, the proportion having IBR ranged from <20% to >40%.	Goal #4 – Improve access to breast reconstruction after mastectomy.	*NICE NG101 recommendation 1.5 Breast Reconstruction* Offer immediate breast reconstruction to women who have been advised to have a mastectomy, including those who need radiotherapy, unless they have comorbidities that rule out reconstructive surgery. Breast Surgery: GIRFT Programme National Specialty Report

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
4. Review rates of re-operation following breast conserving surgery (BCS) and, where rates are higher than expected, units should review local protocols with the view to complying with best practice.	England: Cancer Alliances working with breast care teams and clinical management in NHS trusts. Wales: Breast care teams and clinical management in NHS health boards	16% (England) and 20% (Wales) of people had a re-operation within 12 months of BCS. One in five trusts had re-operation rates >20%.	Goal #5 - Improve and reduce unwarranted variation in primary breast cancer outcomes.	This aligns with *NICE NG101 recommendation 1.4.3* Offer further surgery (re-excision or mastectomy, as appropriate) after breast-conserving surgery where invasive cancer or DCIS is present at the radial margins. ABS: The Management of radial surgical margins in relation to breast conserving surgery for invasive breast cancer ABS: Recommendations for the management of radial surgical margins in patients undergoing breast conserving surgery for DCIS
Data Quality Recommendations				
5. Confirm breast multidisciplinary teams (MDT) have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness should include full tumour characterisation, ER and HER2 status (for invasive breast cancer), performance status, the NABCOP fitness assessment (aged 70+ years), Triple Diagnostic Assessment (TDA) and contact with Clinical Nurse Specialists (CNS).	England: Cancer Alliances working with breast care teams and clinical management in NHS trusts. Wales: Breast care teams and clinical management in NHS health boards	Data completeness in England and Wales combined was <80% for performance status and CNS contact. In England, we estimated TDA using an algorithm as data was not available to use for the current reporting period. In Wales, data completeness for TDA was 51%.	Goals #1 –5	The COSD is the main source for the Rapid Cancer Registration Dataset. Improved completeness of this dataset is required to ensure accurate quarterly reporting. The Welsh Health Circular mandates high quality data submissions.
Note that due to differences in data and methodology between reports, direct comparisons between the 2024 and 2025 reports should not be used to infer about trends over time.				

3. NBOCA Recommendations

The SotN Report can be found here.

Recommendation	Audience	Report Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. Increase the proportion of people who have their ileostomy closed within 18-months of anterior resection for rectal cancer. - Support NHS trusts/ multidisciplinary teams (MDTs) to identify system-level (e.g. access to theatre/ radiological investigations) and patient-level drivers of variation. - Support NHS trusts/MDTs to participate and engage with the local and national quality improvement initiatives to enable more timely reversal of ileostomy. For example, NBOCA & Royal College of Surgeons of England's CloseItQuick Collaborative.	**England:** Cancer Alliances working with NHS trusts **Wales:** health boards	Performance indicator and local target: Less than 35% of people with unclosed diverting ileostomy 18-months after anterior resection. Approximately 38% of people with unclosed diverting ileostomy 18-months after anterior resection. This has not improved since last year's report. See page 11.	2: Improving perioperative care	ACPGBI: Guidelines for the Management of Cancer of the Colon, Rectum and Anus (2017) – Surgical Management. National Bowel Cancer Audit Quality Improvement Plan "Figure 3: Example driver diagram for indicator "Ileostomy closure after rectal cancer resection"
2. In units with chemotherapy utilisation following resection of stage 3 colon cancer below 55%, conduct individual patient analysis to review the rationale for not offering treatment against evidence-based guidelines. - If the resulting findings identify under-utilisation, develop appropriate local action plans to increase rates of chemotherapy whilst maintaining low levels of severe toxicity. Action plans may include integration of geriatric expertise and or rehabilitation into shared chemotherapy decision making.	**England:** Cancer Alliances working with NHS trusts **Wales:** health boards	Performance indicator and local target: More than 55% of people with stage 3 colon cancer receiving adjuvant chemotherapy. In England and Wales, 14 NHS trusts were below the local target. Considerable between-unit variation in the use of adjuvant chemotherapy remains with 15 (12%) NHS trusts/MDTs below the 95% funnel limit. See page 12.	3: Improving oncological care	National Institute for Health and Care Excellence (NICE) Guidelines: Bowel Cancer (Updated 2021). Boyle JM, et al. Measuring variation in the quality of systemic anti-cancer therapy delivery across hospitals: A national population-based evaluation. Eur J Cancer. 2023.
3. Understand variation in the utilisation of neo-adjuvant radiotherapy for people with rectal cancer to optimise their outcomes. - Cancer alliances and health boards to develop standardised evidence-based neo-adjuvant treatment protocols based on high-quality radiological staging. An example guideline is provided as a basis for regional discussions. This will aid decision making and take into account locoregional approaches to neo-adjuvant therapy, incorporating organ preservation techniques and participation in clinical trials.	**England:** Cancer Alliances working with NHS trusts **Wales:** health boards	Performance indicator and local target: 10-60% of people with rectal cancer undergoing major resection receiving neo-adjuvant treatment. Overall, 33% of people received neo-adjuvant radiotherapy for rectal cancer with wide variation between NHS trusts/MDTs from 6% to 87%. See page 13.	3: Improving oncological care	National Institute for Health and Care Excellence (NICE) Guidelines: Bowel Cancer (Updated 2021). An example of an agreed guideline to neo-adjuvant treatment of rectal cancer may be found here: Neo-adjuvant-and-Non-operative-Management-of-Rectal-Cancer-Guidelines-v4.pdf

Recommendation	Audience	Report Findings	Quality Improvement Goal	National Guidance/Standards/Resources
4. Ensure robust sustainable pathways are in place to provide timely genomic assessment where clinically appropriate. To inform personalised treatment options and/or identify those with Lynch syndrome, optimise the proportions of people undergoing: • MMR or MSI testing in stage 1 to 4 cancer • RAS and BRAF assessment in stage 4 cancer	**England:** Cancer Alliances working with NHS trusts Genomic Laboratory Hubs	Contextual measure: More than 70% of people with stage 4 disease at diagnosis and aged under 75 who have genetic tumour profiling (KRAS, NRAS, BRAF). Testing for KRAS, NRAS and BRAF is mandatory to determine eligibility for targeted treatment with encorafenib, cetuximab, or panitumumab. Due to gaps in genomic data submissions, NHS trusts were only included if >70% of patients with histologically confirmed stage 4 bowel cancer who received targeted treatment had a record of KRAS, NRAS or BRAF testing. As a result, data could be reported for only 44 out of 119 NHS trusts. For all patients with histologically confirmed stage 4 bowel cancer in these 44 eligible NHS trust in 2021, 66% had a record of KRAS, NRAS or BRAF testing. Data for genomic testing is only available in England. See page 8.	4: Improving management of stage four disease	National Institute for Health and Care Excellence (NICE) Guidelines: Bowel Cancer (Updated 2021). National Institute for Health and Care Excellence Diagnostics Guidance DG27 (2017)
Data Quality Recommendation				
5. Continue to improve data completeness of key items in the English cancer registration and Wales Cancer Network datasets to allow risk-adjustment of performance indicators. • Provision of a clinical local data lead responsible for working with relevant local teams (e.g. Clinical Effectiveness/Audit) to ensure the quality of data submissions to national datasets. • Data items of focus: tumour, node and metastases (TNM) stage, American Society of Anaesthesiologists' (ASA) grade and performance status.	**England:** NHS England, Cancer Alliances working with NHS trusts **Wales:** health boards	Contextual measure and local target: More than 70% data completeness of seven items for risk adjustment in people undergoing major surgery. For people who underwent major surgery for bowel cancer in 2023, 52% of NHS trusts in England and all MDTs in Wales achieved the data completeness local target. See page 8.	All	Walker K, et al. Model for risk adjustment of postoperative mortality in people with bowel cancer. Br J Surg. 2015. NBOCA Key COSD data items

4. NKCA Recommendations

The SotN Report can be found here.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. Increase the number of people with a small kidney cancer who receive a renal biopsy to confirm the histological diagnosis, by improving availability of timely diagnostics and supporting shared decision making.*	England: Cancer Alliances working with trusts Wales: health boards	**England:** The percentage of people with a small kidney cancer who have a renal biopsy was 20%, with an NHS trust-level interquartile range of 7-31%**, Performance Indicator PI3. **Wales:** Unable to report this performance indicator due to poor differentiation between T1a and T1b stage categories. **Trend: 19% in 2020 to 21% in 2022, pre-pandemic level of 22% in 2019.**	Goal #2: To increase the use of renal tumour biopsy	The Getting It Right First Time (GIRFT) Academy developed a guide on the management of kidney cancer. They recommend offering renal mass biopsy, where technically feasible, if it will impact patient's choice or clinician's recommendation on treatment for patients with solid small renal masses.
2. Review pathways for higher risk renal cell carcinoma (RCC) to understand system-level delays and ensure providers prioritise these people over lower-risk cases, treating them within 31 days from decision to treat in England and 21 days in Wales.*	England: Cancer Alliances working with trusts Wales: health boards	**England:** Percentage of people with a T3+ and/or 10cm+ and/or N1 and M0 renal cell carcinoma (RCC) whose radical nephrectomy is within 31 days of decision to treat (England only) was 68% with an NHS trust-level interquartile range of 57-79%**, PI4. **Wales:** Unable to report this performance indicator due to incomplete recording of the decision-to-treat date. **Trend: 73% in 2020 to 63% in 2022, pre-pandemic level of 76% in 2019.**	Goal #3: To expedite treatment of people with potentially high risk for recurrence localised and locally advanced RCCs (i.e. cT3+, 10cm+, cN1 tumours)	GIRFT recommends fast-tracking the assessment of people with higher risk disease (>10cm, cT3+, cN1 tumours) and expediting their treatment. The benchmark defined for cancer waiting times from decision to treat to treatment is 31 days in England and 21 days in Wales. The above cancer waiting times aligns with the NHS Wales Cancer Improvement Plan for 2023-2026, to treat cancer effectively. NHS England's standard set at 96%.
3. Identify and address reasons why people with kidney cancer, stage T1b-3NX RCC are not considered for surgical treatment and increase the proportion of eligible people assessed and treated.	England: Cancer Alliances working with trusts Wales: health boards	**England:** The percentage of people with T1b-3NXM0 RCC who have surgery was 78%. This is with an NHS trust-level interquartile range of 70-83%**, PI5. **Wales:** The percentage of people with T2-3NXM0 RCC who have surgery was 82% with a health board interquartile range of 70 – 90%**, PI5. T1b is missing due to poor differentiation between T1a and T1b stage categories. **Trend in England: 76% in 2020 to 78% in 2022, pre-pandemic level of 81% in 2019.**	Goal #4: To increase use of surgery, if medically appropriate, for initially localised RCC at risk of progression	Kidney Cancer UK (KCUK) Accord Report 2022 measured the quality of kidney cancer services in England between 2017 to 2018 and emphasised the importance of prioritising curative surgery for T1b-3NXM0 RCC if medically appropriate (QPI2).

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
4. Ensure that people with kidney cancer, stage T1aN0M0 RCC are discussed in specialist multidisciplinary team meetings to support consistent and appropriate consideration for nephron sparing treatment.*	England: Cancer Alliances working with trusts Wales: health boards	**England:** The percentage of people with T1aN0M0 RCC who undergo nephron sparing treatment was 69% with an NHS trust-level interquartile range of 58-77%**, PI6. **Wales:** Unable to report this performance indicator due to poor differentiation between T1a and T1b stage categories. **Trend: 66% in 2020 to 70% in 2022, pre-pandemic level of 68% in 2019.**	Goal #4: To reduce the use of unnecessary extensive surgery for low-risk RCC	Better Cancer Ambition and Action (2016) recognised the need for national cancer QPIs to support a culture of continuous quality improvement. Scottish QPI7 aims to improve the percentage of people with T1a renal cancer receiving nephron sparing treatment to preserve renal function and reduce frequency of cardiovascular events.
5. Ensure people diagnosed with metastatic RCC are evaluated by a medical/clinical oncologist with expertise in renal cancer management to increase the proportion of people considered for receipt of systemic anti-cancer therapy (SACT) if appropriate.	England: Cancer Alliances working with trusts Wales: health boards	**England:** The percentage of people with metastatic RCC receiving initial SACT within 12 months of diagnosis was 49%. This is with an NHS trust-level interquartile range of 40-56%**, PI7. **Wales:** The percentage of people with metastatic RCC receiving initial SACT within 12 months of diagnosis was 54%. This is with a health board interquartile range of 58 – 68%**, PI7. **Trend in England: 48% in 2020 to 50% in 2022, pre-pandemic level of 48% in 2019.**	Goal #5: To increase use of evidence based SACT treatment in eligible people with kidney cancer without severe toxicity	KCUK Accord QPI4 and Scottish QPI9 aim to increase the number of people with metastatic RCC receiving SACT as clinical trials show SACT can improve quality of life and extend survival.

*Measured in England only due to the availability of relevant data for Wales.

**Interquartile Range, representing the range between the 25th and 75th percentiles.

5. NNHLA Recommendations

The SotN Report can be found here.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. **Reduce the current rate of emergency presentations of NHL by reviewing diagnostic pathways into and within secondary care to improve timely investigation, and examine variation in rates of emergency presentation by geographies and population groups to identify potential causes of this.**	England: NHS England, Primary Care, Cancer Alliances working with NHS trusts Wales: Primary care, health boards	**Proportion of people with NHL presenting with a new diagnosis of NHL via the emergency department or presenting to the emergency department within 28 days prior to diagnosis:** England 2022: Mean: 28.4% (Range*: 0.0-75.0%) Median (IQR**): 27.5% (22.7-33.0%)	Goal #1: Improving timely diagnosis and treatment.	NHS Cancer Programme: Faster Diagnosis Framework 2022 UK Blood Cancer Action Plan 2024 NICE guidance, "Haematological cancers: improving outcomes" (NG47) 2016 Cancer Genomic Improvement Programme 2023 Kane E, Howell D, Smith A, Crouch S, Burton C, Roman E, Patmore R. Emergency admission and survival from aggressive non-Hodgkin lymphoma: a report from the UK's population-based haematological malignancy research network. European journal of cancer. 2017 Smith MJ, Fernandez MA, Belot A, Quartagno M, Bonaventure A, Majano SB, Rachet B, Njagi EN. Investigating the inequalities in route to diagnosis amongst patients with diffuse large B-cell or follicular lymphoma in England. British journal of cancer. 2021 Howell D, Hart R, Smith A, Macleod U, Patmore R, Roman E. 'Unpacking'pathways to lymphoma and myeloma diagnosis: Do experiences align with the Model of Pathways to Treatment? Findings from a UK qualitative study with patients and relatives. BMJ open. 2020
2. **Local review at NHS trust/health board level is needed to identify diagnostic and treatment pathway delays and reduce inter-provider variation in people with high-grade NHL starting SACT within 62 days of referral. This may include examination of delays along the pathway, chemotherapy unit capacity and staffing, and mode of delivery of SACT, in order to understand system-level delays.**	England: Cancer Alliances working with NHS trusts Wales: health boards	**Proportion of people with high grade NHL commencing 1st line SACT within 62 days of referral.** England 2022: 55.0% (Range* 0-100.0%); Median (IQR)**: 54.0% (45.0-64.0%) Wales 2023***: 48.2% (Range* 8.0-91.0%) Median (IQR)**: 43.0% (35.0-56.0%) Note: results for this performance indicator have worsened compared to 2020 and 2021 in England.	Goal #1: Improving timely diagnosis and treatment.	NHS England (2023) Changes to cancer waiting times standards from 1 Oct 2023

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
3. **Identify patient and hospital factors contributing to delays in starting radiotherapy after last administered dose of SACT and explore strategies to reduce inter-provider variation across NHS trusts and health boards.** **This may include ensuring specialist representation at MDT meetings, in line with the national requirement for individual scheduled treatment planning MDT meetings to be quorate on 95% or more occasions, earlier identification of appropriate candidates for radiotherapy through an MDT setting with mandated clinical oncology attendance and earlier referral and review by clinical oncology teams to discuss radiotherapy suitability prior to completion of systemic treatment. It may also include review of radiotherapy unit capacity and staffing.**	England: Cancer Alliances working with NHS trusts Wales: health boards	**Proportion of people with NHL receiving radiotherapy within 8 weeks of last administered dose of SACT:** England 2022: 32.5% (Range*: 0.0-100.0%) Median (IQR**): 28.6% (11.1-50.0%) Wales 2023: Not available Note: results for this performance indicator have worsened compared to 2020 and 2021 in England.	Goal #1: Improving timely diagnosis and treatment.	No national guidance set. Recommendation agreed by the NNHLA Clinical Reference Group NHS England (2020) Multi-disciplinary team streamlining guidance
4. **Identify reasons why individuals with non-Hodgkin lymphoma are not enrolled in clinical trials to ensure equitable access to research opportunities, while also strengthening clinical record-keeping practices to support identification and reduction of participation disparities.**	England: Cancer Alliances working with NHS trusts Wales: health boards	**Proportion of people diagnosed with NHL who are recorded as having received an episode of care that was delivered as part of a clinical trial.** England 2022: 2.0% (Range**** 0-14.55%) Median (IQR**): 0.0% (0.0-0.0%) Wales: Not available	Goal #1: Improving timely diagnosis and treatment.	No national guidance set. Recommendation agreed by the NNHLA Clinical Reference Group

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Data Quality Recommendation				
5. **Ensure there is a designated coordinator or clinician to improve the completeness and quality of data items recorded in the national cancer datasets at each NHS trust/health board (with particular focus on staging in England and Wales and treatment delivery in Wales).** **This will allow better risk adjustment of outcome variables including survival outcomes for people with non-Hodgkin lymphoma and effectively inform outlier identification.** **The launch of the Audit's national quality improvement initiative in October 2025 will further support this effort. NHS trusts/health boards are encouraged to participate in the initiative to enhance data quality.**	England: Integrated Care Boards (ICBs) working with NHS trusts Wales: health boards	**Completeness for staging as follows:** (Binet – chronic lymphocytic leukaemia CLL, Ann Arbor – All other NHL) England 2022: 63.0% (Ann Arbor), 29.1% (Binet) Wales 2023: 67.5% (Ann Arbor), 7.8% (Binet)	N/A	NHS organisations have an obligation to submit accurate and timely data to the English National Disease Registration Service (NDRS) and Wales Cancer Network (WCN). 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 CancerStats2. COSD is the main source for the rapid cancer registration dataset and improved completeness of this dataset is required to ensure quarterly reporting. The Welsh Health Circular (NHS Wales) mandates high quality data submissions for the national cancer audits.

* Range - across all NHS trusts in England and health boards in Wales

** IQR – interquartile range

*** Results updated using the Patient Episode Database for Wales (PEDW)

**** Range - across all Cancer Alliances in England

6. NOCA Recommendations

The SotN Report can be found here.

Recommendation	Audience	Audit findings	Quality Improvement Goal	National guidance/standards/resources
Clinical Recommendations				
1. Reduce the current rate of emergency admissions: • NHS England and the Wales Cancer Network to continue working with gynaecological cancer systems, Cancer Alliances, health boards, and primary care organisations to explore the use of innovative approaches to early diagnosis in community settings, and including: ◦ Gynaecological cancer systems, Cancer Alliances, health boards to continue engaging with their local populations alongside ovarian cancer charities to improve recognition of ovarian cancer symptoms, particularly among older adults and those living in more deprived areas. ◦ Referring hospitals to review cases of emergency admissions to identify potential missed opportunities and share learning with primary care partners to support earlier diagnosis in the future.	England: NHS England, Cancer Alliances working with gynaecological cancer systems[7] and NHS trusts. Wales: health boards working with gynaecological cancer systems.	Performance indicator 1: 40.1% of women diagnosed in England in 2022 and 41.3% diagnosed in Wales in 2023 had an emergency admission within 28 days prior to diagnosis (lowest percentage 29.9% and highest 52.0% across the 40 gynaecological cancer systems in England; lowest percentage 33.3% and highest 47.4% across three gynaecological cancer systems in Wales).	Goal #1: Increase the proportion of patients receiving timely diagnosis and treatment decisions.	Women can be diagnosed late with advanced disease due to delays in presenting for medical care, difficulties in access to care, delays in primary care, or delays in secondary care[8]. The short-term mortality report from the Ovarian Cancer Audit Feasibility Pilot (OCAFP) showed that women diagnosed via an emergency presentation were four times more likely to die within two months of diagnosis than those diagnosed via the urgent suspected cancer referral system. Our data show that approximately 40% of women with ovarian cancer have an emergency admission 28 days prior to diagnosis which implies that there is considerable scope to improve outcomes by enhancing symptom awareness, increasing access to primary care and increasing the number of women diagnosed through rapid access pathways. Symptom triggered testing and fast track pathways are associated with low volume disease and early-stage diagnosis[9]. Promoting awareness amongst women and health care professionals in primary care through collaboration with cancer alliances and cancer charities will facilitate this.

---

[7] The main organisational unit for audit reporting is the gynaecological cancer system. This was recommended as a level for reporting performance indicators in the British Gynaecological Cancer Society's recommendations for evidence-based, population data derived quality performance indicators for ovarian cancer. This choice of unit acknowledges that decisions about ovarian cancer care are not always attributable to an individual NHS Trust such as the trust or hospital where a woman is diagnosed. It also avoids the problem of reporting indicators for individual trusts or hospitals that may diagnose a small number of patients each year.

[8] Abel GA, Mendonca SC, McPhail S, Zhou Y, Elliss-Brookes L, Lyratzopoulos G. Emergency diagnosis of cancer and previous general practice consultations: insights from linked patient survey data. Br J Gen Pract. 2017 Jun;67(659):e377-e387.

[9] Kwong FLA, Kristunas C, Davenport C, Deeks J, Mallett S, Agarwal R, et al. Symptom-triggered testing detects early stage and low volume resectable advanced stage ovarian cancer. International Journal of Gynecological Cancer Published Online First: 13 August 2024. doi: 10.1136/ijgc-2024-005371.

Recommendation	Audience	Audit findings	Quality Improvement Goal	National guidance/standards/resources
2. Investigate why women diagnosed with ovarian cancer within 28 days following an emergency admission did not receive any treatment (surgery and/or chemotherapy) and aim to reduce that proportion by: • engaging with NOCA's Quality Improvement Intervention/Initiative. • performing a detailed case-note review to identify the reasons why women did not receive treatment. • assessing eligibility for treatment based on the women's pre-admission fitness and consider timely involvement of prehabilitation service. • ensuring close collaboration between the centre and the units within a gynaecological cancer system.	England: Cancer Alliances working with gynaecological cancer systems and NHS trusts. Wales: health boards working with gynaecological cancer systems.	Performance indicator 2: 61.3% of women in England in 2022 and 71.0% of women in Wales in 2023 who had an emergency admission 28 days prior to ovarian cancer diagnosis had any treatment (surgery and/or chemotherapy) recorded between one month prior and three months following diagnosis (lowest percentage 46.2% and highest 81.8% across the 40 gynaecological cancer systems in England; lowest percentage 62.2% and highest 75.8% across three gynaecological cancer systems in Wales).	Goal #1: Increase the proportion of patients receiving timely diagnosis and treatment decisions Goal #3: Increase the proportion of patients receiving surgery. Goal #4: Increase the proportion of patients receiving chemotherapy.	Surgery and platinum-based chemotherapy is the standard of care for women with ovarian cancer. Our data show that approximately 40% of women who have an emergency admission prior to their diagnosis do not have any treatment recorded within 3 months of diagnosis.
3. Review the percentage of women with stage 2 to 4, or unstaged ovarian cancer who receive treatment (any type), explore and address some of the reasons behind the variation across gynaecological cancer systems by: • performing a detailed case-note review to identify why women did not receive any treatment. • documenting whether women eligible for treatment were offered it and the reasons for not treating, if appropriate.	England: Cancer Alliances working with gynaecological cancer systems. Wales: health boards working with gynaecological cancer systems.	Performance indicator 3: 74.2% of women in England in 2022 and 80.3% in Wales in 2023 who were diagnosed with stage 2 to 4, or unstaged ovarian cancer had any treatment (i.e., surgery and/or chemotherapy) recorded between one month prior and nine months following diagnosis (lowest percentage 62.0% and highest 87.8% across the 40 gynaecological cancer systems in England; lowest percentage 75.0% and highest 82.1% across three gynaecological cancer systems in Wales).	Goal #3: Increase the proportion of patients receiving surgery. Goal #4: Increase the proportion of patients receiving chemotherapy.	Surgery and platinum-based chemotherapy is the standard of care for these women. The short-term mortality report from the OCAFP showed that 22.2% of all women with ovarian cancer, regardless of stage, did not have any treatment recorded between one month prior and nine months following diagnosis. Those women were also more likely to die within 2 months following diagnosis (56.9%) than women who received treatment. The NHS Cancer Programme and the Cancer Alliance Treatment Variation Working Group have set the recommended treatment rate for these women at 80%.

Recommendation	Audience	Audit findings	Quality Improvement Goal	National guidance/standards/resources
4. Identify opportunities to increase the utilisation of platinum-based chemotherapy in women with epithelial ovarian cancer (stage 2 to 4, or unstaged), explore and address some of the reasons behind the variation across gynaecological cancer systems by: • performing a detailed case-note review to identify why women did not receive any chemotherapy. • documenting whether women eligible for treatment were offered it and the reasons for not treating, if appropriate. • assessing eligibility for treatment based on the women's pre-admission fitness and consider timely involvement of prehabilitation service.	England: Cancer Alliances working with gynaecological cancer systems.	Performance indicator 4: 66.0% of women diagnosed in England in 2022 with stage 2 to 4, or unstaged epithelial ovarian cancer were recorded as receiving platinum-based chemotherapy one month prior to three months following diagnosis (lowest percentage 44.7% and highest 83.8% across the 40 gynaecological cancer systems in England)[10].	Goal #4: Increase the proportion of patients receiving chemotherapy.	First-line chemotherapy treatment in ovarian cancer should include a platinum-based compound either in combination or as a single agent.
5. Review one-year survival in women diagnosed with ovarian cancer, explore and address some of the reasons behind the variation across gynaecological cancer systems by: • taking into account the performance of gynaecological cancer systems across the previous indicators. • identifying key pressure points in the ovarian cancer care pathway.	England: Cancer Alliances working with gynaecological cancer systems. Wales: health boards working with gynaecological cancer systems.	Performance indicator 5: 70.2% of women diagnosed in England in 2022 and 73.8% in Wales in 2023 were alive at least one year after diagnosis (lowest percentage 58.4% and highest 86.9% across the gynaecological cancer systems in England; lowest percentage 67.9% and highest 76.0% across three gynaecological cancer systems in Wales).	Goal #5: Improve rates of survival and reduce variation in survival.	One-year net survival according to the profile and treatment report from the OCAFP in women diagnosed between 2015 and 2019 in England was 68.4%. An international study has demonstrated similar results and has reported that one-year net survival in women diagnosed between 2010 and 2014 in the UK was 70.3% which lags behind countries with similar health systems[11], i.e., Australia 78.5%, Canada 72.6%, Denmark 77.4%, New Zealand 71.5%, and Norway 77.5%.

---

[10] This performance indicator was not available for Wales due to absence of data for chemotherapy regimens..

[11] Arnold M, Rutherford MJ, Bardot A, Ferlay J, Andersson TM, Myklebust TÅ, et al. Progress in cancer survival, mortality, and incidence in seven high-income countries 1995-2014 (ICBP SURVMARK-2): a population-based study. Lancet Oncol. 2019 Nov;20(11):1493-1505.

7. NOGCA Recommendations

The SotN Report can be found here.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. Expand the use of approaches to improve early diagnosis in community settings, including: – Explore strategies to improve engagement with their local populations and address identified hotspots of emergency cancer presentation. – Case reviews of emergency presentation or late-stage diagnosis by referring hospitals to identify potential missed opportunities and share learning with primary care partners to support earlier diagnosis in the future.	England: NHS England, Cancer Alliances working with NHS trusts Wales: Wales Cancer Network, health boards Primary care organisations	1 in 5 people (21% in England, 14% in Wales) with OG cancer were diagnosed following an emergency hospital admission. For gastric cancer this figure was higher: 30% in England and 21% in Wales. People aged 80 years and over had the highest rates of diagnosis via emergency admission. Over one third of all people included in the Audit were diagnosed with either stage 4 OG cancer (38% in England, 32% in Wales) or unknown stage (16% in England, 16% in Wales).	Goal #1: Reduce rates of emergency and late-stage diagnosis of OG cancer.	NHS Long Term Plan: the proportion of cancers diagnosed at stages 1 and 2 will rise to three-quarters of cancer patients (2028). Wales Cancer Network, A Cancer Improvement Plan for NHS Wales: reducing emergency presentation and first presentation with advanced disease.
2. Explore opportunities to streamline diagnostic and decision-making pathways. This includes considering implementation of new models of care that reduce delays and support timely initiation of treatment for people with OG cancer.	England: Cancer Alliances working with NHS trusts Wales: health boards	The median time between diagnostic endoscopy and initiation of disease-targeted treatment for people with OG cancer was 64 days (interquartile range (IQR) 49 to 84 days) in England and 72 days (IQR 51 to 104) in Wales. Wait times were longer for people undergoing curative treatment (69 days, IQR 55 to 88 days in England; 75 days, IQR 55 to 107.5 days in Wales) vs. non-curative treatment (60 days, IQR 45 to 79 days in England; 70 days, IQR 49 to 100 days in Wales). Wait times were longest for people whose primary treatment was surgical resection without neoadjuvant chemotherapy or radiotherapy, with a median of 78 days (IQR 52 to 107 days) in England.	Goal #2: Improve timely access to staging investigations to reduce delays between diagnostic endoscopy and the start of disease-targeted treatment.	No national guidance set. Recommendation identified as a priority by NOGCA Clinical Reference Group.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
3. Carry out thorough assessment and counselling for all people being considered for palliative systemic anti-cancer therapy (SACT) to ensure treatment decisions are based on a clear understanding of potential risks and benefits. In older populations, use formalised fitness assessments, such as the Clinical Frailty Scale. Where there is a high risk of early mortality (within 90 days), best supportive care to be discussed as an alternative. To support continuous improvement in decision-making, all people who die within 30-days of receiving palliative SACT to be reviewed through local morbidity and mortality processes.	England: Cancer Alliances working with NHS trusts Wales: health boards	In England, 4.3% of people with stage 4 OG cancer receiving systemic anti-cancer therapy (SACT) died within 30 days, and 16.7% of people died within 90 days of starting treatment. There was considerable variation between NHS trusts in England, with a median 90-day mortality rate of 16.7% (IQR 12.3% to 21.7%) and a range from 0% up to a maximum of 50%. Data not reported for Wales.	Goal #5: Improve completion and reduce complications of palliative chemotherapy for people with OG cancer.	NCEPOD: all deaths within 30 days of SACT should be considered at a morbidity and mortality or a clinical governance meeting.
4. All people diagnosed with OG cancer to have timely access to a Clinical Nurse Specialist (CNS) ideally within 72 hours of diagnosis. NHS organisations to review CNS provision where data show low levels of CNS contact and take steps to address workforce or service gaps. Accurate recording of CNS involvement to be prioritised in clinical data systems to support ongoing monitoring and improvement.	England: Integrated Care Boards (ICBs) working with NHS trusts Wales: health boards	In England, where data were complete, 93% of people with OG cancer were seen by a CNS. However, overall data completeness for CNS review was limited (68%), with information about CNS involvement missing for a third of people. In four-fifths of NHS trusts in England, >=90% of people were seen by a CNS; however, in seven NHS trusts this figure was <80%. People diagnosed by emergency admission in England were less likely to see a CNS, as were people with survival of less than 90 days after diagnosis. *Data not reported for Wales.*	Goal #3: Increase the percentage of people with OG cancer who have access to a clinical nurse specialist (CNS).	NHS England Cancer Programme: All people with OG cancer should have access to a CNS or other support worker.
Data Quality Recommendation				
5. Ensure there is a national and local level focus on improving the capture and availability of pathology data in routine datasets in England, to enable reporting of key cancer outcomes	England: NHS England, NHS trust pathology laboratories	There are poor levels of completeness of pathology data in national cancer datasets (England), which limits the reporting of surgical-pathology indicators for OG cancer. Data on excision margin were only available for three out of 32 OG surgical centres in England; some data on lymph node yield were available from all OG surgical centres but had high levels of data missing.	Goal #4: Improve the quality and consistency of pathology data flows to enable robust national assessment and benchmarking of surgical performance.	AUGIS The provision of services for specialist OG surgery (2024): ≥15 lymph nodes removed and examined. AUGIS The provision of services for specialist OG surgery (2024): Longitudinal resection margin positivity rate for oesophagectomies <5%

8. NPaCA Recommendations

The SotN Report can be found here.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. All NHS pancreatic cancer service providers should map their diagnostic pathways and benchmark their processes in line with hepatopancreatobiliary (HPB) cancer pathway guidance, which sets out recommended sequencing of events for the diagnostic process. Providers should consider performing a case analysis to review cases to understand and develop mitigation strategies for challenges in their pathways and identify areas of good practice.	England: Cancer Alliances working with NHS trusts Wales: health boards	Among people diagnosed via an urgent GP referral route, the median time from referral to disease-targeted treatment (surgery, chemotherapy and/or radiotherapy) was 78 days (IQR[4] 59 to 100) in England and 90 days (IQR 63 to 121) in Wales. Median time from referral to diagnosis: 20 days (IQR 9 to 36) in England and 21 days (IQR 7 to 43) in Wales. 54% of people in England and 51% in Wales were diagnosed within 21 days of urgent GP referral, and 64% in England and 60% in Wales were diagnosed within 28 days.	Goal #2: Optimise diagnostic and treatment pathways to reduce the time between referral and start of disease-targeted treatment	NHSE 2024: HPB best practice timed diagnostic pathway NHS Wales National Optimal Pathway for pancreatic cancer PCUK Optimal Care Pathway report
2. Review pancreatic cancer referral pathways to ensure all patients are discussed at an appropriate MDT meeting to maximise the opportunity for patients to receive specialist care in line with best practice guidance. Providers should ensure information about MDT discussions is submitted to NDRS.	England: Cancer Alliances working with NHS trusts	76% of people diagnosed with pancreatic cancer in England had a record of being discussed at an MDT meeting, as recommended by NICE (QS 177). In 16 of 119 NHS trusts, more than 90% of patients had a record of MDT discussion; in 28 NHS trusts, this figure was less than 70%. Information not available for Wales.	Goal #1: Increase the percentage of people who have diagnostic procedures and a process of diagnosis consistent with national recommendations for pancreatic cancer	NICE guideline NG85 2018: *A specialist pancreatic cancer multidisciplinary team should decide what care is needed and involve the person with suspected or confirmed pancreatic cancer in the decision. Care should be delivered in partnership with local cancer units.*

---

[4] IQR – Interquartile range

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
3. Ensure a personalised approach is taken to optimise a person's fitness, nutrition and medication to prevent deconditioning prior to starting treatment. This may include the implementation of prehabilitation, oncogeriatric services, dietetic support and early access to enhanced supportive care/supportive oncology services. Providers should review cases of people who survived more than three months but did not receive any disease-targeted treatment to understand the reasons for decisions not to treat.	England: Cancer Alliances working with NHS trusts Wales: health boards	Among people diagnosed with non-metastatic (stage 1-3) pancreatic cancer, 57% in England and 51% in Wales received a form of disease-targeted treatment (surgery, chemotherapy and/or radiotherapy). In England, this ranged widely across NHS trusts, IQR 43% to 63%. Among those with performance status (PS) 0-2, rates of treatment were 65% in England and 60% in Wales. Among people diagnosed with metastatic (stage 4) pancreatic cancer, 27% in England (IQR 20% to 32%) and 24% in Wales received a form of disease-targeted treatment. Among those with PS 0-2, these figures were 36% in England and 33% in Wales.	Goal #3: 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)	NHS England HPB cancer service spec NHS Wales Cancer Network Service Specification for HPB surgery services PCUK Optimal Care Pathway report
4. Review provision of clinical nurse specialists (CNS) in providers where there has been a shortfall in CNS review. Ensure that everyone diagnosed with pancreatic cancer has access to a specialist CNS from the point of diagnosis. Providers should ensure contacts with CNS are being recorded and that information is submitted to NDRS.	England: Integrated Care Boards working with NHS trusts Wales: health boards	England: Among people diagnosed with pancreatic cancer who had information about access to a clinical nurse specialist, 87% were seen by a CNS. Information on CNS was missing for 48% of people. Information not available for Wales.	Goal #4: Increase the percentage of people with pancreatic cancer who receive supportive care (care that helps the person to live as well as possible with their cancer and its treatment) in line with national recommendations	NHSE 2024: HPB best practice timed diagnostic pathway PCUK Optimal Care Pathway report: *NHS systems should ensure that everyone with pancreatic cancer, regardless of where they are treated or cared for, has an HPB or upper gastrointestinal CNS as their lead point of contact to oversee their care.*
5. Implement protocols to ensure that all people diagnosed with pancreatic cancer are assessed at their first clinical review for eligibility for pancreatic enzyme replacement therapy (PERT). PERT should be offered to eligible patients who are able to tolerate oral intake.	England: Cancer Alliances working with NHS trusts Wales: health boards	England: 54% of people diagnosed with pancreatic cancer were prescribed pancreatic enzyme replacement therapy (PERT) in primary care (IQR 44 to 60% across NHS trusts). 84% of people who had disease-targeted treatment had a PERT prescription in primary care compared to 38% of people who did not receive disease-targeted treatment.	Goal #4: Increase the percentage of people with pancreatic cancer who receive supportive care (care that helps the person to live as well as possible with their cancer and its treatment) in line with national recommendations	NHSE 2024: HPB best practice timed diagnostic pathway: Cancer Alliances and local stakeholders should take action to improve local healthcare professional awareness of PERT. NHS England HPB cancer service spec NHS Wales Cancer Network Service Specification for HPB surgery services

9. NPCA Recommendations

The SotN Report can be found here.

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.

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.