NPaCA
National Pancreatic Cancer Audit

NATCAN
National Cancer Audit Collaborating Centre

National Pancreatic Cancer Audit

Quality Improvement Plan – September 2026



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Executive Summary

The National Pancreatic Cancer Audit (NPaCA) evaluates the quality and outcomes of care for people diagnosed with pancreatic cancer in England and Wales. It aims to help NHS organisations to benchmark their pancreatic cancer care against measurable standards, identify unwarranted variation in care, and to drive improvements in the quality and outcomes of care.

The NPaCA Quality Improvement Plan (QIP) sets out the scope, five quality improvement goals and ten performance indicators for the Audit. To inform the development of this plan, the NPaCA team carried out 1) a review of clinical guidelines, existing audits/registries and literature relevant to pancreatic care, and 2) consultations with key stakeholders, including clinical experts, allied health professionals, patient groups and charities, and representatives from NHS England and NHS Wales. These activities built on a feasibility study conducted by the National Oesophago-Gastric Cancer Audit in 2022, which comprised a stakeholder survey and review of potential performance indicators for an audit of pancreatic cancer.

The NPaCA includes all adults diagnosed with exocrine pancreatic cancer in England and Wales and covers the care pathway from first diagnosis of pancreatic cancer to the end of primary treatment, including treatments with and without curative intent.

The following quality improvement goals have been identified for the NPaCA:

1. Increase the percentage of people who have diagnostic procedures and a process of diagnosis consistent with national recommendations for pancreatic cancer
2. Reduce the time from referral to diagnosis and start of disease-targeted treatment
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)
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
5. Improve outcomes for people diagnosed with pancreatic cancer

The NPaCA reports ten performance indicators, mapped to the five quality improvement goals and clinical guidelines. This QI Plan sets out improvement methods, improvement activities and approaches to evaluation of these goals and activities.

1. Introduction

1.1 Aim and objectives of the Quality Improvement Plan

The National Pancreatic Cancer Audit (NPaCA) Quality Improvement Plan builds on its Scoping Document and previous QI Plans, which set out the Audit's scope and coverage of the care pathway, and identified key quality improvement priorities.

The QI Plan sets out and prioritises the Audit's five quality improvement goals and ten performance indicators, which are designed to support benchmarking, identify unwarranted variation, and enable targeted improvement at service level. The QI Plan outlines key improvement activities that will support implementation of the plan, in addition to the approaches to evaluate progress and impact.

The NPaCA Quality Improvement Plan was developed in consultation with key stakeholders, including people with lived experience of pancreatic cancer, and was last reviewed in 2026.

1.2 The National Cancer Audit Collaborating Centre

The NPaCA is part of the National Cancer Audit Collaborating Centre (NATCAN), a national centre of excellence which aims to strengthen NHS cancer services by analysing patterns of care, treatments and patient outcomes across England and Wales. It was set up on 1 October 2022 to deliver six new national cancer audits, including kidney, ovarian, pancreatic, breast cancer (two separate audits in primary and metastatic disease) and non-Hodgkin Lymphoma. In addition, existing audits in prostate, lung,

bowel, and oesophago-gastric cancers moved into NATCAN in 2023-24. The centre is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government.

The aims of the ten NATCAN Audits are to:

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

Further information about NATCAN and the key features of its approach to audit can be found in the appendix.

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2. Background: pancreatic cancer

2.1 Main issues in pancreatic cancer care and outcomes

Patterns of care provided to people with pancreatic cancer have been reported to vary across England and Wales.[1]

In its 2020 report[2], Pancreatic Cancer UK (PCUK) highlighted results from the global surveillance of trends in cancer survival 2000–14 (CONCORD-3)[3], which demonstrated that the UK was ranked 29th out of 33 countries for five-year survival for pancreatic cancer and had a lower proportion of people diagnosed with early stage (1 or 2) disease than other countries. The PCUK report went on to highlight:

- regional variation in the distribution of disease stage,
- low rates of surgery with curative intent,
- regional variation in the proportion of patients who had chemotherapy after surgery, and
- regional variation in the proportion of patients who received palliative chemotherapy.

While these figures relate to care delivered before 2020, the evidence highlights various areas of concern.

The COVID-19 pandemic had a major impact on routine care pathways for people with cancer. Although there was not a reduction in the number of people diagnosed with pancreatic cancer during the pandemic, fewer people underwent a surgical resection (6 for every 100 people diagnosed) compared with the pre-pandemic period (8-9 per 100 people). (Lemanska et al.)[4]

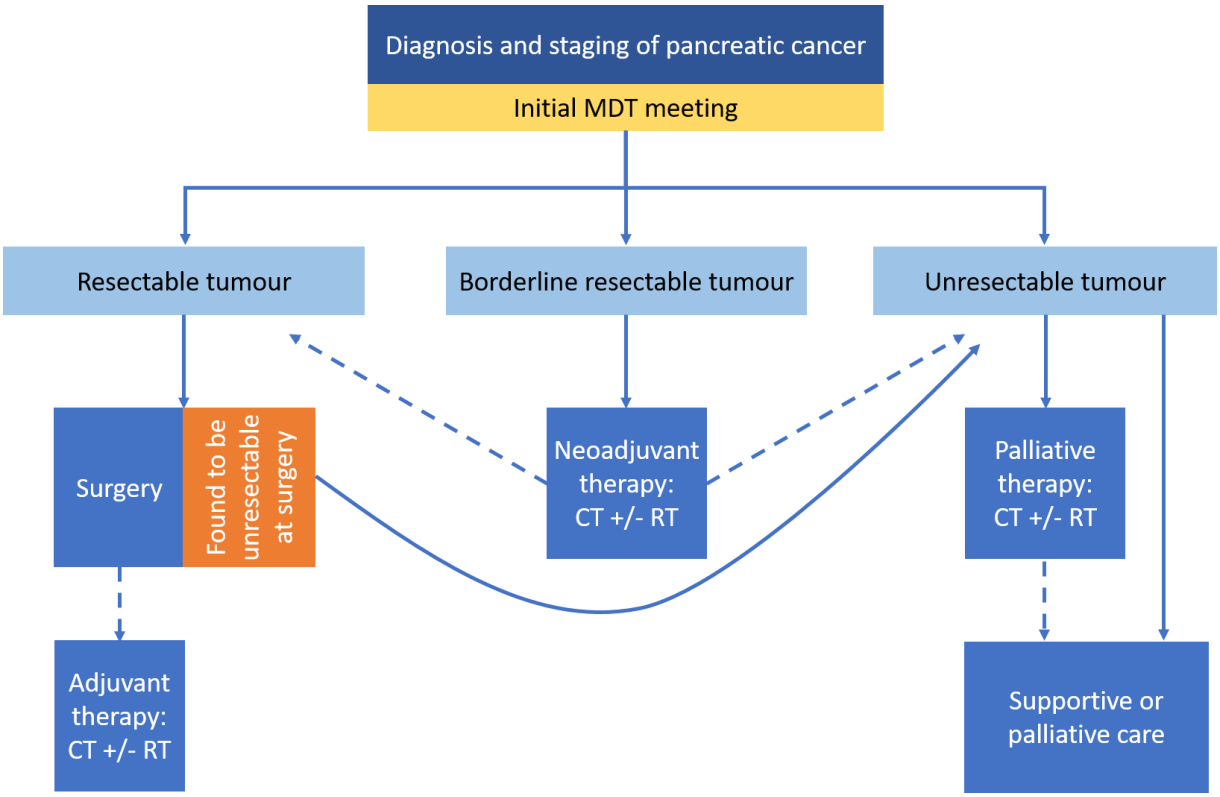
Variation in prescribing of pancreatic enzyme replacement therapy (PERT), a treatment that is recommended for all people with unresectable pancreatic cancer to manage digestive problems caused by pancreatic cancer, has been found in two recently published studies. In a prospective study by the RICOCHET Study Group, rates of PERT prescribing in the UK were 74.4% in people with potentially resectable disease and 45.3% in those with unresectable disease in 2018.[5] A second study using a primary care prescribing database in England estimated prescribing rates in England were far below the expected 100% level, at only 48% nationally in December 2022.[6] Regional rates ranged from approximately 30 to 60%.

2.2 Care pathways

The management of pancreatic cancer involves a variable sequence of treatments which depend on the characteristics of the individual (Figure 1, overleaf). People who are diagnosed with a tumour that has not spread beyond the pancreas, and does not involve important local blood vessels, are considered to have resectable (operable) cancer, and if they are sufficiently fit will have surgery to remove the tumour. Following this, they may receive systemic anti-cancer therapy (such as chemotherapy) with or without radiotherapy. A tumour can be classified as borderline resectable if local arteries and veins are involved. In this scenario, individuals may receive systemic therapy with or without radiotherapy, with the aim of reducing the size of the tumour to enable surgical removal. People who have advanced pancreatic cancer (precluding surgery) may receive treatments aimed at extending life and/or managing symptoms caused by the cancer.

[1] Exarchakou A, et al. Pancreatic cancer incidence and survival and the role of specialist centres in resection rates in England, 2000 to 2014: A population-based study Pancreatology. 2020;20(3):454-61.
[2] Pancreatic Cancer UK PCUK-Variation-Report-Aug-2020.pdf
[3] Allemani C, et al. Global surveillance of trends in cancer survival 2000-14 (CONCORD-3): analysis of individual records for 37 513 025 patients diagnosed with one of 18 cancers from 322 population-based registries in 71 countries Lancet. 2018;391(10125):1023-75.
[4] Lemanska A, et al. Healthcare in England was affected by the COVID-19 pandemic across the pancreatic cancer pathway: A cohort study using OpenSAFELY-TPP. Elife. 2023;12.
[5] RICOCHET Study Group. Pancreatic enzyme replacement therapy in patients with pancreatic cancer: A national prospective study. Pancreatology. 2021.
[6] Lemanska A, et al. A national audit of pancreatic enzyme prescribing in pancreatic cancer from 2015 to 2023 in England using OpenSAFELY-TPP. medRxiv. 2023

Figure 1: Sequence of steps in common pancreatic cancer pathway, from diagnosis to treatment, in English and Welsh NHS organisations



CT: chemotherapy; MDT: Multi-disciplinary team; PS: performance status; RT: radiotherapy; Supportive care: helps the person to cope with their cancer and its treatment; Palliative care: care towards the end of life that aims to provide relief from pain and other distressing symptoms.
NOTE: Dashed lines indicate variations or alternative steps in pathways; some patients may not proceed along these routes

2.3 Guidelines on the management of pancreatic cancer

There are several UK-specific guidelines relevant to pancreatic cancer care, which were reviewed as part of the set-up of NPaCA and are referenced where applicable within the Audit's scoping document:

- NICE Guideline NG85: "Pancreatic cancer in adults: diagnosis and management"
- NICE Quality Standard QS177: "Pancreatic cancer quality standard"
- NICE Guideline NG12: "Suspected cancer: recognition and referral"
- NHS England Clinical Commissioning Policy Statement: "Stereotactic ablative body radiotherapy for patients with locally advanced, inoperable, non-metastatic pancreatic carcinoma"
- European Society for Medical Oncology (ESMO) clinical practice guideline: "Pancreatic cancer: ESMO Clinical Practice Guideline for diagnosis, treatment and follow-up"

Pancreatic cancer care may involve a combination of treatment modalities: surgery, systemic anti-cancer therapy, radiotherapy, endoscopic treatments, and pancreatic enzyme replacement therapy (PERT). There are ongoing developments within each of the different modalities. For example, the range of available systemic anti-cancer therapies is expanding, along with research into the optimal timing for its use, with new targeted therapies being developed for individualised genetic and molecular tumour profiles. Other changes include an increasing use of neoadjuvant systemic anti-cancer therapy over the last decade.

Guidance is also available on the organisation of services. In Wales, the NHS Wales National Optimal Pathways (NOPs) programme produced guidance to support pancreatic cancer services in establishing an effective and efficient pancreatic cancer pathway. It covers the pathway from diagnosis, staging and the various treatment options, as well as highlighting when patients should receive information and support to meet their individual needs.

3. Approach to developing the Quality Improvement Plan

The NPaCA Quality Improvement Plan builds on the Audit's Scoping Exercise and ongoing consultation with key clinical, policy and patient stakeholders. This work ensures that the Audit scope remains clinically relevant, feasible using available data, and aligned with national priorities for cancer quality improvement.

3.1 Approach to developing the audit scope

The scope of the NPaCA has been developed and reviewed in consultation with a range of stakeholders. The following approaches were taken:

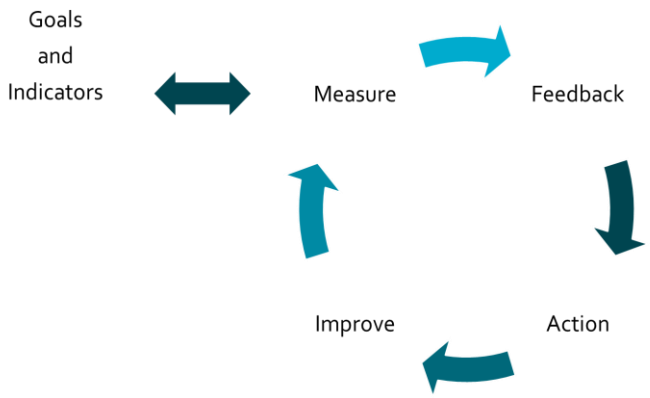
- **A feasibility study** for an audit of pancreatic cancer was conducted in 2022 by the National Oesophago-gastric Cancer Audit (NOGCA) team. The study comprised an online stakeholder survey and review of potential performance indicators. Responses were received from a range of stakeholders including medical professionals and Pancreatic Cancer UK.
- **Consultation with the Clinical Reference Group (CRG).** The CRG for NPaCA includes representation from surgery, medical oncology, clinical oncology, radiology, gastroenterology, palliative care, cancer nurse specialists, HPB specialist dietitians, patient groups, NHS England, and NHS Wales.
- **Consultation with patient charities,** Pancreatic Cancer UK and Pancreatic Cancer Action, to hear about the experience of their members and understand their priorities.

Details of the scoping exercise, including the results of the feasibility study and meeting discussion points, can be found in the NPaCA Scoping Document.

3.2 Approach to prioritising performance indicators

Clinical Performance Feedback Intervention Theory (CP-FIT)[7] states that developing improvement goals and performance indicators are the first steps in the audit and feedback cycle (Figure 2).

Figure 2: The audit and feedback cycle



Based on the quality improvement priorities identified in the scoping exercise, the NPaCA developed a list of candidate performance indicators. Prioritisation of ten indicators from this list of candidates was informed by the following set of key principles. To enhance the NPaCA's ability to inform improvements in care, its performance indicators were required to meet the following criteria:

[7] Brown B, Gude WT, Blakeman T, van der Veer SN, Ivers N, Francis JJ, et al. Clinical Performance Feedback Intervention Theory (CP-FIT): a new theory for designing, implementing, and evaluating feedback in health care based on a systematic review and meta-synthesis of qualitative research. Implement Sci 2019;14:40.

- **Measurable** so that they can be the basis of credible feedback about performance. This property means that the indicators can be defined with available data in a valid, reliable, and fair manner that allows performance to be attributed to a specific unit.[8]
- **Actionable** so that feedback translates into action to improve care. Indicators should therefore be important and address a specific pathway of care that is clear to all stakeholders. Stakeholders should understand the drivers of variation in performance within this pathway and control the levers for change. These changes should be evidence-based and address policy priorities.
- **Improvable** so that actions have the desired effect on patient care. There should therefore be clear scope for improvement (low baseline levels or large unwarranted variation) in a large population and a receptive context, with no unintended consequences. Some interventions may have demonstrated improvements to certain indicators in existing literature.

3.3 Data provision

The NPaCA utilises information from routine national healthcare datasets. These datasets capture details on the diagnosis, management and treatment of every person who is diagnosed with pancreatic cancer in England and Wales. Further details on data acquisition can be found in the appendix.

3.4 Data limitations

For accurate and timely benchmarking, it is essential that data used by the NPaCA:

1. Include all the data items required to measure and risk-adjust performance indicators
2. Are timely
3. Have a high-level of case-ascertainment
4. Have high levels of data completeness
5. Are accurate.

For people treated in England, Rapid Cancer Registration Data (RCRD) linked to other national healthcare datasets is used for quarterly reporting. This dataset is mainly compiled from Cancer Outcomes and Services Dataset (COSD) records and is made available more quickly than the gold standard National Cancer Registration Data (NCRD). The speed of production means that case ascertainment and data completeness are lower, and fewer data items are available in the RCRD compared to the NCRD. The NCRD is used to inform the annual State of the Nation Report. This dataset has a longer lag than RCRD, but higher case ascertainment and data completeness due to additional curation by NDRS and linkage to additional datasets such as the Medicines Prescribed in Primary Care.

For people treated in Wales, reporting uses data submitted to the National Cancer Team, NHS Wales Performance and Improvement. These data are linked to other national datasets including hospital admissions and treatment data.

3.5 Stakeholder involvement

The NPaCA is delivered through a partnership that combines clinical leadership, methodological expertise, project management and a secure environment for data analysis, representing the following organisations), Royal College of Radiologists (RCR), British Society of Gastroenterology (BSG), and NATCAN.

The Audit team is supported by twice-yearly meetings of stakeholders in its Clinical Reference Group (CRG), which includes clinicians from across the patient pathway, patient representatives, commissioners and funder representatives. The CRG provides clinical oversight and advises on audit scope, indicator selection, interpretation of findings and improvement priorities. NPaCA also has a Patient and Public Involvement (PPI) Forum, whose members represent people with lived experience of pancreatic cancer and several patient organisations.

[8] Geary RS, Knight HE, Carroll FE, Gurol-Urganci I, Morris E, Cromwell DA, van der Meulen JH. A step-wise approach to developing indicators to compare the performance of maternity units using hospital administrative data. BJOG 2018;125:857-65.

3.6 Service provision

Pancreatic cancer care in England and Wales is organised around specialist centres, where specialist multidisciplinary teams review new diagnoses of pancreatic cancer, plan treatment, and carry out surgical resections for people who are eligible. There are 23 specialist hepatopancreaticobiliary (HPB) centres in England, and one surgical and two oncology specialist centres in Wales[9]. This centralised service model was implemented following the publication of national guidance in 2001, which recommended that specialist teams for pancreatic cancer serve populations of two to four million, to ensure the teams reach minimum treatment volumes associated with improved outcomes[10].

4. Audit scope

4.1. Patient inclusion criteria

NPaCA includes adults (≥18 years of age) diagnosed and/or treated in England or Wales by NHS hospital services for exocrine pancreatic cancer (ICD-10 code C25; see Table 1 for exclusions).

Patients are eligible if they have a radiologic or clinical diagnosis; eligibility is not limited to those with a histological diagnosis because a large proportion of people with pancreatic cancer are too unwell to undergo biopsy for histological diagnosis. Neuroendocrine tumours can be identified on imaging and are excluded.

4.2. Care pathway

The Audit covers the pathway from diagnosis of pancreatic cancer through to the end of primary treatment.

Primary treatment includes planned treatments with, and without, curative intent. Treatments may be multimodal and include any of surgery, chemotherapy (CT), radiotherapy (RT), supportive or palliative care. Interventions aimed at relief of symptoms, such as a biliary drainage stent or PERT, will not be considered primary treatment unless they are part of best supportive care.

Compared to some other tumour types, pancreatic cancer has relatively few known biomarkers and targeted therapies. However, the Audit will monitor emerging personalised medicine approaches in pancreatic cancer and report on system factors that support personalisation.

Table 1. ICD-10 diagnosis codes for defining people who are eligible for inclusion

Inclusion criteria	**Rationale**
Diagnosis is one of the following: • C25.x Malignant neoplasm of pancreas	
Exclusion criteria	**Rationale**
Diagnosis is one the following: • C25.4 Pancreatic neuroendocrine tumour	• Neuroendocrine tumours have a different treatment pathway and outcomes compared to exocrine pancreatic cancers

[9] Pancreatic Cancer UK. Specialist centres 2022 [Available from: https://www.pancreaticcancer.org.uk/support-for-you/your-care/your-local-pancreatic-cancerspecialist-centre/
[10] NHS Executive. Guidance on Commissioning Cancer Services: Improving Outcomes in Upper Gastro-intestinal Cancers, The Manual. 2001

5. Quality Improvement Goals & Performance indicators

Quality improvement goal	Performance indicators	National Guidance/standards
Increase the percentage of people who have diagnostic procedures and a process of diagnosis consistent with national recommendations for pancreatic cancer	PI1.Percentage of people who had an FDG-PET/CT scan prior to surgery for pancreatic cancer	NICE Quality Statements (QS 177 - Pancreatic cancer): 1. "Adults with suspected pancreatic cancer have their diagnosis and care agreed by a specialist pancreatic cancer multidisciplinary team (MDT)" (QS1) 2. "Adults with localised pancreatic cancer on CT have staging using FDG-PET/CT before they have surgery, radiotherapy, or systemic therapy" (QS2) NICE guideline NG85 2018
	PI2. Percentage of people who had a record of being discussed at a multidisciplinary (MDT) meeting	
	PI3. Percentage of people undergoing a Whipple procedure (without neo-adjuvant chemotherapy) who had a biliary stent placed prior to surgery	
Reduce the time from referral to diagnosis and start of disease-targeted treatment	PI4 Time from referral to first disease-targeted treatment	NHSE Best Practice Timed Diagnostic Pathway for HPB cancer NHS Wales National Optimal Pathway for pancreatic cancer PCUK Optimal Care Pathway report
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)	PI5. Percentage of people with non-metastatic (stage 1-3) pancreatic cancer who received disease-targeted treatment*	Pancreatic Cancer UK reports that only 3 out of 10 people with pancreatic cancer receive active treatment. Furthermore, expert clinical input believes current clinical practice has moved beyond the NICE guidelines for pancreatic cancer published in 2018, with greater use of CT/RT in practice than is recommended in the guidelines. NHS England HPB cancer service spec NHS Wales Cancer Network Service Specification for HPB surgery services
	PI6. Percentage of people with metastatic (stage 4) pancreatic cancer who received disease-targeted treatment*	
	PI7. Percentage of people with pancreatic cancer who received chemotherapy and/or radiotherapy alongside surgery	
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	PI8. Percentage of people with pancreatic cancer and complete data on CNS who were seen by a clinical nurse specialist (CNS)	NICE Quality Statement (QS 177 - Pancreatic cancer): 1. “Adults with unresectable pancreatic cancer are prescribed enteric-coated pancreatin” (QS4) 2. “Effective interventions to address psychological needs” (QS5), but no guidance is currently available. The PCUK Optimal Care Pathway Policy Report recommends an HPB CNS should be responsible for coordinating access to psycho-social support. NHSE 2024: HPB best practice timed diagnostic pathway: *Cancer Alliances and local stakeholders should take action to improve local healthcare professional awareness of PERT.*
	PI9. Percentage of people who survived at least 90 days from diagnosis were prescribed pancreatic enzyme replacement therapy (PERT) in primary care	
Improve outcomes for people diagnosed with pancreatic cancer	P10. Survival at 30- and 90-days, and 1- and 2- years after diagnosis	N/A

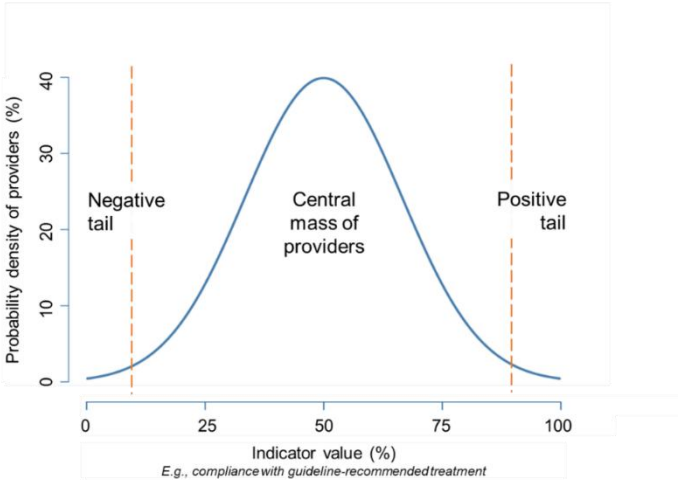
*” Disease-targeted treatment” includes surgery, chemotherapy and radiotherapy, and includes treatments with curative and palliative intent; this may include both treatments targeting the disease and symptom management.

6. Quality Improvement Methods

The figure below shows a hypothetical example of how a performance indicator may be distributed across NHS providers nationally at a single time point. For quality improvement purposes, this distribution can be considered in three domains: the negative tail (suggestive of worse performance), the central mass (where most providers cluster), and the positive tail (suggestive of better performance).

Each domain is associated with a different set of methods for improving healthcare.

Figure 3. Hypothetical distribution of organisational values on a performance indicator across NHS providers



Negative tail

Example methods: Regulation and public reporting of outliers

- Clinical audit has traditionally focused on the negative tail to improve healthcare. This approach is primarily concerned with identifying providers at risk of delivering substandard care and ensuring that minimum standards are met. Such intervention may be necessary to assure minimum standards of care and to reduce inequality between the best and worst performing NHS providers.

Central mass

Example methods: Statistical process control and iterative testing of interventions

- Most providers have indicator values that lie in the central mass of the distribution. Efforts focused here may present the greatest scope for improving average levels of care nationally. Methods in this domain suggest that all providers can improve their performance, regardless of current levels. Local audits and evaluations can inform the iterative deployment of interventions which incrementally raise standards. Longitudinal monitoring by national clinical audits provides feedback about whether improvements occur or not.

Positive tail

Example methods: Positive deviance

- Some NHS providers perform exceptionally well despite similar constraints to others, which presents opportunities to learn and share how this is achieved. 'Positive deviance' approaches assert that generalisable solutions to better performance already exist within the system. Such solutions are therefore likely to be acceptable and transferable within existing resources. These approaches aim to identify local innovations and spread them to other settings (see Appendix 3).

The NPaCA has selected methods to implement to improve pancreatic cancer care after investigating the distributions of its performance indicators (outlined in section 5). This includes the distribution of performance indicators between providers at a given time point and within providers over time.

7. Improvement activities

7.1 National and Regional

The NPaCA undertakes activities that directly support system-level improvement in the delivery of pancreatic cancer services. These activities use audit outputs to inform policy, assurance, and coordinated improvement action at national and regional levels. These include:

Stakeholder	NPaCA activity
NATIONAL	
NHS England / Welsh Cancer Network	Identify issues and make recommendations on the organisation and delivery of pancreatic cancer services which might involve large-scale investment, national leadership or service reorganisation.
Care Quality Commission	Provide Care Quality Commission CQC with information to support local inspections of NHS trusts and highlighting areas of concern identified after an organisation is flagged as a potential outlier on a NPaCA performance indicator.
Professional societies	Identify issues and make recommendations regarding the delivery of pancreatic cancer services that fall within the remit of the professional associations.
National programmes	Engage with national programmes such as the pancreatic cancer Getting Right First Time (GIRFT) peer review, to identify areas for coordination and shared learning.
REGIONAL	
Cancer Networks / Alliances / Vanguards	Support the monitoring role of Welsh Cancer Networks and the English Cancer Alliances / Vanguards by publishing results for their region/area.

At a national level, the NPaCA team also provides the National Cancer Registration and Analysis Service (NCRAS) Data Improvement Leads (in England), and the Wales Cancer Network with information to help them support their NHS organisations to improve the quality of their routine data submissions.

7.2 Local

The NPaCA will support local NHS cancer services in the provision of quality care to people with pancreatic cancer in the following ways:

Feedback activity	Description
Annual State of the Nation Report	State of the Nation report that enables NHS organisations to benchmark themselves against clinical guideline recommendations and national performance.
Web-based data dashboard	Presents results for individual NHS organisations that allows the user to view the results of selected indicators and providers, as a “snapshot” and over time. Updated on a quarterly basis.
Local Action Plan template	Template that allows NHS organisations to document how they will respond to the State of the Nation Report recommendations.
Outlier reporting	Reporting of NHS provider values that are more than three standard deviations from the expected level of performance (i.e. deemed a potential outlier). NPaCA will support outliers to understand the findings and identify areas for improvement.

7.3 Improvement tools

The NATCAN website includes a Quality Improvement Resources page that directs healthcare providers to quality improvement tools including:

- ‘How to’ guides including quality improvement methodology
- Links to existing resources
- Links to training courses for quality improvement
- Good practice repository with contact information where possible.

NPaCA will continue to share findings and support learning through relevant national professional meetings and quality improvement initiatives, helping to spread effective practice and engage clinical teams.

7.4 National Quality Improvement Intervention

NPaCA has developed a national quality improvement (QI) intervention to support Cancer Alliances and NHS trusts in improving rates of disease-targeted treatment for people with pancreatic cancer. (For more details see our Quality Improvement web pages).

This intervention focuses on the performance indicator “Percentage of people with non-metastatic (stage 1-3) pancreatic cancer who received disease-targeted treatment”, which aligns with the NHS England Treatment Variation Working Group (TVWG) recommendation for pancreatic cancer.

The intervention is underpinned by analysis of routinely collected cancer data that shows substantial variation in treatment rates across England. As part of the intervention, NPaCA is providing Cancer Alliance-specific reports that present recent performance benchmarked against the target set by the NHSE TVWG, alongside detailed trust-level results within each Alliance.

These reports are intended to support local review of treatment pathways, identification of potential barriers and equity gaps, and discussion between Cancer Alliances and trusts to agree and implement targeted improvement actions. This intervention supports the translation of audit findings into coordinated system-level quality improvement activity.

7.5 Patient and Public Involvement

Patient representatives are regularly consulted on the design of the Audit and the communication of its results, via the NPaCA Patient and Public Involvement (PPI) Forum. The chair of the PPI Forum also acts as a patient representative on the Clinical Reference Group to advise on Audit priorities and participate in the development and review of key Audit outputs. The PPI Forum:

- Has a key advisory role in developing the design and function of the Audit website to ensure that patients and the public can easily access the information they are seeking,
- Contributes to the design and content of patient information materials and NPaCA reports for the public,
- Provides input into the development of the Audit’s quality improvement goals, activities and outputs to ensure they reflect priorities from the patient perspective, and
- Supports dissemination of NPaCA findings and outputs through patient networks and charitable organisations.

7.6 Communication & dissemination activities

NPaCA uses a range of communication and dissemination activities to support awareness, interpretation and uptake of audit findings among stakeholders, providers, patients and the public, including:

- Regular posts and interactions with the pancreatic cancer community on LinkedIn and BlueSky.
- Distribution of quarterly newsletters
- Contribution of items for newsletters created by medical associations, patient associations
- Presentations at national conferences
- Publication of articles in medical journals and other media.

Together, these activities support dissemination of NPaCA findings, engagement with key audiences, and the spread of learning to inform quality improvement across pancreatic cancer services.

8. Evaluation

The NPaCA reports year-on-year progress against improvement goals to the Audit's Clinical Reference Group and in the State of the Nation reports on an annual basis. Evaluation focuses on assessing change over time in performance indicators at national, regional and provider levels where appropriate, and on understanding patterns of variation and improvement.

The impact of the national quality improvement intervention is undertaken through ongoing monitoring of the relevant performance indicator within routine NPaCA reporting. Changes in performance over time are examined at national and Cancer Alliance level, with particular attention to trends and variation before and after introduction of the intervention. Given the use of routinely collected cancer registry data, improvements resulting from local action are expected to emerge over time rather than immediately.

Early evaluation will also consider engagement with the Cancer Alliance reports as an indicator of implementation and reach.

Findings from this evaluation will be used to support interpretation of audit results, inform refinement of quality improvement activity, and guide prioritisation of future improvement efforts.

Appendix

National Cancer Audit Collaborating Centre (NATCAN)

NPaCA is part of the National Cancer Audit Collaborating Centre (NATCAN), a national centre of excellence launched on 1 October 2022 to strengthen NHS cancer services by looking at treatments and patient outcomes in multiple cancer types across England and Wales. The centre was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government with funding in place for an initial period of three years.

NATCAN is based within the Clinical Effectiveness Unit (CEU), the academic partnership between the Royal College of Surgeons of England (RCS Eng) and the London School of Hygiene & Tropical Medicine. The CEU is recognised as a national centre of expertise in analytic methodology and the development of administrative and logistic infrastructure for collating and handling large-scale data for assessment of healthcare performance.

The aim of the ten NATCAN Audits is to:

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

Key features of NATCAN's Audit approach

The design and delivery of the Audits in NATCAN has been informed by the CEU's experience delivering national Audits, built up since its inception in 1998. Key features of all Audit projects within the CEU include:

- Close clinical-methodological collaboration
- Use of national existing linked datasets as much as possible
- Close collaboration with data providers in England (National Disease Registration Service [NDRS, NHSE] and Wales (Wales Cancer Network [WCN], Public Health Wales [PHW])
- A clinical epidemiological approach, informing quality improvement activities
- "Audit" informed by "research".

All these features support NATCAN's focus on the three "Rs", ensuring that all its activities are clinically relevant, methodologically robust, and technically rigorous.

Data provision

The NATCAN Executive Team has worked closely with data providers in England and in Wales to establish efficient "common data channels" for timely and frequent access to datasets, combining data needs for all cancers into a single request in each Nation and only using routinely collected data, thereby minimising the burden of data collection on provider teams.