NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Colorectal cancer

NICE quality standard

Draft for consultation

06 September 2021

|  |
| --- |
| **This quality standard covers** the diagnosis and management of colorectal (bowel) cancer in adults, including management of local disease and of secondary tumours (metastatic disease). It describes high-quality care in priority areas for improvement. This quality standard will update and replace the existing quality standard on [colorectal cancer](https://www.nice.org.uk/guidance/qs20) (published August 2012). The topic was identified for update following the annual review of quality standards. The review identified: * updated NICE guidance on colorectal cancer.

For more information see [update information](#_Quality_statement_X).This is the draft quality standard for consultation (from 06 September to 11 October 2021). The final quality standard is expected to publish in February 2022. |

# Quality statements

[Statement 1](#_Quality_statement_1:) Adults with a new diagnosis of colorectal cancer have testing to determine whether or not they have Lynch syndrome. **[new 2022]**

[Statement 2](#_Quality_statement_2:) Adults with early rectal cancer discuss the implications of each treatment with their healthcare professional and reach a shared decision on which treatment is the best option for them. **[new 2022]**

[Statement 3](#_Quality_statement_3:) Adults with node-positive or locally advanced rectal cancer have preoperative radiotherapy or chemoradiotherapy. **[2012, updated 2022]**

[Statement 4](#_Quality_statement_4:) Adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment have testing to identify tumours with RAS and BRAF V600E mutations. **[new 2022]**

[Statement 5](#_Quality_statement_5:) Adults who have had potentially curative surgical treatment for non-metastatic colorectal cancer have follow up for the first 3 years to detect local recurrence and distant metastases. **[2012, updated 2022]**

Statement 3 from the [2016 quality standard for suspected cancer](https://www.nice.org.uk/guidance/qs124) should be considered when commissioning or providing colorectal cancer services:

* Adults presenting in primary care with symptoms that suggest colorectal cancer, who do not meet the referral pathway criteria, have a test for blood in their faeces.

Statements from the 2012 quality standard for colorectal cancer that are still supported by the evidence may still be useful at a local level:

* People with metastatic colorectal cancer in the liver have their scans reviewed by the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for local treatment.

The [2012 quality standard for colorectal cancer](https://www.nice.org.uk/guidance/qs20) is available as a pdf.

|  |
| --- |
| Questions for consultation Questions about the quality standard**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?**Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.Questions about the individual quality statements**Question 4** For draft quality statement 3: Draft quality statement 3 includes the term ‘node-positive or locally advanced rectal cancer’ to refer to rectal cancer at stage cT1‑T2, cN1‑N2, M0, or cT3‑T4, any cN, M0. Is this an accurate term to refer to rectal cancer at these stages?**Question 5** For draft quality statement 5: Process measure b) measures at least 2 CT scans done in the first 3 years after potentially curative surgery based on NICE’s guideline on colorectal cancer, evidence review E1. Could there be any unintended consequences from specifying this number as a minimum?Local practice case studies**Question 6** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form. |

# Quality statement 1: Testing at diagnosis

## Quality statement

Adults with a new diagnosis of colorectal cancer have testing to determine whether or not they have Lynch syndrome. **[new 2022]**

## Rationale

An estimated 175,000 people in the UK have Lynch syndrome, a large proportion of whom will be unaware that they have the condition. For some cancer sites, risk-reducing strategies can prevent associated cancers or allow their early diagnosis in those with a diagnosis of Lynch syndrome. Molecular testing on tumours when adults are first diagnosed with colorectal cancer can guide further genetic testing to identify those in whom the cancer may have occurred because of Lynch syndrome and can help adults with colorectal cancer to be placed on an appropriate pathway for 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.

### Structure

Evidence of local arrangements to ensure there is a clinical lead responsible for the implementation of the testing pathway for Lynch syndrome.

**Data source:** No routinely collected national data for this measure has been identified. Data could be collected from information recorded locally, for example a service specification.

### Process

a) Proportion of adults with a new diagnosis of colorectal cancer who had molecular testing to identify tumours with deficient DNA mismatch repair.

Numerator – the number in the denominator who had molecular testing to identify tumours with deficient DNA mismatch repair.

Denominator – the number of adults with a new diagnosis of colorectal cancer.

**Data source:** Performance of mismatch repair protein (MMR) immunohistochemistry and microsatellite instability testing (MSI) are included in the [Royal College of Pathologists dataset for histopathological reporting of colorectal cancer](https://www.rcpath.org/profession/guidelines/cancer-datasets-and-tissue-pathways.html), appendix E. [The National Bowel Cancer Audit](https://www.hqip.org.uk/a-z-of-nca/national-bowel-cancer-audit/#.YPaQYMSSkdU) collects data on performance of MMR and MSI tests (from April 2021). The [National Disease Registration Service](https://www.ndrs.nhs.uk/) germline dataset collects data on testing for MMR and MSI.

b) Proportion of adults with a new diagnosis of colorectal cancer and a tumour with deficient DNA mismatch repair who had molecular testing to differentiate sporadic and Lynch syndrome-associated colorectal cancer.

Numerator – the number in the denominator who had molecular testing to differentiate sporadic and Lynch syndrome-associated cancer.

Denominator – the number of adults with a new diagnosis of colorectal cancer and a tumour with deficient DNA mismatch repair.

**Data source:** Performance of MLH1 promoter hypermethylation testing and BRAF V600E testing are included in the [Royal College of Pathologists dataset for histopathological reporting of colorectal cancer](https://www.rcpath.org/profession/guidelines/cancer-datasets-and-tissue-pathways.html), appendix E.

c) Proportion of adults with a new diagnosis of colorectal cancer and molecular testing results suggestive of Lynch syndrome-associated colorectal cancer who had genetic testing of germline DNA to confirm Lynch syndrome.

Numerator – the number in the denominator who had genetic testing of germline DNA to confirm Lynch syndrome.

Denominator – the number of adults with a new diagnosis of colorectal cancer and molecular testing results suggestive of Lynch syndrome-associated colorectal cancer.

**Data source:** The [National Disease Registration Service](https://www.ndrs.nhs.uk/) germline dataset collects data on germline testing for Lynch syndrome.

### Outcome

Diagnosis of Lynch syndrome.

**Data source:**The [National Disease Registration Service](https://www.ndrs.nhs.uk/) germline dataset collects data on germline testing for Lynch syndrome.

## What the quality statement means for different audiences

**Service providers** (such as histopathology laboratory services, molecular genetics laboratory services or genomic laboratory hubs) ensure that laboratory protocols are in place to provide molecular testing on tumours to identify deficient DNA mismatch repair and to differentiate sporadic and Lynch syndrome-associated colorectal cancer in adults with a new diagnosis of colorectal cancer. They include results in the standard pathology report requested by oncology. They ensure that laboratory protocols are in place to provide genetic testing of germline DNA for Lynch syndrome in adults with a new diagnosis of colorectal cancer and molecular testing results suggestive of Lynch syndrome.

**Healthcare professionals** (such as gastroenterologists, colorectal surgeons and consultant histopathologists) identify a clinical lead responsible for implementation of the testing pathway for Lynch syndrome and are aware of local protocols to ensure that adults with a new diagnosis of colorectal cancer have testing to determine whether or not they Lynch syndrome. Healthcare professionals are aware of referral pathways and can identify when to refer to clinical genetics services for the diagnosis of Lynch syndrome.

**Commissioners** (clinical commissioning groups, integrated care systems or NHS England) ensure that they commission services that can provide molecular tests for adults with a new diagnosis of colorectal cancer and genetic tests for those with results that suggest Lynch syndrome-associated cancer.

**Adults with** **colorectal cancer** have testing to determine whether or not they have Lynch syndrome.

## Source guidance

[Molecular testing strategies for Lynch syndrome in people with colorectal cancer. NICE guideline DG27](https://www.nice.org.uk/guidance/dg27/chapter/1-Recommendations) (2017), recommendations 1.1 to 1.3.

## Definitions of terms used in this quality statement

### Testing to determine whether or not they have Lynch syndrome

Molecular testing for Lynch syndrome in adults with colorectal cancer uses immunohistochemistry testing for mismatch repair proteins or microsatellite instability testing to identify tumours with deficient DNA mismatch repair. Results from these tests guide further sequential testing for Lynch syndrome. Further testing includes BRAF V600E and MLH1 promoter hypermethylation tests. If these are both negative, Lynch syndrome can be confirmed by genetic testing of germline DNA. Discussion of genetic testing should be done with a healthcare professional with appropriate training. [Adapted from [NICE’s diagnostic guideline on molecular testing strategies for Lynch syndrome in people with colorectal cancer](https://www.nice.org.uk/guidance/dg27), recommendations 1.1 to 1.4]

### Molecular testing to differentiate sporadic and Lynch syndrome-associated colorectal cancer

Sequential BRAF V600E and MLH1 promoter hypermethylation testing can differentiate sporadic and Lynch syndrome-associated colorectal cancer in tumours with deficient DNA mismatch repair. [Adapted from [NICE’s diagnostic guideline on molecular testing strategies for Lynch syndrome in people with colorectal cancer](https://www.nice.org.uk/guidance/dg27), recommendations 1.2 and 1.3]

### Molecular testing results suggestive of Lynch syndrome-associated colorectal cancer

An abnormal MLH1 immunohistochemistry or positive microsatellite instability result and negative tests for BRAF V600E and MLH1 promoter hypermethylation, or abnormal MSH2, MSH6 or PMS2 immunohistochemistry results. [Adapted from [NICE’s diagnostic guideline on molecular testing strategies for Lynch syndrome in people with colorectal cancer](https://www.nice.org.uk/guidance/dg27), recommendations 1.2 and 1.3]

## Equality and diversity considerations

Testing to determine whether or not they have Lynch syndrome should be offered to all adults with a new diagnosis of colorectal cancer, regardless of age.

# Quality statement 2: Treatment choice for early rectal cancer

## Quality statement

Adults with early rectal cancer discuss the implications of each treatment with their healthcare professional and reach a shared decision on which treatment is the best option for them. **[new 2022]**

## Rationale

Adults with early rectal cancer should be offered access to all suitable treatments. This includes endoscopic and minimally invasive local procedures as well as rectal resection and no treatment. There are risks and benefits associated with each treatment option, and these should be discussed with their healthcare professional before reaching a shared decision about the best option.

## 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.

### Structure

Evidence of availability of written information on different treatment options to ensure that adults with early rectal cancer have a discussion with their healthcare professional about treatment options.

**Data source:** No routinely collected national data for this measure has been identified. Data could be collected from information recorded locally by healthcare professionals, for example the availability of patient decision aids.

### Process

Proportion of adults with early rectal cancer who had a discussion about treatment options with their healthcare professional.

Numerator – the number in the denominator who had a discussion about treatment options with their healthcare professional.

Denominator – the number of adults with early rectal cancer.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals, for example from patient records.

### Outcome

Adults with early rectal cancer feel informed about their treatment options.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals, for example from patient surveys. The [National Cancer Patient Experience Survey](https://www.ncpes.co.uk/) includes a question that asks if treatment options were discussed with the person with colorectal cancer before cancer treatment started.

## What the quality statement means for different audiences

**Service providers** (such as secondary care services and specialist tertiary care services) ensure that staff are aware of all treatment options for early rectal cancer and are trained to discuss the implications of each treatment before they reach a shared decision with adults with early rectal cancer about the best option for them. Service providers ensure that adults with early rectal cancer have the option to be referred to another service provider if they do not offer a particular treatment option.

**Healthcare professionals** (such as colorectal cancer specialists) are aware of all treatments for early rectal cancer, including endoscopic procedures, minimally invasive local surgical procedures, rectal resection and no treatment, and discuss the implications of all options with adults with early rectal cancer before they reach a shared decision about the best option for them.

**Commissioners** (such as clinical commissioning groups, integrated care systems or NHS England) ensure that they commission services that can provide all treatment options for adults with early rectal cancer, including endoscopic and minimally invasive procedures.

**Adults with early rectal cancer** have a discussion with their healthcare professional about all treatments including no treatment and procedures that do not need surgery. They feel informed to reach a decision about the best option for them.

## Source guidance

[Colorectal cancer. NICE guideline NG151](https://www.nice.org.uk/guidance/ng151) (2020), recommendation 1.3.1.

## Definitions of terms used in this quality statement

### Early rectal cancer

### Rectal cancer at stage cT1‑T2, cN0, M0. [[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151), recommendation 1.3.1] Treatments suitable for early rectal cancer

Transanal excision including transanal minimally invasive surgery and transanal endoscopic microsurgery, endoscopic submucosal dissection or total mesorectal excision. [[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151), table 1]

## Equality and diversity considerations

Adults with early rectal cancer should be offered treatment options based on clinical considerations rather than on their age alone.

Adults with early rectal cancer should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to those who do not speak or read English, and it should be culturally appropriate and age appropriate. Adults with early rectal cancer should have access to an interpreter or advocate if needed.

For those 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](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

# Quality statement 3: Preoperative treatment of rectal cancer

## Quality statement

Adults with node-positive or locally advanced rectal cancer have preoperative radiotherapy or chemoradiotherapy. **[2012, updated 2022]**

## Rationale

Adults with node-positive or locally advanced rectal cancer who have preoperative radiotherapy or chemoradiotherapy have less local recurrence and better overall and disease-free survival compared with those who do not have preoperative therapy. Adults with early rectal cancer should not be offered preoperative radiotherapy unless as part of a clinical trial.

## 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.

### Structure

Evidence of local arrangements and written clinical protocols to ensure that preoperative radiotherapy or chemoradiotherapy is available for adults with node-positive or locally advanced rectal cancer.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected for information recorded locally by healthcare professionals and provider organisations, for example written clinical protocols for the use of preoperative treatment in the management of rectal cancer.

### Process

Proportion of adults with node-positive or locally advanced rectal cancer who had preoperative radiotherapy or chemoradiotherapy.

Numerator – the number in the denominator who had preoperative radiotherapy or chemoradiotherapy.

Denominator – the number of adults with node-positive or locally advanced rectal cancer.

**Data source:** Data on receipt of neoadjuvant treatment in rectal cancer, including radiotherapy and chemoradiotherapy, is included in the [National Bowel Cancer Audit](https://www.hqip.org.uk/a-z-of-nca/national-bowel-cancer-audit/#.YPaQYMSSkdU).

### Outcome

Local recurrence of rectal cancer in adults who have been treated for node-positive or locally advanced rectal cancer.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

## What the quality statement means for different audiences

**Service providers** (such as secondary care services and tertiary care specialist centres) ensure that treatment pathways and protocols are in place for adults with node-positive or locally advanced rectal cancer to have preoperative radiotherapy or chemoradiotherapy.

**Healthcare professionals** (such as clinical oncologists) are aware of the local treatment pathways and protocols for adults with node-positive or locally advanced rectal cancer and ensure that they have preoperative radiotherapy or chemoradiotherapy if the treatment is suitable for them.

**Commissioners** (such as clinical commissioning groups, integrated care systems or NHS England) ensure that they commission services that can provide preoperative radiotherapy and chemoradiotherapy for adults with node-positive or locally advanced rectal cancer.

**Adults with node-positive or locally advanced rectal cancer** have radiation treatment with or without chemotherapy to destroy cancer cells before surgery.

## Source guidance

[Colorectal cancer. NICE guideline NG151](https://www.nice.org.uk/guidance/ng151) (2020), recommendation 1.3.3.

## Definition of terms used in this quality statement

### Node-positive or locally advanced rectal cancer

Rectal cancer at stage cT1‑T2, cN1‑N2, M0, or cT3‑T4, any cN, M0. [[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151), recommendation 1.3.3 and expert opinion]

## Equality and diversity considerations

Adults with node-positive or locally advanced rectal cancer should be offered preoperative treatment based on clinical considerations rather than on their age alone.

## Question for consultation

Draft quality statement 3 includes the term ‘node-positive or locally advanced rectal cancer’ to refer to rectal cancer at stage cT1‑T2, cN1‑N2, M0, or cT3‑T4, any cN, M0. Is this an accurate term to refer to rectal cancer at these stages?

# Quality statement 4: Molecular testing to guide systemic anti-cancer treatment

## Quality statement

Adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment have testing to identify tumours with RAS and BRAF V600E mutations. **[new 2022]**

## Rationale

Systemic anti-cancer treatment includes several chemotherapy drugs and targeted therapy, such as anti-epidermal growth factor receptor (anti-EGFR) and anti-BRAF targeted therapy. Some drugs offer benefits to certain patients, while in others they may be toxic. RAS and BRAF V600E mutation testing is used to select adults with metastatic colorectal cancer who are most likely to benefit from anti-EGFR and anti-BRAF targeted therapy.

## 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.

### Structure

Evidence of local arrangements and clinical protocols to ensure that adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment have testing to identify tumours with RAS and BRAF V600E mutations.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example written clinical protocols.

### Process

Proportion of adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment who had testing to identify tumours with RAS and BRAF V600E mutations before they started systemic anti-cancer treatment.

Numerator – the number in the denominator who had testing to identify tumours with RAS and BRAF V600E mutations before they started systemic anti-cancer treatment.

Denominator – the number of adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment.

**Data source:** Performance of KRAS, NRAS and BRAF V600E mutations testing are included in the [Royal College of Pathologists dataset for histopathological reporting of colorectal cancer](https://www.rcpath.org/profession/guidelines/cancer-datasets-and-tissue-pathways.html), appendix E. The [National Disease Registration Service](https://www.ndrs.nhs.uk/) collects data on performance of RAS and BRAF V600E testing from NHS England’s genomic laboratory hubs. The [National Bowel Cancer Audit](https://www.hqip.org.uk/a-z-of-nca/national-bowel-cancer-audit/#.YPaQYMSSkdU) contains a dataset item for the collection of genomic tests including KRAS, NRAS and BRAF

### Outcome

Progression free survival for adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected routinely from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

## What the quality statement means for different audiences

**Service providers** (such as laboratory services) ensure that systems are in place to provide molecular testing to identify tumours with RAS and BRAF V600E mutations in adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment.

**Healthcare professionals** (such as oncologists) are aware of local referral pathways for molecular testing to identify tumours with RAS and BRAF V600E mutations and ensure that adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment have this test before they start systemic anti-cancer treatment.

**Commissioners** (such as clinical commissioning groups, integrated care systems or NHS England) ensure that they commission services that provide molecular testing to identify tumours with RAS and BRAF V600E mutations in adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment.

**Adults with metastatic colorectal cancer suitable for systemic anti-cancer treatment** have testing to identify the most beneficial treatment for them.

## Source guidance

[Colorectal cancer. NICE guideline NG151](https://www.nice.org.uk/guidance/ng151) (2020), recommendation 1.4.1.

# Quality statement 5: Follow up for detection of local recurrence and distant metastases

## Quality statement

Adults who have had potentially curative surgical treatment for non-metastatic colorectal cancer have follow up for the first 3 years to detect local recurrence and distant metastases. **[2012, updated 2022]**

## Rationale

Following up adults in the first 3 years after they have had potentially curative surgical treatment for non-metastatic colorectal cancer can help detect and treat recurrences at the earliest stage. Recurrent disease is more likely to be resectable when there is regular follow up.

## 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.

### Structure

Evidence of local arrangements and written clinical protocols to ensure that adults who have had potentially curative surgery for non-metastatic colorectal cancer have follow-up tests for the first 3 years after treatment.

**Data source:** No routinely collected national data has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example written surveillance protocols.

### Process

a) Proportion of adults who had potentially curative surgery for non-metastatic colorectal cancer who had 6 monthly serum carcinoembryonic antigen (CEA) measurement in the 3 years after potentially curative surgery.

Numerator – the number in the denominator who had 6 monthly serum CEA measurement in the 3 years after potentially curative surgery.

Denominator – the number of adults who had potentially curative surgery for non-metastatic colorectal cancer.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of adults who had potentially curative surgery for non-metastatic colorectal cancer who had at least 2 CT scans of the chest, abdomen and pelvis in the 3 years after potentially curative surgery.

Numerator – the number in the denominator who had at least 2 CT scans of the chest, abdomen and pelvis in the 3 years after potentially curative surgery.

Denominator – the number of adults who had potentially curative surgery for non-metastatic colorectal cancer.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

c) Proportion of adults who had potentially curative surgery for non-metastatic colorectal cancer who had a clearance colonoscopy within 1 year of their diagnosis.

Numerator – the number in the denominator who had a clearance colonoscopy within 1 year of their diagnosis.

Denominator – the number of adults who had potentially curative surgery for non-metastatic colorectal cancer.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

### Outcome

Resectability of locally recurrent disease in adults who have had potentially curative surgery for non-metastatic colorectal cancer.

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

## What the quality statement means for different audiences

**Service providers** (such as laboratory services, secondary care services and tertiary care centres) ensure that systems are in place for adults who have had potentially curative surgery for non-metastatic colorectal cancer to be referred for and to have follow-up testing, including serum CEA, CT scan and colonoscopy, in the first 3 years after potentially curative surgery.

**Healthcare professionals** (such as colorectal cancer nurse specialists) are aware of local pathways and clinical protocols for follow up of adults who have had potentially curative surgery for non-metastatic colorectal cancer and ensure that they have regular testing of serum CEA, CT scans and colonoscopy in the first 3 years after potentially curative surgery.

**Commissioners** (such as clinical commissioning groups, integrated care systems or NHS England) ensure that they commission services that provide regular follow up of adults after potentially curative surgery for colorectal cancer, including measurement of serum CEA, CT scan and colonoscopy.

**Adults with colorectal cancer that has not spread to other parts of their body and who have had surgery that may cure their cancer** have regular check-ups and investigations for the first 3 years to check for signs that the cancer has returned or has spread.

## Source guidance

[Colorectal cancer. NICE guideline NG151](https://www.nice.org.uk/guidance/ng151) (2020), recommendation 1.6.1.

[BSG/ACPGBI/PHE post-polypectomy and post-colorectal cancer resection surveillance guidelines](https://www.bsg.org.uk/clinical-resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectal-cancer-resection-surveillance-guidelines/) (2020), page 207.

## Definitions of terms used in this quality standard

### Follow up to detect local recurrence and distant metastases

Follow up includes measurement of serum CEA at least every 6 months and a minimum of 2 CT scans of the chest, abdomen and pelvis in the first 3 years. Clearance colonoscopy should be done within a year of diagnosis. [Adapted from [NICE’s guideline for colorectal cancer](https://www.nice.org.uk/guidance/ng151), recommendation 1.6.1 and evidence review E1 and [BSG/ACPGBI/PHE post-polypectomy and post-colorectal cancer resection surveillance guidelines](https://www.bsg.org.uk/clinical-resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectal-cancer-resection-surveillance-guidelines/)  (2020), page 207]

## Question for consultation

Process measure b) measures at least 2 CT scans done in the first 3 years after potentially curative surgery based on NICE’s guideline on colorectal cancer, evidence review E1. Could there be any unintended consequences from specifying this number as a minimum?

# Update information

**February 2022:** This quality standard was updated and statements prioritised in 2012 were replaced. The topic was identified for update following the annual review of quality standards. The review identified:

* updated guidance on colorectal cancer.

Statements are marked as:

* **[new 2022]** if the statement covers a new area for quality improvement
* **[2012, updated 2022]** if the statement covers an area for quality improvement included in the 2012 quality standard and has been updated.

Statements numbered 4 and 8 in the 2012 version have been updated and are included in the updated quality standard, marked as **[2012, updated 2022]**.

Statements from 2012 that are still supported by the evidence may still be relevant to existing local quality improvement projects, and are listed in the [quality statements section](#_Quality_statements).

The [2012 quality standard for colorectal cancer](https://www.nice.org.uk/guidance/qs20) is available as a pdf.

# 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 NICE-accredited 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](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standards advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details of standing committee 2 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](http://www.nice.org.uk/guidance/gid-qs10141/documents).

This quality standard has been included in the [NICE Pathway on colorectal cancer](https://pathways.nice.org.uk/pathways/colorectal-cancer), which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/guidance/qs20/resources) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

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 by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [resource impact statement for the NICE guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151/resources) to help estimate local costs.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10141/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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.

ISBN:

© NICE 2021. All rights reserved. Subject to [Notice of rights](https://www.nice.org.uk/terms-and-conditions#notice-of-rights).