
National Cancer Audit Collaborating Centre Recommendations – October 2026





NATCAN

National Cancer Audit
Collaborating Centre

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Summary of the Recommendations from the NATCAN audits published in February 2026, June 2026, September 2026 and October 2026. More information and the full Reports can be found here:

NAoMe:

<https://www.natcan.org.uk/reports/naome-state-of-the-nation-report-2026/>

NAoPri:

<https://www.natcan.org.uk/reports/naopri-state-of-the-nation-report-2026/>

NBOCA:

<https://www.natcan.org.uk/reports/nboca-state-of-the-nation-report-2026/>

NKCA:

<https://www.natcan.org.uk/reports/nkca-state-of-the-nation-report-2026/>

NLCA:

<https://www.natcan.org.uk/reports/nlca-state-of-the-nation-report-2026-2/>

NNHLA:

<https://www.natcan.org.uk/reports/nnhla-state-of-the-nation-report-2026/>

NOCA:

<https://www.natcan.org.uk/reports/noca-state-of-the-nation-report-2026-2/>

NOGCA:

<https://www.natcan.org.uk/reports/nogca-state-of-the-nation-report-2026/>

NPaCA:

<https://www.natcan.org.uk/reports/npaca-state-of-the-nation-report-2026/>

NPCA:

<https://www.natcan.org.uk/reports/npca-state-of-the-nation-report-2026/>



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

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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 that all people newly diagnosed with MBC are discussed at a specialist breast MDT meeting, in line with NICE guidance. Cancer Alliances should work with their constituent units to remove local barriers to MDT discussion and use the NAOme Quarterly Reports to monitor when MDT discussion did not occur (and ensure data are complete).	England: Cancer Alliances working with breast care teams and clinical management in NHS trusts Wales: Breast care teams and clinical management in health boards	81% (England) and 68% (Wales) of people with de novo MBC had a record that their care was discussed within an MDT.	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. Breast units with low reported use of CDK4/6 inhibitors for people with de novo ER-positive, HER2-negative MBC should identify the underlying causes and implement actions to improve equitable access to guideline-recommended treatment. This may include ensuring the completeness of systemic anti-cancer therapy (SACT) recording for oral therapies in the SACT dataset.	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 health boards	In England, 41% of people with de novo ER positive HER2 negative MBC received a CDK 4/6 inhibitor.	Goal #5: Improve and reduce unwarranted variation in MBC outcomes.	NICE Technology Appraisal Guidance recommend use of CDK4/6 inhibitors for the treatment of ER+ve HER2- metastatic breast cancer.
3. Breast units should monitor rates of 30-day mortality following cytotoxic chemotherapy for metastatic breast cancer and consider outcome reviews and/or an evaluation of local prescribing practices, peer-discussion, and the use of prognostic information 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 health boards	In England, 30-day mortality rates following cytotoxic chemotherapy was 9% for people with de novo MBC compared to 16% among people with recurrent MBC.	Goal #5: Improve and reduce unwarranted variation in MBC outcomes.	NICE Guidelines NG101 & CG81 for Early and Advanced breast cancer recommends assessment of the prognostic and predictive factors, and the possible risks and benefits of cytotoxic chemotherapy treatment.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/ Resources
Data Quality Recommendations				
4. Confirm breast MDTs have a data lead responsible for ensuring the accurate recording of data and type of breast cancer recurrence. Reviews of data completeness should ensure that full tumour characterisation (i.e., stage, grade, histology), ER and HER2 and contact with clinical nurse specialists (CNS) are recorded.	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 health boards	The NAO Me recurrent MBC cohort is smaller than expected. Improvements in data quality are needed. In England, molecular status* among people with de novo MBC were 70% complete in the cancer registry and in Wales 81% complete.	Goals #1–5.	National Cancer Plan for England, Action 3 commits to improving data on recurrent cancers, starting with metastatic breast cancer. The Welsh Health Circular mandates high quality data submissions.
Note that due to differences in data and methodology between reports, direct comparisons between the 2025 and 2026 reports should not be used to infer about trends over time. * ER and HER2 status combined.				

2. NAOpri Recommendations

The SotN Report can be found [here](#).

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
1. Where rates of triple diagnostic assessment (TDA) in a single visit are lower than expected, organisations should assess local diagnostic pathways to ensure people from non-screening pathways can receive clinical assessment, imaging and biopsy within a single visit. NHS organisations should complete the specific TDA data item (BR4400 in COSD) to support monitoring 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 health boards	68.1% of people on a non-screening pathway in England were identified as being diagnosed through a TDA clinic, with rates ranging from 5.3% to 89.3% by organisation of diagnosis. In Wales, the estimated TDA rate was 72.9% based on the specific TDA item available in the second half of 2023.	Goal #1: Improve the movement of patients through the diagnostic 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. Breast Surgery: GIRFT Programme Follow-up Report
2. Where rates of breast-conserving surgery (BCS) for people with early invasive breast cancer and DCIS differ substantively from the national average, organisations should review local surgical resources and shared decision-making processes to ensure eligible people are offered BCS where clinically appropriate.	England: Cancer Alliances working with breast care teams and clinical management in NHS trusts. Wales: Breast care teams and clinical management in health boards.	On average across England and Wales, 74.0% of people with early breast cancer (stage 0 to 3A), underwent BCS as their first operation within 12 months of diagnosis (England = 74%; Wales = 71%). Adjusted BCS rates varied between NHS organisations, ranging from 59.2%–90.2%.	Goal #2: Reduce unwarranted variation for patients undergoing surgery.	Breast Surgery: GIRFT Programme Follow-up Report ABS-Mastectomy-Avoidance-Toolkit.pdf
3. Review protocols for re-operation following breast-conserving surgery (BCS) to ensure consistency with recommended practice and identify options for meeting the aspirational targets of 10% for invasive cancer and 15% for Ductal carcinoma in situ (DCIS).	England: Cancer Alliances working with breast care teams and clinical management in NHS trusts. Wales: Breast care teams and clinical management in health boards	Among women undergoing breast-conserving surgery, on average 27% of those with DCIS and 15% of those with invasive disease required re-operation within 12 months. After adjustment for case mix, re-operation rates varied by operating organisation, ranging from below 10% to over 30%.	Goal #5: Improve and reduce unwarranted variation in primary breast cancer outcomes.	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

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
4. Where uptake of immediate breast reconstruction (IBR) is below 25%, organisations should assess local pathways to ensure all eligible women are offered reconstruction as part of shared decision-making, unless contraindicated by comorbidity or planned adjuvant treatment.	England: Cancer Alliances working with breast care teams and clinical management in NHS trusts. Wales: Breast care teams and clinical management in health boards	On average across England and Wales, just over a quarter (26%) of women undergoing mastectomy had immediate breast reconstruction (England = 27%; Wales = 15%). Marked regional variation remained after risk adjustment, with Cancer Alliance-level rates ranging from 15.2%–38.7%.	Goal #4: Improve access to breast reconstruction after mastectomy.	NICE NG101 recommendation 1.5: 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 Follow-up Report Further Fast Breast Reconstruction Handbook
5. Review local neoadjuvant chemotherapy pathways for people with early invasive triple-negative or HER2-positive breast cancer, particularly where rates differ substantively from national average, to reduce unwarranted variation and ensure eligible people are considered for treatment 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 health boards.	Utilisation of neoadjuvant chemotherapy has increased rapidly over the past decade. On average across England and Wales, 56% of people with stage 2 to 3A triple-negative or HER2-positive breast cancer diagnosed between 2021–2023 received NACT. However, variation observed in use between NHS organisations.	Goal #3: Reduce unwarranted variation for patients having non-surgical oncological treatments.	NICE NG101 recommendations 1.9 & 1.10 : For people with HER2-positive invasive breast cancer offer neoadjuvant chemotherapy where indicated and in line with the commissioning criteria for any related technology appraisal guidance. ABS Neoadjuvant Chemotherapy: Multidisciplinary Guidance
Note that due to differences in data and methodology between State of the Nation reports, direct comparisons with earlier 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
1. Increase the proportion of people undergoing timely ileostomy closure after anterior resection, recognising that the patient's cancer treatment pathway is not complete until ileostomy reversal: - Identify and address local barriers to timely closure through process mapping (e.g. access to theatre/ radiological investigation). - Participate in local and national quality improvement initiatives aimed at reducing delays to ileostomy closure, including the Royal College of Surgeons of England's Close It Quick Collaborative.	England: Cancer Alliances working with NHS trusts Wales: health boards	Only 37% of NHS trusts/MDTs met the local target of fewer than 35% of patients having an unclosed diverting ileostomy 18 months after anterior resection. Substantial between-unit variation remained, ranging from 13% to 83%.	Goal #2: Improving peri-operative care	ACPGBI: Guidelines for the Management of Cancer of the Colon, Rectum and Anus National Bowel Cancer Audit Quality Improvement Plan Figure 3: Example driver diagram for indicator "Ileostomy closure after rectal cancer resection" Close It Quick – Ileostomy Closure QI Collaborative
2. Case selection should be optimised in units giving adjuvant chemotherapy to less than 55% of people with stage 3 colon cancer: - Develop local action plans to increase rates of chemotherapy while maintaining low levels of severe toxicity. - Integrate geriatric expertise and rehabilitation into shared chemotherapy decision making.	England: Cancer Alliances working with NHS trusts Wales: health boards	In 10 (8%) NHS trusts/MDTs, less than 55% of people with stage 3 colon cancer received adjuvant chemotherapy. Substantial between-unit variation in the use of adjuvant chemotherapy persists, ranging from 45% to 88%.	Goal #3: Improving oncological care	NICE Guidelines: Bowel Cancer Measuring variation in the quality of systemic anti-cancer therapy delivery across hospitals: A national population-based evaluation. 2023 British Geriatrics Society/Royal College of Radiologists. Implementing frailty assessment and management in oncology services
3. Optimise neo-adjuvant radiotherapy and straight to surgery treatment pathways, with improved radiological staging, for people with rectal cancer: - Protocols should be based on high-quality radiological staging using standardised reporting templates. - Support equitable access to organ preservation strategies and participation in clinical trials. - Engage with GIRFT's national programme of process mapping in delivery of rectal cancer treatment. - Develop national consensus-driven guidelines for rectal cancer to inform MDT recommendations and shared decision-making with patients. - Engage with NICE, and professional bodies (ACPGBI/ Royal College of Radiologists/GIRFT), to undertake a targeted review of the management of rectal cancer.	England: Cancer Alliances working with NHS trusts Wales: health boards	Overall, 27% of people received neo-adjuvant radiotherapy for rectal cancer with wide variation between NHS trusts/MDTs ranging from 0% to 84%.	Goal #3: Improving oncological care	MRI to guide clinical management of rectal cancer: updated consensus recommendations. 2026 Neo-adjuvant and Non-operative Management of Rectal Cancer Guidelines Watch-and-wait after neo-adjuvant treatment in rectal cancer: a practical guide to management and surveillance. 2023

Recommendation	Audience	Report Findings	Quality Improvement Goal	National Guidance/Standards/Resources
4. Optimise histopathology pathways to provide timely genomic assessment where clinically appropriate to inform personalised treatment options, improve access to clinical trials and identify people with Lynch syndrome: • Increase mismatch repair (MMR) or microsatellite instability (MSI) testing in stage 1 to 4 cancer. • Deliver RAS and BRAF assessment in stage 4 cancer, with consideration of broader molecular profiling for targeted therapies.	England: Cancer Alliances working with NHS trusts and Genomic Laboratory Hubs Wales: health boards All Wales Medical Genomics Service	The proportion with a record of MMR testing increased from 45% in 2019 to 60% in 2024. The proportion tested within one month of diagnosis increased from 66% (2019) to 77% (2024).	Goal #4: Improving management of stage 4 disease	NICE Guidelines: Bowel Cancer Guidelines for the management of hereditary colorectal cancer The National Cancer Plan for England (Section 3, Action 17) The Royal College of Pathologists Dataset for histopathological reporting of colorectal cancer
5. Ensure timely treatment decision-making, regardless of referral route, following a diagnosis of bowel cancer: • Review secondary care pathways to understand and address system-level delays from diagnosis to treatment decision-making for people diagnosed following routine GP referral. • Identify and address sources of delay, which may include patient tracking, access to radiological investigations, and streamlining MDT decision-making.	England: NHS England, Cancer Alliances working with NHS trusts Wales: health boards	People diagnosed through routine GP referrals wait over a week longer for treatment decision than those diagnosed following a GP urgent suspected cancer referral.	All	Cancer treatment delays need systematic attention. 2026 Cancer decision making needs a radical rethink. 2025 NHS England — National cancer waiting times monitoring dataset guidance
Several recommendations reinforce priorities identified in the NBOCA State of the Nation Report October 2025, reflecting their ongoing importance. Additional implementation strategies have been proposed to stimulate improvements.				

4. NKCA Recommendations

The SotN Report can be found [here](#).

Recommendation****	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
1. Conduct a local review of people with a small kidney cancer who were not recorded as undergoing a renal biopsy to identify potential barriers to timely diagnostics and data recording. Ensure that all eligible people have the option of a renal biopsy to confirm the histological diagnosis and to support shared decision making.	England: Cancer Alliances working with NHS trusts Wales: health boards	England: The percentage of people with a small kidney cancer who have a renal biopsy recorded was 22%, with an NHS trust-level IQR of 10-35%**, PI 3. Wales: The percentage of people with a small kidney cancer who have a renal biopsy was 46%, with a health board-level IQR of 11-59%**, PI 3. English national average consistent from 2019 to 2023. Welsh data only available for 2024. 25% of providers perform better than 35% (England) and 59% (Wales).*****	Goal #2: To increase the use of renal tumour biopsy	NG256 recommendation 1.3.1 offer renal biopsy to confirm diagnosis and inform management for people with suspected localised or locally advanced RCC with a solid renal lesion ≤4 cm where a tissue sample can be obtained. QS215 Statement 2: Adults with a suitable renal lesion 4 cm in diameter or smaller have a renal biopsy to help confirm the diagnosis.
2. Review pathways for higher risk 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 NHS trusts Wales: health boards	England: The percentage of people with a T3+ and/or 10cm+ and/or N1 and M0 RCC whose radical nephrectomy is within 31 days of decision to treat (England only) was 68% with an NHS trust-level IQR of 57-81%**, PI 4. Wales: Unable to report this performance indicator due to incomplete recording of the decision-to-treat date. Significant decreasing trend in English national average: 81% (2019), 78% (2020), 73% (2021), 67% (2022), 64% (2023). 25% of providers perform better than 81% (England).*****	Goal #3: To expedite treatment of people with potentially high risk for recurrence localised and locally advanced RCCs (i.e. cT3+, 10cm+, cN1 tumours)	QS215 Statement 4: Adults with high-risk localised or locally advanced RCC, for whom surgery is suitable, have surgery with curative intent within 31 days of the decision to treat.
3. Identify and address reasons why people diagnosed with kidney cancer, stage T1b-3NXM0 RCC are not considered for surgical treatment and increase the percentage of eligible people assessed and treated.	England: Cancer Alliances working with NHS 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 IQR of 72-83%**, PI 5. Wales: The percentage of people with T1b-3NXM0 RCC who have surgery was 82% with a health board-level IQR of 71-82%**, PI 5. English national average consistent from 2019 to 2023. Welsh national average consistent from 2022 to 2024. 25% of providers perform better than 83% (England) and 82% (Wales).*****	Goal #4: To increase use of surgery, if medically appropriate, for initially localised RCC at risk of progression	NG256 recommendation 1.5.3 offers surgery for localised solid renal masses or Bosniak 4 cysts ≥2 cm after imaging and uro-oncology MDT discussion.

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 NHS trusts Wales: health boards	England: The percentage of people with T1aN0M0 RCC who undergo nephron sparing treatment was 72% with an NHS trust-level IQR of 59-81%**, PI 6. Wales: Unable to report this performance indicator due to poor differentiation between T1a and T1b stage categories in 2022-2023 data and insufficient follow-up in 2024 data. English national average consistent from 2019 to 2023. 25% of providers perform better than 81% (England).*****	Goal #4: To reduce the use of unnecessary extensive surgery for low-risk RCC	NG256 Table 1 sets out that total nephrectomy should be preferred over partial nephrectomy for localised RCC when either (i) the renal lesion cannot be entirely removed with partial nephrectomy based on lesion location, size and complexity, and the person's clinical characteristics, or (ii) reducing the risk of complications is more important than preserving kidney function.
5. Ensure people diagnosed with metastatic RCC are evaluated by a medical/clinical oncologist with expertise in renal cancer management to increase the percentage of people considered for receipt of systemic anti-cancer therapy (SACT), if appropriate.	England: Cancer Alliances working with NHS trusts Wales: health boards	England: The percentage of people with metastatic RCC receiving initial SACT within 12 months of diagnosis was 50%. This is with an NHS trust-level IQR of 43-58%**, PI 7. Wales: The percentage of people with metastatic RCC receiving initial SACT within 12 months of diagnosis was 59%. This is with a health board-level IQR of 56-68%**, PI 7. Significant increasing trend in English national average: 48% (2019), 48% (2020), 52% (2021), 50% (2022), 54% (2023). Welsh national average consistent from 2022 to 2024. 25% of providers perform better than 58% (England) and 68% (Wales).*****	Goal #5: To increase use of evidence based SACT treatment in eligible people with kidney cancer without severe toxicity	NG256 recommendation 1.12.1 requires referral of people with advanced RCC to a uro-oncology MDT with relevant expertise (radiologist, pathologist, oncologist, and urologist with specialty in kidney cancer surgery). QS215 Statement 6: Adults with advanced RCC have their treatment options discussed by a uro-oncology multidisciplinary team.
* Measured in England only due to the availability of relevant data for Wales. ** Interquartile range, representing the range between the 25th and 75th percentiles. *** The audit's measure of treatment within 31 days of decision to treat is specific to kidney cancer and risk stratified. **** All recommendations reinforce priorities identified in previous NKCA State of the Nation reports reflecting their importance. The clinical recommendations are consistent with previous year's recommendations as not enough time has passed to be able to assess whether improvement has taken place following publication of previous NKCA State of the Nation reports. ***** Providers with a low percentage should review their data and investigate the reasons as part of their quality improvement activity.				

5. NLCA Recommendations

The SotN Report can be found [here](#).

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/ Standards/ Resources
1. Audit Multi-Disciplinary Team (MDT) decisions for patients with Non-small Cell Lung Cancer (NSCLC) stage 3A (Performance Status (PS) 0–2) to identify barriers (e.g., comorbidity management) preventing curative intent treatments.	England: Cancer Alliances working with NHS trusts Wales: Local Health Boards	England: 59% of people with stage 3A NSCLC (PS 0–2) had treatment with curative intent Wales: 62% of people with stage 3A NSCLC (PS 0–2) had treatment with curative intent	Goal 3: Increase the proportion of people receiving SACT and reduce variation in access Goal 5: Improve and reduce variation in lung cancer outcomes	NICE Guideline NG122 https://www.nice.org.uk/guidance/ng122
2. Review the care pathway for opportunities to increase the proportion of patients with advanced Non-Small Cell Lung Cancer (NSCLC) (Performance Status (PS) 0–1) who receive Systemic Anti-Cancer Therapy (SACT). This might include ensuring performance status is accurately recorded at Multi-Disciplinary Team (MDT) meetings.	England: Cancer Alliances working with NHS trusts Wales: Local Health Boards	England: 63% of people with stage 3B–4 NSCLC (PS 0–1) received SACT Wales: 62% of people with stage 3B–4 NSCLC (PS 0–1) received SACT	Goal 3: Increase the proportion of people receiving SACT and reduce variation in access Goal 5: Improve and reduce variation in lung cancer outcomes	Royal College of Radiology “Policy priorities for clinical oncology 2021–2026” https://www.rcr.ac.uk/media/boq1ppx/policy-priorities-clinical-oncology-2021-2026-1.pdf
3. Ensure providers have sufficient thoracic surgery capacity to accommodate the growth in demand among Non-Small Cell Lung Cancer (NSCLC) patients who are candidates for curative surgery.	England: Cancer Alliances working with NHS trusts Wales: Local Health Boards	England: 22% of people with NSCLC had surgical treatment for their cancer (20% in 2023). Median waiting time from referral to surgery in people with stage 1 – 2 NSCLC: 81 days (IQR 61 to 106) Wales: 15% of people with NSCLC had surgical treatment for their cancer (17% in 2023). Median waiting time from referral to surgery in people with stage 1 – 2 NSCLC: 91 days (IQR: 67 to 115)	Goal 2: Increase the proportion of patients who have treatment with curative intent	NICE Guideline NG122 https://www.nice.org.uk/guidance/ng122 Commissioning Guidance for the whole lung cancer pathway 2024: https://roycastle.org/for-healthcare-professionals/clinical-expert-group/

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/ Standards/ Resources
4. Ensure measures to remove causes of avoidable delay are prioritised for patients to start Systemic Anti-Cancer Therapy (SACT), particularly for people with Small Cell Lung Cancer (SCLC).	England: Cancer Alliances working with NHS trusts Wales: Local Health Boards	England: Median waiting time from referral to SACT in people with stage 3B-4 NSCLC: 63 days (IQR: 49 - 84 days) Median waiting time from 'decision to treat' to SACT in people with SCLC: 16 days (IQR: 10 – 25 days) Wales: Median waiting time from referral to SACT in people with stage 3B-4 NSCLC: 75 days (IQR: 58 – 98 days) Median waiting time from 'decision to treat' to SACT in people with SCLC: 21 days (IQR: 15 – 31 days)	Goal 4: Improve the quality of the patient pathway	NHS England. National Optimal Lung Cancer Pathway (NOLCP) https://rmpartners.nhs.uk/wp-content/uploads/2024/09/national-optimal-lung-cancer-pathway_v4_01jan2024.pdf NHS Wales. National optimal pathway for lung cancer: 2nd Edition (2022) Commissioning Guidance for the whole lung cancer pathway 2024: https://roycastle.org/for-healthcare-professionals/clinical-expert-group/
5. Ensure people diagnosed with stage 1 - 3 cancer are recommended regular aerobic and resistance exercise during treatment with curative intent. This includes recommending preoperative exercise for patients having lung cancer surgery.	England: Cancer Alliances working with NHS trusts Wales: Local Health Boards	The proportion of people with stage 1-2 lung cancer having surgery decreased amongst people with poorer fitness England: Performance Status (PS) 0=75.3%; PS 1=52.2%; PS 2=19.2% Wales: PS 0=70.5%; PS 1=54.3%; PS 2=32.9%.	Goal 2: Increase the proportion of patients who have treatment with curative intent Goal 5: Improve and reduce variation in lung cancer outcomes	ASCO Guideline on Exercise, Diet, and Weight Management during Cancer Treatment (2022) https://ascopubs.org/doi/10.1200/JCO.22.00687

6. NNHLA Recommendations

The SotN Report can be found [here](#).

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
1. Identify patient and tumour factors associated with emergency presentation, including referrals to hospital in the previous 6-12 months that did not lead to a diagnosis of NHL. The poor survival in this group highlights the need to move these patients urgently through the pathway. Examine the timelines within secondary care for this group, including time to biopsy.	England: Cancer Alliances working with NHS trusts Wales: health boards	Proportion of people diagnosed with NHL presenting as an emergency prior to diagnosis: England 2023: 29.4% (IQR*: 26-33%) Wales 2024: 29.0% (IQR: 18-37%) Survival of people diagnosed with NHL following an emergency presentation: 1-year survival: England 2023: 59.1% (95% CI+: 58-61%) Wales 2024: 59.5% (95% CI: 53-66%) 2-year survival: England 2022: 51.4% (95% CI: 50-53%) Wales: not enough follow-up	Goal #1: Improving timely diagnosis and treatment.	NHS Cancer Programme: Faster Diagnosis Framework 2022 UK Blood Cancer Action Plan NICE guidance, "Haematological cancers: improving outcomes" (NG47) 2016 National Cancer Plan 2026 . (3. A global leader in cancer outcomes by 2035: 'improve and modernise the early detection pathway'; 'reducing the proportion of cancers diagnosed in an emergency setting')
2. Identify opportunities to shorten the longest median time intervals (time from referral to seeing a haematologist and time from diagnosis to starting SACT) within the patient pathway in order to understand system-level delays.	England: Cancer Alliances working with NHS trusts Wales: health boards	Median time from referral to seeing a haematologist: England 2023: 36 days (IQR: 29-44 days) Wales 2024: not available Median time from diagnosis to starting SACT: England 2023: 35 days (IQR: 29-42 days) Wales 2024: 33 days (IQR: 32-44 days)	Goal #1: Improving timely diagnosis and treatment.	NHS England Cancer Waiting Times Standards (October 2023) UK Blood Cancer Action Plan National Cancer Plan 2026 (2. Driving up NHS cancer performance: 'to meet all cancer waiting time performance by 2029'; 'cut down unnecessary appointments through straight-to-test pathways')
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 - earlier identification of suitable candidates for radiotherapy through timely MDT referral and pre-SACT review by clinical oncologist	England: Cancer Alliances working with NHS trusts Wales: health boards	Proportion of people with high-grade lymphoma whose radiotherapy started within 8 weeks of end of first-line SACT: England 2023: 31.5% (IQR: 22-50%) Wales 2024: not available	Goal #1: Improving timely diagnosis and treatment. Goal #5: Reducing variation in NHL management among NHS providers.	Streamlining Multidisciplinary Team Meetings – Guidance for Cancer Alliances (2020) NICE guidance, "Haematological cancers: improving outcomes" (NG47) 2016 Clinical Oncology Workforce Census 2024 National Cancer Plan 2026 (2. Driving up NHS cancer performance: 'harness new technology to speed up access to treatment'; 'improve the effectiveness of multi-disciplinary team working')

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
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 were recorded as having received an episode of care that was delivered as part of a clinical trial: England 2023: 2.6% (IQR: 0-4%) Wales 2024: not available	Goal #1: Improving timely diagnosis and treatment.	UK Blood Cancer Action Plan NIHR (2020) Improving inclusion of under-served groups in clinical research: Guidance from the NIHR-INCLUDE project. UK: NIHR. National Cancer Plan 2026 (5. Delivering world class cancer care through world class research: 'ensure faster set up of clinical trials and more equitable access'; 'NIHR will make research more inclusive, so it reaches more underrepresented communities'; 'Cancer trials will be made more accessible')
5. Monitor rates of severe acute toxicity after SACT for NHL and investigate the reasons underlying toxicity. Encourage the utilisation of appropriate risk stratification tools for severe acute toxicity, for example frailty scoring, and regularly review systems of SACT delivery and safety monitoring to ensure treatment-related adverse effects are minimised.	England: Cancer Alliances working with NHS trusts Wales: health boards	Proportion of people diagnosed with NHL with severe acute toxicity within 8 weeks of completing SACT: England 2023: 47.4% (IQR: 41-54%) Wales 2024: not available	Goal #3: Improving safety and reducing toxicity of NHL therapy.	NICE guidance, "Haematological cancers: improving outcomes" (NG47) 2016 Fox CP, Chaganti S, McIlroy G, Barrington SF, Burton C, Cwynarski K, Eyre TA, Illidge T, Kalakonda N, Kuhn A, McKay P, Davies AJ. The management of newly diagnosed large B-cell lymphoma: A British Society for Haematology Guideline. Br J Haematol. 2024 Apr;204(4):1178-1192. doi: 10.1111/bjh.19273. Epub 2024 Jan 21. PMID: 38247115; PMCID: PMC7616447.
*IQR: interquartile range according to trust/hospital level results. + CI: confidence interval. ^ The clinical recommendation remains consistent with previous year's recommendation, as the performance indicator results continue to support findings from previous reports. There is currently insufficient follow-up time to assess whether improvements have occurred following the publication of previous NNHLA State of the Nation reports.				

7. NOCA Recommendations

The SotN Report can be found [here](#).

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

Recommendation	Audience	Audit findings	Quality Improvement Goal	National guidance/standards/resources
Clinical Recommendations				
1. Reduce the current rate of emergency admissions: - NHS England and the Wales Cancer Network should continue working with gynaecological cancer systems, Cancer Alliances, health boards, and primary care providers to explore the use of innovative approaches to early diagnosis in community settings and with local non-specific symptoms pathway teams to establish clear referral pathways. - Gynaecological cancer systems, Cancer Alliances, and 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 areas⁶. - Referring hospitals to review cases of emergency admissions to identify potential missed opportunities and engage in collaborative learning with primary care partners to facilitate earlier diagnosis in the future.	England: NHS England, Cancer Alliances working with gynaecological cancer systems⁷ and NHS trusts. Wales: health boards working with gynaecological cancer systems.	Performance indicator 1: 40.3% (27.7%-58.6%) of women diagnosed in England in 2023 and 42.7% (26.7%-51.6%) diagnosed in Wales in 2024 had an emergency admission within 28 days prior to diagnosis.	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 care⁸. 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 diagnosis⁹. Promoting awareness amongst women and health care professionals in primary care through collaboration with cancer alliances and cancer charities will facilitate this.

⁶ BMJ Oncology (accepted for publication)

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 women each year. See methodology supplement for the mapping of gynaecological cancer systems.

⁸ [Abel GA, Mendonca SC, McPhail S, Zhou Y, Ellis-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. For women diagnosed with ovarian cancer within 28 days following an emergency admission, increase the proportion of these women who receive treatment (surgery and/or chemotherapy), by: - conducting a case-note review to identify the rationale for not administering any treatment. - engaging with NOCA's Quality Improvement Intervention/Initiative. - implementing best-practice examples identified in NOCA's Quality Improvement Intervention (to be shared later in the year). These may also include assessing eligibility for treatment based on the women's pre-admission fitness using objective assessment, such as comprehensive frailty assessment tools, timely involvement of prehabilitation service, and expedited diagnostic and treatment pathways. - 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: 59.7% (43.8%-80.0%) of women in England in 2023 and 70.1% (52.2%-78.7%) of women in Wales in 2024 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.	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. There is also wide variation among gynaecological cancer systems, ranging from 43.8% to 80.0%, with four cancer systems above the upper 95% control limit and three systems below the lower 95% control limit. Notably, a cluster of systems fall below the national average, while a considerable number sit above it.
3. For women with stage 2 to 4 or unstaged ovarian cancer, increase the proportion of these women who receive treatment, 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 if not, to record the reasons for this decision. - reviewing the performance of gynaecological cancer systems for receipt of surgery and receipt of chemotherapy.	England: Cancer Alliances working with gynaecological cancer systems. Wales: health boards working with gynaecological cancer systems.	Performance indicator 3: 73.5% (59.6%-88.4%) of women in England in 2023 and 76.0% (71.7%-80.6%) in Wales in 2024 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.	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. 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. For women with epithelial ovarian cancer (stage 2 to 4, or unstaged), increase the proportion of these women who receive platinum-based chemotherapy, by: - conducting a case-note review to identify the rationale why women did not receive any chemotherapy. - documenting whether women eligible for treatment were offered it and if not, to record the reasons for this decision. - if the resulting findings suggest under-utilisation, develop appropriate local action plans to increase rates of chemotherapy whilst maintaining low levels of severe toxicity. Action plans may include timely involvement of prehabilitation service and/or integration of geriatric expertise into shared chemotherapy decision making.	England: Cancer Alliances working with gynaecological cancer systems.	Performance indicator 6: 64.3% (43.1%-82.9%) of women diagnosed in England in 2023 with stage 2 to 4, or unstaged epithelial ovarian cancer were recorded as receiving platinum-based chemotherapy one month prior to three months following diagnosis¹⁰.	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 opportunities to improve one- and two-year survival in women diagnosed with ovarian cancer, especially when according to the performance indicator survival is lower than expected, by: - taking into account the performance of gynaecological cancer systems across all the indicators reported by NOCA. - identifying key pressure points in the ovarian cancer diagnostic or treatment care pathway and implementing quality improvement projects to address these. - using the NOCA quarterly dashboard to evaluate the impact of the quality improvement projects on survival.	England: Cancer Alliances working with gynaecological cancer systems. Wales: health boards working with gynaecological cancer systems.	Performance indicator 7a: 70.1% (59.4%-82.1%) of women diagnosed in England and 73.8% (67.9%-76.0%) in Wales in 2023 were alive at least one year after diagnosis. Performance indicator 7b: 58.4% (43.9%-80.0%) of women diagnosed in England and 67.6% (64.9%-69.4%) in Wales in 2022 were alive at least two years after diagnosis.	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 systems¹¹, 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.](#)

8. NOGCA Recommendations

The SotN Report can be found [here](#).

Recommendation	Audience	Audit Findings	Quality Improvement (QI) Goal	National Guidance/Standards/Resources
1. Providers to review why people were recorded as not being seen by a Clinical Nurse Specialist (CNS) to identify potential barriers to timely CNS support. All people diagnosed with oesophageal or gastric (OG) cancer to be offered specialist CNS input, ideally within 72 hours of diagnosis.	England: Cancer Alliances working with Integrated Care Boards (ICBs) and NHS trusts Wales: health boards	In England, where data were complete, 94% of people with OG cancer were seen by a Clinical Nurse Specialist (CNS). However, variation was observed between trusts: IQR 94% to 98%. Among the subgroup of people diagnosed in Wales who had their information submitted via the new Cancer Dataset Forms, CDF, 94% of those with complete data had a record of being seen by a CNS (IQR 90% to 97%).	Goal #2: Improve access to Clinical Nurse Specialist (CNS) support and care coordination.	The National Cancer Plan for England: Action 23 : Every patient will have a Clinical Nurse Specialist or other named lead to support them through diagnosis and treatment. NHS Wales Cancer Improvement Plan : Every person diagnosed with cancer should have a named Key Worker [...] a role undertaken ordinarily by a Clinical Nurse Specialist
2. Specialist multidisciplinary teams (MDTs) with comparatively low rates of treatment with curative intent among people with stages 1–3 OG cancer to ensure that people are offered appropriate optimisation and prehabilitation strategies, and to consider mechanisms for wider specialist MDT discussion or second-opinion review for people with complex or borderline disease where suitability for curative treatment may be unclear.	England and Wales: Upper Gastrointestinal (UGI) MDTs (specialist and non-specialist)	The overall proportion of people who initiated potentially curative treatment was 34% in England and 25% in Wales. Among people with stages 1–3 disease and a performance status of 0 or 1 at diagnosis, 67% initiated potentially curative treatment in England (range across Cancer Alliances: 55%–77%) and 47% in Wales.	Goal #3: Improve access to potentially curative treatment, where appropriate.	NICE guideline 83 : All people with confirmed OG cancer should be reviewed within an MDT that includes an oncologist and radiologist with an interest in OG cancer, and people with non-metastatic disease should additionally be discussed at a specialist OG cancer MDT. Macmillan Cancer Support Prehabilitation for people with cancer clinical and implementation guidelines : prehabilitation should be widely adopted to benefit patients' preparation for and recovery from cancer treatment.
3. Surgical OG cancer centres to undertake a structured review of people with a length of stay (LOS) >15 days following OG resection to identify complications or other factors contributing to delayed discharge, evaluate opportunities for prevention, including timeliness of management, escalation pathways and postoperative decision-making.	England: Cancer Alliances, specialist surgical centres Wales: health boards, specialist surgical centres	Postoperative length of stay exceeding 15 days occurred in 25% of people undergoing curative surgery for OG cancer in England and 33% in Wales. In England, adjusted rates varied across surgical centres, ranging from 11% to 40%.	Goal #4: Improve short-term outcomes for people receiving treatment for OG cancer.	NHS England Theatres, surgery and perioperative care: A clinical and operational improvement guide : compliance with an enhanced recovery bundle is associated with shorter LOS. General Surgery GIRFT Programme Follow-up Report : Mortality and morbidity (M&M) meetings should evolve beyond a traditional focus on deaths and major complications to include routine review of performance data.

Recommendation	Audience	Audit Findings	Quality Improvement (QI) Goal	National Guidance/Standards/Resources
4. Specialist centres with comparatively high rates of readmission within 30 days of discharge following an OG resection to ensure there is adequate discharge planning within Enhanced Recovery after Surgery (ERAS) pathways, so that people are prepared for recovery at home and can access follow-up nutritional and support services. Centres should also undertake regular local audit and review of readmissions, including root cause analysis of potentially preventable readmissions, to identify opportunities for service improvement and reduce avoidable hospital reattendance.	England and Wales: Specialist surgical centres	Following curative surgery for OG cancer, 15% of people in England and 11% in Wales were readmitted to hospital within 30 days of discharge, requiring an overnight stay. After case-mix adjustment, rates across surgical centres in England ranged from 7% to 29%.	Goal #4: Improve short-term outcomes for people receiving treatment for OG cancer.	NICE guideline 94 Chapter 35 Discharge Planning : 30-day readmission is an important outcome measure linked to discharge processes and transitional care.
5. Optimise decision-making and supportive care for all people being considered for palliative systemic anti-cancer therapy (SACT). - Carry out thorough assessment, counselling, and consideration of specialist palliative care involvement. In older people, 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 should be discussed as an alternative. - Review all deaths within 30 days of palliative SACT through local morbidity and mortality processes to support continuous improvement in treatment decision-making.	England: Cancer Alliances working with Integrated Care Boards (ICBs) and NHS trusts Wales: health boards	Among people with stage 4 OG cancer receiving SACT, 4.2% in England and 4.6% in Wales died within 30 days of starting treatment. Within 90 days of starting treatment, 16.0% of people in England and 14.9% in Wales had died. There was variation between NHS trusts in England for 90-day mortality: IQR 12% to 21%.	Goal #4: Improve short-term outcomes for people receiving treatment for OG cancer.	NCEPOD : all deaths within 30 days of SACT should be considered at a morbidity and mortality or a clinical governance meeting. The UK SACT Board has developed a template for an operational policy and pro forma for reviewing deaths within 30 days of SACT. RCR : Centres should present mortality figures so that departments can put their short-term mortality into context. BGS : Late recognition of end of life in people with frailty can impede patient-centred decisions.

9. NPaCA Recommendations

The SotN Report can be found [here](#).

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/ Standards/ Resources
1. Review the pathways of people who waited longer than three months from referral to receive treatment, to identify potential bottlenecks in pancreatic cancer pathways. - Compare diagnostic processes against the recommended sequencing of diagnostic events set out in hepatopancreatobiliary (HPB) cancer pathway guidance. - Review treatment pathways in line with best practice guidelines to improve people's access to timely treatment, including pathways to expert HPB oncology review.	England: Cancer Alliances working with NHS trusts and specialist centres Wales: health boards	68% of people with pancreatic cancer in England and 66% of those in Wales were diagnosed within 21 days of referral. Median time from referral to treatment: England: 74 days, trust-level variation (IQR) 65.5–82 days. Wales: 76 days, local health board-level variation (range) 67–96 days.	Goal #2: Reduce the time from referral to diagnosis 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 GIRFT 2025: Pancreatic cancer specialty report
2. Conduct a review of people who were not recorded as being discussed at a multidisciplinary team (MDT) meeting to identify the reasons. Where issues are identified, ensure these are captured in local MDT improvement work plans to increase the percentage of people who are discussed at an appropriate MDT meeting.	England: Cancer Alliances working with NHS trusts Wales: health boards	77% of people diagnosed with pancreatic cancer in England had a record of being discussed at an MDT meeting. Trust-level variation (IQR) 72%–88%. Wales: Information on MDT meetings was available for only 28% of people diagnosed in Wales, who had their information submitted via the new Cancer Dataset Forms (CDF). Among this group, 91% had a recorded MDT date.	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).	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.
3. Conduct a review of people who had good performance status (0/1) at diagnosis but did not receive any disease-targeted treatment to understand the reasons for decisions not to treat. Where deconditioning prior to treatment is identified as an issue, improving access to early enhanced supportive care and supportive oncology services, prehabilitation, oncogeriatric services and dietetic support should be prioritised.	England: Cancer Alliances working with NHS trusts Wales: health boards	Among people diagnosed with stages 1-3 pancreatic cancer, 57% in England and 50% in Wales received any disease-targeted treatment within 9 months of diagnosis. Among those with good performance status (PS 0/1) at diagnosis, rates of treatment were 72% in England and 63% 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 specification NHS Wales Cancer Network Service Specification for HPB surgery services PCUK Optimal Care Pathway report Macmillan Cancer Support (2025) Prehabilitation for people with cancer: clinical and implementation guidelines

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/ Standards/ Resources
4. Conduct a review of people who were not recorded as being seen by a Clinical Nurse Specialist (CNS) to identify potential barriers to timely CNS support and data recording. Ensure that everyone diagnosed with pancreatic cancer has access to a specialist CNS from the point of diagnosis.	England: Cancer Alliances working with Integrated Care Boards (ICBs) and NHS trusts Wales: health boards	Among people diagnosed with pancreatic cancer in England with complete data on CNS, 88% were seen by a CNS around the time of diagnosis. Trust-level variation (IQR): 83%–98%. Information on CNS was available for only 55% of people diagnosed in England. Trust-level variation (IQR): 42%–74%. Wales: Information on CNS was available for only 24% of people diagnosed in Wales, who had complete information submitted via the new Cancer Dataset Forms (CDF). Among this group, 91% had a record of being seen by a CNS.	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, including those who do not undergo any treatment, have access to enhanced supportive care including assessment for eligibility for pancreatic enzyme replacement therapy (PERT) at the first clinical review. PERT should be offered to all eligible patients.	England: Cancer Alliances working with MDT leads Wales: health boards working with MDT leads	Among all people diagnosed with pancreatic cancer in England, 55% had a primary care prescription for PERT. Among the subgroup of people who survived at least 90 days from diagnosis, this figure was 67%. Trust-level variation (IQR): 57% to 76%. People who received disease-targeted treatment were more likely to have a prescription for PERT than those who did not receive treatment (74% versus 57%). Wales: not reported due to data availability	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 specification NHS Wales Cancer Network Service Specification for HPB surgery services

10. NPCA Recommendations

The SotN Report can be found [here](#).

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. Continue to advocate active surveillance for men with low-risk prostate cancer by: - documenting whether men eligible for active surveillance are offered it and reasons for treating, where appropriate - performing a detailed case-note review to determine why low-risk men are not undergoing active surveillance in specialist multidisciplinary teams (sMDTs) with a higher-than-expected percentage of men receiving radical treatment for low-risk disease - using the findings of the case-note review, centres should design local quality improvement interventions to decrease overtreatment rates	England: Cancer Alliances working with NHS trusts Wales: health boards	7% of men diagnosed with low-risk localised disease in England and 11% in Wales underwent radical treatment within 12 months of diagnosis	Goal #2: To reduce potential overtreatment	NICE Guideline [NG131] , 2019 1.3.8 For people with CPG 1 localised prostate cancer: - offer active surveillance - consider radical prostatectomy or radical radiotherapy if active surveillance is not suitable or acceptable to the person.
2. Investigate why men with high-risk/locally advanced disease are not considered for radical treatment and aim to reduce that percentage, if appropriate, by: - documenting by sMDTs whether men eligible for radical treatment are offered it and reasons for not treating, where appropriate - performing a detailed case-note review to determine why high-risk men are not receiving radical treatment in sMDTs with a lower-than-expected percentage of men receiving radical treatment for high-risk disease - assessing fitness for treatment regardless of chronological age and considering referral to oncogeriatric services, if appropriate - using the findings of the case-note review, centres should design local quality improvement interventions to reduce potential undertreatment	England: Cancer Alliances working with NHS trusts Wales: health boards	69% of men diagnosed with high-risk/locally advanced disease in England and 54% in Wales underwent radical treatment within 12 months of diagnosis	Goal #3: To reduce potential undertreatment	NICE Guideline [NG131] , 2019 1.3.11 Do not offer active surveillance to people with high-risk localised and locally advanced prostate cancer. NICE Guideline [NG131] , 2019 1.3.12, 1.3.21 Offer radical prostatectomy or alternatively radical radiotherapy in combination with androgen deprivation therapy (ADT) to men with high-risk localised and locally advanced prostate cancer. NPCA Data Dashboard

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
3. Review variation between providers in rates of 90-day readmission rates and GU/GI complications by: - ensuring proactive onward referral to specialist services for the management of side effects - using the NPCA quarterly report feedback to evaluate quality improvement relating to readmissions	England: Cancer Alliances working with NHS trusts Wales: health boards	Variation (IQR) between providers for emergency readmission within 90 days of surgery is 8-15% (England) and 6-26% (Wales); for GU complications post radical prostatectomy is 4-7% (England) and 3-8% (Wales); for GI complications post radical radiotherapy is 5-11% (England) and 6-11% (Wales); for GU complications post radical radiotherapy is 3-6% (England) and 5-7% (Wales)	Goal #4: To reduce short-term complications after radical prostate cancer surgery Goal #5: To reduce medium-term complications after radical prostate cancer surgery and radiotherapy	EAU - EANM - ESTRO - ESUR - ISUP - SIOG Guidelines on Prostate Cancer [2025] 6.2.2.4 Acute and chronic complications of radical prostatectomy. Royal College of Radiologists Guidance: "Radiotherapy target volume definition and peer review". NPCA Prostate Radiotherapy Masterclass Part 1 & 2.
4. Decisions regarding treatment should consider life expectancy and co-morbidity, balancing the treatment benefits and risks, to ensure equitable care by: - using individualised assessment, such as comprehensive geriatric assessment (CGA) tools, to accurately measure men's health status and not deny men investigations or treatment based on chronological age alone - involving men and their families in shared decision-making, clearly explaining potential outcomes and aligning treatment decisions with their preferences, values, and quality of life goals - checking that standardised clinical pathways for prostate cancer treatment are shared across the sMDT, ensuring that every man receives evidence-based care regardless of their socio-demographic characteristics	England: Cancer Alliances working with NHS trusts Wales: health boards	In England, three-year mortality rates for men with newly diagnosed metastatic prostate cancer fell from 55.8% (overall) and 44.6% (prostate cancer-specific) in 2015 to 47.1% (overall) and 35.1% (prostate cancer-specific) in 2022 respectively	Goal #1: To improve timely diagnosis and treatment of high-risk prostate cancer Goal #3: To reduce potential undertreatment	EAU - EANM - ESTRO - ESUR - ISUP - SIOG Guidelines on Prostate Cancer [2025] 6.1.3 Heterogeneity in performance increases with advancing age, so it is important to use measures other than just age or performance status when considering treatment options. NICE Guideline [NG131], 2019 Offer people with metastatic prostate cancer tailored information and access to specialist urology and palliative care teams to address their specific needs. NPCA Quality Improvement Intervention 2026 – Educational Webinar: "The Use of Systemic Anti-Cancer Treatment in Metastatic Prostate Cancer"

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Data Quality Recommendation				
5. Aim to achieve greater completeness of key data items at the point of collection by NHS organisations in England and Wales, particularly tumour, node and metastasis (TNM) staging, prostate-specific antigen (PSA) and Gleason score variables by: • appointing a clinical data lead within SMDTs with protected time for reviewing and checking the team's data returns and for championing improvements in data completeness • integrating routine documentation of staging, PSA and Gleason information into MDT meetings • using the NPCA quarterly report feedback to evaluate quality improvement relating to data completeness	England: Cancer Alliances working with NHS trusts Wales: health boards	Data completeness in NCRD: TNM: England 79% Wales 76% PSA: England 62% Wales 98% Gleason score: England 82% Wales 54%	Applies to all QI goals: improved data completeness underpins all clinical recommendations and QI goals and allows all performance indicators and QI goals to be better assessed	The Cancer Outcome and Services Dataset (COSD) has been the national standard for reporting cancer in the NHS in England since January 2013. Feedback reports for the data submitted are available through the National Disease Registration Service (NDRS) Data Quality and Insights Hub. COSD is the main source for the Rapid Cancer Registration Dataset. The Cancer Network Information System Cymru (CaNISC) collects, analyses and releases information about cancer in Wales.
All recommendations reinforce priorities identified in previous NPCA State of the Nation reports reflecting their importance. The clinical recommendations are consistent with previous year's recommendations as not enough time has passed to be able to assess whether improvement has taken place following publication of previous NPCA State of the Nation reports.				