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Performance and Improvement

NATIONAL OPTIMAL PATHWAY FOR RENAL CANCER:

2nd EDITION (2025)

Point of Suspicion to First Definitive Treatment in Adults (aged 16 and over)

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FOREWORD

The NHS Wales National Optimal Pathways (NOPs) have been developed as part of the Suspected Cancer Pathway (SCP) programme of work. They aim to establish consistent generic and site specific pathways that describe all routes of entry onto the pathway from the point of suspicion (PoS) of cancer. They describe good practice diagnostic and treatment pathways, the diagnostic pathway, including staging, should be performed within 28 days from PoS; and definitive treatment commenced within 21 days from date of Decision to Treat (DTT). The pathways also describe where patients should receive consistent information and support, tailored to meet their needs.

The NOPs aim to provide a platform to standardise care, reduce unwarranted variation and drive improvement whilst increasing quality across each of the cancer pathways in order to:

- meet the SCP cancer waiting time of 62 days for patients presenting with a suspicion of cancer,
- improve cancer patient experience, and,
- improve cancer patient outcomes throughout Wales to that comparable with the best outcomes in Europe.

The Renal NOP is designed to help renal cancer service providers and their commissioners see the basic structure of an effective and efficient renal cancer pathway. In essence, this optimal pathway is about ensuring that each stage of the pathway happens quickly, that communications with patients are effective and that the entire team works in a coordinated but flexible way, focusing always on the patient's journey. It is recognised that the introduction of the National Optimal Pathway for renal Cancer may present challenges for the urological multidisciplinary teams. However, introducing a nationally agreed, clinically endorsed pathway will support service improvement. They will also provide clarity and consistency for primary care around the referral process into secondary care, including access to diagnostics, to ensure the patients move through the system in a timely manner.

GROUP CONSULTATION

The Urological Cancer Site Group (CSG) is led by Mr Nicholas Gill, Consultant Urologist. The pathways work has been led by Mr Nicholas Gill and Mr Haitham Abdelmoteleb, Consultant Urologist. The group includes representation from the full range of professions involved in delivering cancer services. They were all able to contribute and comment on the development of the optimal pathway during a range of pathway workshops, CSG meetings and educational days, commenced in May 2019. In addition, an educational session was held in January 2019 at the Annual Meeting of the Urological Society, who also subsequently consulted upon pathway reviews. An early draft was sent to Urological Multidisciplinary Teams (MDTs), Health Boards and Velindre NHS Trust in September 2019. Separate workshops were also held with the Clinical Nurse Specialist (CNS) and Allied Health Professional (AHP) members to embed the Rehabilitation and Person Centred Care (PCC) into the pathway, ensuring all patient's needs are assessed and met in a timely manner. Wider consultation was sought in November and December 2019 from NHS Wales's stakeholders, including National Imaging and Pathology Networks and the Third sector, prior to a final version being issued in January 2020.

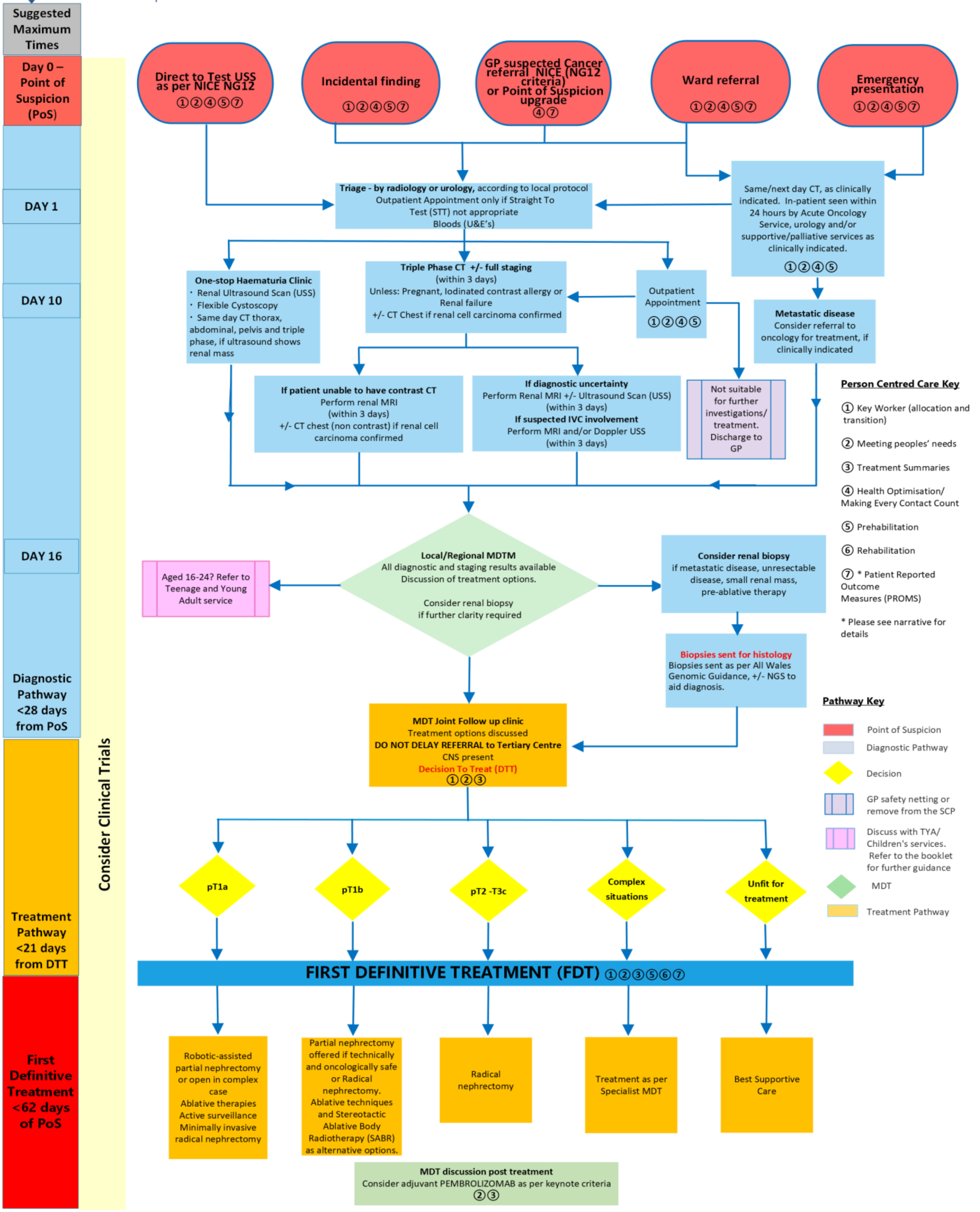
This second edition (2025) of the NOP incorporates best practice guidance.

Mr Nicholas Gill (Urological CSG Lead Clinician)

Mr Haitham Abdelmoteleb (Consultant Urologist)

Professor Tom Crosby (National Cancer Clinical Director – National Cancer Team)

National Optimal Cancer Pathway for Suspected and Confirmed Renal Cancer: Point of Suspicion (POS) to First Definitive Treatment (FDT) for Patients Aged 16 and Over



Suggested Maximum Times

Day 0 – Point of Suspicion (PoS)

DAY 1

DAY 10

DAY 16

Diagnostic Pathway <28 days from PoS

Treatment Pathway <21 days from DTT

First Definitive Treatment <62 days of PoS

Consider Clinical Trials

Direct to Test USS as per NICE NG12 ①②④⑤⑦

Incidental finding ①②④⑤⑦

GP suspected Cancer referral NICE (NG12 criteria) or Point of Suspicion upgrade ④⑦

Ward referral ①②④⑤⑦

Emergency presentation ①②④⑤⑦

Triage - by radiology or urology, according to local protocol
Outpatient Appointment only if Straight To Test (STT) not appropriate
Bloods (U&E's)

Same/next day CT, as clinically indicated. In-patient seen within 24 hours by Acute Oncology Service, urology and/or supportive/palliative services as clinically indicated.
①②④⑤

One-stop Haematuria Clinic
- Renal Ultrasound Scan (USS)
- Flexible Cystoscopy
- Same day CT thorax, abdominal, pelvis and triple phase, if ultrasound shows renal mass

Triple Phase CT +/- full staging
(within 3 days)
Unless: Pregnant, Iodinated contrast allergy or Renal failure
+/- CT Chest if renal cell carcinoma confirmed

Outpatient Appointment
①②④⑤

Metastatic disease
Consider referral to oncology for treatment, if clinically indicated

If patient unable to have contrast CT
Perform renal MRI
(within 3 days)
+/- CT chest (non contrast) if renal cell carcinoma confirmed

If diagnostic uncertainty
Perform Renal MRI +/- Ultrasound Scan (USS)
(within 3 days)
If suspected IVC involvement
Perform MRI and/or Doppler USS
(within 3 days)

Not suitable for further investigations/ treatment. Discharge to GP

Aged 16-24? Refer to Teenage and Young Adult service

Local/Regional MDTM
All diagnostic and staging results available
Discussion of treatment options.

Consider renal biopsy
if further clarity required

Consider renal biopsy
if metastatic disease, unresectable disease, small renal mass, pre-ablative therapy

Biopsies sent for histology
Biopsies sent as per All Wales Genomic Guidance, +/- NGS to aid diagnosis.

MDT Joint Follow up clinic
Treatment options discussed
DO NOT DELAY REFERRAL to Tertiary Centre
CNS present
Decision To Treat (DTT)
①②③

pT1a

pT1b

pT2 -T3c

Complex situations

Unfit for treatment

FIRST DEFINITIVE TREATMENT (FDT) ①②③⑤⑥⑦

Robotic-assisted partial nephrectomy or open in complex case
Ablative therapies
Active surveillance
Minimally invasive radical nephrectomy

Partial nephrectomy offered if technically and oncologically safe or Radical nephrectomy. Ablative techniques and Stereotactic Ablative Body Radiotherapy (SABR) as alternative options.

Radical nephrectomy

Treatment as per Specialist MDT

Best Supportive Care

MDT discussion post treatment
Consider adjuvant PEMBROLIZOMAB as per keynote criteria
②③

Person Centred Care Key

① Key Worker (allocation and transition)

② Meeting peoples' needs

③ Treatment Summaries

④ Health Optimisation/ Making Every Contact Count

⑤ Prehabilitation

⑥ Rehabilitation

⑦ * Patient Reported Outcome Measures (PROMS)

* Please see narrative for details

Pathway Key

🟥	Point of Suspicion
▭	Diagnostic Pathway
◆	Decision
▥	GP safety netting or remove from the SCP
▥	Discuss with TYA/ Children's services. Refer to the booklet for further guidance
◆	MDT
▭	Treatment Pathway

BEST PRACTICE GUIDANCE

Vetting & Triage	It is recommended that the triage of referrals is undertaken using an electronic system (e.g. Welsh Patient Referral Service) to improve the timeliness, traceability and governance of pathways. Referrals received as suspected cancer (USC) should be prioritised within 1 day and urgent / routine referrals within 3 days due to the potential need for upgrade to suspected cancer (pathway entry date: date referral originally made by primary care).
Diagnosis of Patients	For all patients with solid small renal masses consider offering biopsy, where technically feasible, if it will impact patient's choice or clinician's recommendation on treatment.
Diagnostic Imaging	All patients with a suspected renal mass should have either a triple phase renal CT or MRI if iodinated contrast allergy.
Accelerated Treatment	Patients with a cT3+ or 10cm+ or cN1 tumour should have surgery within 4 weeks of diagnosis.
Key worker role	A Urology CNS should be involved in the patient's journey and is an integral part of the kidney cancer team. The Key Worker facilitates necessary timely discussions with relevant MDT Members, avoiding the need to wait until the next MDT meeting.
Physiological optimisation	Patients should undergo an objective assessment of peri-operative risk to help inform peri-operative care requirements. They should also have access to peri-operative optimisation resources such as nutritional support, smoking cessation advice, exercise prehabilitation and intravenous iron.
Adjuvant Therapy	Decisions surrounding adjuvant systemic treatment need to be personalised based on risk vs benefits for individual patients, taking into account risk of recurrence, potential impact of toxicity, and eligibility for trials.

DEFINITIONS

Decision to Treat	The DATE on which a **Decision to treat** is made. For the cancer data sets, the **Decision to treat** DATE is the DATE that the consultation between the PATIENT and the clinician took place and a Planned Cancer Treatment was agreed. Source: NHS Data Model and Dictionary (datadictionary.nhs.uk)
Direct to Test	GPs have direct access to diagnostic ultrasound, MRI, X-ray and CT for people suspected of cancer. Source: National Institute for Health and Care Excellence, Quality Standard 2016 (QS 124)

First Definitive Treatment	**First Definitive Treatment** is the **first** CLINICAL INTERVENTION intended to manage a PATIENT's disease, condition or injury and avoid further CLINICAL INTERVENTIONS. What constitutes **First Definitive Treatment** is a matter of clinical judgement in consultation with others, where appropriate, including the PATIENT. Source: NHS Data Model and Dictionary (datadictionary.nhs.uk)
Safety Netting	"Safety netting is a management strategy of patients, tests and referrals used in the context of diagnostic uncertainty in healthcare. It aims to ensure patients are monitored until signs and symptoms are explained or resolved." Source: Royal College of General Practitioners (RCGP) - Home
Straight to Test	Following clear referral criteria into secondary care (usually NICE guidance) the secondary care clinician (defined as per local protocol) will arrange a diagnostic procedure as the first episode of care in place of an outpatient episode. The clinician will retain clinical responsibility for the result including acting on the result, and onward referral to an MDT where appropriate. Source: Delivering Cancer Waiting Times NHSE
Teenagers and Young Adults (TYA) Service	Young people (aged 16-24 years) with cancer have their diagnosis treatment and support agreed and delivered by a cancer-site specific multidisciplinary team and a teenage and young adult multidisciplinary team. Source: National Institute for Health and Care Excellence (NICE), 2014. Cancer services for children and young people (QS55) STANDARD FOR TEENAGERS AND YOUNG ADULTS WITH CANCER (nhs.wales)

CLINICAL EVIDENCE

Point of Suspicion/ Referral	The point of suspicion is when a clinician refers a patient or requests a test concerns a patient may have cancer. Pathway start dates are defined in Appendix 1: Suspected Cancer Pathway Definitions – pathway start date (pages 23 – 29) in the following guidance: Suspected cancer pathway: guidelines (WHC/2024/07) | GOV.WALES Additional information: Clinical Decision Support Tools: Cancer Research UK Q Cancer Risk Assessment Tool
Diagnosis and Management	GIRFT: Urology - Towards Better Care for Patients With Kidney Cancer European Association of Urologists (EAU) Renal Cell Carcinoma Guidelines

PERSON CENTRED CARE

Person-centred cancer care is culturally embedded and supported by a common approach to assessing and managing people's needs, and care should be co-produced to ensure people affected by cancer achieve the outcomes that matter to them (Cancer Quality Statement, 2021).

Key Worker	QS 14: Patients are made aware of who to contact, how to contact them and when to make contact about their ongoing healthcare needs. National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services A cancer key worker is *"a person who, with the patient's consent and agreement, takes a key role in coordinating the patient's care and promoting continuity, ensuring the patient knows who to access for information and advice"*. 1. All cancer patients must have an allocated key worker. 2. Allocation / Review of key worker to take place at key time points including: *a.* Around the time of diagnosis **please note: allocation of key worker **may** occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology.* b. Commencement of treatment Key workers for cancer patients (Welsh Health Circular /2014/001) GOV.WALES Cancer Improvement Plan for Wales
Meeting People's Needs	QS 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care. QS 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services Assessment and discussion of patients' needs for physical, psychological, social, spiritual and financial support should be undertaken at key points including: • Around diagnosis **please note: undertaking a Holistic Needs Assessment **may** occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology, endoscopy; and it is supported by professional judgement.* • At commencement, during, and at the end of treatment National Institute for Clinical Excellence (NICE, 2004) CSG4 Improving Supportive & Palliative care for adults with cancer Ideally Holistic Needs Assessments should be undertaken electronically (Cancer Improvement plan for Wales/). Macmillan eHNA is *one* tool which is both valid and reliable. Snowden A & Fleming M (2015) Validation of the electronic HNA. Where appropriate, the impact of the cancer and its treatment on future fertility should be discussed with the cancer team at the earliest opportunity. The eligibility criteria for treatment are set out in the WHSSC Specialist Fertility Commissioning Policy, CP38 (link

	below). Opportunity should be provided to explore any individual concerns and address any unmet needs and early speciality referral should also be offered. whssc.nhs.wales/commissioning/whssc-policies/fertility/specialist-fertility-services-commissioning-policy-cp38-feb-2020/
Health Optimisation / MECC	QS 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions. National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services Health Optimisation refers to a proactive approach to supporting people who present to NHS services with concurrent comorbid health conditions (e.g. anaemia, diabetes), or health risk behaviours (e.g. smoking, physical inactivity). Welsh Government (2018) A Healthier Wales. Welsh Government (2015) Wellbeing of Future Generations Act. Making Every Contact Count (MECC) is a behaviour change approach that helps health and social care professionals support people to improve their health and wellbeing through prevention and early intervention. Public Health Wales Strategic Plan 2023-2026 ***Lifestyle advice / resources are available*** *from* Making Every Contact Count (MECC) **Please note: Whilst addressing concurrent comorbidities and health risk behaviours is the responsibility of **all** health and social care professionals, at **every** contact throughout the pathway; earliest possible intervention **may** impact on cancer treatment choices / outcomes (especially in respect to tobacco smoking).* National Institute for Clinical Excellence (NICE, 2018) NICE Guidance - Tobacco: preventing uptake, promoting quitting and treating dependence
Prehabilitation	All patients should be given multimodal prehabilitation advice and support covering physical activity, emotional wellbeing, eating well, stopping smoking and reducing alcohol intake prior to undergoing treatment in order to enhance patient outcomes. Patient needs and goals should be evaluated on an individual basis and appropriate levels of support, from universal self-management advice to specialist support which includes timely access to allied health professional should be provided. Patients should have the opportunity to take part in evidence-based education and rehabilitative activities, including self-management programmes, *where available*, that promote their ability to manage their own health if appropriate. National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services Welsh Government (2018) A Healthier Wales. Welsh Government (2015) Wellbeing of Future Generations Act. The Quality Statement for Cancer.
Rehabilitation	All patients will have their needs for rehabilitation services assessed, with referral to an appropriate level of rehabilitative support, throughout the patient pathway including timely access to allied health professional to meet individual holistic patient needs and goals.

	Please note: not **all patients will require specialist cancer rehabilitation services. Referral into non-cancer rehabilitation, self-management, and fitness services **may** be suitable to meet some patients' needs.* National Institute for Health and Care Excellence (NICE) CSG4 (2004) resources for improving supportive and palliative care for adults with cancer.
Patient Reported Outcome Measures (PROMs) / Patient Reported Experience Measures (PREMs)	Patient Reported Outcome Measures (PROMs) are questionnaires that patients are asked to complete before and after treatment to assess the impact on health and wellbeing. ***Some*** of the Cancer Site Groups (CSGs) have been working with the International Collaboration for Health Outcome Measurement (ICHOM), National Value in Health Team (Home - Value in Health) and other partners, to pilot tools and data capture methods, which will inform a consistent approach to PROMS for cancer The Quality Statement for Cancer. *Experience Measures (PREMs) *Please note: there are outstanding questions relating to tool selection, data capture intervals, data capture methods and data analysis / reporting which may prevent the implementation of PROMS & PREMS across all pathways at this time. PROMS & PREMS have been included in the pathways, in recognition of this work, and will be updated pending further advice from the CSGs.* Patient Reported Experience Measures (PREMs) are questionnaires that patients are asked to complete at any time during their pathway to help professionals to understand their experience of NHS services. This information is crucial to understanding the value of healthcare as perceived by patients. Welsh Government (2024/25) People's experience framework. **Please Note: Whilst it is good practice to collect PREMS throughout the pathway, there is no current standard for cancer PREMS in Wales; further advice regarding this will be sought via the CSGs in due course.*
Communication	Clinicians must ensure patients are kept up to date about their care pathway and are supported to make individualised choices about their treatment. Clinicians should consider the value of interventions and discuss with the patient the likely outcome of treatment options. Clinicians in secondary and tertiary care must ensure that all decisions relating to a patient's care or treatment are communicated to the patient and their primary care clinician in a timely manner and within 24 hours of diagnosis. Clinicians must ensure that the clinical intention of any intervention such as tests or treatment is clear to patients, and whether it is just a stage of the agreed pathway or considered start of first definitive treatment and as such ends the pathway. Clinicians must make contemporaneous records of discussions and decisions and include reasons for deviations from recommended clinical practice in the patient's clinical record. Decisions should be made in a timely manner, and any onward referrals be completed promptly, according to local/national guidelines and optimal pathways and include adequate information to allow the receiving clinician to initiate appropriate interventions with the minimum of delay. Referrers must ensure that the patient is aware and is in agreement for a suspected cancer referral to be made. Suspected cancer pathway: guidelines (WHC/2023/025) | GOV.WALES

	A treatment summary is a tool completed by secondary care professionals after a significant phase of a patient's cancer treatment. A treatment summary describes the patient's cancer diagnosis, prognosis, and aim, types and side effects of any treatment that they have had. It also highlights any signs and symptoms of recurrence that the patient needs to be aware of. It is designed to be shared with the person living with cancer and their GP either electronically or as a paper document, and should use easy to understand, clear and concise language. Additionally, it can be used by the person affected by cancer to help inform other health and social care professionals, employers/occupational health, or financial institutions e.g., benefits services or banks, about their cancer care and treatment.
Research	Patients should have the opportunity to take part in research and clinical trials where available. People in research | Health Care Research Wales (healthandcareresearchwales.org) EC Trial Finder | ECMC (ecmcnetwork.org.uk)