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Performance and Improvement

NATIONAL OPTIMAL PATHWAY FOR RENAL 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:
Renal Cancer National Optimal Pathway Review triggered by the publication (19 March 2026) of the NICE Kidney Cancer: Diagnosis And Management Guideline (NG256)

Owner: Urology Cancer Site Group

NATIONAL OPTIMAL PATHWAYS FOR CANCER

NOP Notice:	Renal NOP
Date of Issue:	November2026

Issuer: National Cancer Team – Performance and Improvement	**Subject:** National Optimal Pathway – Adjustments
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 National Optimal Pathway was approved by the Cancer Reference Group (CRG) at its meeting on 19/08/2026

Summary:
To introduce the new edition of the National Optimal Pathway for Renal Cancer - Adjustments to pathway and booklet following the publication of new NICE guidelines.

Pathway / Booklet affected:

The Cancer Reference Group is responsible for endorsing 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 review of the Renal Cancer National Optimal Pathway was triggered by the publication (19 March 2026) of the NICE Kidney Cancer: Diagnosis and Management Guideline (NG256). This review includes new content relating to changes in the pathway for the diagnostic and management of pathway for patients with renal cancer.
Description of Change:	**Point of Suspicion / Referral:** NICE NG12 Referral Criteria for Renal Cancer is shown below: Renal cancer Refer people using a suspected cancer pathway referral for renal cancer if they are aged 45 and over and have: • unexplained visible haematuria without urinary tract infection, or • visible haematuria that persists or recurs after successful treatment of urinary tract infection.
Diagnosis and Management	**Inclusion of signposting to** NICE NG256 Kidney Cancer: Diagnosis and Management
Renal Cancer Diagnosis and Imaging	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. Images should be discussed in the MDT and checked with an experienced uro-radiologist if a biopsy is feasible. All patients with a suspected renal mass should have either a triple phase renal CT or MRI if iodinated contrast allergy.
Renal Cancer Accelerated Treatment	Patients with a cT3+ or 10cm+ or cN1 tumour should have surgery within 4 weeks of diagnosis.

Hereditary Renal Cell Cancer	Hereditary Renal Cell Cancer should be managed jointly with the genetics team and refer for genetic testing as part of a multidisciplinary approach.
Oncocytomas	Offer active surveillance for Oncocytoma's. Active surveillance should be every 6 months for the first year then annually thereafter. Could consider intervening if symptomatic.
Direct to Test / Straight to Test	GPs have direct access to diagnostic ultrasound, MRI, X-ray and CT for people suspected of cancer. Source: 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, and onward referral to an MDT where appropriate. Source: Delivering Cancer Waiting Times NHSE

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

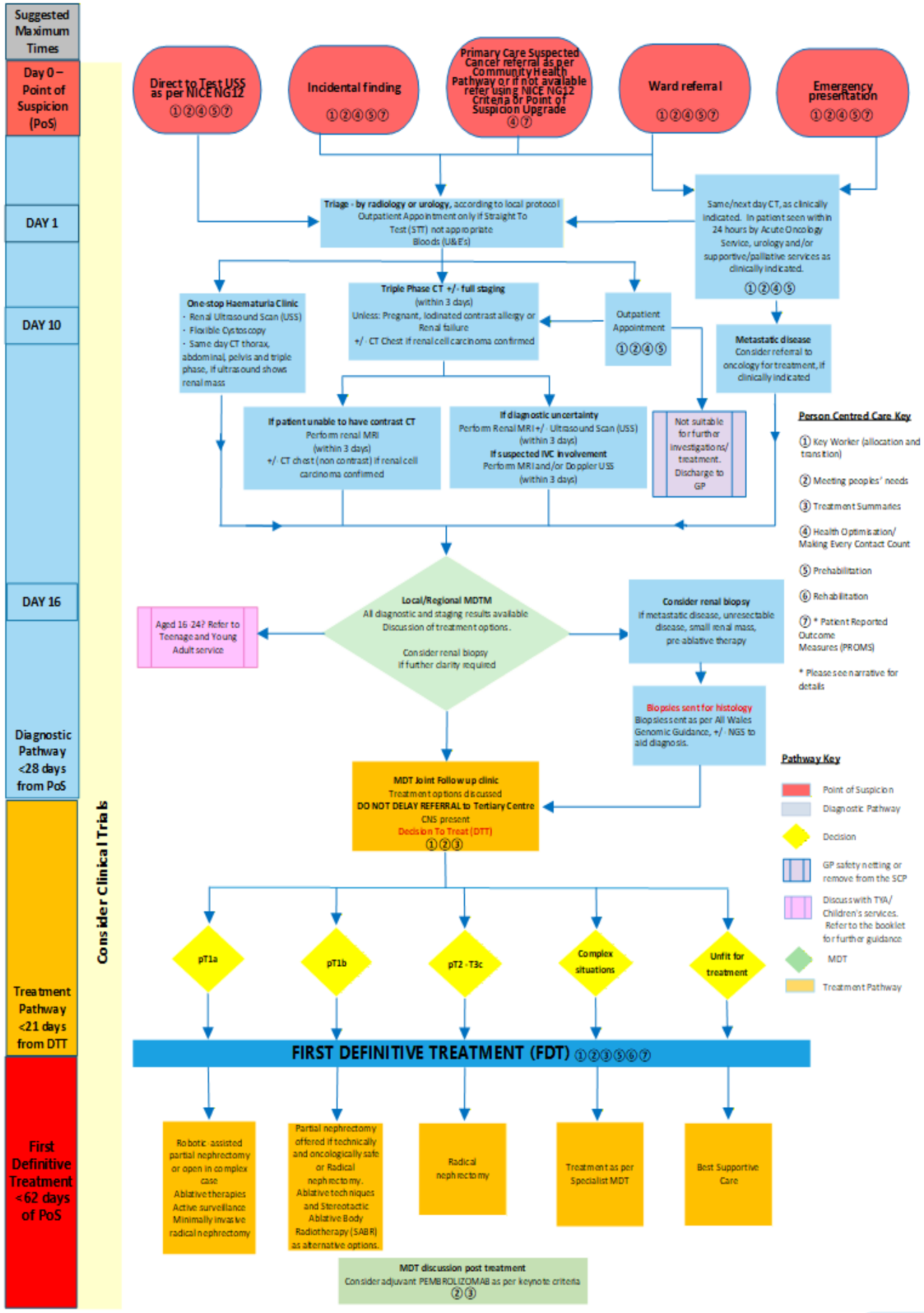
The third edition was developed with leadership from Mr Haitham Abdelmoteleb, Consultant Urologist following the recent publication of the second edition in December 2025.

The second edition pathway work was led by Mr Nicholas Gill and Mr Haitham Abdelmoteleb, Consultant Urologists. Multi-disciplinary representation contributed to the review of the optimal pathway during a range of pathway workshops, CSG meetings and education days.

Separate workshops were held with Clinical Nurse Specialist (CNS) and Allied Health Professional (AHP) members to embed the rehabilitation and Person-Centred Care (PCC) into the pathway. Wider consultation was sought in the summer of 2025 from NHS Wales stakeholders including MUO / CUP, Vague Symptoms, Primary Care, Urology Cancer Site Groups core memberships, NHS Performance and Improvement Programme Leads, Executive Leads for Cancer, Health Board Clinical and Managerial Leads, Cancer Coordinators, All Wales Medical Genomics Service, Joint Commissioning Committee, Digital Health Care Wales, Health Education Improvement Wales, General Practitioners Committee and other stakeholders including Third Sector organisations. All responses were considered for inclusion.

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



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

NICE NG12 Referral Criteria for Renal Cancer is shown below:
Renal cancer
Refer people using a suspected cancer pathway referral for renal cancer if they are aged 45 and over and have:
• unexplained visible haematuria without urinary tract infection, or
• visible haematuria that persists or recurs after successful treatment of urinary tract infection.

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

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

NICE NG256 Kidney Cancer: Diagnosis and Management
GIRFT: Urology - Towards Better Care for Patients With Kidney Cancer
European Association of Urologists (EAU) Renal Cell Carcinoma Guidelines

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

All-Wales Referral Proforma

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).

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

Renal Cancer Diagnosis and Imaging

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.

Images should be discussed in the MDT and checked with an experienced uro-radiologist if a biopsy is feasible.

All patients with a suspected renal mass should have either a triple phase renal CT or MRI if iodinated contrast allergy.

Renal Cancer Accelerated Treatment

Patients with a cT3+ or 10cm+ or cN1 tumour should have surgery within 4 weeks of diagnosis.

Hereditary Renal Cell Cancer

Hereditary Renal Cell Cancer should be managed jointly with the genetics team and refer for genetic testing as part of a multidisciplinary approach.

Oncocytomas

Offer active surveillance for Oncocytoma's.
Active surveillance should be every 6 months for the first year then annually thereafter.
Could consider intervening if symptomatic.

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.

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.

Direct to Test / Straight to Test

GPs have direct access to diagnostic ultrasound, MRI, X-ray and CT for people suspected of cancer.

Source: 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, and onward referral to an MDT where appropriate.

Source: Delivering Cancer Waiting Times NHSE

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

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.

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 site 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 (25th to 75th 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