NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Suspected cancer

NICE quality standard

Draft for consultation

30 June 2016 (first published)

18 August 2023 (update consultation)

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| **This quality standard covers** the recognition of and investigation for suspected cancer, and referral to specialist cancer services for adults, young people and children. It describes high-quality care in priority areas for improvement. It does not cover care from the point of diagnosis onwards. This quality standard will update and replace the existing quality standard on [suspected cancer](https://www.nice.org.uk/guidance/qs124) (published June 2016). The topic was identified for update following the annual review of quality standards. The review identified changes in the priority areas for improvement. For more information see [update information](http://www.nice.org.uk/guidance/qsXXX/chapter/Update-information).This is the draft quality standard for consultation (from 18 August 2023 to 18 September 2023). The final quality standard is expected to publish in January 2024.  |

# Quality statements

[Statement 1](#_Quality_statement_1:) People with suspected cancer are given personalised information and support at all stages of the diagnostic pathway, including communication on test results and safety netting. **[2016, updated 2023]**

[Statement 2](#_Quality_statement_2:) People needing urgent referral for suspected cancer with non-site-specific symptoms are placed on a non-specific symptoms pathway. **[new 2023]**

[Statement 3](#_Quality_statement_3:) GP practices are able to order diagnostic imaging tests directly for adults with concerning symptoms who do not meet the criteria for an urgent referral. **[2016, updated 2023]**

[Statement 4](#_Quality_statement_4:) People with suspected cancer who meet the criteria for urgent referral are referred urgently via a straight-to-test Faster Diagnosis Standard pathway and have a diagnosis of cancer confirmed or excluded within 28 days of referral. **[new 2023]**

[Statement 5](#_Update_information_2): Adults presenting in primary care with symptoms that suggest colorectal cancer (excluding anal or rectal masses, or anal ulceration) have a quantitative faecal immunochemical test (FIT) to guide referral. **[2016, updated 2023]**

[Statement 6](#_Quality_statement_6:) Women aged 50 years or over reporting 1 or more symptoms occurring persistently or frequently that suggest ovarian cancer are offered a CA125 test. **[2012]**

[Statement 7](#_Quality_statement_7:) Women with raised CA125 have an ultrasound of their abdomen and pelvis within 2 weeks of receiving the CA125 test results. **[2012]**

Statements from NICE’s quality standard on [ovarian cancer](https://www.nice.org.uk/guidance/qs18/) are cross-referenced because the quality standards advisory committee prioritised site-specific quality improvement areas covered by existing quality statements for ovarian cancer.

Statements 6 and 7 are from our quality standard on ovarian cancer, which uses the term 'women'. The statements also apply to trans men and non-binary people with some or all of the following female reproductive organs: ovaries, fallopian tubes and/or a uterus.

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| Questions for consultation Questions about the quality standard**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?**Question 2** Can data for the proposed quality measures be collected locally? Please include in your answer any data sources that can be used or reasons why data cannot be collected.**Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.Questions about the individual quality statements Question 4 For draft quality statement 1: How is provision of safety netting advice being monitored in practice?Implementing NICE guidelines**Question 5** What are the challenges to implementing the NICE guidance underpinning this quality standard? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives). |

# Quality statement 1: Information and support

## Quality statement

People with suspected cancer are given personalised information and support at all stages of the diagnostic pathway, including communication on test results and safety netting. **[2016, updated 2023]**

## Rationale

Providing information to people with suspected cancer helps to support their understanding of the diagnostic process (up to the point of diagnosis), including what to expect. Personalising the information considers each person’s needs and preferences so that the content and method of delivery is meaningful to them. Personalised information and support also help people to formulate questions from the point of referral and supports shared decision making. Providing written information to people who have been offered safety netting allows them to be aware of which symptoms to look out for and when they should return for re-evaluation.

## Quality measures

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

### Outcome

a) The proportion of people who reported that when they were referred for diagnostic tests for suspected cancer, staff at their GP practice explained the reason for the referral in a way they could completely understand.

Numerator – the number in the denominator who reported that when they were referred for diagnostic tests on a 2-week-wait referral or Faster Diagnosis Standard pathway, staff at their GP practice explained the reason for the referral in a way they could completely understand.

Denominator – the number of people referred for diagnostic tests on a 2-week-wait referral or Faster Diagnosis Standard pathway for suspected cancer.

**Data source:**[The Cancer Patient Experience Survey](https://www.ncpes.co.uk/) (young people and adults aged 16 and over) contains the following question: When you were referred for diagnostic tests, did staff at your GP practice explain why you were being referred in a way that you could understand? For the under 16s: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey.

b) The proportion of people who reported that they received all the information they needed before they attended 1 or more tests to confirm or rule out a diagnosis of cancer.

Numerator – the number in the denominator who reported that they received all the information they needed before attending 1 or more tests to confirm or rule out a diagnosis of cancer.

Denominator – the number of people who attended 1 or more tests for suspected cancer.

**Data source:**[The Cancer Patient Experience Survey](https://www.ncpes.co.uk/) (young people and adults aged 16 and over) contains the following question: Before you went for your test(s), were you given all the information you needed about the test(s) you were having, including where they would be and how long you would be waiting? For the under 16s: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey.

c) The proportion of people who reported their test results for suspected cancer were explained in a way they could completely understand.

Numerator – the number in the denominator who reported their test results for suspected cancer were explained in a way they could completely understand.

Denominator – the number of people who received one or more test results for suspected cancer.

**Data source:**[The Cancer Patient Experience Survey](https://www.ncpes.co.uk/) (young people and adults aged 16 and over) contains the following question: Were the results of the tests explained in a way you could understand? For the under 16s: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey.

d) The proportion of people with suspected cancer without a confirmed diagnosis of cancer who reported that they were given enough information about what to look out for, and what to do if they had concerns.

Numerator – the number in the denominator who reported that they were given enough information about what to look out for and what to do if they had concerns.

Denominator – the number of people without a confirmed diagnosis of cancer who received one or more test results for suspected cancer.

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

## What the quality statement means for different audiences

**Service providers** (such as GP practices, community diagnostic services and secondary care cancer services) ensure that healthcare professionals have the skills and knowledge to give personalised information in a suitable format during the diagnostic process. Primary care services ensure that systems are in place for people who have been offered safety netting to receive written information about what symptoms to look out for and when they should return for re-evaluation. All services have standard operating procedures in place for reviewing and acting on test results and make sure that these are available to healthcare professionals.

**Healthcare professionals** (such as GPs, staff performing diagnostic tests) ensure they give information about the referral that is in a format and language suitable for the person’s needs and which enables them to ask questions and use after the appointment. To allay anxiety, healthcare professionals working in primary care ensure that people who have been referred are aware that the outcome may be a benign or a cancer diagnosis. They communicate details of any additional support needs arising from personal circumstances to community diagnostic and secondary care services. They give written information to people who have been offered safety netting which supports them to be aware of which symptoms to look out for and when they should return for re-evaluation. All healthcare professionals take responsibility for reviewing and acting on test results, according to requirements set out by the service.

**Commissioners** ensure that services provide personalised information and support, including safety netting, and provide training to support healthcare professionals deliver this effectively. They ensure that standard operating procedures are in place for services to report on test results.

**People with suspected cancer** are given personalised information and support at each stage of the diagnostic process. This can help reduce anxiety, encourage engagement with the diagnostic process and improve their experience of the diagnostic process.

## Source guidance

[Suspected cancer: recognition and referral. NICE guideline NG12](https://www.nice.org.uk/guidance/ng12) (2015), recommendations 1.14.1 to 1.14.9, 1.15.2

## Definitions of terms used in this quality statement

### Personalised information and support at all stages of the diagnostic pathway

People with suspected cancer and their families or carers, or both (taking into account their confidentiality) are provided with information and support at all stages including the following:

* where the person is being referred to
* how long they will have to wait for the appointment
* how to obtain further information about the type of cancer suspected or help before the specialist appointment
* what to expect from the service the person will be attending
* what type of tests may be carried out, and what will happen during diagnostic procedures
* how long it will take to get a diagnosis or test results
* whether they can take someone with them to the appointment
* who to contact if they do not receive confirmation of an appointment
* other sources of support.

Explain to people who are being offered safety netting which symptoms to look out for and when they should return for re-evaluation. It may be appropriate to offer written information.

The information should be delivered in a format that is suitable for the person, in terms of language ability and culture, taking into account the potential for different cultural meanings associated with the possibility of cancer. The information should be available in variety of formats and provided to the person in the format of their preference.

Assessment of need for continuing support may include inviting the person to contact their primary healthcare professional if they have concerns or questions while waiting for their referral appointment.

[[NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12/), recommendations 1.14.1, 1.14.5, 1.14.6 1.14.7, 1.14.9, 1.14.10 and expert opinion]

### Safety netting

The active monitoring in primary care of people who have presented with symptoms. It has 2 separate aspects:

* timely review and action after investigations
* active monitoring of symptoms in people at low risk (but not no risk) of having cancer to see if their risk of cancer changes.

[[NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12/), recommendations 1.15.2, 1.16.5 and terms used in the guideline]

## Equality and diversity considerations

Some adults may need additional support, for example:

* adults with communication difficulties (for example, sensory or cognitive disabilities, or autism)
* adults with acquired cognitive impairments that affect communication (for example, dementia, Parkinson's disease or traumatic brain injury)
* adults who do not speak English.

Examples of additional support include:

* using a method of communication appropriate for the person’s needs (for example, using a British Sign Language interpreter, or augmentative and alternative communication)
* using interpreters from the same cultural background
* using language that takes into account family background and wider context.

# Quality statement 2: Non-site-specific symptoms

## Quality statement

People needing urgent referral for suspected cancer with non-site-specific symptoms are placed on a non-specific symptoms pathway. **[new 2023]**

## Rationale

Some people present with persistent symptoms that do not fit clearly in a site-specific referral pathway because the symptoms are common to several different cancer sites. If results of tests in primary care cannot establish the most likely site of the suspected cancer, people are urgently referred onto a non-specific symptoms pathway to confirm or exclude a diagnosis of cancer.

This enables them to have their symptoms further investigated with a multidisciplinary approach, avoiding the need for further primary care referrals. This further supports achieving [NHS England’s Faster Diagnosis Standard Framework](https://www.england.nhs.uk/publication/cancer-programme-faster-diagnosis-framework/), section 5.2. If cancer is ruled out, people are referred onto other pathways for further investigation of their symptoms There may be local variation in how these pathways are implemented.

## Quality measures

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

### Outcome

a) The proportion of people who have a diagnosis of cancer confirmed or ruled out by 28 days when referred via a non-specific symptoms pathway.

Numerator – the number in the denominator who have a diagnosis of cancer confirmed or ruled out by 28 days.

Denominator – the number of people who are referred via a non-specific symptoms pathway.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. [NHS England’s Cancer Waiting Times](https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/) report the proportion of people who have a diagnosis of cancer confirmed or ruled out by 28 days who were referred via a non-specific symptoms pathway. Details of coding and data collection are available in [NHS Digital’s national Cancer Waiting Times monitoring dataset guidance (v11.1).](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt)

b) Proportion of cancers diagnosed at stage 1 or 2.

Numerator – the number in the denominator diagnosed at stage 1 or 2.

Denominator – the number of cancers diagnosed.

**Data source:** [NHS England's Cancer registration statistics, England](https://digital.nhs.uk/data-and-information/publications/statistical/cancer-registration-statistics) reports annual counts, age-specific and directly age-standardised rates of cancer incidence by ICD-10 codes and stage at diagnosis.

## What the quality statement means for different audiences

**Service providers** (cancer alliances, community diagnostic services, primary-care led non-site specific symptoms services and secondary care services offering specialist symptom-based clinics) ensure that systems are in place for people presenting with non-site-specific symptoms suggestive of cancer to be referred.

**Service providers** (such as GP practices) ensure that secondary care access to tests and scans is in place so that people presenting with non-site specific symptoms that do not fit clearly into a site-specific pathway can be referred onto a non-specific symptoms pathway. They ensure that specified pre-referral tests are available to support a referral onto a non-specific symptoms pathway.

**Commissioners** work with system partners to establish and support provider monitoring of the pathway to support investigation of non-site-specific symptoms. They ensure that providers implement local referral protocols for referring people urgently with non-site-specific symptoms onto a non-specific symptoms pathway. These pathways are to operate in accordance with the Faster Diagnosis Standard from the point of GP referral.

**People with symptoms of suspected cancer** that are not clearly associated with a specific cancer tumour have an initial consultation and investigations before being given an urgent referral for further investigations. This will enable a diagnosis of cancer to be confirmed or excluded as part of a single experience of care.

## Source guidance

[Suspected cancer: recognition and referral. NICE guideline NG12](https://www.nice.org.uk/guidance/ng12) (2015), recommendations 1.13.2 to 1.13.4

## Definitions of terms used in this quality statement

### Non-site-specific symptoms

Some symptoms or symptom combinations may be features of several different cancers. For some of these symptoms, the risk for each individual cancer may be low but the total risk of cancer of any type may be higher.

The NHS Cancer Programme Faster Diagnosis Framework provides a core referral criteria for non-specific symptoms pathways and these are:

* new unexplained and unintentional weight loss (either documented >5% in 3 months or with strong clinical suspicion)
* new unexplained constitutional symptoms of 4 weeks or more (less if very significant concern). Symptoms include loss of appetite, fatigue, nausea, malaise, bloating
* new unexplained vague abdominal pain of 4 weeks or more (less if very significant concern)
* new unexplained, unexpected or progressive pain, including bone pain, of 4 weeks or more
* GP ‘gut feeling’ of cancer diagnosis – reasons to be clearly described at referral
* abnormal radiology suggesting cancer; not needing admission and not suitable for existing urgent cancer referral or cancer of unknown primary pathway.
* NHS Cancer Programme: Faster Diagnosis Framework.

[[Suspected cancer: recognition and referral. NICE guideline NG12](https://www.nice.org.uk/guidance/ng12) (2015), section 1.13, [NHS England’s Faster Diagnosis Standard Framework](https://www.england.nhs.uk/publication/cancer-programme-faster-diagnosis-framework/), Annex 1]

## Equality and diversity considerations

Providers should ensure that there is access to services for non-specific symptoms pathways among underserved groups with known inequalities.

[NHS England’s Faster Diagnosis Standard Framework](https://www.england.nhs.uk/publication/cancer-programme-faster-diagnosis-framework/) highlights that cancer alliances should consider local priorities and actions that might be of particular benefit to their services or communities and as a means of developing targeted actions to address local health inequalities.

# Quality statement 3: GP non-urgent direct access to diagnostic tests

## Quality statement

GP practices are able to order diagnostic imaging tests directly for adults with concerning symptoms who do not meet the criteria for an urgent referral **[2016, updated 2023]**

## Rationale

The expansion of direct access to diagnostic imaging tests across all GP practices helps cut waiting times and speed up cancer diagnosis. GP teams can directly order diagnostic imaging tests for people who do not currently meet the criteria for an urgent referral to a specialist, as defined in [NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12). This [national scheme](https://www.england.nhs.uk/2022/11/nhs-gives-gp-teams-direct-access-to-tests-to-speed-up-cancer-diagnosis/) allows for national targets to be met by cutting down waiting times to 4 weeks or less and is to operate alongside direct access arrangements recommended in [NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12).

## Quality measures

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

### Structure

Evidence that GP practices have access to and are actively using direct access to diagnostic imaging tests for adults with concerning symptoms who do not meet the criteria for an urgent referral for suspected cancer.

**Data source:** Data can be collected from information recorded locally by provider organisations, for example, service specifications to support [NHS England’s 2023/24 operational planning guidance](https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/).

### Outcome

a) Time between requesting the diagnostic imaging test and the test being carried out.

**Data source:** Data can be collected from information recorded locally by health professionals, for example, from patient records. [NHS England's Diagnostic imaging dataset](https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostic-imaging-dataset/) includes details of the date the test was requested and the date it was performed for GP direct referrals for diagnostic imaging tests.

b) Time to the imaging report being received following the diagnostic imaging test.

**Data source** Data can be collected from information recorded by health professionals, for example, from patient records. [NHS England's Diagnostic imaging dataset](https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostic-imaging-dataset/) includes metrics of the test and the date the report was issued for GP direct referrals for tests that can contribute to the early diagnosis of cancer.
It is not possible to distinguish within the data between the different uses of these tests or tests which were ordered under the national scheme.

## What the quality statement means for different audiences

**Service providers** (primary care, secondary care and community imaging services) ensure that direct access referral pathways are in place for GPs to refer adults with concerning symptoms. Providers ensure that the clinical significance of any findings on imaging reports are made clear. Interpretive reporting, considering the primary care background of the requester, is needed to support clinical decision making. GP practices have safety netting procedures in place to ensure that all GP direct access imaging test results are noted and acted on, including for urgent referral for abnormal results suggestive of cancer and prompt communication with patients. There are local escalation pathways so that adults with abnormal findings receive further investigations without the need for further referral from primary care. Findings and next steps are communicated to primary care.

**Healthcare professionals** (GPs, secondary care clinicians). GPs ensure that adults with concerning symptoms are sent for a diagnostic imaging test, directly from the GP practice. Secondary care clinicians carry out further investigations as needed and inform the primary care healthcare professional who made the referral of the results and next steps.

**Commissioners** ensure that GP services have direct access to refer adults with concerning symptoms. They commission services which have pathways and operating procedures in place to support escalation within secondary care if further investigations are needed and have communication channels to inform primary care about the results and next steps. They ensure that this service is provided in addition to direct access arrangements recommended in [NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12).

**Adults with symptoms that may suggest cancer** may sometimes be sent directly for a diagnostic imaging test to help find out the cause of their symptoms.

## Source guidance

[Suspected cancer: recognition and referral. NICE guideline NG12](https://www.nice.org.uk/guidance/ng12) (2015), 1.16.4 and relevant ‘recommendations organised by symptom and findings of primary care investigations’.

[NHS gives GP teams direct access to tests to speed up cancer diagnosis](https://www.england.nhs.uk/2022/11/nhs-gives-gp-teams-direct-access-to-tests-to-speed-up-cancer-diagnosis/) [online, accessed 2 August]

## Definitions of terms used in this quality statement

### Diagnostic imaging tests

As described in [NHS gives GP teams direct access to tests to speed up cancer diagnosis](https://www.england.nhs.uk/2022/11/nhs-gives-gp-teams-direct-access-to-tests-to-speed-up-cancer-diagnosis/) [online, accessed 2 August 2023]

### Concerning symptoms

See the relevant recommendations in [NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/NG12).

### Direct access

This refers to GP direct access to scans. Primary care also retain clinical responsibility throughout, including acting on the result. There are local escalation pathways so that adults with abnormal findings receive further investigations without the need for further referral from primary care. Findings and next steps are communicated to primary care. [Adapted from [NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/NG12), terms used in this guideline and expert opinion]

### Urgent referral

An appointment with a specialist to take place within 2 weeks of the referral in accordance with criteria in [NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/NG12) [[NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/NG12), terms used in this guideline for urgent referrals, and expert opinion]

# Quality statement 4: Straight-to-test pathways

## Quality statement

People with suspected cancer who meet the criteria for urgent referral are referred urgently via a straight-to-test Faster Diagnosis Standard pathway and have a diagnosis of cancer confirmed or excluded within 28 days of referral. **[new 2023]**

## Rationale

Timely diagnostic investigations are important for a quick and accurate diagnosis of cancer. People may be referred for a diagnostic investigation without having an outpatient appointment first, following specialist triage, as part of a ‘straight-to-test’ pathway. If people are medically unfit to have the diagnostic scan or procedure directly they may have an assessment at an outpatient clinic instead. Healthcare professionals usually work as part of a team in a community diagnostic service or local multidisciplinary team, and provide a confirmation or exclusion of a diagnosis of cancer within 28 days.

## Quality measures

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

### Outcome

The proportion of people who have a diagnosis of cancer confirmed or ruled out by 28 days when referred via a straight-to-test pathway.

Numerator – the number in the denominator who have a diagnosis of cancer confirmed or ruled out by 28 days.

Denominator – the number of people who are referred via a straight-to-test pathway.

**Data source**: [NHS England’s Cancer Waiting Times](https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/) report the proportion of people who have a diagnosis of cancer confirmed or ruled out by 28 days who were referred via a straight-to-test pathway. Details of coding and data collection are available in [NHS England’s National Cancer Waiting Times monitoring dataset guidance (v11.1).](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt)

## What the quality statement means for different audiences

**Service providers** (secondary care and community diagnostic services) ensure that straight-to-test pathways using the Faster Diagnostic Standard are in place for people with suspected cancer

**Commissioners** ensure that straight-to-test referral pathways using the Faster Diagnostic Standard are in place for people with suspected cancer.

**People with symptoms that may suggest cancer** may be referred onto pathways where they receive coordinated testing to establish whether or not the symptoms are caused by cancer. This should enable them to have a diagnosis of cancer confirmed or excluded within a maximum of 28 days following an initial referral from primary care**.**

## Source guidance

[Suspected cancer: recognition and referral. NICE guideline NG12](https://www.nice.org.uk/guidance/ng12) (2015) recommendations 1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.1.5, 1.1.6, 1.2.1, 1.2.4, 1.2.5, 1.2.7, 1.10.7, 1.2.10, 1.2.11, 1.3.1, 1.4.1, 1.5.1, 1.5.10, 1.6.1, 1.6.4, 1.6.6, 1.7.1, 1.7.2, 1.9.1, 1.10.9, 1.11.2, 1.11.3, 1.11.4, 1.11.6, 1.12.1, 1.12.2, 1.12.3

## Definitions of terms used in this quality statement

### Straight-to-test pathways

Pathways which, regardless of tumour type, are implemented to streamline the start of cancer pathways. Their purpose is to promote working across primary and secondary care, maximise use of diagnostics and support implementation of timed clinical pathways. The pathways support the Faster Diagnosis Standard (diagnosis or exclusion of cancer within a maximum of 28 days after referral), specifying clinical events and tests and their sequencing for people with symptoms of suspected cancer.

[[NHS England's Faster Diagnosis Standard Framework](https://www.england.nhs.uk/publication/cancer-programme-faster-diagnosis-framework/)]

# Quality statement 5: Testing for suspected colorectal cancer in primary care

## Quality statement

Adults presenting in primary care with symptoms that suggest colorectal cancer (excluding anal or rectal masses, or anal ulceration) have a quantitative faecal immunochemical test (FIT) to guide referral. **[2016, updated 2023]**

**Please note:** This statement is based on [NICE’s draft diagnostics guidance on quantitative faecal immunochemical testing to guide colorectal cancer pathway referral in primary care](https://www.nice.org.uk/guidance/indevelopment/GID-DG10036) currently in development (expected to publish 24 August 2023). This statement may need to be revised in order to align with the final version of the guidance.

## Rationale

Many colorectal cancers leak blood into the bowel intermittently. Adults presenting with symptoms of colorectal cancer (excluding anal or rectal masses, or anal ulceration) should be offered a FIT to ensure they receive the most appropriate referral. Those with a FIT result of 10 or more micrograms of haemoglobin per gram of faeces are referred using a suspected cancer pathway (for an appointment within 2 weeks), resulting in earlier treatment if diagnosed with cancer. Adults with a FIT result of less than 10 micrograms of haemoglobin per gram of faeces can have their symptoms managed through a range of safety netting approaches, which may include repeating the FIT test. But they should not be excluded or delayed from referral based on the FIT score alone. Adults who do not return a sample but have ongoing symptoms suggestive of colorectal cancer can have advice and guidance taken or be referred but should be advised this might delay their diagnostic pathway.

## Quality measures

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

### Process

Proportion of referrals to a suspected cancer pathway for colorectal cancer (excluding anal or rectal masses, or anal ulceration) for which a FIT had been carried out.

Numerator – the number in the denominator with a recorded FIT.

Denominator – the number of referrals to a suspected cancer pathway for colorectal cancer (excluding anal or rectal masses, or anal ulceration).

**Data source:** The [Investment and Impact Fund for 2023/24 contains the indicator CAN-02](https://www.england.nhs.uk/publication/network-contract-des-investment-and-impact-fund-iif-guidance-for-2023-24/): Percentage of lower gastrointestinal 2-week wait (fast track) cancer referrals accompanied by a FIT result, with the result recorded in the 21 days leading up to the referral.

### Outcome

a) Time from referral from primary care to a diagnosis of colorectal cancer being confirmed or ruled out for referrals for colorectal cancer.

**Data source:**[NHS England’s Cancer Waiting Times](https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/) report the proportion of people who have a diagnosis of cancer or cancer ruled out by 28 days as an urgent referral. [NHS England’s best practice timed pathway for colorectal cancer](https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/) highlights that urgent GP referrals should include the FIT result. Details of coding and data collection are available in [NHS Digital’s national Cancer Waiting Times monitoring dataset guidance (v11.1).](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt) Non-urgent referrals: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Detection rate (%) for urgent referrals for lower gastrointestinal cancers.

**Data source:** Data is reported at a range of geographies as part of [NHS England’s Cancer Data: Cancer Waiting Times urgent suspected cancer referrals: referral, conversion and detection rates: interactive dashboard](https://www.cancerdata.nhs.uk/), for each financial year.

c) Stage of colorectal cancer at diagnosis.

**Data source:**[NHS Digitals Cancer registration statistics, England](https://digital.nhs.uk/data-and-information/publications/statistical/cancer-registration-statistics) reports annual counts, age-specific and directly age-standardised rates of cancer incidence by stage. The [National Bowel Cancer Audit](https://www.nboca.org.uk/) reports on the proportion of patients presenting with stage I or II colorectal cancer.

## What the quality statement means for different audiences

**Service providers** (such as GP practices) ensure that FIT kits and referral protocols are in place to offer a FIT to adults presenting with symptoms of colorectal cancer (excluding anal or rectal masses, or anal ulceration) and ensure that referrals are guided by the FIT result. They ensure that arrangements are in place to send reminders to patients to return the test sample and that urgent referral protocols are in place to enable adults who do not return it to be referred on the basis of their symptoms.

**Service providers** (such as acute trusts, local pathology networks) ensure that referrals for suspected cancer are not rejected based on the FIT score alone, or the absence of FIT results. Specialist advice and guidance responses should be made available to primary care within 48 hours of receipt of the letter (or any other format used by the GP to submit a request for support and guidance mechanisms) to avoid lengthy delays to urgent referrals being made. Further details on using FIT to support the diagnostic pathway for colorectal cancer is available in [NHS England’s best practice timed pathway for colorectal cancer](https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/).

**Healthcare professionals (GPs)** offer FIT to adults presenting with symptoms of colorectal cancer (excluding anal or rectal masses, or anal ulceration) and encourage take-up and prompt return of the sample. They consider obtaining specialist advice if there is uncertainty about the interpretation of symptoms and signs and include details of a FIT result on the referral form. They refer adults who cannot or do not return the sample but whose symptoms require referral.

**Commissioners** ensure that they provide FIT kits to enable testing in primary care before referral for suspected lower gastrointestinal cancer. They monitor the proportion of referrals for suspected cancer for which a positive FIT result is provided, including the proportion of urgent referrals. They ensure that pathways are in place for adults to be referred on an urgent pathway for colorectal cancer based on the FIT result and symptoms. They also ensure that GP practices enable adults who do not return the FIT sample and have symptoms suggestive of colorectal cancer to be referred.

**Adults who have symptoms that may suggest cancer of the colon or rectum** are offered a test to check for traces of blood in their faeces unless they have anal or rectal masses, or anal ulceration. The results of the test are used to help decide if a referral is needed.

## Source guidance

* [Suspected cancer: recognition and referral. NICE guideline NG12](https://www.nice.org.uk/guidance/ng12) (2015), recommendation 1.3.4, expert opinion
* [NICE’s draft diagnostics guidance on quantitative faecal immunochemical testing to guide colorectal cancer pathway referral](https://www.nice.org.uk/guidance/indevelopment/GID-DG10036) (expected publication of final guidance, 24 August 2023), recommendations 1.1 to 1.2
* [Faecal immunochemical testing (FIT) in patients with signs or symptoms of suspected colorectal cancer (CRC): a joint guideline from the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the British Society of Gastroenterology (BSG)](https://www.bsg.org.uk/clinical-resource/faecal-immunochemical-testing-fit-in-patients-with-signs-or-symptoms-of-suspected-colorectal-cancer-crc-a-joint-guideline-from-the-acpgbi-and-the-bsg/) (2022)

## Definitions of terms used in this quality statement

### Adults with symptoms that suggest colorectal cancer

Adults who have symptoms of colorectal cancer as defined in [NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12/), recommendations 1.3.1 to 1.3.4.

[[NICE’s draft diagnostics guidance on quantitative faecal immunochemical testing to guide colorectal cancer pathway referral in primary care](https://www.nice.org.uk/guidance/indevelopment/GID-DG10036), recommendation 1.1]

### Quantitative faecal immunochemical test (FIT)

A chemical test that can pick up the presence of small amounts of blood in faeces. Recommended tests are described in [NICE’s draft diagnostics guidance on quantitative faecal immunochemical testing to guide colorectal cancer pathway referral in primary care,](https://www.nice.org.uk/guidance/indevelopment/GID-DG10036) recommendation 1.

[[NICE’s draft diagnostics guidance on quantitative faecal immunochemical testing to guide colorectal cancer pathway referral in primary care,](https://www.nice.org.uk/guidance/indevelopment/GID-DG10036) recommendation 1 and section 2.1].

## Equality and diversity considerations

Healthcare professionals asking adults to provide a sample for FIT should provide additional support for:

* people with learning disabilities
* people with cognitive disabilities
* people with physical disabilities including sensory disabilities
* autistic people.

Instructions for FIT should be provided in line with [NHS England’s Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations for these groups. The information should be accessible to people who do not speak or read English or have additional needs relating to literacy.

Healthcare professionals should also be mindful of the different cultural meanings associated with the possibility of cancer when giving advice and information about testing.

In addition, it may be inappropriate to expect some patients to complete the test, especially if they have significant physical, sensory or cognitive impairments.

# Quality statement 6: Ovarian cancer - symptoms and CA125

## Quality statement

Women aged 50 years or over reporting 1 or more symptoms occurring persistently or frequently that suggest ovarian cancer are offered a CA125 test **[2012]**

See [NICE’s quality standard on ovarian cancer QS18](https://www.nice.org.uk/guidance/qs18/) for the full statement.

# Quality statement 7: Ovarian cancer - ultrasound

## Quality statement

Women with raised CA125 have an ultrasound of their abdomen and pelvis within 2 weeks of receiving the CA125 test results. **[2012]**

See [NICE’s quality standard on ovarian cancer QS18](https://www.nice.org.uk/guidance/qs18/) for the full statement.

# Update information

**August 2023:** This quality standard was updated and statements prioritised in 2016 were replaced. The topic was identified for update following the annual review of quality standards. The review identified changes in the priority areas for improvement.

Statements are marked as:

* **[2016]** if the statement remains unchanged
* **[new 2023]** if the statement covers a new area for quality improvement
* **[2016, updated 2023]** if the statement covers an area for quality improvement included in the 2016 quality standard and has been updated.

Statements 6 and 7:

Statements from [NICE’s quality standard on ovarian cancer](https://www.nice.org.uk/guidance/qs18/) are cross-referenced because the quality standards advisory committee prioritised site-specific quality improvement areas covered by existing quality statements for ovarian cancer.

The [previous version of the quality standard for suspected cancer](http://www.nice.org.uk/guidance/QS124/documents) is available as a pdf.

# About this quality standard

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

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

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standards advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10176).

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/guidance/indevelopment/gid-qs10176) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

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

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs:

* [resource impact statement for NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12/resources).

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10176) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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

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