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Quality standards

Briefing paper: colorectal cancer

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Contents

[1 Introduction 2](#_Toc81471748)

[2 Overview 3](#_Toc81471750)

[3 Summary of suggestions 5](#_Toc81471755)

[4 Suggested improvement areas 7](#_Toc81471757)

[4.1 Diagnosis 7](#_Toc81471758)

[4.2 Treatment 13](#_Toc81471759)

[4.3 Surgery 18](#_Toc81471760)

[4.4 Metastatic disease 23](#_Toc81471761)

[4.5 Ongoing care and support 25](#_Toc81471762)

[4.6 Additional areas 28](#_Toc81471763)

[Appendix 1: BSG/ACGBI/PHE Guideline for post-polypectomy and post-cancer section surveillance algorithm 30](#_Toc81471764)

[Appendix 2: Suggestions from registered stakeholders 31](#_Toc81471765)

1. Introduction

This briefing paper presents a structured overview of potential quality improvement areas for colorectal cancer. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

Recommendations selected from the key development source are included to help the committee in considering potential statements and measures.

* 1. Development source

The key development sources referenced in this briefing paper are:

[Suspected cancer: recognition and referral. NICE guideline NG12](https://www.nice.org.uk/guidance/ng12) (2015, updated 2021)

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

[Perioperative care in adults. NICE guideline NG180](https://www.nice.org.uk/guidance/ng180) (2020)

[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)

[Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care. NICE diagnostics guidance DG30](https://www.nice.org.uk/guidance/dg30) (2017)

[Molecular testing strategies for Lynch syndrome in people with colorectal cancer. NICE diagnostics guidance DG27](https://www.nice.org.uk/guidance/dg27) (2017)

[Colorectal cancer prevention: colonoscopic surveillance win adults with ulcerative colitis, Crohn’s disease or adenoma. NICE guideline CG118](https://www.nice.org.uk/guidance/cg118) (2011). The check of this guideline has been suspended because of ongoing work on colorectal post-polypectomy surveillance guidelines being developed by the British Society of gastroenterology, the Association of Coloproctology of Great Britain and Ireland and Public Health England.

1. Overview
   1. Focus of quality standard

This quality standard will cover the diagnosis and management of colorectal (bowel) cancer in adults, including management of local disease and of secondary tumours (metastatic disease). It will update and replace the existing quality standard for [colorectal cancer](https://www.nice.org.uk/guidance/qs20) (QS20).

* 1. Definition

Colorectal cancer occurs when cancerous growths form in the colon (colon cancer) or rectum (rectal cancer). Most colorectal cancers arise from adenomatous polyps. These are usually benign, but some develop into cancer over time.

* 1. Incidence and prevalence

Colorectal cancer is the fourth most common cancer in the UK, accounting for 11% of all new cancer cases with over 42,000 new cases diagnosed each year according to [Cancer Research UK’s bowel cancer statistics](https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer). Risk factors include increasing age, genetics and family history (particularly syndromes such as familial adenomatous polyposis and Lynch syndrome), inflammatory bowel disease (IBD) and diet and lifestyle factors.

Colorectal cancer is the second most common cause of cancer death in the UK as reported in the [National Bowel Cancer Audit (NBOCA) annual report 2020.](https://www.hqip.org.uk/resource/national-bowel-cancer-audit-annual-report-2020/) Survival rates have improved over time, with almost 60% of people diagnosed with colorectal cancer surviving for at least 5 years. Survival is linked to disease stage at presentation, with better survival the earlier the disease is detected and treated.

People who have been treated for colorectal cancer may have long term side-effects of their treatments. For example, lower anterior resection syndrome can have major impact on quality of life and daily living, and it affects around 40% of those who have undergone sphincter-preserving surgery for rectal cancer. Long-term side-effects of treatment for colorectal cancer include nerve damage and changes in bladder and sexual function.

* 1. Management

[NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12) recommends referring adults using a suspected cancer pathway for colorectal cancer if:

* they are aged 40 and over with unexplained weight loss and abdominal pain or
* they are aged 50 and over with unexplained rectal bleeding or
* they are aged 60 or over with:
  + iron deficiency anaemia or
  + changes in their bowel habit, or

tests show occult blood in their faeces.

The [NHS offers colorectal cancer screening](https://www.gov.uk/guidance/bowel-cancer-screening-programme-overview) to adults aged 60 to 74 in England every 2 years using a home test kit. This is a faecal immunochemical test (FIT). The screening programme offers colonoscopy to people with an abnormal screening result. Colonoscopic surveillance in people with IBD or adenomas can detect problems early and potentially prevent progression to colorectal cancer. [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/) recommend that people post-polypectomy at high risk of colorectal cancer should undergo a one-off surveillance colonoscopy at 3 years.

The [National Bowel Cancer Audit (NBOCA) annual report](https://www.hqip.org.uk/resource/national-bowel-cancer-audit-annual-report-2020/#.YJT7b8CSkdU) (2020) found that between April 2018 and March 2019, 54% of people with colorectal cancer were referred via their GP, 19% by emergency presentation and 10% via screening (the referral pathway was unknown for 18% of people). The audit found that emergency patients were considerably less likely to have early-stage disease.

Management of colorectal cancer has advanced over time with new treatment methods and strategies being trialled and used. The standard practice for colon cancer is to offer surgery to those who are fit for it. Recent trials have studied the effectiveness of preoperative systemic anti-cancer therapy for colon cancer to improve survival. Adjuvant chemotherapy may be offered post-surgery dependent on the staging of the cancer. Treatment for rectal cancer is more complex. There is variation in current practice in the treatment for early rectal cancer, use of preoperative (chemo)radiotherapy, surgical technique for rectal cancer surgery and treatment for locally advanced or recurrent rectal cancer. Treatment for metastatic colorectal cancer depends on the site and number of the metastases and if the metastases are amenable to local treatment.

People treated for colorectal cancer should under-go follow-up to detect recurrence. [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/) recommend that patients post-colorectal cancer resection should undergo a 1-year clearance colonoscopy, then a surveillance colonoscopy after 3 more years.

1. Summary of suggestions
   1. Responses

In total 18 registered stakeholders responded to the 2-week engagement exercise.

* 13 stakeholders suggested areas
* 5 stakeholders had no comments

6 specialist committee members suggested areas

The responses have been summarised in table 1 for further consideration by the committee.

Table 1 Summary of suggested quality improvement areas

| Area for improvement | Stakeholders |
| --- | --- |
| **Diagnosis**   * Use of quantitative faecal immunochemical tests (qFIT) in primary care * Colonoscopy * Molecular testing (Lynch syndrome and metastases) | ACPGBI, BCUK, MEDT, MSD, NBOCA, NHSEI, PF, RD, SCM1, SCM2, SCM3, SCM5, SCM6, UHB. |
| **Treatment**   * Treatment options * Adjuvant chemotherapy in stage III colon cancer | ACPGBI, BCUK, BS, NBOCA, SCM1, SCM2, SCM3, SIRTMED, UHB. |
| **Surgery**   * Care pathways * Minimally invasive surgery * Minimum case volumes/ specialist centres * Ileostomy closure * Colonic stents | ACPGBI, BASO, CRH, MEDT, NBOCA, SCM1, SCM2, SCM3. |
| **Metastatic disease**   * Specialist MDT involvement * Access to SIRT | BS, NBOCA, SCM1, SCM3 SIRTMED. |
| **Ongoing care and support**   * Patient information * Follow-up regimes | MSD, SCM4, SCM6. |
| **Additional areas**   * Targeted screening and uptake * Support for research * Use of real-world evidence and PROMS to review outcomes | ACPGBI, CRH, MSD, SIRTMED, UHB. |
| **No comments on areas for improvement** | RCN, RCPATH, RCR, ASCN, RCSENG |

Abbreviations:

* ACPGBI, The Association of Coloproctology of Great Britain and Ireland
* ASCN, Association of Stoma Care Nurses UK
* BASO, British Association of Surgical Oncology
* BCUK, Bowel Cancer UK
* BS, Boston Scientific
* CRH, Chesterfield Royal Hospital NHS Foundation Trust
* MEDT, Medtronic Ltd
* MSD, MSD UK Limited
* NBOCA, National Bowel Cancer Audit (sponsored by HQIP)
* NHSEI, NHS England and NHS Improvement
* PF, Pierre Fabre Ltd
* RCN, Royal College of Nursing
* RCPATH, Royal College of Pathologists
* RCR, Royal College of Radiologists
* RCSENG, Royal College of Surgeons of England
* RD, Roche Diagnostics Ltd
* SIRTMED, Sirtex Medical Limited
* UHB, University Hospital Birmingham NHS Foundation Trust

SCM, Specialist Committee Member

Full details of all the suggestions provided are given in appendix 2 for information.

1. Suggested improvement areas

Section 4 presents a summary of the suggested improvement areas, with provisional recommendations that may support statement development and information on current UK practice.

* 1. Diagnosis

### Use of FIT in primary care

Stakeholders noted the recommendations for the use of quantitative faecal immunochemical tests (qFIT) in people with lower gastrointestinal (GI) symptoms and suggested this as an area for quality improvement. They note that qFIT supports the effective use of resource by ensuring endoscopy capacity is prioritised for those at highest risk of cancer. Stakeholders commented on the variation in local pathways and implementation of the test. Stakeholders also commented on the use of qFIT to guide referral using the suspected cancer pathway.

#### Selected recommendations

[NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12) (NG12):

1.3.1 Refer adults using a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer if:

* they are aged 40 and over with unexplained weight loss and abdominal pain or
* they are aged 50 and over with unexplained rectal bleeding or
* they are aged 60 and over with:
  + iron-deficiency anaemia or
  + changes in their bowel habit, or

tests show occult blood in their faeces. [2015]

1.3.4 Offer testing with quantitative faecal immunochemical tests (see the [NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care](https://www.nice.org.uk/guidance/dg30)) to assess for colorectal cancer in adults without rectal bleeding who:

* are aged 50 and over with unexplained:
  + abdominal pain or
  + weight loss, or
* are aged under 60 with:
  + changes in their bowel habit, or
  + iron-deficiency anaemia, or

are aged 60 and over and have anaemia even in the absence of iron deficiency. [2021]

[NICE’s diagnostic guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care](https://www.nice.org.uk/guidance/dg30) (DG30):

1.1 The OC Sensor, HM-JACKarc and FOB Gold quantitative faecal immunochemical tests are recommended for adoption in primary care to guide referral for suspected colorectal cancer in people without rectal bleeding who have unexplained symptoms but do not meet the criteria for a suspected cancer pathway outlined in [NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12) (recommendation 1.3.4).

Statements in existing quality standards

[NICE’s quality standard on suspected cancer](https://www.nice.org.uk/guidance/qs20) (QS124):

Statement 3. 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.

#### Current UK practice

[A national survey of general practitioners by Von Wagner et al](https://bmjopen.bmj.com/content/9/4/e025737) (2019) assessed awareness of NICE’s DG30 in primary care 6 months after publication. A total of 1024 GPs completed the survey. They found that 432/1024 (42%) were aware of the recommendations in NICE’s DG30 but only 102 (10%) GPs had used it to guide their referrals.

### Colonoscopy

Stakeholder comments suggested provision and quality of colonoscopy services as areas for quality improvement. Stakeholders commented on the importance of colonoscopy services and noted the increase in numbers of people referred for endoscopy. Stakeholders highlighted the NICE-accredited [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/) and noted that “full implementation of the guidance has the real potential to support more efficient and effective use of available endoscopy resources”. Stakeholders commented on variation in practice and in the quality of colonoscopy services. They highlighted key performance indicators collected by the [National Endoscopy Database](https://nedpilot.thejag.org.uk/Default.aspx?ReturnUrl=%2f). Stakeholders also noted that colon capsule endoscopy is being rolled out to pilot sites across England and suggested this as an area of emergent practice.

#### Selected recommendations

[NICE’s guideline on colorectal cancer prevention: colonoscopic surveillance in adults with ulcerative colitis, Crohn’s disease or adenomas](https://www.nice.org.uk/guidance/cg118) (CG118):

1.1.9 Offer the appropriate colonoscopic surveillance strategy to people with adenomas based on their risk of developing colorectal cancer as determined at initial adenoma removal (see table 2).

* Low risk: consider colonoscopy at 5 years:
  + if the colonoscopy is negative (that is, no adenomas are found) stop surveillance
  + if low risk, consider the next colonoscopy at 5 years (with follow-up surveillance as for low risk)
  + if intermediate risk, offer the next colonoscopy at 3 years (with follow-up surveillance as for intermediate risk)
  + if high risk, offer the next colonoscopy at 1 year (with follow-up surveillance as for high risk).
* Intermediate risk: offer colonoscopy at 3 years:
  + if the colonoscopy is negative, offer the next colonoscopy at 3 years. Stop surveillance if there is a further negative result.
  + if low or intermediate risk, offer the next colonoscopy at 3 years (with follow-up surveillance as for intermediate risk)
  + if high risk, off the next colonoscopy at 1 year (with follow-up surveillance as for high risk).
* High risk: offer colonoscopy at 1 year.
  + if the colonoscopy is negative, or low or intermediate risk, offer the next colonoscopy at 3 years (with follow-up surveillance as for intermediate risk)
  + if high risk, offer the next colonoscopy at 1 year (with follow-up surveillance as for high risk).

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

We recommend that the high-risk criteria for future colorectal cancer (CRC) comprise either:

* two or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10 mm in size or containing any grade of dysplasia, or an adenoma of at least 10 mm in size or containing high-grade dysplasia); or

five or more premalignant polyps

This cohort should undergo a one-off surveillance colonoscopy at 3 years.

We recommend that patients who have undergone a potentially curative CRC resection should have a clearance colonoscopy within a year of their diagnosis.

We recommend that once a clearance colonoscopy has been performed in the postoperative period in patients who have had a CRC resection, their next surveillance should be performed after an interval of 3 years. The need for further surveillance should then be determined in accordance with the post-polypectomy high-risk criteria.

See appendix 1 for BSG/ACPGBI/PHE surveillance algorithm.

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

We recommend that surveillance colonoscopies should only be performed by colonoscopists who are either screening accredited, or whose colonoscopy performance measures (key performance indicators – KPIs) exceed the minimum standard as defined in the BSG lower GI quality standards publication.

#### Current UK practice

[The national census of UK endoscopy services](https://www.thejag.org.uk/census-2019) in 2019 showed that where known, 44.34% of services surveyed were JAG (Joint Advisory Group) accredited. The census was sent to all eligible UK JAG-registered services in 2019 with a 68% response rate (322/471). JAG accreditation is voluntary.

### Molecular testing

Stakeholders suggested molecular testing at diagnosis and in metastatic disease as areas for quality improvement.

Stakeholders suggested that molecular testing at diagnosis for Lynch syndrome and subsequent cascade testing of relatives is important for tailored surveillance and prevention strategies to be put in place. This could impact on the ambition in the NHS Long Term Plan to diagnose 75% of cancer early by 2028. Stakeholders suggest uptake of testing for Lynch syndrome shows variation across the country.

Stakeholders commented on the importance of molecular testing for BRAF V600E and RAS (KRAS and NRAS) mutations in metastatic disease as the genetic profile of the tumour has implications for prognosis, treatment options and potential response to systemic anti-cancer therapy (SACT).

#### Selected recommendations

[NICE’s diagnostic guidance on molecular testing strategies for Lynch syndrome in people with colorectal cancer](https://www.nice.org.uk/guidance/dg27) (DG27):

1.1 Offer testing to all people with colorectal cancer, when first diagnosed, using immunohistochemistry for mismatch repair proteins or microsatellite instability testing to identify tumours with deficient DNA mismatch repair, and to guide further sequential testing for Lynch syndrome (see 1.2 and 1.3). Do not wait for the results before starting treatment.

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.4.1 Test for RAS and BRAF V600E mutations in all people with metastatic colorectal cancer suitable for systemic anti-cancer treatment.

#### Current UK practice

The [NBOCA organisational survey](https://www.nboca.org.uk/reports/organisational-survey-results-2019/) is sent to all NHS trusts/hospitals in England and all multidisciplinary teams within Wales. In 2019 153/154 services responded. The survey in (2019) reported that 58% of hospitals/trusts/MDTs were offering routine genetic testing for Lynch syndrome to all patients. 36% were offering testing only to selected age groups.

[Bowel Cancer UK’s Time to Test report](https://www.bowelcanceruk.org.uk/campaigning/policy-reports-and-consultations/) (2018) details response to a freedom of information request sent to every hospital/health board/health and social care trust in the UK, as well as each CCG in England. 99% of CCGs and 92% of trusts/hospitals in England responded. The report found that 6% of CCG’s commissioned testing for Lynch syndrome in all people with bowel cancer and 65% stated that they do not commission this testing. 29% of CCGs did not hold this information or did not know whether they commissioned NICE DG27. Reasons provided for not commissioning the test include it coming under the remit of another commissioning body or programme, the expectation that local hospitals would implement NICE guidance or that they are still in the planning phases for commissioning this test. At the time of this report, 35% of hospitals in England offered testing to all bowel cancer patients.

One stakeholder noted data provided to the National Cancer Registration and Analysis Service (NCRAS) by NHS genomic laboratories on the number of full-screen germline genetic tests performed in 2018 suggests that current practice does not comply with recommendations in NICE’s DG27.

No published studies on current practice were highlighted for molecular testing in metastatic disease; this area is based on stakeholder’s knowledge and experience. [NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) states that RAS testing is current practice but BRAF v600E testing is not routinely done.

### Resource impact

During development of NG151, NICE produced a resource impact statement indicating that the resource impact of implementing the recommendations in the guideline was not anticipated to be significant.

### Issues for consideration

**For discussion:**

* What is the priority area for improvement?
* What is the key action that will lead to improvement?
* Could we focus on a specific population or setting?
* Can we develop a specific measurable statement on quality of colonoscopy services?
* The misalignment between NICE CG118 and the BSG/ACPGBI/PHE post-polypectomy and post-colorectal cancer resection surveillance guidelines.
* The existing quality statement on testing for blood in faeces in NICE’s quality standard for suspected cancer.

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Treatment

### Treatment options

Stakeholders commented that people with colorectal cancer should be offered all possible treatments. They highlighted variation in the management of rectal cancer in the UK and the need to provide equivalent access to treatment that allows for organ preservation by local excision or neoadjuvant radiotherapy. Stakeholders also noted the use of contact radiotherapy and the need to clarify where this fits into the pathway. Additionally, it was suggested that people who choose to defer surgery for rectal cancer should be enrolled in a trial or national registry, and this is an area for quality improvement.

Stakeholders commented that elective waiting lists were put on hold during the COVID crisis. They suggested patient access to cancer interventions specifically at this time as an area for quality improvement. They highlighted the variation in the implementation of NICE’s COVID-19 rapid guideline on delivery of systemic anticancer treatments that includes the option for offering a treatment break without losing funding and the implementation of NHS England advice on interim treatment options. Stakeholders commented that treatment options that support expediting care could help elective care numbers to return to pre-pandemic levels as soon as possible and prevent further delays to treatment. Stakeholders also commented on other modifications to treatment used during the pandemic such as follow-up using imaging and colonoscopy rather than surgery for those patients with rectal cancer who were complete responders. They question if this is an option that should be considered for selected patients.

#### Selected recommendations

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.2.2 Give people information on all treatment options for colorectal cancer available to them, including:

* surgery, radiotherapy, systemic anti-cancer therapy or palliative care

the potential benefits, risks, side effects and implications of treatments, for example, possible effects on bowel and sexual function (see also recommendation 1.6.2), quality of life and independence.

1.3.1 Offer one of the treatments shown in [table 1](https://www.nice.org.uk/guidance/ng151/chapter/Recommendations#management-of-local-disease) to people with early rectal cancer (cT1-T2, cN0, M0) after discussing the implications of each treatment and reaching a shared decision with the person about the best option.

1.3.3 Offer preoperative radiotherapy or chemotherapy to people with rectal cancer that is cT1-T2, cN1-N2, M0, or cT3-T4, any cN, M0.

1.3.4 Offer surgery to people with rectal cancer (cT1-T2, cN1-N2, M0, or cT3-T4, any cN, M0) who have a resectable tumour.

1.3.5 Inform people with a complete clinical and radiological response to neoadjuvant treatment who wish to defer surgery that there is a risk of recurrence, and there are no prognostic factors to guide selection for deferral of surgery. For those who choose to defer, encourage their participation in a clinical trial and ensure that data is collected via a national registry.

[NICE’s COVID-19 rapid guideline on delivery of systemic anticancer treatments](https://www.nice.org.uk/guidance/ng161) (NG161):

4.3 Try to deliver systemic anticancer treatment using different and less immunosuppressive regimens, different locations or via another route of administration where possible. Options include:

* switching intravenous treatments to subcutaneous or oral alternatives where this would be beneficial (subject to agreement with commissioners)
* using shorter treatment regimens
* decreasing the frequency of immunotherapy regimens, for example moving to 4-weekly or 6-weekly
* providing repeat prescriptions of oral medicines or other at-home treatments without patients need to attend hospital
* using home delivery of oral and subcutaneous medicines where possible
* using treatment breaks for long term treatments (possibly for longer than 6 weeks)

providing interim treatment regimens

Statements in existing quality standards

[NICE’s quality standard on colorectal cancer](https://www.nice.org.uk/guidance/qs20) (QS20):

Statement 4. People with rectal cancer are offered a preoperative treatment strategy appropriate to their stage of local disease recurrence.

#### Current UK practice

[The National Cancer Experience Survey](https://www.ncpes.co.uk/2019-national-level-results/) in 2019 surveyed all adult NHS patients with a confirmed primary diagnosis of cancer discharged from an NHS trust after an inpatient or day case attendance for cancer related treatment in April to June 2019. The response rate was 61% in 2019 (total 67,858 responses), with 7,646 responses regarding colorectal/lower gastrointestinal tract cancer (LGT). The survey found that 76% of responses from people with colorectal/LGT cancer answered “yes, completely” when asked if they had their treatment options explained before the start of treatment (Q14; national data 75%).

[The NBOCA annual report](https://www.hqip.org.uk/resource/national-bowel-cancer-audit-annual-report-2020/#.YK5p3o2Sncs) for 2020 includes data on over 30,000 patients diagnosed with bowel cancer between 01 April 2018 and 31 March 2019. The report reviewed treatment of 8,454 people diagnosed with rectal cancer. 46% had major resection, 7% had local excisional procedures and 7% had non-resectional surgery. 40% had no surgery. Compared with previous years, there was a 6 to 8% reduction in people recorded as undergoing major resection. The audit report notes that this may have been because of COVID-19 (reduced data submission).

[The NBOCA annual report](https://www.hqip.org.uk/resource/national-bowel-cancer-audit-annual-report-2020/#.YK5p3o2Sncs) (2020) shows that 34% of the 3,816 people diagnosed between 1 January 2018 and 31 December 2018 who underwent major resection received neo-adjuvant treatment. 74% received long-course chemoradiotherapy, 20% short-course radiotherapy and 6% unclassified regimes. Variation in the use of neo-adjuvant treatment was found across England cancer alliances (18% to 61%). The use of long-course chemoradiotherapy varied from 53% to 95% and short-course radiotherapy varied from 0% to 36%.

### Adjuvant chemotherapy in stage III colon cancer

Stakeholders commented on variation in the use of adjuvant chemotherapy in stage III colon cancer. They suggested this is an area for quality improvement and pointed out the benefits in the use of adjuvant chemotherapy after potentially curative resection.

#### Selected recommendations

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.3.14 For people with stage III colon cancer (pT1-4, pN1-2, M0), or stage III rectal cancer (pT1-4, pN1-2, M0) treated with short-course radiotherapy or no pre-operative treatment, offer:

* capecitabine in combination with oxaliplatin (CAPOX) for 3 months, or if this is not suitable
* oxaliplatin in combination with 5-fluorouracil and folinic acid (FOLFOX) for 3 to 6 months, or

single-agent fluoropyrimidine (for example, capecitabine) for 6 months, in line with NICE technology appraisal guidance (see adjuvant treatment of stage III colon cancer in the NICE pathway on colorectal cancer).

Base the choice on the person’s histopathology (for example pT1-T3 and pN1, and pT4 and/or pN2), performance status, any comorbidities, age and personal preference.

In January 2020, the use of some treatments was off label:

* oxaliplatin in combination with capecitabine (though CAPOX is common in UK clinical practice)
* capecitabine for 3 months duration of adjuvant treatment in people with colon cancer

CAPOX and FOLFOX in stage III rectal cancer.

See [NICE’s information on prescribing medicines](https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/making-decisions-using-nice-guidelines#prescribing-medicines).

#### Current UK practice

[The NBOCA annual report](https://www.hqip.org.uk/a-z-of-nca/national-bowel-cancer-audit/#.YK0VcY2SkdU) (2020) found that 61% of people with stage III colon cancer received adjuvant therapy (England and Wales) but noted variation in rates according to surgical trust at English hospital/trust level and for Welsh MDTs.

[A study by Boyle et al](https://www.clinicaloncologyonline.net/article/S0936-6555(19)30538-2/fulltext) (2020) on determinants of variation in the use of adjuvant chemotherapy involved 11,932 patients with stage III colon cancer (diagnosed 2014-2017) identified from the NBOCA. This found that there is considerable variation in hospitals across England and age is the strongest determinant. They observed proportions of adjuvant chemotherapy administration of 46% to 100% in the young (80% of hospitals 74% to 90%) and 10% to 81% in the elderly (80% of hospitals 33% to 65%).

Resource impact

During development of NG151 this was not considered to have a significant resource impact.

### Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Could we focus on a specific population or setting?
  + Most comments from stakeholders about choice of treatment were focussed on rectal cancer.
* Can we develop a specific, measurable statement?
* The existing quality statement in colorectal cancer quality standard 20:
  + Statement 4: People with rectal cancer are offered a preoperative treatment strategy appropriate to their stage of local disease recurrence.

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Surgery

### Care pathways

Stakeholders suggested the surgical care pathway as an area for quality improvement. Stakeholders noted the importance of prehabilitation for patients undergoing surgery, and noted that pre-operative risk assessment and stratification, for example with the use of cardiopulmonary exercise testing (CPET), could improve outcomes and reduce complications after surgery. Stakeholders also highlighted implementation of enhanced recovery after surgery (ERAS) guidance as a way to improve outcomes. One stakeholder noted that “identification of higher risk patients would lead to personalised recovery packages”.

#### Selected recommendations

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.2.4 If recovery protocols (such as ‘enhanced recovery after surgery’, ERAS) are used, explain to people with colorectal cancer what these involve and their value in improving their recovery after surgery.

[NICE’s guideline on perioperative care in adults](https://www.nice.org.uk/guidance/NG180) (NG180):

1.2.1 Offer an enhanced recovery programme to people having elective major or complex surgery.

1.2.2 Use an enhanced recovery programme that includes preoperative, intraoperative and post-operative components.

1.3.1 Use a validated risk stratification tool to supplement clinical assessment when planning surgery, including dental surgery. Discuss the person’s risks and surgical options with them to allow for informed shared decision making.

#### Current UK practice

[The NBOCA organisational survey](https://www.nboca.org.uk/reports/organisational-survey-results-2019/) (2019) reported that 56% of hospitals/trusts/MDTs in England and Wales had dedicated nurses for ERAS services.

[A survey by Reeves et al](https://perioperativemedicinejournal.biomedcentral.com/articles/10.1186/s13741-017-0082-3) (2018) evaluated current CPET practice in the UK. The online survey was sent to CPET service leads for trusts with adult elective surgery in the UK. The response rate was 73% (144/197). 68% reported an established clinical service. This found that colorectal surgical patients are the most frequently tested (89.5% of departments test colorectal patients). [The NBOCA organisational survey](https://www.nboca.org.uk/reports/organisational-survey-results-2019/) (2019) reported that 63% of hospitals/trusts/MDTs in England and Wales have on-site CPET facilities.

No further published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

### Minimally invasive surgery

Stakeholders suggested the use of minimally invasive surgery as an area for quality improvement. Stakeholders commented that minimally invasive surgery may lead to better functional outcomes and quality of life. Other stakeholders commented on the use of robotic surgery as a new and developing area of colorectal practice and the need for definition of quality standards for a new surgical technique.

#### Selected recommendations

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.3.1 Offer one of the treatments shown in [table 1](https://www.nice.org.uk/guidance/ng151/chapter/Recommendations) to people with early rectal cancer (cT1-T2, cN0, M0) after discussing the implications of each treatment and reaching a shared decision with the person about the best option.

1.3.6 Offer laparoscopic surgery for rectal cancer, in line with NICE technology appraisal guidance (see surgical techniques for rectal cancer in the NICE pathway on colorectal cancer).

1.3.8 Only consider robotic surgery within established programmes that have appropriate audited outcomes.

#### Current UK practice

[The NBOCA annual report](https://www.hqip.org.uk/a-z-of-nca/national-bowel-cancer-audit/#.YK1L942SkdW) (2020) showed that the proportion of patients undergoing laparoscopically completed surgery increased from 52% in 2014/15 to 64% in 2018/19. Laparoscopic surgery has increased from 58% in 2014/15 to 70% in 2018/19 for elective cases, and from 21% to 30% for emergency cases. This varied in 2018/19 across cancer alliances in England and Wales from 45% to 80% and between trusts/hospitals/MDTs. Fifteen trusts/hospitals/MDTs had less than 50% of major resections attempted laparoscopically.

[The NBOCA organisational survey](https://www.nboca.org.uk/reports/organisational-survey-results-2019/) (2019) collected information regarding the use of robotic surgery for colorectal cancer. There were 31 trusts in England regularly performing robotic surgery.

[The NBOCA annual report](https://www.hqip.org.uk/a-z-of-nca/national-bowel-cancer-audit/#.YK1L942SkdW) (2020) shows that the number of robotic cases has more than doubled with 239 cases in 2015/16 and 494 in 2018/19. The number of surgeons performing robotic surgery increased from 74 in 2017/18 to 102 in 2018/19. The annual case load for robotic surgery per trust varies from 2 to 216.

### Minimum case volumes and specialist centres

Stakeholders noted the need for centralisation of treatment for locally advanced colorectal cancers. Stakeholders suggested that surgery for rectal cancer should be undertaken in high volume centres by surgeons who perform more than a minimum number of surgeries each year. Stakeholders highlighted data from the NBOCA that shows variability in rectal cancer surgery volumes by centre and by surgeon. They noted evidence that higher volume hospitals have better outcomes than lower volume hospitals. Stakeholders also commented on the need to improve delivery of exenterative surgery and the referral pathways and ensure equivalent access to this type of surgery (multi-visceral or beyond-total mesorectal excision). They note that this could be achieved by referral to a specialist centre for people who may need this type of surgery.

#### Selected recommendations

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.3.10 Consider referring people with locally advanced primary or recurrent rectal cancer that might potentially need multi-visceral or beyond-TME surgery to a specialist centre to discuss exenterative surgery.

1.3.11 Hospitals performing major resection for rectal cancer should perform at least 10 of these operations each year.

1.3.12 Individual surgeons performing major resection for rectal cancer should perform at least 5 of these operations each year.

#### Current UK practice

[The NBOCA annual report](https://www.hqip.org.uk/a-z-of-nca/national-bowel-cancer-audit/#.YK1L942SkdW) (2020) reviewed mean annual volume of rectal resections for patients who underwent surgery between 1 April 2015 and 31 March 2019. This showed that the median annual number of rectal resections reported at institutional level was 25. One trust/hospital/MDT (1%) had an average annual volume of 5 or less rectal resections, 8 (5%) had less than 10 and 43 (28%) had less than 20 rectal resections. The report also reviewed mean annual volume of rectal resections at surgeon level for patients who underwent surgery between 01 April 2015 and 31 March 2019. This identified 811 colorectal surgeons in England and Wales. Overall, 56% of individual surgeons performed 5 or more resections annually.

[The NBOCA organisational survey](https://www.nboca.org.uk/reports/organisational-survey-results-2019/) (2019) reported that 63% of hospitals/trusts/MDTs had services for multi-visceral resection for locally advanced colon cancer and 46% had services for locally recurrent colon cancer. 29% of centres offered pelvic exenteration for locally advanced rectal cancer and 18% of centres offered this for locally recurrent rectal cancer.

### Ileostomy closure

One stakeholder suggested that closure of diverting ileostomies is an area for quality improvement. They noted that there is no cancer pathway target to ensure timely closure of stomas and highlighted that “patients with diverting ileostomies are at risk of high output stomas and deterioration in renal function that may affect long-term survival. Delayed closure may affect functional outcomes and impact quality of life in long-term”.

#### Selected recommendations

No recommendations identified.

#### Current UK practice

[The NBOCA annual report](https://www.hqip.org.uk/resource/national-bowel-cancer-audit-annual-report-2020/#.YK4y6I2Sncs) (2020) shows that the proportion of patients with unclosed ileostomy at 18 months did not improve in the period 2015/16 to 2018/19 and remains at 28 to 30%. There is wide variation at hospital/trust/MDT level in England and Wales (5% to 65%).

### Colonic stents

Stakeholders noted variation in hospital departments that offer colonic stents and suggested this as an area for quality improvement. They suggested that people who undergo stenting have reduced stoma rates than those who undergo emergency surgery and note the benefits that stenting offers before undertaking potentially curative surgery. They commented on workforce shortage in interventional radiology and the availability of this treatment out of hours.

#### Selected recommendations

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.3.15 Consider stenting for people presenting with acute left-sided large bowel obstruction who are to be treated with palliative intent.

1.3.16 Offer either stenting or emergency surgery for people presenting with acute left-sided large bowel obstruction if potentially curative treatment is suitable for them.

#### Current UK practice

A national study of current practice by [Boyle et al](https://onlinelibrary.wiley.com/doi/full/10.1111/codi.14386) (2018; poster abstract) reported 369 people had self-expandable metal stent (SEM) at 82/146 hospitals in England in 2013-2015. Data from the NBOCA was linked to hospital episode statistics and people recorded as having emergency palliative procedures of left-sided colonic cancer were included. The authors suggest that this shows that SEMs are used infrequently in the palliative setting.

[The NBOCA annual report](https://www.hqip.org.uk/resource/national-bowel-cancer-audit-annual-report-2020/#.YK4y6I2Sncs) (2020) showed that 1.6% of people who were referred as an emergency admission underwent surgery for stenting, this is more than GP (0.7%) or screening referrals (0.2%). For comparison, 47.7% of people referred as an emergency admission underwent major resection (40.8% of people in this referral group had no surgical treatment recorded). The report also found that the proportion of people with dementia receiving stents was double that of those without (2.4% versus 1.1%).

[The NBOCA organisational survey](https://www.nboca.org.uk/reports/organisational-survey-results-2019/) (2019) reported that 39/154 (25%) hospitals/trusts/MDTs offered on-site bowel stenting facilities 24 hours a day, 7 days a week. This showed two geographical areas that had no provision of this service at any of their sites.

Resource impact

During development of NG151 this was not considered to have a significant resource impact.

### Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
  + Should we focus on laparoscopic surgery over open surgery, or the use of organ preserving treatment in rectal cancer as summarised in section 4.2.
* Can we develop a specific, measurable statement?
  + Note the use of ‘consider’ recommendations in the areas of robotic surgery and referral to specialist centres for exenterative surgery.
  + No recommendations were identified for timely ileostomy closure.

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Metastatic disease

### Specialist multidisciplinary team involvement

Stakeholders suggested that the proportion of people with liver or lung metastases discussed by specialist multidisciplinary teams (MDT) is an area for quality improvement. They note the variation in numbers of people offered liver or lung resection.

#### Selected recommendations

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.5.3 Consider resection, either simultaneous or sequential, after discussion by a multidisciplinary team with expertise in resection of disease in all involved sites.

1.5.5 Consider chemotherapy with local ablative techniques for people with colorectal liver metastases that are unsuitable for liver resection after discussion by a specialist multidisciplinary team.

1.5.7 Consider metastasectomy, ablation or stereotactic body radiation therapy for people with lung metastases that are suitable for local treatment, after discussion by a multidisciplinary team that includes a thoracic surgeon and a specialist in non-surgical ablation.

Statements in existing quality standards

[NICE’s quality standard on colorectal cancer](https://www.nice.org.uk/guidance/qs20) (QS20):

Statement 6: 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.

#### Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

### Access to selective internal radiation therapy (SIRT)

Stakeholders highlighted the variation in access to selective internal radiation therapy (SIRT) for metastatic colorectal cancer; they noted that “currently SIRT is funded in a limited number of patients by NHS England”. They suggested this as an area of quality improvement and noted equality issues that can affect access to this treatment such as geography, disability, age and socio-economic factors.

#### Selected recommendations

No recommendations identified.

#### Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Resource impact

During development of NG151 this was not considered to have a significant resource impact.

### Issues for consideration

**For discussion:**

* What is the priority for improvement?
* Can we develop a specific, measurable statement?
  + Note the use of ‘consider’ recommendations for this suggested area.
  + Recommendation 1.5.6 in NG151 is a ‘do not offer’ recommendation for SIRT as a first-line treatment.
* The existing quality statement in colorectal cancer quality standard 20:
  + Statement 6: 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.

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Ongoing care and support

### Patient information

Stakeholders suggested that provision of patient information is an area for quality improvement. Stakeholders commented on the importance of pre- and post-treatment information including the risks and benefits of treatment. Stakeholders noted that provision of high-quality information post-treatment can help patients to manage ongoing conditions and the life-style changes required. They also highlighted the need for cancer survivorship support to be integrated into all pathways.

#### Selected recommendations

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.2.1 Provide people with colorectal cancer information about their treatment (both written and spoken) in a sensitive and timely manner throughout their care, tailored to their needs and circumstances. Make sure the information is relevant to them, based on the treatment they might have and the possible side effects. Also see the NICE guidelines on patient experience in adult NHS services and decision-making and mental capacity.

1.2.2 Give people information on all treatment options for colorectal cancer available to them, including:

* surgery, radiotherapy, systemic anti-cancer therapy or palliative care

the potential benefits, risks, side effects and implications of treatments, for example, possible effects on bowel and sexual function (see also recommendation 1.6.2), quality of life and independence.

1.2.7 Give people who have had treatments for colorectal cancer information about possible short-term, long-term, permanent and late side effects which can affect quality of life, including:

* pain
* altered bowel, urinary or sexual function
* nerve damage and neuropathy

mental and emotional changes, including anxiety, depression, chemotherapy-related cognitive impairment, and changes to self-perception and social identity.

1.2.8 Prepare people for discharge after treatment for colorectal cancer by giving them advice on:

* adapting physical activity to maintain their quality of life
* diet, including advice on foods that can cause or contribute to bowel problems such as diarrhoea, flatulence, incontinence and difficulty in emptying the bowels
* weight management, physical activity and healthy lifestyle choices (for example stopping smoking and reducing alcohol use)
* how long their recovery might take

how, when and where to seek help if side effects become problematic.

#### Current UK practice

[The National Cancer Patient Experience Survey](https://www.ncpes.co.uk/2019-national-level-results/) (2019) found that:

* 74% of people with colorectal/LGT cancer responding answered “yes, definitely” when asked if the possible side effects of cancer treatment were explained in a way they could understand (Q15; national data 70%).
* 55% of respondents answered “yes, definitely” when asked if they were also told about side effects of treatment that could affect in the future (Q17; national data 52%).
* 68% of respondents answered “yes, definitely” when asked if they were offered practical advice and support in dealing with the side effects of the treatment (Q16; national data 65%).

### Follow-up regimes

Stakeholders identified follow-up regimes post-treatment as an area for quality improvement as they vary between centres in frequency, length and in what tests are offered. They note that follow-up regimes impact on patient’s quality of life, mental health and their ability to return to as normal lifestyle as possible.

#### Selected recommendations

[NICE’s guideline on colorectal cancer](https://www.nice.org.uk/guidance/ng151) (NG151):

1.6.1 For people who have had potentially curative surgical treatment for non-metastatic colorectal cancer, offer follow-up for detection of local recurrence and distant metastases for the first 3 years. Follow-up should include serum carcinoembryonic antigen (CEA) and CT scans of the chest, abdomen and pelvis.

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

We recommend that patients who have undergone a potentially curative CRC resection should have a clearance colonoscopy within a year of their diagnosis.

We recommend that once a clearance colonoscopy has been performed in the postoperative period in patients who have had a CRC resection, their next surveillance should be performed after an interval of 3 years. The need for further surveillance should then be determined in accordance with the post-polypectomy high-risk criteria.

See appendix 1 for BSG/ACPGBI/PHE surveillance algorithm.

Statements in existing quality standards

[NICE’s quality standard on colorectal cancer](https://www.nice.org.uk/guidance/qs20) (QS20):

Statement 8. People free from disease after treatment for colorectal cancer are offered regular surveillance.

#### Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Resource impact

During development of NG151 this was not considered to have a significant resource impact.

### Issues for consideration

**For discussion:**

* What is the priority for improvement?
* Could we focus on a specific population or setting?
  + For example, giving patients information when they are first diagnosed, post-surgery or after completion of treatment?
* Can we develop a specific, measurable statement?
  + Current practice information is limited for this area. Is this routinely measured?
* The existing quality statement in colorectal cancer quality standard 20:
  + Statement 8. People free from disease after treatment for colorectal cancer are offered regular surveillance.

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Additional areas

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However, they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or need further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the Advisory Committee meeting.

Table 2 Summary of information available for additional areas

| Suggested area for improvement | Within remit of NICE QS | In scope | Guideline recs | Relevant  existing QS |
| --- | --- | --- | --- | --- |
| Targeted screening and uptake | No | No | No | No |
| Support for research | No | No | No | No |
| Use of real-world evidence and PROMS to review outcomes | No | No | No | No |

### Targeted screening and uptake

Stakeholders suggested that uptake in the National Bowel Cancer Screening programme is an area for quality improvement.

This suggestion has not been progressed. Population screening is not usually addressed within NICE quality standards. Screening is within the remit of the UK National Screening Committee.

### Support for research

Stakeholders suggested support for research as an area for quality improvement. Stakeholders also suggested that recruitment to trials should be included as a quality initiative.

These suggestions have not been progressed. Research is within the remit of the National Institute for Health Research. Quality statements focus on actions that demonstrate high quality care and support, not the methods by which evidence is generated. There is a suggestion in a previous section for encouraging enrolment in clinical trials specifically for people with rectal cancer who defer surgery.

### Use of real-world evidence and PROMS to review outcomes

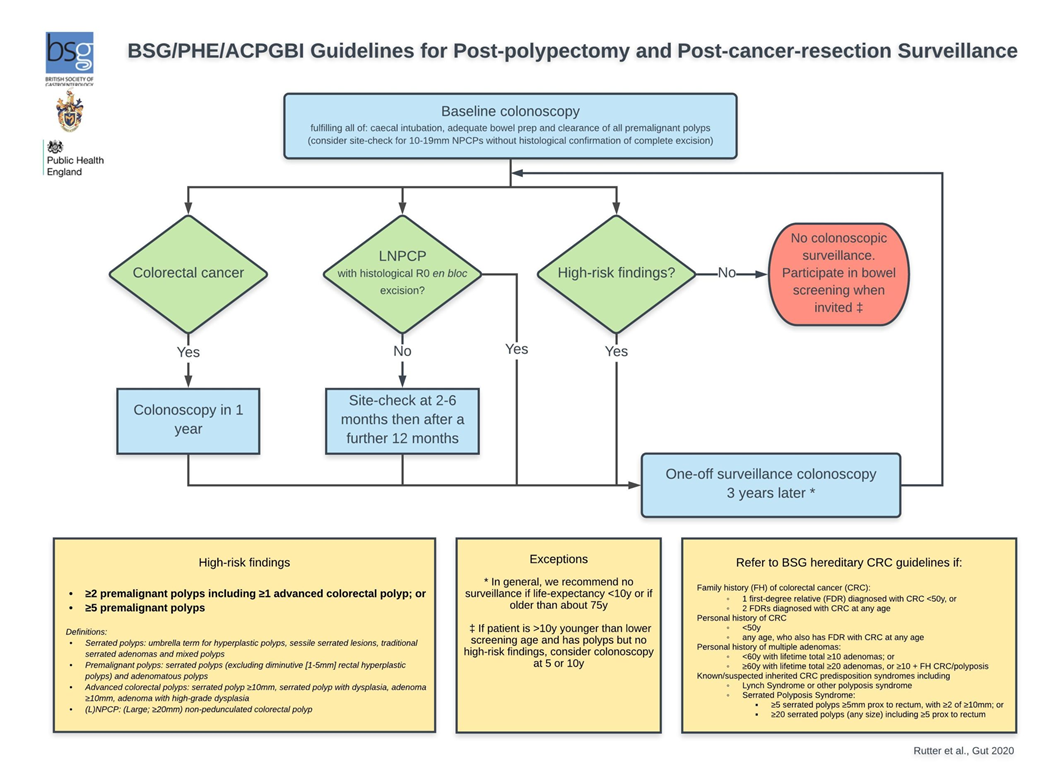
Stakeholders commented that there has been a focus on the oncological outcomes of cancer treatments when reviewing impact of different treatments. Stakeholders suggest that this should be extended to include real world evidence and quality of life outcomes and suggest this as an area of quality improvement.

This suggestion has not been progressed. Quality standards focus on actions that demonstrate high quality care or support, not the methods by which evidence is collated. However, current practice and patient outcomes may be referred to in the quality measures for each statement.

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# Appendix 1: [BSG/ACGBI/PHE Guideline for post-polypectomy and post-cancer section surveillance algorithm](https://www.bsg.org.uk/clinical-resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectal-cancer-resection-surveillance-guidelines/)[[1]](#footnote-1)



# Appendix 2: Suggestions from registered stakeholders

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
| --- | --- | --- | --- | --- | --- |
| 1 | Bowel cancer UK | Diagnosis: Quantitative faecal immunochemical test (qFIT) to guide referral for colorectal cancer in primary care | Early diagnosis and prevention of cancer is a key priority for the Government and underpins the ambition of the NHS Long Term.  The COVID-19 pandemic has had a profound impact on diagnostics services with a substantial growing backlog. qFIT can, alongside the patient’s clinical features, help GPs and other healthcare professionals decide who to refer based on their risk of having cancer. It is helpful to understand which patients are at highest risk, so they can be prioritised for further testing.  For patients who are deemed at lower risk it is important to ensure that there are appropriate safety-netting measures in place to ensure adequate follow up as some on them will have cancer. | [DG30](https://www.nice.org.uk/guidance/dg30) was beginning to be rolled out before the COVID-19 pandemic. There was variation in local pathways and accessibility for qFIT testing in people with ‘low risk’ symptoms.  As a result of the COVID-19 pandemic, there has been swifter roll out which is welcome however a Quality Standard would be welcome to ensure equity of access across England, as well as the sharing of best practice. |  |
| 2 | NHS England and NHS Improvement | Diagnosis: FIT implementation in the lower GI 2WW pathway | FIT is recommended for use in the ‘low risk’ population through NICE guideline [DG30](https://www.nice.org.uk/guidance/dg30) as a ‘rule in’ test.  In June 2020 NHSEI published [clinical guidance](https://www.nice.org.uk/Media/Default/About/COVID-19/Specialty-guides/triaging-patients-with-lower-gi-symptoms.pdf) on triaging lower GI referrals using FIT.  Both these sets of guidance support prioritisation of referrals across the lower GI pathway ensuring those at highest risk of cancer are prioritised for endoscopy. | Endoscopy capacity was significantly reduced during the pandemic and services are still recovering their backlogs. FIT supports effective use of resource by ensuring colonoscopy capacity is prioritised for those at highest risk of cancer.  FIT implementation in the symptomatic pathway will also free up capacity which can then be used to support the age extension of the NHS Bowel Cancer Screening Programme, a key Long Term Plan ambition. | [DG30 NICE guidance](https://www.nice.org.uk/guidance/dg30)  [Clinical guidance on triaging lower GI referrals](https://www.nice.org.uk/Media/Default/About/COVID-19/Specialty-guides/triaging-patients-with-lower-gi-symptoms.pdf) |
| 3 | SCM5 | Diagnosis: Use of FIT testing in primary care | DG30 “quantitative faecal immunochemical tests are recommended for adoption in primary care to guide referral for suspected colorectal cancer in people without rectal bleeding who have unexplained symptoms but do not meet the criteria for a suspected cancer pathway referral  “ | There is significant variation in provision of FIT testing for patients with lower risk symptoms in primary care – different CCGs are using different approaches to implementation | A FIT of <10 excludes >90% of CRC <https://onlinelibrary.wiley.com/doi/abs/10.1111/apt.15969>  <https://fg.bmj.com/content/11/1/28> |
| 4 | The Association of Coloproctology of Great Britain and Ireland | Diagnosis: Diagnostic pathways for patients with bowel symptoms | Current USC referral guidelines lead to referral of large numbers of patients with only a very small (3%) incidence of malignancy. The large numbers of referrals are overwhelming current investigative pathways | There is increasing volume of published evidence demonstrating the benefit of the use of tests including Faecal Immunotherapy Testing to stratify referral and investigation of patients with bowel symptoms. | There are a number of UK population-based studies of the use of FIT testing in patient with bowel symptoms demonstrating a high sensitivity and specificity for identifying individuals with a high risk of significant bowel disease. |
| 5 | Bowel cancer UK | Diagnosis: Compliance of surveillance guidelines post-polypectomy and post-colorectal cancer resection | Early diagnosis and prevention of cancer is a key priority for the Government and underpins the ambition of the NHS Long Term.  The vast majority of colorectal cancers arise from premalignant polyps, which take years to develop. Endoscopic polypectomy is effective in reducing colorectal cancer incidence and mortality.  Yet some patients who have premalignant polyps detected at colonoscopy are more likely to develop metachronous polyps or colorectal cancer.  Surveillance aims to detect and remove polyps and lesions not identified in the initial colonoscopy, therefore can prevent colorectal cancer and reduce incidence.  It is crucial that patients who meet the high-risk criteria for future colorectal cancer are offered the appropriate surveillance in a timely and safe manner. | As a result of the pandemic, endoscopy services have had to prioritise patients with symptomatic presentation referred for urgent suspicion of cancer therefore patients on surveillance pathways have struggled to access appropriate tests.  However it is important that patients who are higher risk of developing polys or colorectal cancer are offered gold standard treatment.  A Quality Standard would help with compliance of the guideline and reduce variation in accessibility. |  |
| 6 | Bowel cancer UK | Diagnosis: Additional developmental areas of emergent practice: Colon Capsule Endoscopy is currently being rolled out to pilot sites across England as part of the urgent suspected cancer referral pathway (NG12 guidance).  As the data is collected on the effectiveness and acceptability of CCE within clinical practice, and if it is to be rolled out to other parts of England and even considered for routine and/or surveillance pathways, a Quality Standard may need to be developed to prevent variation in access. |  |  |  |
| 7 | Bowel cancer UK | Diagnosis: Quality Assurance Standards for Colonoscopy | Early diagnosis and prevention of cancer is a key priority for the Government and underpins the ambition of the NHS Long Term.  Colonoscopy is the ‘gold standard’ investigation for assessment of the large bowel which diagnoses and can prevent colorectal cancer.  As demand for colonoscopy continues to increase, it is important that patients receive the highest quality of practice to reduce the chance of serious complications or the development of interval cancers. | The Joint Advisory Group of GI Endoscopy, the British Society of Gastroenterology and Association of Coloproctology reviewed existing and defined new [quality measures and key performance indicators for colonoscopy.](https://www.bsg.org.uk/wp-content/uploads/2019/12/UK-Key-Performance-Indicators-and-Quality-Assurance-Standards-for-Colonoscopy-1.pdf)  Colonoscopy can lead to rare but serious complications and poor quality colonoscopy is associated with increased rates of interval cancers. The quality of UK colonoscopy has improved over recent years but unacceptable variation in practice still exists. A Quality Standard should be developed to reduce variation and provide patients with the highest quality of practice. |  |
| 8 | Medtronic Ltd | Diagnosis: Colonic imaging for the diagnosis of Colorectal Cancer | Early diagnosis of colorectal cancer is critical for the effective treatment of the disease. To diagnose or rule out cancer within the timeframe set out in the NHS Long Term Plan, a rapid and effective modality is required.  We feel that it is important to explicitly include colon capsule endoscopy. | Patients should not be discharged from the Two Week Wait pathway based on a faecal immunochemical test (FIT) alone. Patients with results of 10-100ug/gm and patients with FIT>100ug/gm who have had a colonoscopy requiring no further investigation within three years, should be considered for further investigation to rule out colorectal cancer. <https://www.nice.org.uk/Media/Default/About/COVID-19/Specialty-guides/triaging-patients-with-lower-gi-symptoms.pdf> | In March 2021 NHS England initiated a roll out of colon capsule endoscopy devices to patients referred on the Two Week Wait pathway. <https://www.england.nhs.uk/2021/03/nhs-rolls-out-capsule-cameras-to-test-for-cancer/> |
| 9 | MSD UK Limited | Diagnosis: Sufficient resourcing within endoscopy services | A timely diagnostic pathway is important in ensuring patients can be diagnosed and subsequently able to begin appropriate treatment swiftly in order for patients to achieve their best possible outcomes.  In patients presenting with late stage disease in particular, where a patient’s health may deteriorate rapidly, speed within the diagnostic pathway can be critical in providing a patient has the opportunity to be treated with SACT, before their disease or health status may worsen and make active treatment no longer a viable option | The rollout of the FIT test within the bowel cancer screening programme is a welcome introduction, and one which is expected to result in an increase in bowel cancer screening uptake.  In order to manage with the increased number of patients referred to endoscopy for further investigation this is likely to cause, in addition to the increase in the number of referred patients if the FIT sensitivity threshold is reduced in England and Wales to match international standards, endoscopy services need to be designed to cope with this anticipated increase in demand. |  |
| 10 | NHS England and NHS Improvement | Diagnosis: Implementation of the BSG/ACPGBI/PHE polyp surveillance guidance | In 2019, the BSG/ACPGBI/PHE released the Post-polypectomy and post-colorectal cancer resection surveillance guidance. This guidance considered the use of surveillance colonoscopies and bowel imaging in people who have had either bowel polyps or a bowel cancer removed | Full implementation of this guidance has the real potential to support more efficient and effective use of available endoscopy resources – a service that we know is often particularly challenged – by taking a more targeted approach to surveillance. Expert clinical opinion suggests that full implementation of the guidance could reduce the demand for surveillance colonoscopy in the symptomatic service by up to 70%.  In addition, introduction of the guidance will mean surveillance is more personalised, ensuring those who need it can access colonoscopy more easily, whilst avoiding unnecessary colonoscopy in those who won’t benefit | [BSG/ACPGBI/PHE polyp surveillance guidance](https://www.bsg.org.uk/clinical-resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectal-cancer-resection-surveillance-guidelines/) |
| 11 | SCM5 | Diagnosis: Colonoscopic surveillance and utilisation | Post-colonoscopy CRC | Compliance with surveillance guidelines  Median time from referral to colonoscopy | With increasing endoscopy demand and limited access related to Covid19 we should ensure that resources are effectively utilised and monitored e.g. locally by NSHE supported endoscopy surveillance leads which now exist at every NHS trust |
| 12 | SCM5 | Diagnosis: Colonoscopic surveillance and quality | Colonoscopy quality indicators (see BSG NICE accredited guidelines x2 in topic overview) “We recommend that all surveillance colonoscopies are performed by endoscopists who consistently achieve BSG colonoscopy KPI (key performance indicators) minimum standards, specifically caecal intubation rate, adenoma/polyp  detection rate and comfort score. “ | National endoscopy database (NED) collects data about KPIs of colonoscopists however there is significant variation in the quality of colonoscopy delivered.  The national colorectal cancer intelligence Hub indicates that missed colorectal cancers occur in 7.4% of people after colonoscopy, with the highest rates in non-NHS providers, and the lowest in BCSP accredited colonoscopists  <https://www.bmj.com/content/367/bmj.l6090> | 1. PCCRC rate (organisational level, done by national team and NOT by each provider, as needs linkage to NCRAS)  2. PCCRC case root cause analysis – done  3. CRC PPV of diagnostic colonoscopy – as a measure of whether the “right sort of patients” are being scoped – very useful metric & we can calculate this automatically within National Endoscopy Database. NED would be keen to assist in its development (devil is in the detail). It will, for example, show benefit/otherwise of improved pathways (e.g. FIT)  4. Colonoscopy polyp detection rate (NED have created an optimised procedure-adjusted detection rate through NED – e.g. see NED-APRIQOT RCT– again, this can be fully automated) – as a measure of high quality colonoscopy detection |
| 13 | University Hospitals Birmingham NHS Foundation Trust | Diagnosis: Equal access to expedited investigations |  |  |  |
| 14 | Bowel cancer UK | Diagnosis: Direct cascade testing for relatives of people diagnosed with colorectal cancer who and Lynch syndrome | Early diagnosis and prevention of cancer is a key priority for the Government and underpins the ambition of the NHS Long Term. | Uptake of Lynch syndrome cascade testing is patchy across the country. A Quality Standard must be must be put in place to encourage reduction in unwarranted variation in care across the entire Lynch syndrome testing and surveillance pathway. | [Bowel Cancer UK: Time to Test report](https://bowelcancerorguk.s3.amazonaws.com/Campaigns/LYNCH%20SYNDROME%20REPORT%20FINAL.pdf) (2018) provides further evidence on why universal testing for Lynch syndrome is crucial and the gap in implementing best practice.  National Disease Registration Service molecular and genomics team have undertaken research, using the NCRAS somatic and Germline dataset, funded by Bowel Cancer UK and in collaboration with Newcastle University.  The national registry will help inform surveillance, treatment and care for people with the condition. |
| 15 | Bowel cancer UK | Diagnosis: Universal testing for Lynch syndrome in all patients newly diagnosed with colorectal cancer | Early diagnosis and prevention of cancer is a key priority for the Government and underpins the ambition of the NHS Long Term.  [NICE DG27](https://www.nice.org.uk/guidance/dg27) supports offering testing to people with colorectal cancer, when first diagnosed. As it allows for cascade testing of relatives and for targeted surveillance and prevention strategies to be put in place.  Universal testing for Lynch syndrome is highly cost-effective and the evidence demonstrates the clinical benefits of testing and consequent surveillance pathway for those who diagnosed with Lynch syndrome to improve early detection of colorectal cancer. | Uptake of Lynch syndrome testing is patchy across the country. A Quality Standard must be must be put in place to encourage reduction in unwarranted variation in care across the entire Lynch syndrome testing and surveillance pathway. | [Bowel Cancer UK: Time to Test report](https://bowelcancerorguk.s3.amazonaws.com/Campaigns/LYNCH%20SYNDROME%20REPORT%20FINAL.pdf) (2018) provides further evidence on why universal testing for Lynch syndrome is crucial and the gap in implementing best practice.  National Disease Registration Service molecular and genomics team have undertaken research, using the NCRAS somatic and Germline dataset, funded by Bowel Cancer UK and in collaboration with Newcastle University.  The national registry will help inform surveillance, treatment and care for people with the condition. |
| 16 | MSD UK Limited | Diagnosis: Lynch Syndrome testing at point of diagnosis | Lynch syndrome can increase a person’s lifetime risk of bowel cancer to up to 80%.  Identifying people with Lynch syndrome is important as it can allow for the identification of more high-risk individuals through offering testing to family members, can enable earlier diagnosis as identified individuals can be placed on screening or surveillance programmes, and can enable additional treatment options. | NICE Diagnostics Guidance [[DG27](https://www.nice.org.uk/guidance/dg27)] recommends that testing be offered to all people with colorectal cancer when first diagnosed.  However, evidence gathered within a report by Bowel Cancer UK suggested that only 6% of CCG’s commissioned their local hospital(s) to test all bowel cancer patients4 in line with the DG27 NICE guidance.  In addition, the 2020 National Bowel Cancer Audit Annual Report showed variation in the implementation of DG27, with only 57% of trusts testing any of their patients, and only 12% testing at least 70% of their patients for Lynch syndrome.5  Assessment of mismatch repair proteins or microsatellite instability, as carried out through Lynch syndrome testing as per DG27, may impact treatment strategies both in advising on the extent of surgical resection and more recently eligibility for immunotherapy treatment in the metastatic setting. In regard to the latter, it is important that these tests are carried out at the point of diagnosis and that variation in Lynch syndrome testing is addressed to identify those patients where immunotherapy is an appropriate option.  Furthermore, in relation to the last sentence of Recommendation 1.1 of the DG27 guidance; “Do not wait for the results before starting treatment”, there may be opportunity within the Quality Standards to provide clarity in relation to how the recent availability of immunotherapies in the metastatic setting through [NHSE interim COVID guidance](https://www.nice.org.uk/guidance/ng161/resources/nhs-england-interim-treatment-options-during-the-covid19-pandemic-pdf-8715724381) has impacted this guidance. Clinicians now must test tumours and receive a result showing MSI-H/dMMR to determine eligibility for immunotherapy treatment, therefore in the current climate clinicians must wait for these results before starting treatment with immunotherapy. | 3. Bowel Cancer UK. Time to Test. Accessed online May 2021.  4. National Bowel Cancer Audit. Annual Report 2020. Accessed online May 2021. |
| 17 | MSD UK Limited | Diagnosis: The colorectal cancer diagnostic pathway and management with systemic anticancer therapy (SACT) | Activities to prevent or reduce the risk of people developing colorectal cancer, along with efforts to improve the rates of earlier detection via screening are to be encouraged to improve overall survival rates.  However, approximately 22% of colorectal cancer patients in England are diagnosed at stage IV6, representing a significant patient need in this setting for improved treatments and outcomes, where survival outcomes are drastically poorer than in those diagnosed at earlier stages (5yr net survival; stage I = 92%, stage II = 84%, stage III = 65%, stage IV = 10%).7 | In recent years, improved treatment options have been made available in the metastatic setting for certain colorectal patients by NICE and NHSE8, with these treatments requiring additional diagnostic tests to confirm a patient’s eligibility.  In the metastatic setting in particular, time is of the essence to treat the patient before their disease worsens and potentially makes them no longer fit for active treatment or impacts their chance of response.  With treatments available requiring further diagnostic tests to confirm eligibility, it is important that the diagnostic pathway is run optimally, with consideration of the NHSE 28 day standard9, and variation across regions is identified and best practices shared to give patients with metastatic colorectal cancer their best chance to access the treatment right for them. | CRUK. [Bowel cancer incidence statistics](https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer/incidence#heading-Three). Accessed online May 2021.  CRUK. [Bowel cancer survival statistics](https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer/survival#heading-Three). Accessed online May 2021.  NICE. [TA439](https://www.nice.org.uk/guidance/TA439). Accessed May 2021.  NHSE. [Implementing a timed colorectal cancer diagnostic pathway](https://www.england.nhs.uk/wp-content/uploads/2018/04/implementing-timed-colorectal-cancer-diagnostic-pathway.pdf). Accessed May 2021. |
| 18 | National Bowel Cancer Audit (sponsored by HQIP) | Diagnosis: Proportion of patients with mismatch repair (MMR) status at diagnosis | Patients with MMR deficient cancers may respond to immunotherapy if they have metastatic or unresectable disease OR may require alternative surgical resection options eg subtotal colectomy rather than segmental resection. | MMR status changes treatment strategies and allows potential for affected family members to access appropriate screening if the patient is confirmed to have Lynch Syndrome. | NBOCA QI programme has set local target for each MDT of more than 90% patients tested at diagnosis with either mismatch repair immunohistochemistry or microsatellite instability  <https://www.nice.org.uk/guidance/dg27/chapter/2-Clinical-need-and-practice> |
| 19 | National Bowel Cancer Audit (sponsored by HQIP) | Diagnosis: Proportion of patients with Stage IV disease who have genetic mutational analysis | In patients with metastatic colorectal cancer, the genetic profile of the individual tumour has significant implications for prognosis, determining best treatment options and predicting potential response to systemic anticancer therapy (SACT). Current best practice includes determination of tumour genomic profile with mismatch repair (MMR) status determined through either MMR immunohistochemistry and/or microsatellite instability (MSI) in all CRCs, together with mutation analysis of the *KRAS, NRAS* and *BRAF* genes in patients with metastatic disease. Knowing this basic genomic profile guides initial and subsequent treatment choices for patients with Stage IV cancer by guiding recommendations for systemic treatment strategy and informing prognosis. | Capalbo C, Belardinilli F, Raimondo D, et al. A Simplified Genomic Profiling Approach Predicts Outcome in Metastatic Colorectal Cancer. Cancers. 2019;11(2).  Sepulveda AR, Hamilton SR, Allegra CJ, et al. Molecular Biomarkers for the Evaluation of Colorectal Cancer: Guideline From the American Society for Clinical Pathology, College of American Pathologists, Association for Molecular Pathology, and the American Society of Clinical Oncology. J Clin Oncol. 2017;35(13):1453-1486.  Afrasanie VA, Marinca MV, Alexa-Stratulat T, et al. KRAS, NRAS, BRAF, HER2 and microsatellite instability in metastatic colorectal cancer - practical implications for the clinician. Radiol Oncol. 2019;53(3):265-274. | NBOCA QI programme has set local institutional target that more than 80% of patients with Stage IV disease should have genetic tumour profiling (KRAS, NRAS, BRAF) to guide optimal palliative systemic treatment |
| 20 | NHS England and NHS Improvement | Diagnosis: Increasing uptake of Lynch syndrome testing in line with NICE guidance | Testing of all colorectal cancers for Lynch syndrome has been recommended by [NICE DG27 guidance](https://www.nice.org.uk/guidance/dg27) since 2017. | Data provided to NCRAS by the NHS genomic laboratories on the number of full-screen germline genetic tests for Lynch syndrome performed in 2018 suggests that we need to do more to improve compliance with existing NICE guidance.  If all people with colorectal cancer and their family members were tested for Lynch syndrome and enrolled into appropriate surveillance pathways in 2028, we would expect up to 380 more colorectal cancers to be diagnosed early. That’s up to a 0.9% point increase against the Long Term Plan ambition to diagnose 75% of cancers early by 2028. | [NICE DG27](https://www.nice.org.uk/guidance/dg27) |
| 21 | Pierre Fabre Ltd | Diagnosis: Genomic testing for all patients prior to systemic anti-cancer treatment | It is important for all patients to have access to genomic testing at the right time in order to ensure appropriate targeted therapy | The NICE guideline for colorectal cancer (NG151) supports genomic testing. |  |
| 22 | Roche Diagnostics Ltd. | Diagnosis: Diagnosis of Lynch Syndrome in people newly presenting with CRC | Testing for Lynch syndrome in people newly diagnosed with CRC allows for cascade testing of relatives and for tailored surveillance and prevention strategies to be put in place. These strategies improve early detection rates and therefore life expectancy in both probands and relatives who are positive for Lynch syndrome. | Uptake of Lynch syndrome testing is patchy across the country. We suggest a QS be put in place to encourage reduction in this unwarranted variation in care. We suggest the following metric: Numerator = number of CRC patients tested for Lynch syndrome. Denominator = number of patients with a new CRC diagnosis | The evidence for Lynch syndrome testing in CRC is supported by [NICE DG27](https://www.nice.org.uk/guidance/dg27/), which finds that it is highly cost-effective. The full report for this appraisal contains a wealth of evidence on the clinical benefits of testing and consequent surveillance/prevention.  Early diagnosis and prevention of cancer is a key government and NHS long term plan priority. |
| 23 | Roche Diagnostics Ltd. | Diagnosis: Cascade testing relatives of people with CRC and Lynch syndrome | Lynch syndrome is a highly inheritable disorder. Relatives of positive CRC patients have a 44% probability to be positive for Lynch syndrome. There is strong evidence that surveillance and prevention strategies will lead to earlier diagnosis of new cancers and increased life expectancy for these patients. | Uptake of Lynch syndrome cascade testing is patchy across the country. We suggest a QS be put in place to encourage reduction in this unwarranted variation in care. NICE DG27 found that it was highly cost-effective to test an average of 6 relatives per positive patient with CRC (of which 2.5 were first-degree relatives). We suggest the following metrics: **Numerator:** Number of new CRC patients whose relatives have been offered genetic counselling and a Lynch syndrome test. Denominator**:** Number of patients with new CRC.  Numerator**:** Number of Lynch syndrome tests offered to patients/relatives  Denominator**:** Number of patients with new CRC  These measures would have to be benchmarked against the proportion of new cases expected to test positive (2.8%), or they could be used in line with our first suggestion and the denominator changed to be all patients with Lynch syndrome and new CRC.  The calculations in NICE DG27 suggest that the total number of Lynch syndrome test should equal ~117% of the total incidence of CRC (1 for each proband and 6\*2.8% probands testing positive). | The evidence for Lynch syndrome testing in CRC is supported by [NICE DG27](https://www.nice.org.uk/guidance/dg27/), which finds that it is highly cost-effective. The full report for this appraisal contains a wealth of evidence on the clinical benefits of testing and consequent surveillance/prevention. For example, surveillance of relatives with Lynch syndrome reduces the probability of death from CRC by 72%.  Early diagnosis and prevention of cancer is a key government and NHS long term plan priority. |
| 24 | SCM1 | Diagnosis: There should be a clear monitoring of the percentage of patients with CRC who have access to NICE-approved molecular testing: MSI/MMR testing for all CRC patient [https://www.nice.org.uk/guidance/dg27/chapter/1-Recommendations ]; and RAS/BRAF for all metastatic CRC patients [https://www.nice.org.uk/guidance/ng151/chapter/Recommendations#molecular-biomarkers-to-guide-systemic-anti-cancer-therapy ]. |  |  |  |
| 25 | SCM2 | Diagnosis: Offer testing to all people with colorectal cancer, when first diagnosed, using immunohistochemistry for mismatch repair proteins or microsatellite instability testing to identify tumours with deficient DNA mismatch repair, and to guide further sequential testing for Lynch Syndrome. | Expanding testing to all people with colorectal cancer may increase the detection of Lynch syndrome and, because Lynch syndrome is an inherited condition, identify families who could benefit from cascade genetic testing to determine if other family members have Lynch syndrome. | This could lead to increased surveillance and consequently improved patient outcomes through earlier diagnosis and treatment, if cancer is present.  Measure : % of all people diagnosed with CRC getting tested. | Please see NG 151 and NICE GD 27. |
| 26 | SCM2 | Diagnosis: Test for RAS and BRAF V600E mutations in all people with metastatic colorectal cancer suitable for systemic anti-cancer treatment. | RAS and BRAF V600E mutations were predictive of response to anti-epidermal growth factor receptor (EGFR) targeted therapy in people with metastatic colorectal cancer.  People with RAS or BRAF V600E mutant metastatic colorectal cancer also had poorer progression-free and overall survival than those without such mutations. | This ensures best outcome and personalised treatment for people being considered for systemic anti-cancer therapy. | Please see NG 151. |
| 27 | SCM3 | Diagnosis: Proportion of patients with colorectal cancer having molecular biomarker testing to guide SACT |  | There should be a clear monitoring of the percentage of patients with CRC who have access to NICE-approved molecular testing: MSI/MMR testing for all CRC patient [<https://www.nice.org.uk/guidance/dg27/chapter/1-Recommendations> ]; and RAS/BRAF for all metastatic CRC patients [<https://www.nice.org.uk/guidance/ng151/chapter/Recommendations#molecular-biomarkers-to-guide-systemic-anti-cancer-therapy> ]. | NG151 and <https://www.nice.org.uk/guidance/dg27/chapter/1-Recommendations> |
| 28 | SCM5 | Diagnosis: Diagnosis of Lynch Syndrome following a diagnosis of colorectal cancer | Universal testing is recommended by DG27 and BSG hereditary CRC guidelines, with delivery of the entire testing pathway from CRC diagnosis through to diagnosis of Lynch syndrome | There is evidence of variation in patient access to this testing pathway, and variability in provider testing provision  Bowel Cancer UK FOI indicates that uptake of the first step of the testing pathway is low, at around 25% of colorectal MDTs offering this routinely. <https://www.bowelcanceruk.org.uk/campaigning/lynch-syndrome/>  NDRS indicates that less than half of eligible patients are offered genetic testing (Public Health England)  <https://cancerstats.ndrs.nhs.uk/> | NDRS is now collecting detailed information about all steps in the testing pathway for patients diagnosed with CRC  NBOCA collects data from colorectal cancer MDTs about some steps in this pathway, specifically the initial testing step |
| 29 | SCM6 | Diagnosis: Molecular biomarkers testing should be made available to all suitable patients and the results used to guide treatment. | RAS and BRAF V600E mutations are predictive of response to anti-epidermal growth factor receptor (EGFR) targeted therapy in people with metastatic colorectal cancer. People with RAS or BRAF V600E mutant metastatic colorectal cancer have poorer progression-free and overall survival than those without such mutations. While RAS testing is already used to select those people with metastatic colorectal cancer most likely to benefit from anti-EGFR targeted therapy, BRAF V600E testing has the potential to further refine this group. | How molecular biomarkers are used in determining patient treatment varies.  Introduction of standard practice would lead to more informed and targeted treatment and would impact on patient survival and quality of life. |  |
| 30 | University Hospitals Birmingham NHS Foundation Trust | Diagnosis: Access to personalised care (e.g. genetics, stratified follow up, treatment plans) |  |  |  |
| 31 | Boston Scientific | Treatment: Preventing people from dying prematurely. | Catch up on colorectal waiting lists following COVID | Patient access to cancer interventions | Elective waiting lists were put on hold during COVID crisis - NHS recovery plan to fund elective cases |
| 32 | Bowel Cancer UK | Treatment: Additional developmental areas of emergent practice: Throughout the COVID-19 pandemic, NG161 has been used for colorectal cancer patients to be offered a treatment break without losing funding, with implementation guidance from NHS England.  There is an ongoing NICE technology appraisal for development of the final document which is due to be published during the COVID-19 pandemic.  Bowel Cancer UK’s patient community has welcome the interim guidance during the pandemic which has allowed some of them, with their clinicians, to decide whether to take a break from treatment. However there has been variation in patients being able to access this guidance. |  |  |  |
| 33 | Chesterfield Royal Hospital NHS Foundation Trust | Treatment: Role of Papillon contact radiotherapy | Contact radiotherapy is being used either as a primary treatment or as a boost with little evidence of long term outcomes and when it should be used. | Although current evidence is enough to support use of the treatment, there needs to be more research on its efficacy and where it fits into the pathway in a more formal way | NICE guidance IPG532 Low energy contact X-ray brachytherapy |
| 34 | Chesterfield Royal Hospital NHS Foundation Trust | Treatment: Follow-up of complete responders in rectal cancer vs surgery | During COVID a number of patients with rectal cancer who were complete responders have elected to be followed-up with serial imaging and colonoscopy rather than proceed to surgery which is not standard care currently | It would be helpful to rationalise the frequency of imaging and colonoscopy to make best uses of resources.  Is this an option that should be considered for selected patients |  |
| 35 | National Bowel Cancer Audit (sponsored by HQIP) | Treatment: Variation in use of adjuvant chemotherapy | Adjuvant chemotherapy (ACT) after potentially curative resection for Stage III colorectal cancer offers a survival benefit.  There is significant between-hospital variation in ACT use for stage III colon cancer, especially for older patients. Advanced age alone seems to be a greater barrier to ACT use in some hospitals. | With adjustment for other factors, ACT use is more likely in patients with higher socioeconomic status, fewer comorbidities, better performance status, lower ASA grade, more advanced disease, after elective resections, after laparoscopic procedures and with no unplanned readmissions.  Boyle JM, Kuryba A, Cowling TE, Aggarwal A, Hill J, van der Meulen J, Walker K, Braun MS. Determinants of Variation in the Use of Adjuvant Chemotherapy for Stage III Colon Cancer in England. Clin Oncol (R Coll Radiol). 2020 May;32(5):e135-e144. doi: 10.1016/j.clon.2019.12.008. | <https://pubmed.ncbi.nlm.nih.gov/31926818/>  NBOCA QI programme has set local institutional target of more than 50% for patients with resected Stage III colon cancer should receive adjuvant chemotherapy |
| 36 | National Bowel Cancer Audit (sponsored by HQIP) | Treatment: Proportion of patients receiving palliative systemic treatment in final 30 days of life | 30-day mortality after systemic chemotherapy is a useful indicator of avoidable harm to patients from systemic anti-cancer treatments | Wallington M, Saxon EB, Bomb M, et al. 30-day mortality after systemic anticancer treatment for breast and lung cancer in England: a population-based, observational study [published correction appears in Lancet Oncol. 2016 Oct;17 (10 ):e420]. Lancet Oncol. 2016;17(9):1203-1216. doi:10.1016/S1470-2045(16)30383-7  <http://www.chemodataset.nhs.uk/reports/>  The excel sheet from the SACT database includes data on colorectal 30 day mortality and a funnel plot. | NBOCA QI target has been set that less than 20% patients should be receiving palliative systemic treatment in final 30 days of life; this level has been chosen to incorporate dual targets of recognising that young and some other patients wish to explore all treatment options, including Phase I trials, sometimes to exhaustion and even at the very end of life. Ideally level should be less than 10%.  NBOCA recognises that patient choice and shared decision-making is fundamental to end-of-life care but also wishes to focus clinicians on delivery of these complex decisions. |
| 37 | SCM1 | Treatment: Neoadjuvant radiotherapy for rectal cancers | Previous guidance from specialist societies has argued against radiotherapy because of its side-effects but its effect on local recurrence and survival has not been highlighted ie previous guidance not based on the published evidence. |  |  |
| 38 | SCM2 | Treatment: For people choosing to defer surgery for rectal cancer, ensure they are enrolled in a trial or national registry  Measure :  (1) Identify people not undergoing surgery for rectal cancer post neoadjuvant treatment  (2) Record reason why  (3) Measure % of patients enrolled in trials and national registries. Aim : 100%. | With better chemo-radiotherapy regimes, a proportion of patients may experience clinical complete response.  Some people with rectal cancer and clinicians are opting to defer surgery. | There is as yet no robust evidence on  (1) how to safely identify which people are suitable for deferring surgery,  (2)whether these people require additional therapy if opting for deferral,  (3) how to safely identify recurrence or indeed  (4) the optimal surveillance frequency (flexible sigmoidoscopy +/- MRI) and duration.  With COVID, access to endoscopy and imaging facility is limited and people’s follow up regime may lapse, further compromising optimal cancer care. | Please see NICE CRC Guidelines NG 151. |
| 39 | SCM3 | Treatment: Proportion of patients with rectal cancer (excluding early rectal cancer) being offered pre-operative treatment (radio/chemotherapy) |  | Are short term outcomes (surgical complications, clear resection margins) and longer term oncological outcomes eg local recurrence affected according to modality used or not used | NG151 |
| 40 | SCM3 | Treatment: Proportion of patients being offered all possible treatments for early rectal cancer |  | All available treatment options considered, and do short term reductions in complications and improved functional outcomes with local treatments mean worse longer term oncological outcomes | NG151 |
| 41 | Sirtex Medical Limited | Treatment: Cancer services recovery plan: all available treatment options for patients with Colorectal cancer should be considered to support cancer care moving back to pre-Covid-19 levels | The coronavirus pandemic has presented major challenges for all healthcare systems. Cancer waiting times have increased  Latest Cancer Waiting Times data also shows that there are still significantly fewer people starting treatment than we would normally expect.  Specific to Colorectal cancer, it has been predicted that Colorectal cancer care might fare particularly badly due to the impact of NHS service provision by Covid19. | There is still work to do to ensure the capacity rebuilds as rapidly as possible to manage patients that have experienced a delay during Covid-19 disruption, and treatment options that support expediting care and support patient preference should be encouraged for review in the revised Quality Standard.  This Quality Standard review should encourage consideration of treatment options/and dialogue with clinical specialists that could mean patients receive access to care as rapidly as possible. For example a treatment option such as SIRT for Metastatic Colorectal Cancer could allow more patients to be treated rapidly to support elective care numbers to return to pre-pandemic levels as quickly as possible and prevent further delays to treatment. | [NHS Cancer Programme Cancer services recovery plan](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/C0821-COVID-19-Cancer-services-recovery-plan-14-December-2020.pdf)  [MacMillan: The impact of Covid-19 on cancer care](https://www.macmillan.org.uk/assets/forgotten-c-impact-of-covid-19-on-cancer-care.pdf)  [The Lancet: Effect of COVI-19 on colorectal cancer care in England](https://www.thelancet.com/journals/langas/article/PIIS2468-1253(21)00017-0/fulltext) |
| 42 | The Association of Coloproctology of Great Britain and Ireland | Treatment: Early Rectal Cancer – Reduction in the variation in management of early disease | There is evidence of significant variation in the management of early rectal cancer across the UK. There is a need to ensure equivalent access to organ preservation by local excision and or chemo / radiotherapy. | Advances in care and evidence from clinical trials have demonstrated the increased ability to reduce the morbidity of management of early rectal cancer by use of modalities to increase organ (rectal) preservation. | Long Term evaluation of Local Excision for early rectal cancer has demonstrated its safety and reduction in morbidity for selective patients with Early Rectal Cancer.  Randomised clinical trials including TREC and CARTS have demonstrated the benefits of use of neoadjuvant treatment in expanding the options for organ preservation in the management of Early Rectal Cancer. |
| 43 | University Hospitals Birmingham NHS Foundation Trust | Treatment: Equal access to treatment options (surgical, oncological) |  |  |  |
| 44 | Chesterfield Royal Hospital NHS Foundation Trust | Surgery: Enhanced recovery pathway | This has been shown to reduce hospital stay and improve outcomes | Identification of higher risk patients would lead to personalised recovery packages | NICE guidance NG180 Perioperative care in adults |
| 45 | Chesterfield Royal Hospital NHS Foundation Trust | Surgery: Prehab for patients undergoing surgery | This is a hot topic that requires resources and therefore funding | Clear guidance on what specific measures would be beneficial pre-op for CRC patients would allow rationalisation of local services  Formalising prehab would allow business case development for appropriate resources to run prehab clinics | Multimodal prehabilitation in colorectal cancer patients to improve functional capacity and reduce postoperative complications: the first international randomized controlled trial for multimodal prehabilitation  Van Rooijen et al; BMC Cancer 2019 Jan 22; 19(1):98 |
| 46 | The Association of Coloproctology of Great Britain and Ireland | Surgery: Preoperative risk assessment and stratification of colorectal patients | There is evidence that quantitative preoperative assessment (including Cardiopulmonary Exercise Testing, CPET) can be used to risk stratify patients for major colorectal surgery. This is important with the increasing comorbidity and age of the population being treated in the UK for Colorectal Cancer | Use of Preoperative Assessment with CPET testing can be used to identify risk and enable preoperative risk modification and stratify level of care for postoperative patients.  There is a significant variation in the availability of CPET testing and its use can reduce the risk of unplanned critical care admission in higher risk patient associated with poorer outcomes. | Bowel cancer surgery outcomes and pre‐operative cardiopulmonary exercise testing: insights from real‐world data  R. G. Davies et al. Anaesthesia 2018; 73: 1445-6  Cardiopulmonary exercise testing (CPET) in the United Kingdom—a national survey of the structure, conduct, interpretation and funding. T. Reeves et al. Perioperative Medicine 2018; 7: 2 |
| 47 | British Association of Surgical Oncology | Surgery: Robotic surgery for colorectal cancer | There is growing evidence that robotic colorectal cancer surgery has advantages in the treatment of rectal cancer, locally advanced cancers, CME surgery for colon cancer. There is a rapid expansion in the uptake of robotic surgery across the UK | Robotics is an expensive technology and requires significant commitment to training and learning. The quality standards in colorectal cancer surgery have to be maintained to deliver a cost effective yet successful robotic program. Level 1 data for this technology is limited and hence the need for a continuous audit of the results and more importantly training standards and accreditation of surgeons is very important | We saw a rapid expansion of this technology in the USA with some poor outcomes and a repeat of that in the UK can be avoided by setting the framework of standards, quality control, educations, training and accreditation. ACPGBI robotic committee (chaired by myself) is actively engaged in this process and want to work alongside GMC |
| 48 | Medtronic Ltd | Surgery: Minimally invasive surgery for the treatment of colorectal cancer. | Minimally invasive surgery is associated with improved patient outcomes and reduced rates of complications when compared to open surgery. We feel that it is therefore important to explicitly include minimally invasive techniques within the Quality Standard. | The 2019 National Bowel Cancer Audit highlighted the considerable variation in the use of laparoscopic surgery between Trusts/Hospitals/MDTS across England and Wales. <https://www.nboca.org.uk/content/uploads/2020/01/NBOCA-2019-V2.0.pdf> | NICE recommended laparoscopic surgery as an alternative to an open resection procedure for patients with colorectal cancer whom both laparoscopic and open surgery are considered suitable.<https://www.nice.org.uk/guidance/ta105/resources/laparoscopic-surgery-for-colorectal-cancer-pdf-82598014092229> |
| 49 | SCM1 | Surgery: Availability of minimally invasive techniques for early rectal cancers T1-2 N0M0 | Endoscopic techniques (TEM and ESD) may avoid major surgery (TME) and lead to better functional results and quality of life. | Variability in which hospitals are able to offer these techniques-this key area would follow the same argument regarding rectal cancer volumes |  |
| 50 | The Association of Coloproctology of Great Britain and Ireland | Surgery: Robotic Colorectal Surgery | The use of Robotic Surgery to undertake Colorectal Cancer surgery has increased significantly during the last few years. With introduction of a new surgical technique it is important that Quality Standards are defined and applied to ensure safe care for patients. | Robotic Colorectal Surgery is a new and developing area of Colorectal Practice. Quality Improvement will be important to ensure a high level of care is ensured. | Recommend review of Surgical Access Data- National Bowel Cancer Audit Annual Report 2020.  https://www.nboca.org.uk › reports › annual-report-2020  Effect of Robotic-Assisted vs Conventional Laparoscopic Surgery on Risk of Conversion to Open Laparotomy Among Patients Undergoing Resection for Rectal Cancer The ROLARR Randomized Clinical Trial. JAMA. 2017;318(16):1569-1580. |
| 51 | British Association of Surgical Oncology | Surgery: Centralisation of locally advanced colorectal cancers | We are seeing a rapid rise in the number of T3 or T4 cancers requiring more radical surgery such extensive lymph node dissection, CME surgery etc | These services are not available at every trust and rely heavily on the performance of multidisciplinary teams | Stage migration in colorectal cancer has been seen as a result of the COVID effect. More patients are likely to require radial surgery than ever before and this will require a regional effort to tackle with these cases in the best equipped units i.e robotic surgery, ITU, advanced radiology and endoscopy services |
| 52 | National Bowel Cancer Audit (sponsored by HQIP) | Surgery: Proportion of trusts with low volume caseloads (<20/yr) for rectal cancer surgery | 28% of NHS Trusts in England & Wales carry out less than 20 rectal resections per year (NBOCA Annual Report 2020 page 54: https://www.nboca.org.uk/reports/annual-report-2020/)  NBOCA are currently interrogating our data set to look at the following questions.  What are the effects of hospital-level volume and surgeon-level volume on rectal surgery outcomes?  What are the effects of colorectal subspecialisation on rectal surgery outcomes?  What are the effects of training/grade of operating surgeon on rectal surgery outcomes?  Based on the above, are the NICE volume thresholds reasonable and could there be evidence for centralisation of rectal cancer surgery? | Recent NICE review of evidence and recommendations as per <https://www.nice.org.uk/guidance/NG151> :  5 cases per surgeon per year  10 cases per hospital per year  Centralisation of other low volume and highly specialised cancer care has resulted in improved | NBOCA QI programme has set local institutional target of minimum 20 rectal cancer resections per year to ensure high quality MDT decision-making around neoadjuvant treatment, high quality surgery with good outcomes and ensuring all support services and experience available in event of patient needing salvage after complications of rectal cancer surgery.  High volume centres will also be able to recruit suitable rectal cancer patients to organ preservation trials – see below for further detail on this quality metric. |
| 53 | SCM1 | Surgery: Rectal cancer undertaken in high volume centres and by surgeons who do a minimum of 5 rectal resections per year | To improve patient outcomes and quality of surgery. It would also allow access to all the techniques for rectal cancer surgery such as open, laparoscopic and robotic | The NBOCA shows variability in rectal cancer volumes per unit and surgeon. Outcomes are dependent on the quality of surgery. | NICE 151 (1.3.11 and 1.3.12)  NBOCA |
| 54 | SCM1 | Surgery: Refer people with locally advanced primary or recurrent rectal cancer that might potentially need multi-visceral or beyond-TME surgery to a specialist centre to discuss exenterative surgery. | Reduce the variation in people who are offered this type of surgery. Limit this type of surgery to specialist centres with the necessary expertise. | This is complex and major surgery which often involves multiple specialities and expertise | NICE 151 (1.3.10) |
| 55 | SCM2 | Surgery: Maintain high numbers of rectal cancer operations performed by individual surgeons and hospitals.  Measure : Individual surgeon and Hospital should perform a minimum number of rectal cancer operations. | There was evidence that when the threshold is set between 10 and 20 rectal cancer surgery patients per year, higher volume hospitals have better outcomes than lower volume hospitals in terms of overall survival, local recurrence, permanent stoma rates and perioperative mortality.  Similarly, there was evidence of benefit with a surgeon case volume threshold of between 5 and 10 cases per year in terms of resection margins, local recurrence and permanent stoma rates. | Surgery remains the best chance of cure for rectal cancer. Rectal cancer surgery is a technically difficult procedure and should be concentrated in centres who have the infrastructure and volumes to deal with people with this condition. | Please see CRC NICE Guidelines NG 151. |
| 56 | SCM3 | Surgery: Proportion of patients with locally recurrent or locally advanced primary rectal cancer having imaging review and referral on to specialist centre for consideration of exenterative surgery |  | Service evaluation important | NG151 |
| 57 | The Association of Coloproctology of Great Britain and Ireland | Surgery: Extended Resections and Pelvic Exenteration for Locally Advanced and Recurrent Rectal Cancer | The indications for exenterative surgery and the extent of resection for patients with locally advanced and recurrent rectal cancer have expanded. There is variation in the management of patients across the UK with these conditions and a need to ensure equivalent access to specialist surgery for patients throughout the UK | There is a need to improve delivery of this specialist colorectal service, current referral pathways and the structure of specialist MDT decision making. | Recommend review of a series of publications in the literature by the PelvEX Collaborative. Including:  Changing outcomes following pelvic exenteration for locally advanced and recurrent rectal cancer. PelvEx Collaborative. BJS Open. 2019 6;3(4):516-520.  Factors affecting outcomes following pelvic exenteration for locally recurrent rectal cancer.  PelvEx Collaborative .Br J Surg 2018; 105(6):650-657 |
| 58 | National Bowel Cancer Audit (sponsored by HQIP) | Surgery: 18 month rate of unclosed diverting ileostomy after rectal cancer surgery | 25% of patients with “temporary” loop ileostomies do not have their temporary stoma closed due to surgical complications, cancer progression, need for adjuvant treatment, concerns about bowel function and quality of life after stoma closure, and in a few cases patient choice.  Median time to closure 259 days after primary surgery.  NBOCA Annual Report 2020 page 52: https://www.nboca.org.uk/reports/annual-report-2020/) | There is no cancer pathway target to ensure that patients with diverting ileostomy have their stomas closed in a timely manner.  Patients with diverting ileostomies are at risk of high output stomas and deterioration in renal function that may affect long-term survival. Delayed closure may also affect functional outcomes and impact quality of life in long-term. | <https://onlinelibrary.wiley.com/doi/10.1111/codi.15531>  <https://onlinelibrary.wiley.com/doi/10.1111/codi.13524>  <https://onlinelibrary.wiley.com/doi/abs/10.1111/codi.14866?af=R>  NBOCA QI programme has set preliminary local institutional target of less than 35% of diverting ileostomies after rectal cancer surgery unclosed by 18 months to accommodate COVID-19 pandemic delays but intends to revise this once normal surgical services resumed. |
| 59 | Chesterfield Royal Hospital NHS Foundation Trust | Surgery: Use of colonic stenting | Rationalisation of use of stenting in patients who present with LBO with left sided tumours and potentially curable disease. Mainly confined to palliative cases at present | At the moment this is mainly used for patients with obstruction in left sided tumours  It would be helpful to provide some guidance on stenting of right sided tumours which are sometimes getting a stent | CREST trial |
| 60 | SCM1 | Surgery:: Offer stenting for large bowel obstruction | This offers a bridge to surgery with a lower chance of a stoma. It also allows surgery to be done in an elective setting. | Not all departments have stenting and in units which offer stenting it may not be available out of hours | NG151 (1.3.15, 1.3.16) |
| 61 | SCM2 | Surgery: Offer colonic stents for people with colorectal cancer presenting with acute obstruction. Stents should also be offered for  Measure : % of people with obstruction receiving stents (versus open surgery), record reason why not stented and stent success rate. | Although there is no difference to overall or disease free survival, there is evidence of reduced stoma rates in the stenting group compared to the emergency surgery group.  Stenting also allows time to fully assess the patient and stabilise any comorbidities before proceeding with potentially curative surgery | Stenting is provided by Intervention Radiology and Gastroenterology/Surgery. There is marked workforce shortage in Radiology, including Interventional Radiology. Resources need to be put in place to provide this treatment option for people with acute obstruction.  While there is GI haemorrhage endoscopy service, there is no GI stenting service. | Please see NG 151. |
| 62 | National Bowel Cancer Audit (sponsored by HQIP) | Metastatic disease: Proportion of patients with liver metastases discussed at specialist HPB MDT | Accurate staging allows patients with isolated colorectal liver metastases to be classified as having i) resectable disease, ii) potentially resectable disease after neoadjuvant “conversion” treatment, or iii) unresectable disease.  Resectability is defined by technical and oncological factors, and depends on the number of liver metastases, their anatomical distribution within the liver parenchyma and proximity to major vessels as well as estimation of the hepatic remnant after resection in terms of likely size and preservation of hepatic function. | Resection of liver metastases is usually only offered when it is the only site of metastatic disease and when the primary tumour, if still in situ, can also potentially be treated with curative intent.  However, there are circumstances where liver resection may be offered in the presence of low volume extrahepatic metastases or in better prognosis tumours.  Vallance AE, vanderMeulen J, Kuryba A, Botterill ID, Hill J, Jayne DG, Walker K. Impact of hepatobiliary service centralization on treatment and outcomes in patients with colorectal cancer and liver metastases. Br J Surg. 2017 Jun;104(7):918-925. doi: 10.1002/bjs.10501. | NBOCA QI programme has set local institutional target that more than 95% of patients with synchronous liver metastases discussed at specialist liver MDT. |
| 63 | SCM1 | Metastatic disease: Ensure people with metastatic disease are discussed in a MDT with involvement of HPB and thoracic specialists ie discussion with a specialist MDT | Variation in patients who are offered lung or liver resection | Curative options may not be offered to patients with metastatic disease who are medically fit. | NG151 (1.5) |
| 64 | SCM3 | Metastatic disease: Proportion of patients having interventional treatment for metastatic colorectal cancer in the lung |  | Recent data suggest intervention may not be of benefit, so may this be risking harm for unnecessary benefit and there will be economic considerations too | NG151 and recent publications, including Treasure et al. BJS 2020;107:e489-490 and Treasure et al. Colorectal Disease 2021 doi.org/10.1111/codi.15651 |
| 65 | Boston Scientific | Metastatic disease: Treating and caring for people in a safe environment and protecting them from avoidable harm.  and  Ensuring that people have a positive experience of care. | Currently SIRT is funded in a limited number of patients by NHS England. The criteria for a centre to use SIRT is so restrictive that centres are finding it difficult to locate eligible patients. The service is being offered by only 10 hospitals and unfortunately owing to the rigid criteria and very limited numbers centres are finding it tough to provide a service and to maintain competency. Hence very few of the centres are offering the service meaning there is not fair and equitable access for UK patients. NHS England need to review both the criteria and patient numbers | Ensuring there is not a post code lottery for Patients to be able to access a SIRT service | https://www.england.nhs.uk/wp-content/uploads/2018/12/Selective-internal-radiation-therapy-for-chemotherapy-refractory-intolerant-metastatic-colorectal-cancer.pdf |
| 66 | Sirtex Medical Limited | Metastatic disease: Equity of access to care: variance still exists in access to treatment options across the country for patients with Colorectal cancer | Equity of access to health care has been a central aim to the NHS since it began. It remains one of its fundamental objectives and an ongoing challenge particularly in the field of colorectal cancer. Early diagnosis, rapid diagnosis and equity of access to treatment and care are central to the National Cancer Programme to be achieved by 2021.  The NHS Long Term Plan also includes the aspirations of reducing variation and inequalities.  The update of the quality standard for colorectal cancer therefore provides a welcome opportunity to highlight current issues of equity of access and to identify routes for improvement. | Not all treatments are easily accessible to patients. Selective internal radiation therapy (SIRT) is a potential treatment for patients with metastatic colorectal cancer (mCRC). It has been reviewed by NHS England (NHSE) and has been approved for use in a restricted patient cohort, and in only 10 named centres. An additional provider selection process was communicated to happen during 2020-21 but no further communication has occurred to date. This is in contrast to SIRT availability for HCC where there are no such centre restrictions in place.  With SIRT for mCRC still only available at a limited number specialist centres people with colorectal cancer suitable for this type of therapy may therefore have to travel outside of their immediate geographical area to access this targeted treatment option. Some people may therefore have difficulty in accessing SIRT due to the distance and the cost associated with transport, for example those with a disability, older people and other socio-economic factors. This access issue may influence patients decisions not to proceed with a potentially curative therapy option.  The NHSE Clinical Commissioning Policy: Selective internal radiation therapy (SIRT) for chemotherapy refractory / intolerant Metastatic Colorectal Cancer (adults) has also been deemed by specialist physicians to be overly restrictive/unrealistic in its prescribing criteria and does not support optimised clinical decision making.    With regards to both topics of the approved specialist centres and the current commissioned prescribing criteria, it would be welcomed as part of the revised Quality Standard to include principles by which specialist clinicians can expect to engage in purposeful dialogue with commissioners to review, refine and improve access to care based on removal of inequity, and up to date multi-source evidence.  The NHS Long Term Plan for cancer highlights explicitly several objectives that would directly support improving patient experience, encouraging access to innovative treatment options and improving outcomes for mCRC patients:  3.61 We will speed up the path from innovation to business-as-usual, spreading proven new techniques and technologies and reducing variation.  3.62 Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates.  3.64 By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.  The revised Quality Standard should support treatment options such as SIRT for mCRC patients to be considered more widely with input from all stakeholders with the collective aspiration for this treatment to be more accessible for all NHS patients. | References:  [Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020](https://www.england.nhs.uk/wp-content/uploads/2017/10/national-cancer-transformation-programme-2016-17-progress.pdf)  [Selective internal radiation therapies for treating hepatocellular carcinoma: Technology appraisal guidance [TA688]](https://www.nice.org.uk/guidance/ta688)  NHS Specialised Commissioning letter dated 8th April 2019:  Clinical Commissioning Policy for Selective internal radiation therapy (SIRT) for chemotherapy refractory/intolerant metastatic colorectal cancer (Adults) Appendix 1 re. current Colorectal Commissioned providers:   |  |  | | --- | --- | | Appendix 1 – Interim SIRT Providers NHS England Region | Provider | | North West and Yorkshire | The Christie NHS Foundation Trust | | Leeds Teaching Hospitals NHS Trust | | | North East | Newcastle-upon-Tyne Hospitals NHS Trust | | Midlands | Birmingham NHS Foundation Trust | | Nottingham University Hospitals NHS Trust | | | East | Cambridge University Hospitals NHS Foundation Trust | | London | The Royal Free London NHS Foundation Trust | | Kings College Hospital NHS Foundation Trust | | | South East | Southampton NHS Foundation Trust | | South West | Oxford University Hospitals NHS Foundation Trust |   [NHSE Clinical Commissioning Policy: Selective internal radiation therapy (SIRT) for chemotherapy refractory / intolerant metastatic colorectal cancer (adults)](https://www.england.nhs.uk/wp-content/uploads/2018/12/Selective-internal-radiation-therapy-for-chemotherapy-refractory-intolerant-metastatic-colorectal-cancer.pdf)  [NHS Long Term Cancer Plan](https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/cancer/) |
| 67 | MSD UK Limited | Ongoing care and support: Cancer survivorship | Cancer survivorship has been recognised by NHS10 and NICE11 as an important element of the services and guidance documents both organisations provide. | Colorectal cancer survival in the UK has shown consistent improvement over the last 50 years12. This improvement has led to more people surviving their cancer – a trend which is expected to continue as screening programmes are further optimised and improved treatments are made available across all stages of colorectal cancer.  With more people expected to survive colorectal cancer, at all stages of diagnosis, it is important that survivorship support is integrated into all colorectal cancer pathways, recognising the common and distinct needs of all colorectal cancer patients. | NHS. [Living with and beyond cancer: Taking action to improve outcomes](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/181054/9333-TSO-2900664-NCSI_Report_FINAL.pdf). Accessed online May 2021.  NICE. [CSG4](https://www.nice.org.uk/guidance/csg4). Accessed online May 2021.  CRUK. [Bowel cancer survival statistics](https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer/survival#heading-Two). Accessed online May 2021. |
| 68 | SCM4 | Ongoing care and support: Bowel function and dietary needs post-operatively | Is it worth looking at the patient information needs from a dietary perspective. Patients are often telling my teams postoperatively that they are uncertain of what foods that are out there, but very aware that there is a lot of information already available. | We discussed this in detail when we wrote the NICE guidance and focussed on bowel function related to lower anterior resection syndrome. |  |
| 69 | SCM6 | Ongoing care and support: Patient information pre-treatment on all the options including short and long term risks and benefits of treatment. | Provision of high quality information pre-treatment improves patient/ health care professional conversations and helps patients participate in treatment option decisions, ensuring that they feel heard and that the treatment reflects their wishes. It also helps in managing patient expectations of what the impact will be during and after treatment. | Information provision and mechanisms of delivering information varies. Consequently, patient experience is very different, and improved quality standards would ensure a base level that all patients should expect. |  |
| 70 | SCM6 | Ongoing care and support: Patient information and advice post treatment. | Provision of high quality information post treatment can help patients understand and self-manage any on-going conditions and life style changes that they will require. | Information provision and mechanisms of delivering information varies. Consequently, patient experience is very different, and improved quality standards would ensure a base level that all patients should expect.  Helping patients to self-manage on-going conditions would reduce patient appointments and pressure on health services, and improve patient control and quality of life. |  |
| 71 | SCM6 | Ongoing care and support: Ensure that there are appropriate and consistent foilow up regimes offered to all patients post treatment. | Follow up regimes, as well as monitoring patients and capturing any recurrences of cancer can impact on patient well being; their mental health and their ability to return to as normal lifestyle as possible. | Currently follow up regimes vary from centre to centre, both in frequency, and length of follow up, and also in what tests etc are offered. |  |
| 72 | MSD UK Limited | Additional areas: Improvement in the uptake of the National Bowel Cancer Screening programme. | There is good evidence that bowel cancer screening reduces death from colorectal cancer.1 | Around half (53-58%) of people in England & Wales who are invited for bowel cancer screening are screened adequately within 6 months of invitation3.  Whilst achieving the minimum standard set by the Department of Health & Social Care (52%)2 this percentage represents the minimum uptake level required to demonstrate a reduction in colorectal cancer mortality and is far below the screening uptake levels observed for the other two national cancer screening programmes, breast (72%) and cervical (73%).3  Whilst the rollout of the FIT test will likely make a positive contribution toward bowel screening uptake, barriers to participation are likely to remain. | Scholefield JH, Moss SM, Mangham CM, et al [Nottingham trial of faecal occult blood testing for colorectal cancer](https://pubmed.ncbi.nlm.nih.gov/22052062/): a 20-year follow-up Gut 2012;61:1036-1040. Accessed online May 2021.  Public Health England. [Bowel cancer screening programme standards](https://www.gov.uk/government/publications/bowel-cancer-screening-programme-standards/bowel-cancer-screening-programme-standards-valid-for-data-collected-from-1-april-2018#bcsp-s02-uptake). Accessed online May 2021:  CRUK. [Cancer screening and diagnosis statistics](https://www.cancerresearchuk.org/health-professional/cancer-screening-and-diagnosis-statistics#heading-Fourteen). Accessed online May 2021: |
| 73 | University Hospitals Birmingham NHS Foundation Trust | Additional areas: Targeted screening, starting at a younger age |  |  |  |
| 74 | National Bowel Cancer Audit (sponsored by HQIP) | Additional areas: Further area for development:  Embed recruitment to NIHR portfolio trials on CRC in QI initiatives | This item is especially important for patients with rectal cancer who wish to explore treatment algorithms aimed at organ preservation | See STAR-TREC, OnCoRe and OPERA protocols  If NICE decides that this is an important quality standard, NBOCA will investigate feasibility of incorporation of reporting on participation in organ preservation trials in Annual Report | <https://www.birmingham.ac.uk/research/bctu/trials/coloproctology/startrec/index.aspx>  [OnCoRe: The Rectal Cancer Oncological Complete Response Database – Resource Website (complete-response.com)](https://complete-response.com/)  [Organ Preservation for Early Rectal Adenocarcinoma: The OPERA European Trial to Bring Robust Evidence (clinicsinsurgery.com)](https://www.clinicsinsurgery.com/full-text/cis-v2-id1465.php#:~:text=OPERA%20trial%20to%20bring%20the%20evidence%20The%20improved,a%20mean%20dose%20of%2092%20Gy%20is%20necessary.) |
| 75 | University Hospitals Birmingham NHS Foundation Trust | Additional areas: Support for research |  |  |  |
| 76 | Sirtex Medical Limited | Additional areas: Outcomes: UK outcomes for patients with Colorectal cancer are still below European averages | The overall five-year relative survival of colorectal cancer patients in England is 50.7% and there still remains substantial variation by the stage of disease at diagnosis.  Improving the effectiveness and decision making of multi-disciplinary teams (MDT) is a key objective for colorectal cancer as highlighted in the NHS cancer programme update.  We believe that the review and consideration of outcomes should be extended to include real world evidence (RWE), and that this evidence should be seen as providing valuable information on the outcomes and experiences of patients in practice, and that the focus should move away from purely RCT evidence. | Colorectal cancer is the 3rd most prevalent cancer in UK and the second highest cause if cancer death in UK.  Nearly a third of bowel cancer patients experience a delay to their diagnosis that could have been avoided, as cited by Bowel Cancer UK.  Five-year relative survival for colon cancer in men in England (51%) is below the average for Europe (56%). Wales (50%) and Scotland (54%) are also below the European average.  Five-year relative survival for colon cancer in women in England (52%) is below the average for Europe (56%). Wales (50%) and Scotland (54%) are also below the European average.  Considering RWE as well as multiple data sources to complement RCT data should be recommended as part of this Quality Standard review.  The recently communicated new NICE 5 year strategy is a timely update that should be a platform to support improvement and innovation in providing wider access to treatment options for patients with Colorectal cancer. | [Colorectal Cancer Survival by Stage - NCIN Data Briefing](http://www.ncin.org.uk/publications/data_briefings/colorectal_cancer_survival_by_stage)  [NHS Cancer Programme – quarterly report Oct-Dec 2020](https://www.england.nhs.uk/wp-content/uploads/2019/12/nhs-cancer-programme-update-report-october-to-december-2020.pdf)  [MacMillan Cancer Support: Statistics Fact Sheet](https://www.macmillan.org.uk/_images/cancer-statistics-factsheet_tcm9-260514.pdf)  [Cancer Research UK: Cancer mortality for common cancers](https://www.cancerresearchuk.org/health-professional/cancer-statistics/mortality/common-cancers-compared#heading-Zero)  [Bowel Cancer UK](https://www.bowelcanceruk.org.uk/news-and-blogs/news/a-third-of-bowel-cancer-patients-experience-avoidable-delay-to-diagnosis/)  [Cancer Research UK: Bowel cancer survival statistics](https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer/survival#heading-Five)  [NICE 5 year strategy](https://www.nice.org.uk/about/who-we-are/corporate-publications/the-nice-strategy-2021-to-2026?gclid=Cj0KCQjws-OEBhCkARIsAPhOkIYKD475lZfy3j5B8BaIq7Z0Z3xce7ECSxXe-o3hQWIM5lcoxwebbE0aArtPEALw_wcB&utm_campaign=*BM%20%7C%20Google%20%7C%20POST%20%7C%20PRO%20%7C%20SEARCH%20%7C%20ALL&utm_keyword=nice%205%20year%20strategy&utm_medium=cpc&utm_source=google) |
| 77 | The Association of Coloproctology of Great Britain and Ireland | Additional areas: Additional developmental areas of emergent practice  Quality of life following surgery and adjuvant treatment (chemo and radiotherapy) for Colorectal Cancer | There has been a focus on the Oncological Outcomes of treatment of Colorectal Cancer. Development of Patient Centred Care has increasingly identified the impact of treatment on Quality of Life. | Assessment of the impact of different modalities treatment for Colorectal Cancer on Quality of Life should enable better knowledge of this aspect of care and enable improvement in Quality of Care with a balance of choice of treatment modality based on Oncological and Quality of Life aspects. | Colorectal Cancer PROMs Report - NHS England 2015 (https://www.england.nhs.uk › uploads › 2015/03)  Patient Perceptions and Quality of Life After Colon and Rectal Surgery: What Do Patients Really Want?  Dis Colon Rectum 2018;61(8):971-978 |
| 78 | Association of Stoma Care Nurses UK | General: In NG151 in table 1 treatment implications - in my personal experience the chances of having a stoma formation with a TME is high rather than simply possible. |  |  |  |
| 79 | Royal College of Nursing | General: We are supportive of this approach please and have no additional suggestions |  |  |  |
| 80 | Royal college of Pathologists | General: The College commented on the NICE colorectal cancer management standard in 2019/2020, and I and my colleagues at the College are consistently enthusiastic in our support for all NICE standards.    I would imagine that NICE and its officers are similarly enthusiastic about the vital role of pathology in diagnosing and managing all disease, but particularly its role in optimising cancer management.    Colorectal cancer is a prime example of a tumour that demonstrably requires an increasing degree of input, and indeed increasingly specialised input, from histopathologists.    Specifically, colorectal cancer pathology of high quality is now absolutely necessary for definitive diagnosis, phenotypic classification, exclusion of other neoplasms, complex tumour staging, assessing response to neoadjuvant therapy, obtaining diverse further prognostic information, guiding and supporting burgeoning molecular testing, and managing subsequent or concurrent metastatic disease. The bowel cancer screening and inflammatory bowel disease cancer screening programmes are also heavily dependent on pathology services.    Therefore, I suggest that this NICE committee also includes a pathologist (currently absent from the attached list). This will not only enhance the accuracy and relevance of pathology guidance and pathology-related statements within the standard, but will also help stimulate the further development of relevant pathology services in the UK, in turn reducing the risk that suboptimal patient management is the result of low quality pathology input. |  |  |  |

1. Rutter MD, East J, Rees CJ et al. GUT 2020;69:201-223 [↑](#footnote-ref-1)