GIG CYMRU NHS WALES
Perfformiad a Gwella
Performance and Improvement

NATIONAL OPTIMAL PATHWAY FOR COLORECTAL CANCER:

3rd EDITION (2026)

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

Date of Issue: November 2026

Date of Review: November 2029 or on publication of new NICE, GIRFT guidance

Reason for update:
This is a scheduled review. The main changes in the update are further guidance around the usage of symptomatic Faecal Immunochemical Test (FIT) and guidance about genomic testing for MMR / MSI and timeliness of these investigations.

Owner: Colorectal Cancer Site Group

NATIONAL OPTIMAL PATHWAYS FOR CANCER

NOP Notice:	**Colorectal Cancer**
Date of Issue:	**November 2026**

Issuer: National Cancer Team – Performance and Improvement	**Subject:** National Optimal Pathway – Amendment and Changes
Implementation Date: November 2026	

NATIONAL OPTIMAL PATHWAY CHANGE NOTICE

A National Optimal Pathway Change Notice (NOPCH) is an information mandate for a revised Cancer Pathway.

This document was approved by the Cancer Reference Group (CRG) at its meeting on 19th August 2026.

Summary:

This Change Notice provide a summary of key changes made within the updated National Optimal Pathway for Colorectal Cancer. The main changes in the updated National Optimal Pathway for Colorectal Cancer are that it provides further guidance around the usage of symptomatic Faecal Immunochemical Test (FIT) and guidance about genomic testing for MMR / MSI and timeliness of these investigations.

Pathway / Booklet affected: National Optimal Pathway for Colorectal Cancer

The Cancer Reference Group is responsible for appraising National Optimal Pathways. Please address enquiries about this National Optimal Pathway Change Notice to the National Cancer Team: WCN.WalesCancerNetwork@wales.nhs.uk

CHANGE NOTICE SUMMARY

Reason for Change:	The National Optimal Pathway for Colorectal Cancer has been reviewed as scheduled (review required December 2025).
Pathway Diagram	
Description of Change: **Pathway Diagram: Day 0**	**GP Direct Access to minimal-red box** Remove whole box: GP direct access to minimal prep CT/CT pneumocolon + bloods
Pathway Diagram: Day 1	PROMs ⑦ has been removed from triage box
Pathway Diagram: Day 1	**Same / next day CT TAP…** Inpatients to be seen within 24 hours: Inpatients with local disease referred to colorectal services. Patients with metastatic disease referred to colorectal oncology / acute oncology services. **Changed to:** Same/next day CT TAP, as clinically indicated. Inpatients seen within 24hrs: Inpatients with local disease referred to colorectal services. Patients with metastatic disease referred to colorectal oncology / acute oncology services.
Pathway Diagram: Day 1	Colonoscopy – sigmoidoscopy box and Clinic OPA box remove – remove left direction arrow
Pathway Diagram: Day 7	Clinic OPA only if patient not suitable for STT Add to the Clinic OPA only if patient not suitable for STT box: Arrange further investigation as clinically appropriate Inform patient PROMs ⑦ has been removed from Clinic OPA box
Pathway Diagram: Day 7	The left arrow in the clinic OPA box has box has been removed
Pathway Diagram: <Day 8	Further tests as indicated box Delete whole box. Continue arrow down.
Pathway Diagram: <Day 8	Accelerated Imaging Change content of box from: Accelerated Imaging Staging CT TAP performed same / next day Rectal cancer - accelerated MRI performed within 3 days Scans reported within 2 days ① to: Accelerated Imaging

	Consider colonoscopy Consider accelerated imaging /further investigations as guided. Consider CT Thorax if not already done. Liver metastases: consider MRI liver. Rectal cancer; consider MRI rectum. Scans reported within 2 working days
Pathway Diagram: Day 21	MDT discussion box All diagnostic and staging results available Discussion of treatment options then add 'and communicate outcomes to Primary Care within 24 hours'
Pathway Diagram: Day 21	PROMs ⑦ has been added to the Same day clinic OPA box
Pathway Diagram and Patient Reported Outcome Measures (PROMs) MDT Boxes	Remove PROMs from the 2 green MDT boxes
Reference Below Pathway	**WHSSC Commissioning Policy: Positron Emission Tomography (PET) -** SS50 PET Service Specification v2.0.pdf updated to: ****NHS Wales Joint Commissioning Committee:** Positron Emission Tomography (PET) Commissioning Policy: CP50 September 2025
Booklet Amendments	
Biomarker Testing	Biomarker Testing All patients with a new diagnosis of. Insert 'which may alter treatment and identify people with Lynch Syndrome' and delete 'which may identify people in whom the cancer has occurred because of'
Biomarker Testing	Biomarker Testing Stage IV tumours Amend text to 'with DNA Next Generation Sequencing (NGS)', remove 'tested with both DNA and RNA'
Symptomatic FIT – General Principles	Symptomatic FIT – General Principles The Bowel Screening Wales (BSW) programme….Amend to: 'with a current FIT threshold of 80µg Hb/g.' Delete 'with a current FIT threshold of 150µg Hb/g and plans to reduce this to 80µg Hb/g in the future
Symptomatic FIT	Symptomatic FIT – Table First clinical suspicion of cancer table. Positive FIT stool test (≥10µg Hb/g) in secondary care e.g. outpatient clinic, inpatient, emergency presentation. Add at the bottom of the sentence: (including those presenting with IDA)
Referrals and Safety Netting	Referrals and Safety Netting Waiting times…Delete sentence: 'Waiting times across all referral priorities including suspected cancer have been impacted by the COVID pandemic.'
Symptomatic FIT Pathway	Symptomatic FIT Pathway Day 0 Point of Suspicion: Ongoing high clinical suspicion of colorectal cancer Amend Ongoing high clinical suspicion of colorectal cancer OR IDA (≥50 years old or male or non-menstruating/post-menopausal woman)3 To 'Ongoing high clinical suspicion of colorectal cancer'.
Symptomatic FIT Pathway	Symptomatic FIT Pathway Purple box: Persistent or unexplained symptoms, Change 'Persistent or unexplained symptoms, consider urgent or routine referral to secondary care† OR Reassure with safety netting advice' wording to Consider urgent referral to secondary care if: •IDA (>50 years old or male or post-menopausal/non-menstruating woman) •Persistent or explained symptoms
Beneath the FIT Pathway	Included examples of patient information resources relating to FIT: Visual and written information is available to guide patients on how to complete their FIT test. For examples in English and Welsh please see: How

	to complete your FIT (faecal immunochemical test) English, Sut i gwblhau eich FIT (prawf imiwnogemegol ysgarthol) which are produced by Cancer Research UK
CLINICAL EVIDENCE **Point of Suspicion/Referral**	Insert link to: FIT in patients with signs or symptoms of suspected CRC: A joint guideline from ACPGBI and BSG
BEST PRACTICE **Accelerated Imaging**	It is recommended Scans should be reported within 2 working days.

FOREWORD

The NHS Wales National Optimal Pathways (NOPs) were initially developed as part of the Suspected Cancer Pathway (SCP) programme of work. NOPs establish best practice diagnostic site-specific pathways which describe all routes of entry onto the pathway from the point of suspicion (PoS) of cancer. The diagnostic pathway, including any required staging investigations, should be completed within 28 days from PoS. Definitive treatment should commence within 21 days from the date of Decision to Treat (DTT). NOPs outline where every person affected by cancer should receive person centred information and support based upon their holistic needs.

The Duty of Quality (2023) directs health services to continuously, reliably and sustainably improve to meet the needs of the population using a whole system approach. It mandates that health services must provide safe, timely, effective, efficient, equitable and person-centred care (Welsh Government, 2023).

NOPs provide best practice recommendations to standardise care, reduce unwarranted variation and drive improvement across each cancer pathway. They specify:

- complex diagnostic pathways to provide rapid access to treatment and meet the SCP waiting time of 62 days for patients presenting with a suspicion of cancer.
- patient experience best practice to ensure that people are supported and co-produce their care.
- cancer pathways to improve cancer patient survival and mortality rates throughout Wales.

NOPs are designed to help cancer teams, service providers and commissioners see the structure of an effective and efficient cancer pathway. Each step of the pathway is nationally agreed, happens within an optimal timeframe consistent with National Cancer Waiting Time (CWT) targets and that person centred care and communication is provided by the cancer site multidisciplinary team. It is recognised that the introduction of the National Optimal Pathways may present challenges for multidisciplinary teams, service providers and commissioners. However, introducing a nationally agreed, clinically endorsed pathway will support service improvement, commissioning and Local, Regional and National capacity and demand management. NOPs will also provide clarity and consistency for primary care around the referral process into secondary care, including access to diagnostics, to ensure that patients move through the system in a timely manner.

Providing a definitive assessment of adherence to NOPs using nationally available data is challenging due to varying sources of intelligence and implementation of all Wales digital platforms, but it is the aim to improve this. Where national data is available via the national Suspected Cancer Pathway Patient Level Dataset, intelligence has been gathered and made available via the NHS Performance & Improvement Cancer Resources SharePoint.

A core principle of the NOPs is the delivery of high-quality, holistic, person-centred care. While performance metrics often focus on speed and efficiency, quality of care also depends on whether services are safe, clinically effective, and responsive to the individual values, needs, and preferences of each patient. It is essential that quantitative data is considered alongside the experiences and outcomes reported by patients themselves. The integration of Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) is of equal importance, ensuring that improvements are informed not only by operational performance, but by the lived experiences and outcomes of those receiving care.

Further information relating to published National Optimal Pathways can be found at: National Optimal Pathways

GROUP CONSULTATION

This third edition of the Colorectal Cancer National Optimal Pathway was developed via the multi-professional Cancer Site Group for Colorectal Cancer with leadership from Mr Martyn Evans and Dr Craig Barrington. Cancer Site Group members have been encouraged to contribute and comment on the review via Cancer Site Group meetings and consultations. The initial action of the review process was to send the existing NOP out to the CSG for comment on specific elements which require review and updating. Comments have been considered by the review leads.

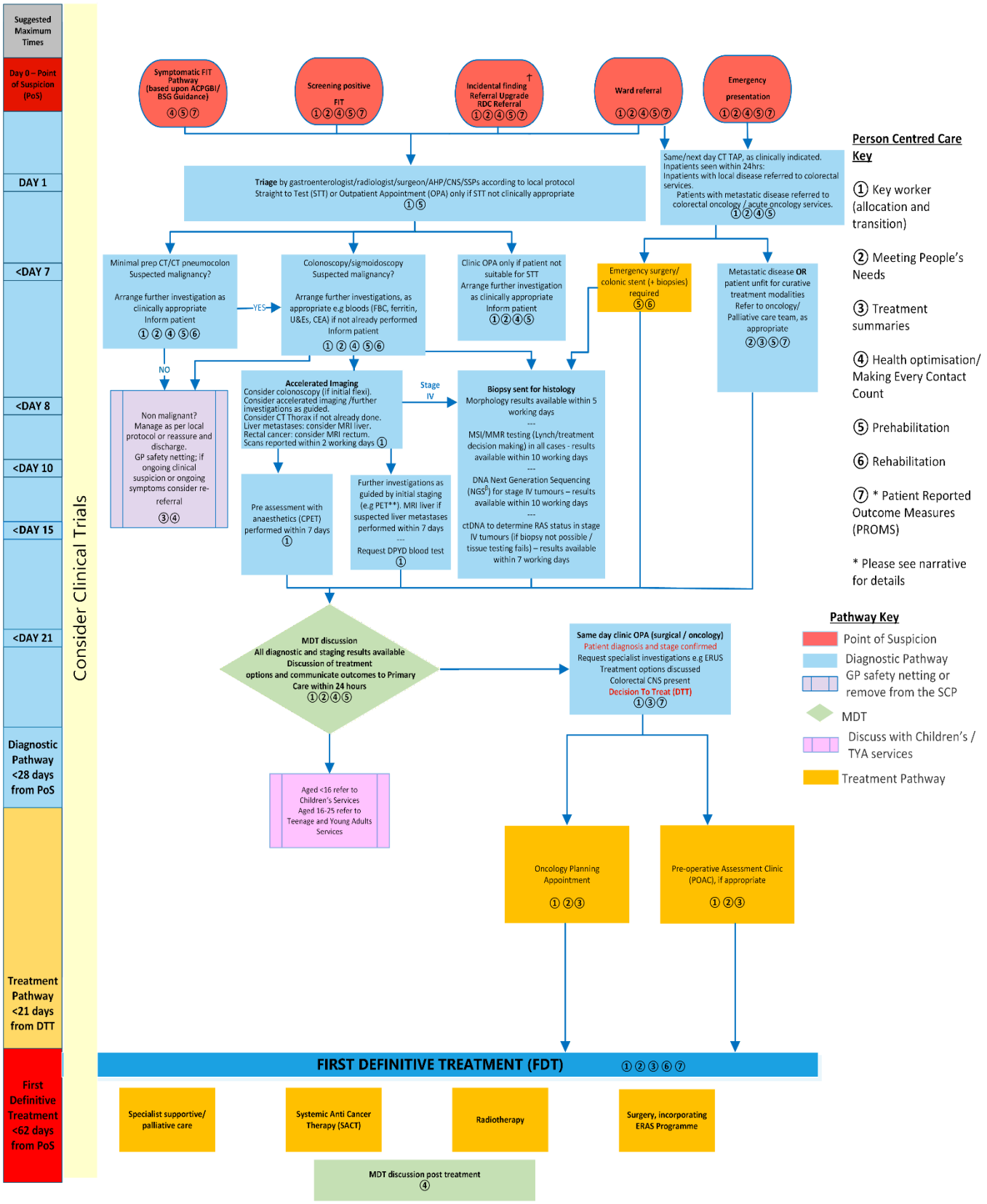
The first edition was developed in 2018 through consultation with the Colorectal Site Group (CSG), a group that includes representation from the full range of professions involved in delivering cancer services. This third edition has been revised to provide updated guidance where the needs of the optimal pathway has changed since the publication of the second edition in 2023. The current version provides the optimal pathways for patients with suspected lower GI cancer in 2026. The main changes in the update are further guidance around the usage of symptomatic Faecal Immunochemical Test (FIT) and guidance about genomic testing for MMR / MSI and timeliness of these investigations. The updated edition has been agreed by the current CSG and should be the default pathway for colorectal teams in Wales managing patients on a suspected cancer pathway.

Person Centred Care Elements have been reviewed by the National Cancer Team Clinical Nurse Specialist (CNS) and Allied Health Professional (AHP) members, who in turn link with Health Board and Trust lead professionals to align and embed the Rehabilitation and Person-Centred Care (PCC) elements into the pathway.

Wider consultation was sought NHS Wales stakeholders. This included Cancer Site Groups, All Wales Genomics Oncology Group (AWGOG), All Wales SACT Group, All Wales Acute Oncology Group, NHS Wales Performance & Improvement's Senior Leadership Team (SLT), Planned Care Programme, Strategic Programme for Primary Care, National Endoscopy and Diagnostic Programmes, Health Board Lead Cancer Clinical Leads and AHPs, Directors of Nursing, Cancer Operational Managers and Service Managers, National Imaging Academy All Wales Medical Genetics Service (AWMGS), Health Board Cancer Managers, Community Health Pathways (CHP) Clinical Editors, Joint Commissioning Committee (JCC), Wales Cancer Alliance, NICE and General Practitioners Committee (GPC) and the Third sector. All responses have been considered for inclusion.

Mr Martyn Evans (CSG Lead Clinician)
Dr Craig Barrington (CSG Deputy Lead)
Dr Jeff Turner (Clinical Lead, National Endoscopy Programme)
Professor Tom Crosby (National Cancer Clinical Director for Wales)

National Optimal Cancer Pathway for Suspected and Confirmed Colorectal Cancers: Point of Suspicion (PoS) to First Definitive Treatment (FDT) for Adult Patients (16 and over)



† **Refer to Appendix 2 p31 -** Guidelines for managing patients on the suspected cancer pathway (WHC/2024/07)

**JCC
WHSSC Commissioning Policy: Positron Emission Tomography (PET)

β AWMGS - Cymru Service for Genomic Oncology Diagnoses - All Wales Medical Genomics Service

BIOMARKER TESTING

All patients with a new diagnosis of colorectal cancer, regardless of stage or planned treatment, should be offered molecular testing to identify tumours with deficient DNA mismatch repair which may alter treatment and identify people with Lynch syndrome NICE HealthTech Guidance (HTG430) recommends either immunohistochemistry for mismatch repair (MMR) proteins (via pathology laboratories) or microsatellite instability (MSI) testing (via the All Wales Medical Genomics Service (AWMGS)) to guide further sequential testing for Lynch Syndrome.

Health Board colorectal MDTs must have an agreed method for testing and ensure results are reviewed and acted upon, with onward referral to Clinical Genetics where appropriate. Patients should be informed of the possible implications of test results for both themselves and their relatives, ensuring relevant support and information is available.

Colorectal cancer patients with MSI-high or MMR deficient tumours may be eligible for non-chemotherapy based systemic anticancer therapy, depending on disease stage.

Stage IV tumours should be tested with DNA Next Generation-Sequencing (NGS) to guide systemic anticancer treatment decision-making. Please note this testing aims to identify somatic (acquired) variants rather than inherited (germline) variants. Test request forms are available via AWMGS and should be directed to the pathology laboratory housing the tissue specimen to be tested; requests should not be directly sent to AWMGS. Circulating tumour DNA (ctDNA) testing (using a blood sample) to detect RAS variants is available when either a biopsy is not possible or where the tumour specimen has been exhausted or molecular testing has failed.

SYMPTOMATIC FAECAL IMMUNOCHEMICAL TESTING

The Faecal Immunochemical Test (FIT) can identify possible colorectal cancer by detecting small amounts of blood (globin component of haemoglobin) in stool samples. It measures the faecal haemoglobin (Hb) concentration as microgram of Hb per gram (µg/g) of faeces. In symptomatic patients, a positive FIT is a result of ≥10µg Hb/g, processed in an UKAS ISO 15189 accredited laboratory.

FIT has a superior positive predictive value for colorectal cancer over symptoms alone[1]. It has a similar diagnostic accuracy in both high and low risk symptomatic patients, including younger age groups where there is an increasing incidence of colorectal cancer[1].

At the time of publication of the first version of the National Optimal Pathway for Colorectal Cancer (NOPCC) in 2019, the recommended use of FIT was limited to people with low risk symptoms[2]. Subsequent to the new joint national guideline by the Association of Coloproctology of Great Britain and Ireland and British Society of Gastroenterology[1], this pathway outlines the integration of symptomatic FIT into the NOP. It also follows NICE guidance which can be found here - Overview | Quantitative faecal immunochemical testing to guide colorectal cancer pathway referral in primary care | Guidance | NICE

General Principals

- We recommend that FIT is available to all General Practices to support the assessment of people presenting with signs or symptoms raising the suspicion of colorectal cancer

and as an adjunct to clinical history, examination (including anorectal examination) and appropriate blood tests (e.g. FBC, ferritin)

- We recommend that FIT is undertaken within primary care **prior** to considering referral in people presenting with signs or symptoms suspicious of colorectal cancer
- In some cases, there may be an ongoing high suspicion of colorectal cancer based upon symptoms and clinical judgement ('gut instinct') in people with a negative FIT. Referrals should clearly outline why cancer is still suspected
- We recommend that the use of FIT should be carefully considered in people potentially unsuitable for onward diagnostic investigation
- We recommend that direct/straight to test investigation is undertaken in people who are FIT positive. Where there is uncertainty regarding suitability for investigation (e.g. frailty or significant comorbidity), referrals should clearly outline this to support decision making in the triage of referrals in secondary care
- The Bowel Screening Wales (BSW) Programme is available for asymptomatic participants, with a current FIT threshold of 80µg Hb/g**.** This compares with a symptomatic FIT threshold of ≥10µg Hb/g. Therefore, we advise that FIT is undertaken in people presenting with signs or symptoms of suspected colorectal cancer at any time point, even following a negative bowel screening programme test. The point of suspicion (POS) for referrals from bowel screening is defined as the 'Date that the lab validates a positive FIT test'.

Criteria

- We recommend that FIT is undertaken in people presenting with signs or symptoms suspicious of colorectal cancer (see flow chart below for guidance related to use of FIT in people with Iron Deficiency Anaemia)[1, 3]
- We recommend that patients with an abdominal mass suspicious of malignancy should have a FIT undertaken alongside investigation (e.g. CT abdomen) or referral
- ACPGBI/BSG advise that a FIT is not required for patients with anal ulceration or anal/rectal mass prior to referral
- There is no indication for FIT in people with upper GI symptoms (e.g. dyspepsia)

Point of Suspicion

A clinical suspicion of cancer may result from:

- Positive FIT result (≥10µg Hb/g)
- Ongoing high clinical suspicion of colorectal cancer in patients with a negative FIT
- Clinical suspicion of cancer in patients unable to complete (e.g. due to physical disability) or declining FIT. The reason for an absent FIT test should be outlined in referrals to secondary care

First clinical suspicion of cancer	**Recording the patient's entry onto the single cancer pathway – day 0**	**Pathway entry**
Referral from primary care: • Positive FIT stool test (≥10µg Hb/g) • High clinical suspicion of colorectal cancer in FIT negative patients ***or*** those unable to complete/declining FIT	Date referral is sent from primary care to the Health Board	Referral from GP
Positive FIT stool test (≥10µg Hb/g) in secondary care e.g. outpatient clinic, inpatient, emergency	Date the lab validate a positive FIT test result	Referral following diagnostic - Other

presentation (including those presenting with IDA)		

Referrals and Safety Netting
Robust safety netting advice is therefore imperative across primary and secondary care for patients who are FIT negative or where the referral priority is downgraded on the basis of the result.

Primary care
We advise that:

- Patients with a positive FIT (≥10µg Hb/g) are notified of the result and referred to secondary care as a suspected cancer priority. Safety netting advice should be provided to contact the General Practice if communication is not received from secondary care within 2 weeks.
- General practices have systems in place to identify and remind patients that have not returned a FIT sample within 2 weeks of request. Where no FIT result can be obtained, clinicians should use existing guidelines to assess the risk of colorectal cancer[2, 4]
- Patients with a negative FIT are provided with safety netting advice to seek further medical review if they have a persistent or change in symptoms or have ongoing concern (outline safety netting letter included in Appendix A)

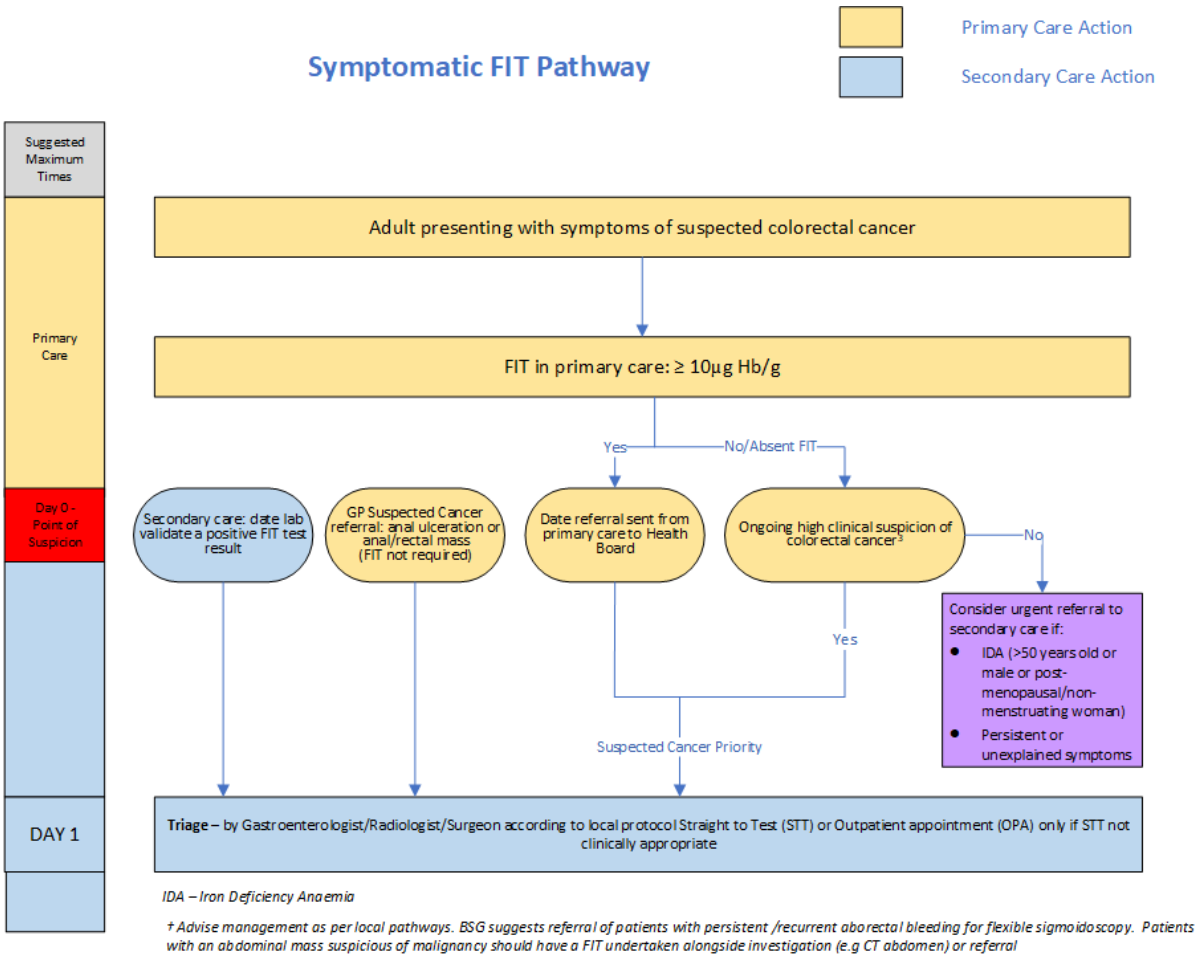
Secondary care

- GP's are notified of all referrals downgraded from a suspected cancer priority, including the reason for priority change and recommendations for safety netting
- Patients should be advised of referral downgrades[5] (outline letter included in Appendix B)
- ACPGBI/BSG recommend that patients should not be excluded from referral from primary care for symptoms based upon the basis of FIT testing alone. In cases where secondary care assessment or investigation is not deemed necessary following receipt of a referral, a clear plan of action should be described, including[6]:
    i. Specific changes in symptoms to flag
    ii. Re-referral thresholds
    iii. Routes to assist in further management (e.g. local pathways)

Pathway Governance
We recommend that Health Board colorectal MDT's document FIT negative cancer diagnoses and review the pathway of individual cases, including changes in referral priority, to identify any opportunities for learning or emerging themes

In the event of supply chain issues with FIT kits, we recommend that clinicians should use existing guidelines to assess the risk of colorectal cancer[2, 4]

Educational Material
Supportive educational material is available for professionals through GatewayC. Patient information is available through CRUK (FIT Symptomatic | Cancer Research UK)



[1] Monahan KJ et al. Faecal immunochemical testing (FIT) in patients with signs of symptoms of suspected colorectal cancer (CRC): a joint guideline from the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the British Society of Gastroenterology (BSG). Gut. Published Online First 12 July 2022

[2]Quantitative faecal immunochemical testing to guide colorectal cancer pathway referral in primary care. HealthTech Guidance Reference Number:HTG690 Published 24 August 2023 - Quantitative faecal immunochemical testing to guide colorectal cancer pathway referral in primary care

[3]BSG/ACPGBI guidelines on the role of FIT in the endoscopic investigation of IDA 2025 – available at: BSG/ACPGBI Guidelines on the Role of FIT in the Endoscopic Investigation of IDA

[4]NICE. Suspected cancer: recognition and referral. NICE guidance [NG12]. Updated 2021. Retrieved from: http://www.nice.org.uk/guidance/ng12

[5]Guidelines for managing patients on the suspected cancer pathway (WHC/2024/07)

[6]National Endoscopy Programme. National framework for the implementation of FIT in the symptomatic service. Updated 2021. Retrieved from: https://collaborative.nhs.wales/programmes/endoscopy/workstreams1/clinical-pathways/

Visual and written information is available to guide patients on how to complete their FIT test. For examples in English and Welsh please see: How to complete your FIT (faecal immunochemical test) English, Sut i gwblhau eich FIT (prawf imiwnogemegol ysgarthol) which are produced by Cancer Research UK

CLINICAL EVIDENCE

Point of Suspicion/ Referral

The point of suspicion is the date when a clinician refers a patient or requests a test concerned that a patient may have cancer.
The point of suspicion via a screening route is defined as the date of the abnormal test report (or date of the colposcopy procedure).
Guidelines for managing patients on the suspected cancer pathway (WHC/2024/07)

The need for an urgent referral due to the possibility of cancer should be explained to the patient by the primary care clinician.
Information for patients is available from Cancer Research UK: Your urgent suspected cancer referral

Clinical Decision Support Tools
Available at:
Q Cancer Risk Assessment Tool

Further information is available from: Suspected Cancer: Recognition and Referral NICE Guidance NG12

FIT in patients with signs or symptoms of suspected CRC: A joint guideline from ACPGBI and BSG

Community HealthPathways

Community HealthPathways offer clinicians locally agreed information to make the right decisions together with patients, at the point of care.

The pathways are designed primarily for general practice teams, but are also available to specialists, allied health professionals, and other health professionals in the local region.
HealthPathways - Find your local HealthPathways site

Diagnosis and Management

National Institute for Health and Care Excellence – NG151 guidance for colorectal cancer

Multi-disciplinary Team Meeting Referral

To ensure that cases submitted for discussion at a Multidisciplinary Team (MDT) meeting have a clearly defined clinical question and are supported by sufficient clinical information to enable informed discussion by MDT members, clinicians should complete the All-Wales Referral Proforma, or an agreed locally developed equivalent, when referring patients for MDT consideration.

Further Information is available from:
Multidisciplinary Team Charter (MDT) Charter

Fertility Information

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 NHS Wales Joint Commissioning Committee (NWJCC) 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.

jcc.nhs.wales/clinical-policies/fertility/specialist-fertility-services-commissioning-policy-cp38-april-2025-pdf/

For information relating to pregnancy and contraception refer to the All Wales Guideline for Pregnancy, Contraception and Cancer (2025)

Research & Innovation

Patients should be offered the opportunity to participate in research and clinical trials whenever possible. Where appropriate, referral to other health boards or trusts should be considered if relevant trials are available elsewhere.

•People in research | Health Care Research Wales (healthandcareresearchwales.org)

•EC Trial Finder | ECMC (ecmcnetwork.org.uk) (For clinicians)

•Be Part of Research (A trial finder that clinicians can signpost patients to)
People in research | Health Care Research Wales

BEST PRACTICE GUIDANCE

Vetting & Triage

The triage of referrals should be undertaken using an electronic system (e.g. Welsh Patient Referral Service) to ensure 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).

Direct Booking Diagnostics

It is recommended that patients attending a face-to-face outpatient clinic appointment as their first point of contact can 'direct book' any onward diagnostic tests such as endoscopy and CT scans on the same day (i.e., leave the hospital with an appointment date and any preparation required for the test).

Accelerated Imaging

It is recommended that following suspected malignant findings at endoscopy, patients should have a staging CT thorax, abdomen, and pelvis (CT TAP) on the same or next day, and for rectal cancers, an MRI scan within 3 days. These scans should be reported within 2 working days.

Imaging Scheduling and Imaging Turnaround Reporting Times

Patients who are referred for imaging tests as part of a Suspected Cancer Pathway referral should be booked for their tests within 10 days of the referral. Reports should be issued in a timely manner to optimise prompt patient care and in a time which is relevant to the urgency of the clinical situation.

Suggested turnaround time targets for reports being issued are:

Cross Sectional Studies

Inpatients	24 Hours
USC Outpatients	36 Hours
Urgent GP & Outpatients	7 Days

Ultrasound and Interventional Radiology

Ultrasound and Interventional Radiology - At the time of examination/ session usually but for monitoring purposes 24 hours

Plain Films

Acutely Unwell /ED Patients during normal working hours	12 hours, ideally <4 hours
Other Inpatients	7 days
Urgent GP/Urgent OPD	7 days

Abnormal Straight to Test Radiology Results

If colorectal cancer is suspected on straight to test radiology imaging, a process should be in place to refer the patient directly to colorectal or gastroenterology services.

Pathology Turn around Times

The Royal College of Pathology have 7- and 10-calendar-day Key Performance Indicators as the nationally recognised benchmark for diagnostic pathology reporting.

- It is acknowledged that some tumour pathways require additional investigations that may extend reporting times; and
- Tumour-specific or test-specific turnaround times are defined locally in line with Royal College of Pathology standards, screening programme requirements, and laboratory accreditation.

Genetics Referral

Guidance for genetic testing (germline and tumour) and criteria for referral to Clinical Genetics are available on the All-Wales Medical Genomics Service website. Guidance on specific genomic biomarker testing is available on the NHS Wales Performance and Improvement website. Where a potential germline finding is identified, the treating clinician is responsible for taking appropriate action. This may include discussion with the All-Wales Genomics clinical services and/or laboratory, or confirmatory germline testing with onward referral to Clinical Genetics where indicated.

DEFINTIONS

Decision to Treat

The date of the decision to treat is the date upon which the **decision to treat** was confirmed between a designated member of the multi-disciplinary team and the patient.

Source NHS Wales Data Dictionary available at:
Annual Operating Framework: Cancer Waiting Times

Direct to Test / Straight to Test

GPs have direct access to diagnostic endoscopy, ultrasound, MRI, X-ray and CT for people with suspected cancer.
Source: Suspected Cancer: Recognition and Referral. Nice Guideline NG12
"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

First Definitive Treatment

First Definitive Treatment (FDT) is defined as the start of the initial intervention (treatment) aimed at removing or eradicating the patient's cancer completely or reducing tumour bulk and stabilising their symptoms. FDT stops the suspected cancer pathway. If FDT is Specialist Palliative Care, the pathway will stop on the date of the first treatment/support meeting.

Guidelines for managing patients on the suspected cancer pathway (WHC/2024/07)

Safety Netting

Safety netting is a diagnostic management strategy that ensures patients - especially those with potential signs and symptoms of cancer - are monitored throughout the diagnostic process until symptoms are explained or resolved, and all results have been acted on.

It plays a vital role in helping primary care professionals manage diagnostic uncertainty (Cancer Research UK)

Safety netting | Cancer Research UK

Also:

CRUK Safety Netting Flowchart:

safety_netting_flow_chart_april_2024.pdf

NICE Suspected Cancer: Recognition and Referral NG12

Suspected cancer: recognition and referral

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)

PERSON CENTRED CARE

Key Worker

Every person affected by cancer must have an allocated key worker who, with the individual's consent, has a central role in coordinating care, promoting continuity, and ensuring the patient knows where to access information and advice. Allocation and review of the key worker should occur at key stages in the cancer pathway, including around the time of diagnosis (or earlier if there is strong clinical suspicion of cancer) and at the commencement of treatment, and should be clearly identifiable within their clinical record as outlined in the Welsh Health Circular (2014/001)

Meeting People's Needs

Every person affected by cancer should have regular opportunities to discuss their health, beliefs, concerns, and preferences to inform person centred care. Holistic needs must be assessed at key points throughout the cancer pathway using supported conversations and/or validated tools (e.g. the Macmillan electronic Holistic Needs Assessment, Distress Thermometer). These assessments should identify physical, emotional, practical, spiritual, and information and support needs, ensuring signposting and access to appropriate support services as required. A co-produced care plan should be developed through shared decision-making, documented clearly, and communicated to the patient and relevant healthcare professionals to enable seamless transitions between care settings.

Health Optimisation /MECC

Making Every Contact Count (MECC) is an approach which encourages health and social care staff to use the opportunities arising during their routine interactions with people affected by cancer to promote healthier lifestyles and improve overall wellbeing. MECC encourages positive lifestyle changes such as stopping smoking, limiting alcohol intake, eating healthily, staying physically active, maintaining mental wellbeing, and keeping up to date with vaccinations to improve outcomes and quality of life throughout and beyond treatment.

The Quality Statement for Cancer (2025) states that clinical teams should apply making every contact count throughout the pathway.

Lifestyle advice / resources are available from Making Every Contact Count (MECC)

Medical Optimisation

Medical Optimisation

It is recommended that if diagnostic investigations (endoscopy or radiology) identify a suspected cancer, that teams give thought to patient medical fitness optimisation to run concurrently with pathological staging investigation. This could include consideration of the need for respiratory or cardiology (e.g., echocardiogram) investigation as well as diabetic and anaemia management.

Patients should undergo an objective assessment of pre-treatment risk to help inform peri-operative care requirements. They should also have access to peri-operative medical optimisation resources such as nutritional support, smoking cessation advice, exercise/physical activity, and well-being support as well as alcohol support services prehabilitation and intravenous iron.

Prehabilitation

Prehabilitation is a needs-based multimodal intervention, before and during cancer treatment, to optimise physical, nutritional and psychological status, enhance readiness for and tolerance of treatments and improve recovery and/or quality of life.

Prehabilitation involves screening before needs based assessment, enabling individualised prescription of exercise, nutrition and psychological interventions supported by behavior change techniques" (Macmillan 2025). 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 professionals.

Prehabilitation and rehabilitation should be offered for all patients who have, or very likely to have cancer, and clinical teams should apply making every contact count along the pathway" (Welsh Government 2025).

This should be part of a holistic, co-produced, person-centered pathway that applies making every contact count throughout.

Macmillan 2025. Prehabilitation for People with Cancer, Clinical and Implementation Guidelines prehabilitation-for-people-with-cancer-clinical-and-implementation-guidelines (macmillan.org.uk)

Welsh government 2025. The Quality Statement for Cancer. The quality statement for cancer [HTML] | GOV.WALES

Rehabilitation

Rehabilitation is defined as “a set of interventions designed to optimise function and reduce disability in individuals with health conditions in interaction with their environment” (WHO 2024). Whilst rehabilitation is often seen as a physical process, psychological wellbeing is recognised as an integral part of any rehabilitation journey (Welsh Government 2022).

Rehabilitation is a holistic person-centred process, which should be centred around the person’s individual needs and goals, with an appropriately skilled workforce to meet the needs in a timely and holistic way. Rehabilitation can span multiple settings across health, social care, and third sectors. Allied Health Professionals are an integral part of the rehabilitation pathway that restores and maintains function, maximises independence, and enables people to live well following illness, injury, or with long-term conditions.

Welsh Government 2022. All Wales Rehabilitation Framework: Principles to achieve a person-centred value-based approach All Wales Rehabilitation Framework: Principles to achieve a person-centred (gov.wales)

World Health Organisation 2024. Rehabilitation (who.int)

Patient Reported Outcome Measures (PROMs) / Patient Reported Experience Measures (PREMs)

Patient Reported Experience Measures (PREMs) capture patients’ experiences through structured questions, providing quantifiable data on relational aspects (e.g., feeling listened to) and functional aspects (e.g., facilities).

PREMs require large sample sizes for standardised, validated results and systems that allow clinicians to act on individual feedback.

PROMs (Patient Reported Outcome Measures) assessments are essentially a structured communication assessment between a person receiving care and their clinical team, delivering standardised responses about symptom burden and quality of life. PROMs are one of the tools used within a wider toolkit, to evidence Value-Based healthcare, to better understand outcomes which matter most to people and patients. PROMs are designed and evaluated for symptoms relating to specific conditions or around general health and quality of life.

Definition taken from: Peoples Experience Framework WHC/2024/015 (Welsh Government, 2025https://www.gov.wales/peoples-experience-framework-guidance-nhs-wales

Further information is available from:

National PROMs Pathways - Value in Health

Value-Based Health Care: What's in it for Patients? - Value in Health

Communication

Clinicians must ensure patients are kept up to date about their care pathway and are supported to make informed choices about their treatment. Clinicians should consider the value of interventions and discuss with the patient the likely outcome of treatment options.

Primary Care clinicians should be notified of a cancer diagnosis within 24 hours. 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 stops the SCP 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/2023/025) | GOV.WALES

Treatment Summary

A treatment summary is a document completed by secondary care professionals following a significant phase of a patient's cancer treatment. It outlines the cancer diagnosis, prognosis, treatment aims, types of treatment received, associated side effects, and signs or symptoms of recurrence that patients should be aware of.

The summary should be shared with the person affected by cancer and their GP, either electronically or in paper format, using clear and accessible language. It can also support communication with other health and social care professionals, employers, occupational health, and financial institutions such as benefits services or banks.

Communication – Endoscopy

Endoscopy

Patient information for all relevant procedures should be given to patients ahead of the procedure. A range of communication methods and materials should be used to inform patients about what they should expect from the service (such as a website, written information, or specialised communication, e.g., pictures).
Patients are informed if they are suspected of having a malignancy on the same day as the procedure unless this is in the patient's best interest not to do so. This should be documented. Patients are told the outcome of their procedure and ongoing care. This information can also be shared with family and carers with the patients consent.
Discussion of the diagnosis should be accompanied by a copy of the endoscopy report (or a patient centred version).
If a cancer is suspected, the patient is referred to a relevant cancer Clinical Nurse Specialist (CNS) who offers contact with the patient before or soon after discharge from their diagnostic procedure.
Endoscopy reports are completed on the day of the procedure and include follow-up details and are sent to the patient's GP and the referring clinician (if different) within 24 hours of the procedure.
There is a process for referring patients with a suspected or definitive cancer diagnosis to the multidisciplinary team (MDT).

Guidance - GRS standards UK 2023.pdf (thejag.org.uk)

EIDO Patient Information

The EIDO InformTM download library provides procedure-specific patient information leaflets. Every Welsh Health Body has its own direct individual link, and clinicians can access the EIDO link for their Welsh Health Body directly via their individual Health Body intranet page.

Key benefits include:

- improved patient understanding of the problem and the treatment options,
- enhanced patient participation in the decision-making process,
- improved patient satisfaction, a more robust consent process as information details risks and benefits,
- information is available bilingually and in accessible formats.

EIDO Healthcare Download Centre (Patient Information Leaflets)

NOP ADHERENCE & CANCER AUDIT REPORTING

Adherence with the delivery of NOPs is difficult to assess directly using easily accessible, nationally provided data. Intelligence reports are available based on the national Suspected Cancer Pathway dataset, where dates on specific events along a patient's suspected cancer pathway are recorded.
Pathway compliance assessment is included on the NHS Performance & Improvement Cancer Resources SharePoint, maintained and managed by the Performance & Assurance Team with NHS P&I, where access is available to all accessing via an NHS Wales account.
Work is ongoing to improve the completeness and recording of sub-tumour sites across Wales.

Suspected Cancer Pathway Compliance

Two reports are available (based on closed/completed suspected cancer pathways) that provide an overview of the time taken for patients to pass through specific pathway elements.
Further intelligence regarding both open and closed suspected cancer pathways are available on the Cancer Resources SharePoint.

Compliance Assessment Dashboard
This report provides a monthly view (by Health Board, Tumour Site and Sub Tumour Site where recorded) of a number of key metrics, either in dashboard form, by benchmark among reporting Health Board, or as a monthly trend for the last 24 months.
Metrics include:

- Total patients treated
- Total patients treated or downgraded
- Percentage/number of pathways closed in month by selected Source of Suspicion
- Percentage of patients who went straight to test (pending approval of STT guidance)
- First appointment within X days of point of suspicion (time period x can be selected)
- First diagnostic within X days of point of suspicion
- Patients informed they do not have cancer by day X
- Patients informed they do have cancer by day X
- First definitive treatment within 21 days of a DTT
- First definitive treatment within 62 days of point of suspicion

Where metrics include a percentage of patients within X days, median and interquartile ranges (25^{th} to 75^{th} percentile) from point of suspicion to event are also included.
Compliance Assessment Pathway Walkthrough
This report includes the same information as the report above but includes a walkthrough of the median (and interquartile range) time in days from point of suspicion to each pathway event recorded in the national Suspected Cancer Pathway dataset. Additional information relating to attrition rates, i.e. the number and percentage of pathways where each event is recorded, is also included.

SCP Event Timings and Breach Analysis

An interactive Power BI report is also available on the same SharePoint page, or directly available here.

Using the report page 'Treatment Component Selected', users can pick any start and end point recorded on the pathway to compared to the median and interquartile range of time from one event to the other, comparing among Health Boards, by route to diagnosis or within tumour site/sub tumour site. Analysis can be filtered by:

- Time period for inclusion, starting December 2020
- Tumour Site
- Sub tumour site
- Region
- Health Board
- UHB of Residence
- First definitive treatment modality
- Route to diagnosis, i.e. GP referral, screening, via A&E etc.

Events included within the analysis are:

- Date of receipt of referral
- Pathway start date
- First Appointment Taken date
- First diagnostic test undertaken date
- First diagnostic test reported date
- First MDT date
- Last diagnostic test before DTT date
- Last MDT date
- Decision to treat date
- First definitive treatment (SCP pathway clock stop) date

Wales National Cancer Audit

The National Cancer Audit Collaborating Centre (NATCAN) is the home of the ten national, tumour specific, cancer audits in both Wales and England.

Audit data is available for:

Bowel, Kidney, Lung, Primary Breast, Metastatic Breast, Non-Hodgkins Lymphoma, Oesophago-Gastric, Ovarian, Pancreatic and Prostate Cancer.

NATCAN aims to provide regular and timely data and evidence to NHS services about where and why patterns of care vary and to support local quality improvement.

Further information, including tumour specific audit data can be found at: Tumour Specific National Cancer Audit Data