GIG CYMRU
NHS WALES
Perfformiad a Gwella
Performance and Improvement

NATIONAL OPTIMAL PATHWAY FOR PROSTATE CANCER:

3rd EDITION (2025)

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

Date of Issue: July 2025

Date of Review: July 2027

Reason for update:
This pathway has been updated to reflect the recommendations from Getting It Right First Time (GIRFT) Urology: Towards Better Diagnosis and Management of Suspected Prostate Cancer (April, 2024) that there is no need for Primary Care to repeat a raised PSA prior to referral to Secondary Care, unless there are other probable causes and therefore changing the point of suspicion. The pathway has also been updated with guidance to move from Transrectal to Transperineal biopsy as standard as per GIRFT guidance.

Owner: Urology Cancer Site Group (CSG)

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 Prostate NOP is designed to help prostate cancer service providers, and their commissioners see the basic structure of an effective and efficient prostate 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 prostate 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 first edition of the National Optimal Pathway for Prostate Cancer (NOPPC) was developed by the Urology CSG, led by Ms. Jane French, Consultant Urologist and deputies Keryn Jones, Lead Urology Nurse Practitioner and Mr. Gokul KandaSwamy, Consultant Urologist. The group included 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. The 'All Wales Planned Care Board in Urology' were also consulted in April 2019. 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 prior to a final version being issued in January 2020.

The second edition (2023) of the NOPPC has been reviewed by the CSG with minor amendments made to reflect the National recommendation regarding a repeat PSA for asymptomatic patients.

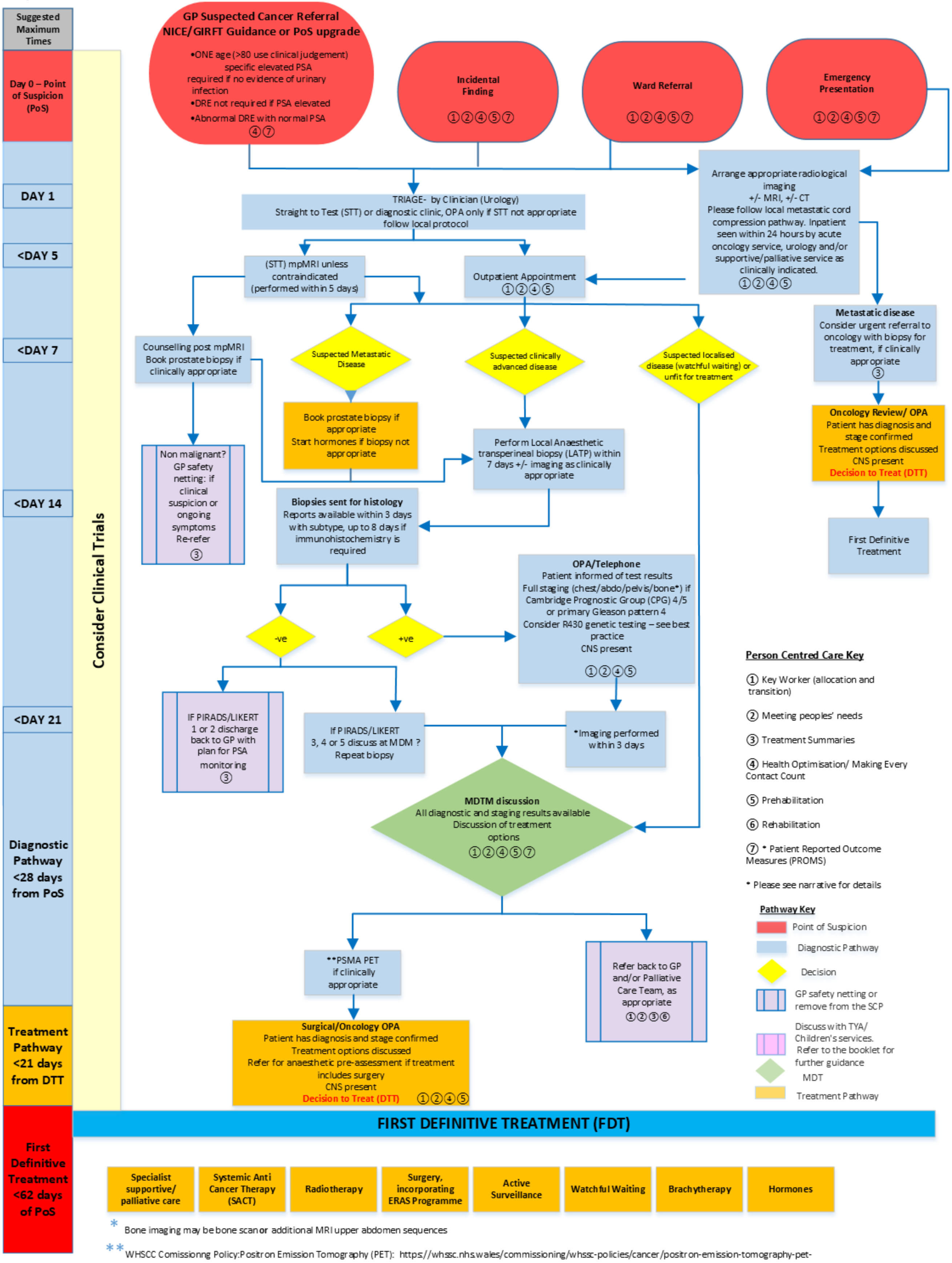
This third edition (2025) of the NOPCC has been reviewed by the CSG with amendments to reflect the recommendations from Getting It Right First Time (GIRFT) Urology: Towards Better Diagnosis and Management for Suspected Prostate Cancer (2024) that there is no need for Primary Care to repeat a raised PSA prior to referral to Secondary Care, if there is no evidence of urinary infection. The Pathway has also been updated to include best practice principles around Local Anaesthetic Transperineal (LATP) technique, Multi parametric MRI (mpMRI), genetic testing and active surveillance. These guidelines were discussed and agreed through a consultation process with the Urology CSG and Urology Clinical Implementation Network (CIN). Additionally, the latest fertility preservation guidance has been added under the relevant Best Practice Guidance section.

Mr Nicholas Gill (Urology CSG Lead Clinician)

Professor Tom Crosby (National Cancer Clinical Director Cancer Team)

GIG CYMRU NHS WALES
Perfformiad a Gwella
Performance and Improvement

National Optimal Cancer Pathway for suspected and confirmed Prostate Cancer: Point of Suspicion (PoS) to First Definitive Treatment (FDT) for adult patients aged 16 and over



Suggested Maximum Times

Day 0 – Point of Suspicion (PoS)

DAY 1

<DAY 5

<DAY 7

<DAY 14

<DAY 21

Diagnostic Pathway <28 days from PoS

Treatment Pathway <21 days from DTT

First Definitive Treatment <62 days of PoS

Consider Clinical Trials

GP Suspected Cancer Referral NICE/GIRFT Guidance or PoS upgrade
- ONE age (>80 use clinical judgement) specific elevated PSA required if no evidence of urinary infection
- DRE not required if PSA elevated
- Abnormal DRE with normal PSA

④⑦

Incidental Finding
①②④⑤⑦

Ward Referral
①②④⑤⑦

Emergency Presentation
①②④⑤⑦

Arrange appropriate radiological imaging
+/- MRI, +/- CT
Please follow local metastatic cord compression pathway. Inpatient seen within 24 hours by acute oncology service, urology and/or supportive/palliative service as clinically indicated.
①②④⑤

TRIAGE- by Clinician (Urology)
Straight to Test (STT) or diagnostic clinic, OPA only if STT not appropriate follow local protocol

(STT) mpMRI unless contraindicated (performed within 5 days)

Outpatient Appointment
①②④⑤

Metastatic disease
Consider urgent referral to oncology with biopsy for treatment, if clinically appropriate
③

Oncology Review/ OPA
Patient has diagnosis and stage confirmed
Treatment options discussed
CNS present
Decision to Treat (DTT)

First Definitive Treatment

Counselling post mpMRI
Book prostate biopsy if clinically appropriate

Suspected Metastatic Disease

Suspected clinically advanced disease

Suspected localised disease (watchful waiting) or unfit for treatment

Book prostate biopsy if appropriate
Start hormones if biopsy not appropriate

Perform Local Anaesthetic transperineal biopsy (LATP) within 7 days +/- imaging as clinically appropriate

Non malignant? GP safety netting: if clinical suspicion or ongoing symptoms Re-refer
③

Biopsies sent for histology
Reports available within 3 days with subtype, up to 8 days if immunohistochemistry is required

-ve

+ve

OPA/Telephone
Patient informed of test results
Full staging (chest/abdo/pelvis/bone*) if Cambridge Prognostic Group (CPG) 4/5 or primary Gleason pattern 4
Consider R430 genetic testing – see best practice
CNS present
①②④⑤

IF PIRADS/LIKERT 1 or 2 discharge back to GP with plan for PSA monitoring
③

If PIRADS/LIKERT 3, 4 or 5 discuss at MDM ? Repeat biopsy

*Imaging performed within 3 days

MDTM discussion
All diagnostic and staging results available
Discussion of treatment options
①②④⑤⑦

**PSMA PET if clinically appropriate

Refer back to GP and/or Palliative Care Team, as appropriate
①②③⑥

Surgical/Oncology OPA
Patient has diagnosis and stage confirmed
Treatment options discussed
Refer for anaesthetic pre-assessment if treatment includes surgery
CNS present
Decision to Treat (DTT) ①②④⑤

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

FIRST DEFINITIVE TREATMENT (FDT)

Specialist supportive/ palliative care

Systemic Anti Cancer Therapy (SACT)

Radiotherapy

Surgery, incorporating ERAS Programme

Active Surveillance

Watchful Waiting

Brachytherapy

Hormones

* Bone imaging may be bone scan or additional MRI upper abdomen sequences

** WHSCC Comissionng Policy:Positron Emission Tomography (PET): https://whssc.nhs.wales/commissioning/whssc-policies/cancer/positron-emission-tomography-pet-cp50-commissioning-policy-april-2024/

BEST PRACTICE GUIDANCE

Vetting and 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).
Straight to test	Initial triage (virtual/telephone) should identify patients as suitable for straight to test Multi parametric MRI (mpMRI) based on age, performance status, co morbidities and PSA level in absence of urine infection. For patients who are potentially suitable for radical treatment with elevated PSA, straight to test mpMRI should be performed.
MRI scan	mpMRI consisting of Diffusion weighted imaging, T2 weighted imaging and dynamic contrast enhancement has been considered the gold standard imaging modality (PRECISION trial), however there is emerging data from the PRIME study that biparametric MRI is non inferior in terms of diagnosing significant prostate cancer, as well as being quicker, cheaper, and more convenient.
Local Anaesthetic Transperineal (LATP) technique	Perform local anaesthetic transperineal (LATP) biopsy in the outpatient setting, with no more than 4 cores from any target area. Consider routine sampling of ipsilateral and contralateral peripheral zones. Do not routinely sample transitional zone unless lesion on MRI.
Key worker	It is recommended that the key worker facilitates discussions with the relevant MDT members as timely as possible, without needing to wait until the next MDT meeting.
Genetic testing	Refer patient directly to the All-Wales Medical Genomics Service (AWMGS) if they have a family history of prostate cancer. Please refer to the National Genomic Test Directory (Version 7.1 - January 2025) for referral criteria.
Active surveillance	For patients where active surveillance (AS) is a management option: Cambridge Prognostic Group 1 & 2: • Active surveillance is the recommended approach. Cambridge Prognostic Group 3: • Active surveillance can be considered, particularly for non-MRI visible Gleason 3 + 4. • Provide shared decision making support and ensure timely review for those patients who want to explore active treatment options. Patients on active surveillance: • Retest PSA 3 monthly in the first year and repeat MRI at 1 year. • Digital rectal examination is not needed for patients on active surveillance who have an MRI at diagnosis and during follow up. • Intensity of follow up will vary with the risk stratification of prostate cancer and the level of risk at which treatment will be triggered. GIRFT Urology: Towards better diagnosis and management of suspected prostate cancer (April 2024).

Fertility Preservation – post-pubertal patients under 18.	If a patient under the age of 18 yrs requires fertility preservation, then the clinician in charge of the patient should e-mail the generic Wales Fertility Institute (WFI) account on Welsh Clinical Portal (WCP) SBU.referrals.WFI@wales.nhs.uk. The referral will be processed by the WFI team who will populate the approval form and submit that to NHS Wales Joint Commissioning Committee (NWJCC). Once NWJCC has approved the patient, then they can be referred by the clinical team directly to WFI for fertility preservation.

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 endoscopy, 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." 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/ Referrals	Suspected cancer pathway: guidelines (WHC/2024/07) | GOV.WALES National Institute for Health and Care Excellence (NICE) NG12 Suspected Cancer Referral Guidance – update 2021 (1.6.3) to reflect age specific PSA thresholds for people with possible symptoms of prostate cancer GIRFT Urology: Towards better diagnosis and management of suspected prostate cancer (April 2024). Cancer Risk Assessment Tool (RAT) Q Cancer Risk Assessment Tool
Diagnosis and Management	National Institute for Health and Care Excellence (NICE, 2019) NG131 Prostate Cancer: Diagnosis and Management Prostate Cancer Risk Management Programme – UK Government Publication GIRFT Urology: Towards better diagnosis and management of suspected prostate cancer (April 2024).

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 to 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, endoscopy.* 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 The Macmillan eHNA is *one* tool which is both valid and reliable. Snowden A & Fleming M (2015) Validation of the electronic HNA.
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 to help people to improve their health and wellbeing through prevention and early intervention. Public Health Wales Strategic Plan 2018-2021 ***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) NG92 NICE Guideline Stop Smoking Interventions and services.
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), Value Based Healthcare Team, National PROMS, PREMS, & Effectiveness Programme (NPP&EP) and other partners, to pilot tools and data capture methods, which will inform a consistent approach to PROMS & PREMS for cancer. The Quality Statement for Cancer. **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 (2018/19). Chief Medical Officer Annual Report. **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 agrees for a suspected cancer referral to be made. Suspected cancer pathway: guidelines (WHC/2024/07) | GOV.WALES
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)