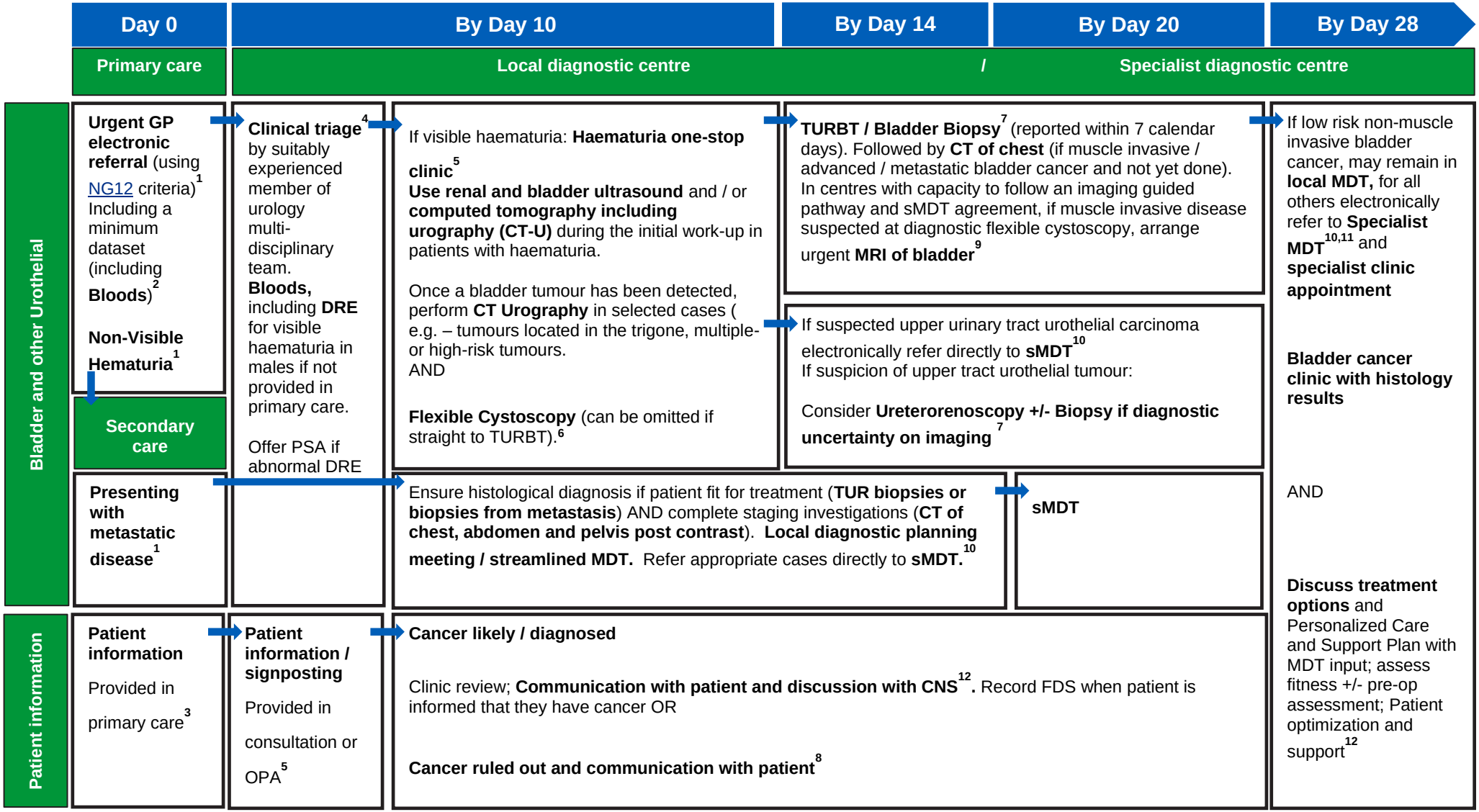
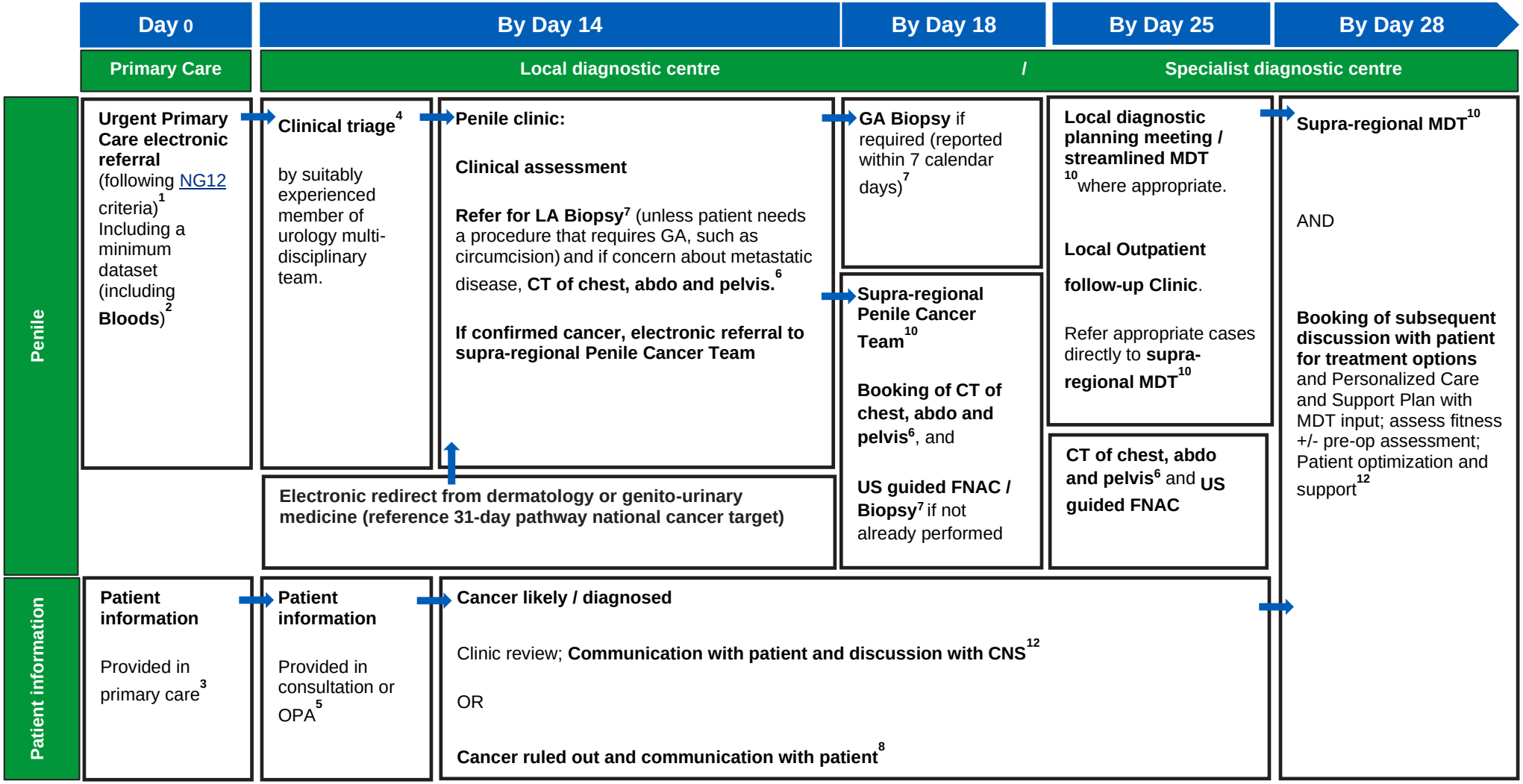
Bladder best practice timed pathway



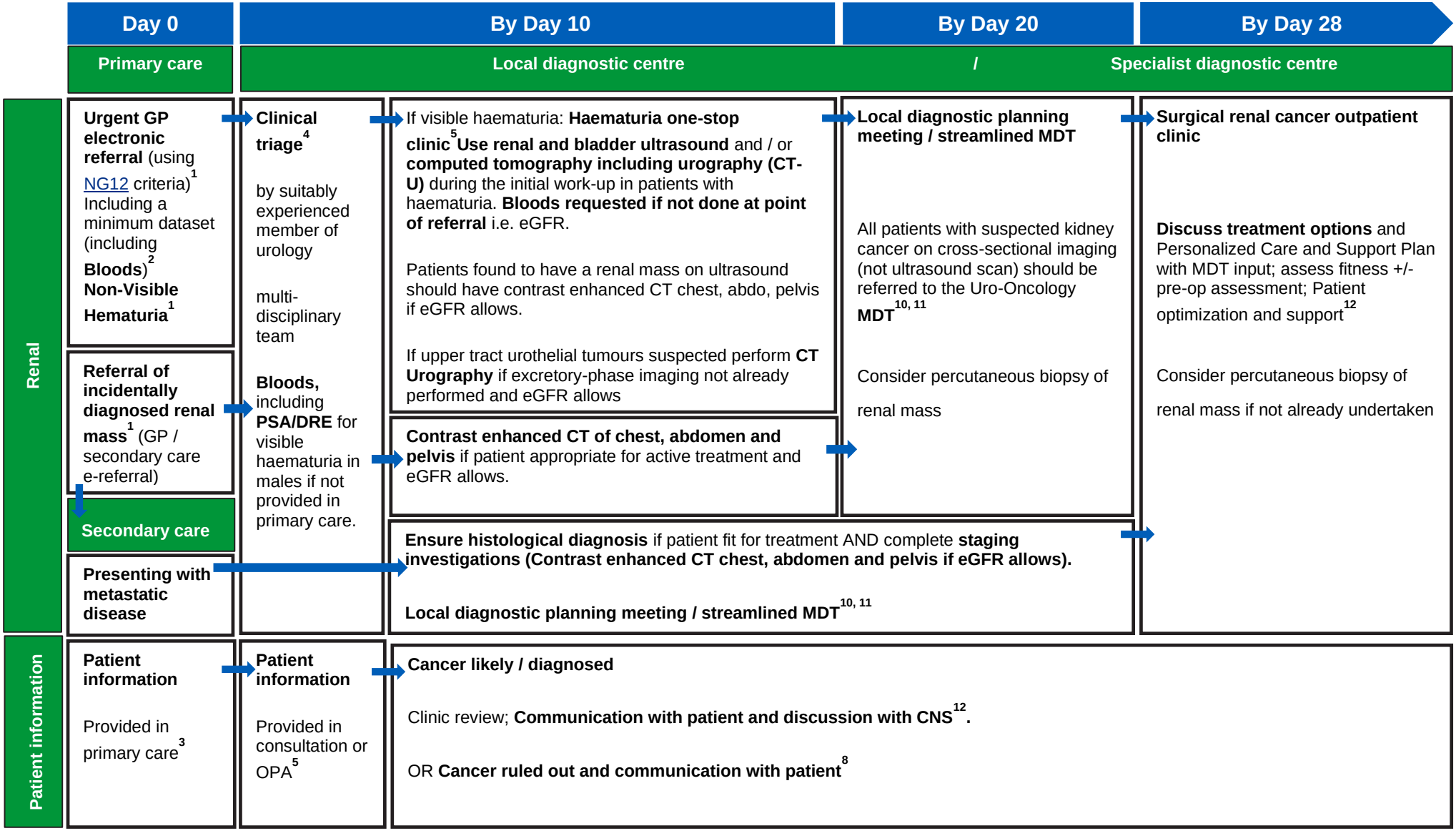
See detailed information below.

Penile best practice timed pathway



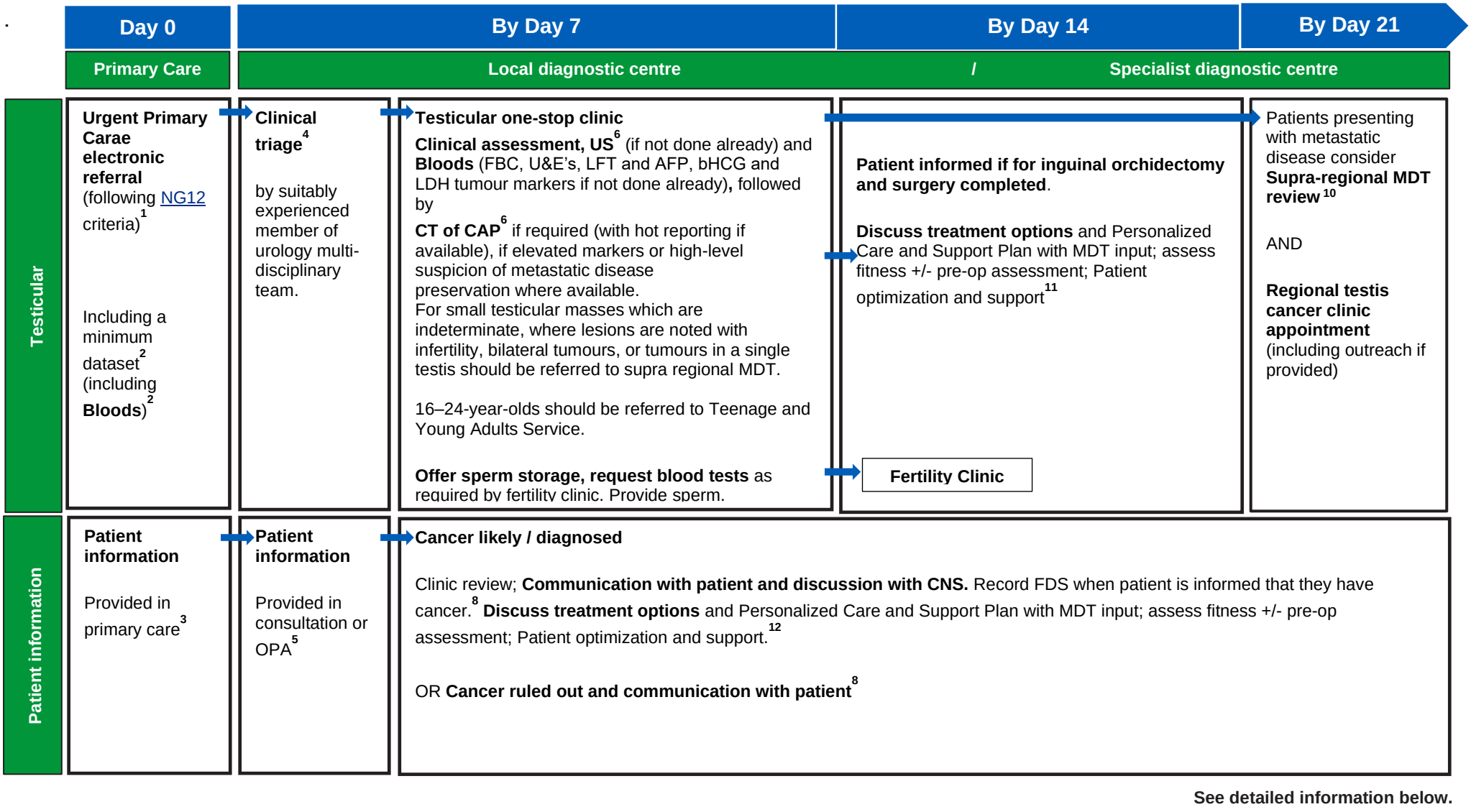
See detailed information below.

Renal best practice timed pathway



See detailed information below.

Testicular best practice timed pathway



See detailed information below.

Detailed information

1. An urgent electronic referral pathway should be used for patients who meet NG12 criteria for suspected cancer pathway referrals. In a scenario where primary care refers the patient for a direct access test as cancer is not initially suspected, and the ultrasound, CT, or bloods are abnormal and suspicious of cancer, patients should be followed up directly by secondary care therefore referred on internally without the need for an additional referral from the GP, without the need for an additional referral from their GP.

   Patients presenting with possible pain, fatigue and weight loss and there is suspicion of metastatic disease either in primary care or secondary care patients should be considered for further diagnostics.

   Bladder and Renal Cancers: Non-visible haematuria-non-visible haematuria (NVH) is a common finding and may (uncommonly) indicate undiagnosed urological cancer. The optimal investigation of NVH is unclear, given the low incidence of cancer and the implications of testing all individuals with this finding. Further study is required to reach consensus on optimal investigation schedules, and in the meantime a risk-benefit discussion should be had with those affected to agree an individualised approach.

   Evidence supports referral via a suspected cancer pathway for individuals aged 60 and over who have unexplained non-visible haematuria and either dysuria or a raised white cell count on a full blood count. Recommendations organised by site of cancer | Suspected cancer: recognition and referral | Guidance | NICE

   The patient would then join the pathway after the first diagnostic test (labelled on this pathway diagram as ‘straight to one-stop clinic’). The National Cancer Waiting Times Monitoring Dataset Guidance v12.0 sets out consultant upgrade rules. A consultant upgrade would also apply to other scenarios where the patient may join the pathway, such as an abnormal CT result following attendance at A&E, or an incidental finding on imaging undertaken for a different indication.

   Consultant upgrade patients are reported alongside urgent suspected cancer referrals from primary care within the single 62-day referral to treatment standard. Cancer Alliances may set out local arrangements to facilitate patient self-referral access to this pathway.

2. A minimum dataset to accompany the referral and facilitate straight to clinic and immediate diagnostics, to be agreed locally, may include:

   - description of referral reason in line with NG12 guidelines
   - patient demographics

- estimated glomerular filtration rate (eGFR)
- full blood count
- urea and electrolytes
- renal function including creatinine.
- calcium
- LFTs
- anticoagulant status
- co-morbidities, including diabetes status.
- dementia
- mental health conditions, such as claustrophobia
- Body Mass Index
- prescribed medication
- allergies
- family history of cancer
- World Health Organization performance status
- presence of metal implants or pacemakers
- need for an interpreter.
- mental capacity to consent.

The referral should not be delayed while obtaining dataset items, such as waiting for blood test results.

3. Primary care should provide information to the patient, including information about FDS and the urgent suspected cancer pathway, expected timelines, including that the patient should be available within the next 10 days initially for appointments and tests, may be required for 28 days. This is also a good point to discuss the importance of stopping smoking and provided information cessation services.

   Cancer Alliances are encouraged to use this guidance and other policies to support work locally, with commissioners, to provide educational opportunities for Primary Care on cancer symptoms, urgent referral processes and the locally agreed minimum dataset. This should include hard to reach and outlier GPs.

4. Clinical triage can be undertaken by a suitably experienced clinician. This may be a supervised CNS, who has the training and authority to triage to one-stop clinics and book imaging tests. Preparation for any tests should be communicated to patients.

   Suitability for treatment and any requirements for pre-habilitation (e.g. Nutrition and exercise advice) should be considered at this stage in the pathway. Patients should be triaged in accordance with NG12 Guidelines for urological cancers and any locally agreed clinical criteria for risk stratification.

   Throughout the pathway, tests will need to be pre-booked at the earliest opportunity to ensure sufficient capacity and patient flow enable all relevant test to be carried to ensure diagnosis of 28 days. Therefore, a consideration should be made to ring-fence urgent cancer slots in advance and releasing them if no longer required.

5. An outpatient appointment (OPA) should be provided for any cohort of patients who are medically unfit for straight to one-stop clinic or may not need a one-stop clinic appointment. Patients who attend an OPA should have same day tests to reduce repeat visits and improve patient experience. If this is not possible, tests should be on the next day (i.e. within 24 hours).

   The recommended first line investigations should be performed as a one-stop clinic where possible so that this cohort can progress on the pathway in the same timeframe. Patients and Carers should receive information about any tests and any preparations they need to make for their appointments. A clear walk through of what the patient will experience, plus leaflets and investigation information should be provided including details of whether they need to have more than one test on different days. Patients should also be asked if they require any accessibility support.

   Preferences for the amount of information and when it is provided will vary, and therefore it will help to provide the pathway navigator or CNS with telephone contact details so they can provide support throughout the pathway and outside of clinic times, provide signposting to charities and support services, provide information about carer attending appointments, and offer follow-up if patients do not receive confirmation of an appointment in expected timescales.

   Where possible, continuity of pathway navigator or CNS should be provided to enable familiar contact and to build trust. Patients should also be informed if they are likely to receive a procedure and/or diagnostic test on the same day at the first face-to-face appointment.

   The clinical triage consultation or first OPA is also an opportunity to collect minimum dataset items from the patient, if not provided in the primary care referral. The haematuria clinic set out in both the renal and bladder pathways can be a combined clinic or separate renal and bladder clinics, as determined by pathway, resourcing and planning requirements locally. The order of diagnostic tests in the haematuria clinic may vary based on local clinical criteria and operational requirements.

6. Standard imaging protocols should be applied for all CT, MRI, and ultrasound. These should comply with Royal College of Radiologists' recommendations or equivalent. Further information is available on the Royal College of Radiologists' iRefer page. Ring-fenced imaging slots should be considered to ensure that capacity is available to meet demand in a timely fashion.

7. Histopathology reports for tissue sampling should usually be available in seven calendar days. This may be longer if ancillary tests are required to establish a diagnosis or if the pathway for a sample reaching the reporting laboratory is delayed.

All histopathology should have a designated point of receipt, sign-off and management responsibility to ensure that reporting is not lost between different clinicians.

Perioperative Care of Older people undergoing Surgery (POPS) assessment should be carried out, at or immediately following one stop clinic, or decision to book, to assess suitability for GA biopsy.

Following tissue sampling results, confirmed cancer tumours should be tested for all clinically relevant molecular markers required to determine onward management. Given the possibility of benign disease, all patients with solid small renal masses should be considered for biopsy where technically feasible, it will impact patients' choice or clinicians recommendation on treatment.

8. Patients should be informed about cancer being ruled out or diagnosed at the earliest face-to-face opportunity following diagnostic test being completed unless the patient has expressed an alternative method of communication to speed up communication.

   When cancer is ruled out, the patient may be informed by telephone or written communication if waiting for diagnostic reporting. Patients may still require further testing in secondary care before an alternative non-cancer diagnosis can be identified.

   Best practice would be to refer the patient to an alternative secondary care service within the same provider if one is identified, rather than being discharged back to primary care. Running parallel general clinics alongside one-stop clinics using 'hot slots' can allow patients to undergo imaging and be followed up by the general clinic on the same day.

   When bladder, renal, penile and testicular cancer is ruled out, and other cancers are not ruled out, it may be appropriate to refer the patient onto an alternative tumour site specific pathway, or to a non-specific pathway, where non-specific or vague symptoms can be considered. When cancer is ruled out patient should be referred to the relevant secondary care speciality.

   For continuity of care, it is best practice for the CNS from triage and diagnostics to be available in the clinic.

   If a suspicious lesion is identified, patients should have access to a CNS with expertise in bladder, penile and renal, and testicular cancer for cancer for support (from the point of diagnosis onwards).

   Cancer waiting time rules (including 'clock start' and 'clock stop') are set out in the National Cancer Waiting Times Monitoring Dataset Guidance v12.0.

9. MRI can be used for further characterising small renal masses if CT is uncertain but should likely be reserved for specialist MDT actioning.

Further information is available on the Royal College of Radiologists' iRefer page. Ring-fenced imaging slots should be considered to ensure that capacity is available to meet demand in a timely fashion.

10. National guidance on how to maximise effectiveness of MDT meetings is available. This aims to improve patient experience, improve communication, and prevent delays in starting treatment. Locally agreed, clear criteria for referral to sMDT can also support with efficient pathway management.

11. In exceptional circumstances where required addition imaging should be completed as below and reviewed as part of MDT

    +/- chest CT if indicated and not yet done.

    +/- Imaging (e.g. MRI)

    +/- Renal Tumour Biopsy / Image Guided Biopsy7 (if not already performed)

12. Outpatient clinic should include the CNS assigned to the patient earlier in the pathway, from clinical triage or when a likely cancer diagnosis was discussed. Personalised care and support planning should be based upon the patient and MDT clinician(s) completing a holistic needs assessment (HNA), usually within / days of diagnosis.

    The HNA ensures conversations focus on what matters to the patient, considering wider health, wellbeing, practical issues, and support in addition to clinical needs and fitness. This enables shared decision-making regarding treatment and care options.

    Early consideration of the patient's fitness for radical therapy should be addressed as soon as possible in the pathway to minimise delays in expediting treatment. Local protocols and initiatives should be developed in collaboration with perioperative medicine, elderly care, and specialist dietitians. Anaesthetic assessments for patients with comorbidities should also be undertaken.