NICE National Institute for Health and Care Excellence

NICE quality standard

Kidney cancer

Quality standard
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This standard is based on NG256.

Quality statements

Statement 1 Adults aged 45 and over with visible haematuria, that is not caused by a urinary tract infection or that persists after successful treatment of a urinary tract infection, are referred for assessment using a suspected cancer pathway.

Statement 2 Adults with a suitable renal lesion 4 cm in diameter or smaller have a renal biopsy to help confirm the diagnosis.

Statement 3 Adults with renal cell carcinoma (RCC) have access to a clinical nurse specialist.

Statement 4 Adults with high-risk localised or locally advanced RCC, for whom surgery is suitable, have surgery with curative intent within 31 days of the decision to treat.

Statement 5 Adults with localised or locally advanced RCC who have finished treatment have follow-up imaging, with results reported to their clinical team within 4 weeks of each scan.

Statement 6 Adults with advanced RCC have their treatment options discussed by a uro–oncology multidisciplinary team.

Quality statement 1: Suspected cancer pathway referral

Quality statement

Adults aged 45 and over with visible haematuria, that is not caused by a urinary tract infection or that persists after successful treatment of a urinary tract infection, are referred for assessment using a suspected cancer pathway.

Rationale

Visible haematuria (blood in the urine) in adults aged 45 and over that is not caused by a urinary tract infection or that persists after successful treatment of a urinary tract infection is a possible symptom of renal or bladder cancer. Referral using a suspected cancer pathway will support a faster diagnosis and earlier access to treatment.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

a) Proportion of adults aged 45 and over with visible haematuria, that is not caused by a urinary tract infection or that persists after successful treatment of a urinary tract infection, who are referred for assessment using a suspected cancer pathway.

Numerator – the number in the denominator who are referred for assessment using a suspected cancer pathway.

Denominator – the number of adults aged 45 and over with visible haematuria that is not caused by a urinary tract infection or that persists after successful treatment of a urinary tract infection.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of adults aged 45 and over with confirmed renal cell carcinoma (RCC) who were referred for assessment using a suspected cancer pathway.

Numerator – the number in the denominator who were referred for assessment using a suspected cancer pathway.

Denominator – the number of adults aged 45 and over with confirmed RCC.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The National Disease Registration Service's Routes to Diagnosis tool (download: time trend data for all cancer sites by age group) presents data on suspected cancer referrals for kidney cancer for adults aged 50 and over.

Outcome

Proportion of adults aged 45 and over with confirmed RCC who were diagnosed after an emergency presentation.

Numerator – the number in the denominator who were diagnosed after an emergency presentation.

Denominator – the number of adults aged 45 and over with confirmed RCC.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The National Disease Registration Service's Routes to Diagnosis tool (download: time trend data for all cancer sites by age group) presents data on emergency presentations for kidney cancer for adults aged 50 and over.

What the quality statement means for different audiences

Service providers (such as GP practices, community hubs and secondary care services)

ensure that systems and processes are in place for adults aged 45 and over with visible haematuria, that is not caused by a urinary tract infection or persists after successful treatment of a urinary tract infection, to be referred for assessment using a suspected cancer pathway.

Healthcare professionals (such as GPs) refer adults aged 45 and over with visible haematuria, that is not caused by a urinary tract infection or persists after successful treatment of a urinary tract infection, for assessment using a suspected cancer pathway.

Commissioners ensure that suspected cancer pathways are in place for adults aged 45 and over with visible haematuria that is not caused by a urinary tract infection or persists after successful treatment of a urinary tract infection.

Adults aged 45 and over with visible blood in their urine, who do not have a urinary tract infection or have been successfully treated for a urinary tract infection, are referred for an urgent assessment to check for cancer.

Source guidance

Suspected cancer: recognition and referral. NICE guideline NG12 (2015, updated 2026), recommendation 1.6.6

Definitions of terms used in this quality statement

Assessment

Assessment should include:

- a urea and electrolyte profile blood test to assess renal function (creatinine and estimated glomerular filtration rate [eGFR]), if not done at referral
- a renal and bladder ultrasound, CT urography (CTU), or both
  - if upper tract urothelial tumours are suspected, excretory-phase imaging has not already been done and eGFR allows, then CTU should be done
- abdominal imaging, if there is not enough information from any previous imaging to inform next steps. The imaging should consist of either or both:

  - multiphasic contrast-enhanced CT (CECT)
  - MRI (ideally with contrast), if the adult cannot have multiphasic CECT or if more information is needed after multiphasic CECT
- CT of the chest and pelvis (ideally with contrast), if possible RCC is detected on abdominal imaging, to complete staging.

[NICE's guideline on kidney cancer, recommendations 1.2.1 to 1.2.3, and NHS England's implementing timed urology cancer diagnostic pathway – bladder, penile, renal and testicular]

Suspected cancer pathway

Adults aged 45 and over with visible haematuria, that is not caused by a urinary tract infection or that persists after successful treatment of a urinary tract infection, receive a diagnosis or ruling out of cancer within 28 days of being referred urgently by their GP. For further details, see NHS England's webpage on operational management, administration and performance – faster diagnosis standard. [NICE's guideline on suspected cancer, terms used in this guideline]

Equality and diversity considerations

Data from Cancer Research UK show that more males than females in the UK develop and die from kidney cancer. The committee highlighted that healthcare professionals should be aware that recurrent urinary tract infection in women, trans men and non-binary adults with a female urinary system who are experiencing menopause may be misdiagnosed. Their urinary tract infections may be incorrectly attributed to menopause rather than recognised a symptom of kidney cancer. This group should be carefully assessed, to help reduce the risk of delayed referral.

Quality statement 2: Renal biopsy for small renal lesions

Quality statement

Adults with a suitable renal lesion 4 cm in diameter or smaller have a renal biopsy to help confirm the diagnosis.

Rationale

The results of a renal biopsy for a suitable small renal lesion will confirm or rule out a diagnosis of renal cell carcinoma (RCC) and inform management options. When offering renal biopsy, healthcare professionals should explain the procedure, including its benefits, to support informed decision making. A biopsy may prevent overtreatment of benign renal lesions or low-risk malignant masses. This will particularly benefit adults who have a high risk of morbidity or mortality from radical treatment, such as partial or total nephrectomy.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of adults with a suitable renal lesion 4 cm in diameter or smaller who have a renal biopsy to help confirm the diagnosis.

Numerator – the number in the denominator who have a renal biopsy to help confirm the diagnosis.

Denominator – the number of adults with a suitable renal lesion 4 cm in diameter or smaller.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The National Kidney Cancer Audit - National Cancer Audit Collaborating Centre's State of the Nation Report performance indicator dashboard presents data on the percentage of people diagnosed with renal cancer 4 cm or smaller, or a renal cancer that is Tumour Node Metastasis (TNM) stage T1aN0M0 who have had a renal biopsy. This data does not capture renal lesions that were not diagnosed as cancer or the suitability of the renal lesion for biopsy. It is not expected that achievement will be 100%. This is because a renal biopsy will not be suitable for all adults with such a renal lesion, and some adults will choose not to have a biopsy. Commissioners and services may wish to focus on local uptake of biopsy compared with the national average.

What the quality statement means for different audiences

Service providers (such as secondary or tertiary care services) ensure that systems are in place so that adults with a suitable renal lesion 4 cm in diameter or smaller can have a renal biopsy to help confirm the diagnosis. They ensure that healthcare professionals who offer biopsy are aware of all aspects of biopsy, including its benefits, so that adults can make an informed decision when renal biopsy is offered.

Healthcare professionals (such as consultants, clinical nurse specialists and interventional radiologists) offer renal biopsy to adults with a suitable renal lesion 4 cm in diameter or smaller to help confirm the diagnosis. They explain all aspects of biopsy, including its benefits, when offering the procedure.

Commissioners ensure that services can provide renal biopsy for adults with a suitable renal lesion 4 cm in diameter or smaller to help confirm the diagnosis.

Adults with a suitable small kidney lesion are offered a renal biopsy (a procedure where a small tissue sample is taken from the lesion to be looked at under a microscope) to help confirm their diagnosis and inform management options. They are supported to make an informed decision through a discussion with their healthcare professional about all aspects of biopsy, including its benefits. Renal biopsy is not an option for everyone. For example, biopsy will not be offered for renal lesions in a location that is not accessible for biopsy, for cysts that do not have a sufficient solid component to do a biopsy, or when the results would not change management.

Source guidance

Kidney cancer: diagnosis and management. NICE guideline NG256 (2026), recommendations 1.3.1 and 1.3.3

Definitions of terms used in this quality statement

Suitable renal lesion for biopsy

A renal lesion with a solid component that is large enough to get a tissue sample from. Renal biopsy should not be offered if:

- it is not going to change management
- the renal lesion has grown into the renal vein or inferior vena cava and the person is a candidate for surgical treatment
- getting a tissue sample is not possible (for example, the renal lesion is in a location that is not accessible for biopsy).

[NICE's guideline on kidney cancer, recommendations 1.3.1 and 1.3.3]

Equality and diversity considerations

All adults with a suitable renal lesion should be offered a renal biopsy regardless of where they live, even if they need to travel to another hospital to have the procedure. Adults should be made aware that they may be eligible for the NHS healthcare travel costs scheme.

Quality statement 3: Clinical nurse specialist

Quality statement

Adults with renal cell carcinoma (RCC) have access to a clinical nurse specialist.

Rationale

Clinical nurse specialists can provide specialist guidance and support for adults with RCC, and their families and carers, from diagnosis and throughout management, follow-up or palliative care. They can act as the key worker, coordinating communication and care between secondary and primary care and providing continuity. Having a clinical nurse specialist will ensure that adults with RCC can access information, advice and support whenever they need it, helping to improve their quality of life and health outcomes.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

a) Proportion of adults newly diagnosed with RCC seen by a clinical nurse specialist.

Numerator – the number in the denominator seen by a clinical nurse specialist.

Denominator – the number of adults with a new diagnosis of RCC.

Data source: The National Kidney Cancer Audit - National Cancer Audit Collaborating Centre's Quarterly Report performance indicator dashboard presents data on the percentage of people diagnosed with kidney cancer that were seen by a clinical nurse specialist.

b) Proportion of adults with RCC who are given contact details of a clinical nurse specialist who will support them.

Numerator – the number in the denominator who are given the details of a clinical nurse specialist who will support them.

Denominator – the number of adults with RCC.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records or audits of clinic letters. The National Cancer Patient Experience Survey includes a question on whether people (aged 16 and over) had a main contact within the care team, such as a clinical nurse specialist, who would support them through their treatment. Survey data for renal cancer (cancer type) are presented on the interactive dashboard at national and various sub-national levels.

Outcome

Proportion of adults with RCC who are satisfied with the support provided by a clinical nurse specialist.

Numerator – the number in the denominator who are satisfied with the support provided by a clinical nurse specialist.

Denominator – the number of adults with RCC.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a survey of adults with RCC. The National Cancer Patient Experience Survey includes a question on how helpful people (aged 16 and over) found the advice received from their main contact in the care team overall. Survey data for renal cancer (cancer type) are presented on the interactive dashboard at national and various sub-national levels.

What the quality statement means for different audiences

Service providers (such as secondary and tertiary care services) ensure that clinical nurse

specialists are available to support adults with RCC from diagnosis and throughout management, follow-up or palliative care.

Healthcare professionals (clinical nurse specialists) are a point of contact and a source of information, advice and support for adults with RCC and their families and carers.

Commissioners ensure that services have enough clinical nurse specialists with training and experience in kidney cancer to support all adults with RCC, from diagnosis and throughout management, follow-up or palliative care.

Adults with RCC can contact a clinical nurse specialist (a nurse experienced in treating and supporting adults with kidney cancer) for information, advice and support throughout their care.

Source guidance

Kidney cancer: diagnosis and management. NICE guideline NG256 (2026), recommendations 1.1.3 and 1.1.4

Definitions of terms used in this quality statement

Access

Being able to contact and use the services provided by a clinical nurse specialist. These services include:

- providing information, advice and support, from diagnosis and throughout management, follow-up or palliative care
- signposting to voluntary or community emotional support services, or referral to NHS psychological health support services, if and when appropriate
- smoking cessation support
- opportunities for involvement in clinical trials and other types of research.

The clinical nurse specialist may do risk factor assessments, holistic needs assessments and personalised care and support planning. [NICE's guideline on kidney cancer,

recommendations 1.1.2 to 1.1.4 and 1.1.6 to 1.1.8]

Clinical nurse specialist

A clinical nurse with training and experience in supporting adults with kidney cancer. This can include surgical or oncology clinical nurse specialists and palliative care clinical nurse specialists, depending on the stage of care. They attend multidisciplinary team meetings, act as a link between the urology and oncology teams, and liaise between primary and secondary care, supporting communication and care coordination. [NICE's guideline on kidney cancer, recommendation 1.1.4, and expert opinion]

Quality statement 4: Surgery with curative intent

Quality statement

Adults with high-risk localised or locally advanced renal cell carcinoma (RCC), for whom surgery is suitable, have surgery with curative intent within 31 days of the decision to treat.

Rationale

Surgery with curative intent for adults with high-risk localised or locally advanced RCC can improve survival and prevent metastatic disease. If it is suitable for the person, surgery with curative intent should be done as quickly as possible after deciding to treat. Surgery options are discussed at multidisciplinary team meetings, with adults with RCC involved in deciding which option best suits them.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of adults with high-risk localised or locally advanced RCC who have surgery with curative intent within 31 days of the decision to treat.

Numerator – the number in the denominator who have surgery within 31 days of the decision to treat.

Denominator – the number of adults with high-risk localised or locally advanced RCC who have surgery with curative intent.

Data source: The National Kidney Cancer Audit - National Cancer Audit Collaborating Centre's State of the Nation Report performance indicator dashboard presents data on surgery within 31 days of the decision to treat.

Outcome

a) One-year survival rate for adults with high-risk localised or locally advanced RCC.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. Cancer survival in England - NHS England (adult cancer survival tables for people aged 15 to 99) includes data on 1-year survival for all people with kidney cancer.

b) Five-year survival rate for adults with high-risk localised or locally advanced RCC.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. Cancer survival in England - NHS England (adult cancer survival tables for people aged 15 to 99) includes data on 5-year survival for all people with kidney cancer.

What the quality statement means for different audiences

Service providers (such as secondary and tertiary care services) ensure that all surgery options are available for adults with high-risk localised or locally advanced RCC. They also ensure that staff are trained to discuss the risks and benefits of options and to support shared decision making.

Healthcare professionals (consultants, and clinical nurse specialists with training and experience in kidney cancer) discuss the risks and benefits of surgery options with adults with high-risk localised or locally advanced RCC, for whom surgery is suitable, and support them to make treatment decisions.

Commissioners ensure that services that provide all surgical options are available for adults with high-risk localised RCC or locally advanced RCC.

Adults with high-risk localised or locally advanced RCC, are offered surgery that may

cure their cancer if it is suitable for them. They discuss options for surgery with a healthcare professional who explains the risks and benefits of each.

Source guidance

- Kidney cancer: diagnosis and management. NICE guideline NG256 (2026), recommendations 1.5.3 and 1.7.1
- The 31 days of the decision to treat timeframe is based on NHS England's Cancer Waiting Times. The timeframe is not derived from NICE's guideline on kidney cancer. It is considered a practical timeframe to enable stakeholders to measure performance.

Definitions of terms used in this quality statement

High-risk localised or locally advanced RCC

Based on the Tumour Node Metastasis (TNM) staging system, this includes RCC with no distant metastases (M0) meeting any of the following criteria:

- T3 or higher
- stage 3 (locally advanced cancer)
- tumour size 10 cm or larger
- N1

that either remains confined to the kidney and surrounding structures or has grown into the surrounding tissue or blood vessels. It may have spread to nearby lymph nodes but has not spread to distant parts of the body and is operable. [NICE's guideline on kidney cancer, terms used in this guideline; the National Kidney Cancer Audit - National Cancer Audit Collaborating Centre's indicator on the management of high-risk renal masses (NKCA metrics 2024 - KC0004)].

For whom surgery is suitable

The suitability of surgery will depend on:

- comorbidities, fitness or performance status
- personal choice
- tumour-related issues.

Adults having neoadjuvant systemic anticancer therapy should be excluded from denominators in the process measure because the 31-day timeframe cannot be met. [NICE's guideline on kidney cancer, terms used in this guideline, rationale and impact sections for recommendations on surgery, thermal ablation, active surveillance or stereotactic ablative radiotherapy (SABR), and for recommendations on surgery for suspected or confirmed locally advanced RCC, and expert opinion]

Surgery with curative intent

Surgery options include partial or total nephrectomy with robot-assisted, minimally invasive or open approaches. The approach to treatment will depend on the clinical stage of the tumour, comorbidities and personal choice. [NICE's guideline on kidney cancer, recommendations 1.5.4 and 1.7.2]

Equality and diversity considerations

Healthcare professionals must ensure that adults with RCC are not excluded from surgery with curative intent because of their age, disability or where they live. They should support adults to consider all the options carefully, even if they will need to travel to another hospital, before deciding which option suits them best. Adults should be made aware that they may be eligible for the NHS healthcare travel costs scheme.

Quality statement 5: Follow-up imaging

Quality statement

Adults with localised or locally advanced renal cell carcinoma (RCC) who have finished treatment have follow-up imaging, with results reported to their clinical team within 4 weeks of each scan.

Rationale

It is important that the results of follow-up imaging after treatment for localised or locally advanced RCC are shared with the person with RCC as soon as possible. Reporting the results of follow-up imaging to the clinical team within 4 weeks of each scan facilitates this. Agreeing a follow-up plan, that includes the follow-up imaging schedule, with the person with RCC who has finished treatment may help to manage their expectations and any anxiety. Follow-up imaging after treatment for localised or locally advanced RCC supports early detection and treatment for any local recurrence or distant metastases.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

a) Proportion of adults with localised or locally advanced RCC who finish treatment who have an agreed follow-up plan that includes the follow-up imaging schedule.

Numerator – the number in the denominator who have an agreed follow-up plan that includes the follow-up imaging schedule.

Denominator – the number of adults with localised or locally advanced RCC who finish treatment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of follow-up imaging results for adults with localised or locally advanced RCC who have finished treatment that are reported to the clinical team within 4 weeks.

Numerator – the number in the denominator that are reported to the clinical team within 4 weeks.

Denominator – the number of follow-up imaging results for adults with localised or locally advanced RCC who have finished treatment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. NHS England's Diagnostic Imaging Dataset includes data on the overall report turnaround times for different types of imaging.

Outcome

Five-year survival rate for adults with localised or locally advanced RCC who have finished treatment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. NHS England's Cancer survival in England (adult cancer survival tables for people aged 15 to 99) includes data on 5-year survival for all people with kidney cancer.

What the quality statement means for different audiences

Service providers (such as secondary care, tertiary care and imaging services) ensure that systems are in place for adults with localised or locally advanced RCC who finish treatment to have follow-up imaging. Providers monitor whether imaging results are reported to the person's clinical team within 4 weeks of each scan.

Healthcare professionals (such as doctors, clinical nurse specialists and radiographers) agree a follow-up plan with adults who have finished treatment for localised or locally

advanced RCC and ensure that imaging appointments are offered in line with the plan. They report imaging results within 4 weeks of each scan and share the results with adults with localised or locally advanced RCC as soon as possible once the results have been received.

Commissioners ensure that services provide follow-up imaging to adults who finish treatment for localised or locally advanced RCC and provide results to the clinical teams within 4 weeks.

Adults with localised or locally advancedRCC who have finished treatment have regular scans to check for signs that the cancer has returned or spread. Scans are reported to the adult's clinical team within 4 weeks of each scan being done. Adults discuss the results of each scan with their healthcare professional as soon as possible after the healthcare professional receives the results.

Source guidance

- Kidney cancer: diagnosis and management. NICE guideline NG256 (2026), recommendations 1.11.1 and 1.11.6 to 1.11.8
- The 4-week timeframe for reporting of imaging is based on NHS England's diagnostic imaging reporting turnaround times for routine outpatient referrals. The timeframe is not derived from NICE's guideline on kidney cancer. It is considered a practical timeframe to enable stakeholders to measure performance.

Definitions of terms used in this quality statement

Finished treatment

All planned treatment for localised or locally advanced RCC is complete, including any adjuvant treatment. [NICE's guideline on kidney cancer, recommendation 1.11.1]

Follow-up imaging

Adults who have had treatment for localised or locally advanced RCC should be offered contrast-enhanced CT (CECT) of the chest, abdomen and pelvis at regular intervals to detect recurrence.

If CECT should be avoided to reduce radiation exposure, both of the following should be offered:

- MRI (with or without contrast) of the abdomen and pelvis, and
- CT (without contrast) of the chest (unless the person cannot have CT).

If CECT should be avoided because the contrast agent is contraindicated, either of the following should be offered:

- CT (without contrast) of the chest and MRI (with or without contrast) of the abdomen and pelvis, or
- CT (without contrast) of the chest, abdomen and pelvis.

The agreed follow-up imaging schedule and the expected duration of follow-up, if there remains no sign of recurrence, should be included in the personalised care plan. [NICE's guideline on kidney cancer, recommendations 1.11.2 and 1.11.6 to 1.11.8]

Equality and diversity considerations

Adults diagnosed with RCC at a young age, especially those with a heritable RCC predisposition syndrome, may need follow-up imaging for long or repeated periods over their lifetime. They will face cumulative risks from any imaging, such as radiation from CT. Healthcare professionals should think about this when choosing imaging type and developing a follow-up plan.

Follow-up imaging may need to be delayed, or a different type of imaging may need to be used, for adults who are pregnant.

Adults should be made aware that they may be eligible for the NHS healthcare travel costs scheme.

Quality statement 6: Uro–oncology multidisciplinary team

Quality statement

Adults with advanced renal cell carcinoma (RCC) have their treatment options discussed by a uro–oncology multidisciplinary team.

Rationale

Improving uptake of systemic anticancer therapy (SACT) is a priority for the care of adults with advanced RCC. Management options for advanced RCC can be very complex because they are based on many factors including the person's performance status, number and location of any metastases, baseline risk group, general health and comorbidities. It is important that treatment opportunities are not delayed or missed, and that treatment risks are well managed through discussion by a uro–oncology multidisciplinary team.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of adults with advanced RCC who have their treatment options discussed by a uro–oncology multidisciplinary team.

Numerator – the number in the denominator who have their treatment options discussed by a uro–oncology multidisciplinary team.

Denominator – the number of adults with advanced RCC.

Data source: The National Kidney Cancer Audit - National Cancer Audit Collaborating Centre's State of the Nation Report performance indicator dashboard presents data on the percentage of people with a new diagnosis of kidney cancer who had a record of being discussed at a multidisciplinary team meeting.

Outcome

Proportion of adults with advanced RCC who have initial SACT treatment within 12 months of diagnosis.

Numerator – the number in the denominator who have initial SACT treatment within 12 months of diagnosis.

Denominator – the number of adults with advanced RCC.

Data source: National Kidney Cancer Audit - National Cancer Audit Collaborating Centre's State of the Nation Report performance indicator dashboard presents data on the proportion of people with metastatic RCC who receive initial SACT within 12 months of diagnosis. It is not expected that achievement will be 100%. This is because SACT is not suitable for all adults with advanced RCC. Commissioners and services may wish to focus on local uptake of SACT compared with the national average.

What the quality statement means for different audiences

Service providers (such as secondary and tertiary care services) ensure that management pathways and policies are in place for adults with advanced RCC to have their treatment options discussed by a uro–oncology multidisciplinary team.

Healthcare professionals (such as doctors, nurses and specialists) are aware of local protocols for adults with advanced RCC to have their treatment options discussed by a uro–oncology multidisciplinary team.

Commissioners ensure that services that have a uro–oncology multidisciplinary team that discusses treatment options for adults with advanced RCC.

Adults with advanced RCC have their treatment discussed by a team of healthcare

professionals who specialise in different areas of treatment. The team make an assessment and discuss all possible treatment options to ensure the person has the treatment and care that will work best for them.

Source guidance

Kidney cancer: diagnosis and management. NICE guideline NG256 (2026), recommendation 1.12.1

Definitions of terms used in this quality statement

Advanced RCC

RCC that is locally advanced and inoperable, or metastatic. Locally advanced RCC has grown into the surrounding tissue or blood vessels. It may have spread to nearby lymph nodes but has not spread to distant parts of the body. Metastatic RCC has spread from the kidney to other parts of the body, such as the lungs, lymph nodes or bones. This is also called stage 4 cancer. [NICE's guideline on kidney cancer, terms used in this guideline]

Uro–oncology multidisciplinary team

A group of healthcare professionals with expertise in managing kidney cancer (for example, a radiologist, pathologist, oncologist and urologist with speciality in kidney cancer surgery). They review clinical information and discuss treatment options, including any potential integration of pharmacological and non-pharmacological treatments, tailored to the person's individual needs. This could include identifying relevant research, including clinical trials, for discussion with the person. [NICE's guideline on kidney cancer, terms used in this guideline, recommendations 1.1.8 and 1.12.1, and the rationale and impact section for recommendations on referring adults with advanced RCC]

Equality and diversity considerations

All adults with advanced RCC should have access to SACT, regardless of their age, disability or where they live. Adults should be made aware that they may be eligible for the NHS healthcare travel costs scheme.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or high-quality external guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts and quality standards advisory committee members invited to join a working group to develop this quality standard is available from the webpage for this quality standard.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered during development, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact report for NICE's guideline on kidney cancer to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

For all quality statements where information is given, it is important that people are provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare services.

Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter if needed. People should also have access to an advocate, if needed, as set out in NICE's guideline on advocacy services for adults with health and social care needs.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of

the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- British Nuclear Medicine Society (BNMS)
- Kidney Cancer UK
- British Uro-oncology Group (BUG)