NICE National Institute for Health and Care Excellence

NICE quality standard

Suspected cancer

Quality standard
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This standard is based on NG12 and DG56.

This standard should be read in conjunction with QS106, QS96, QS91, QS78, QS56, QS55, QS20, QS18, QS17, QS15, QS12, QS130, QS146, QS176, QS177, QS81 and QS47.

List of quality statements

Statement 1 GPs have direct access to diagnostic endoscopy, ultrasound, MRI, X-ray and CT for people with suspected cancer.

Statement 2 People presenting in primary care with symptoms that suggest oesophageal or stomach cancer have an urgent direct access upper gastrointestinal endoscopy.

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.

Statement 4 People with suspected cancer who are referred to a cancer service are given written information encouraging them to attend.

Quality statement 1: Direct access to diagnostic tests

Quality statement

GPs have direct access to diagnostic endoscopy, ultrasound, MRI, X-ray and CT for people with suspected cancer.

Rationale

People who visit their GP with symptoms that may suggest cancer are sent for diagnostic tests to confirm or refute a cancer diagnosis. Enabling GPs to use direct access for specific tests is cost effective and will reduce the time to reach a diagnosis.

Quality measures

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

Structure

Evidence of local arrangements to give GPs direct access to diagnostic endoscopy, ultrasound, MRI, X-ray and CT for people with suspected cancer.

Data source: Local data collection.

Outcome

a) Time to diagnostic test for suspected cancer.

Data source: Local data collection.

b) Time from presentation at GP to cancer diagnosis.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (primary care, secondary care and community imaging services) ensure that systems are in place for GPs to send people with suspected cancer directly for diagnostic endoscopy, ultrasound, MRI, X-ray or CT.

Healthcare professionals (GPs or practice nurses) send people with suspected cancer, when appropriate, directly for diagnostic tests such as endoscopy, ultrasound, MRI, X-ray or CT.

Commissioners (clinical commissioning groups and NHS England) ensure services use direct access pathways to send people with suspected cancer directly to diagnostic endoscopy, ultrasound, MRI, X-ray or CT.

People with symptoms that may suggest cancer sometimes need a test, such as an X-ray or scan. These tests will find out whether or not the person's symptoms are caused by cancer. People who are sent for these tests directly by their GP will find out whether or not they have cancer faster than if they were referred using a cancer pathway.

Source guidance

Suspected cancer: recognition and referral. NICE guideline NG12 (2015, updated 2021)

Definitions of terms used in this quality statement

Direct access

When a person is referred directly by their GP for a test in a specialist service and the GP retains responsibility for the person's care, including following up and acting on the results. [Adapted from NICE's guideline on suspected cancer]

Quality statement 2: Urgent direct access endoscopy for oesophageal or stomach cancer

Quality statement

People presenting in primary care with symptoms that suggest oesophageal or stomach cancer have an urgent direct access upper gastrointestinal endoscopy.

Rationale

Urgent direct access for upper gastrointestinal endoscopy is cost effective and can lead to faster diagnosis of oesophageal or stomach cancer. Early detection and diagnosis is important to successfully treat and survive cancer, and to improve the quality of life for people with oesophageal or stomach cancer.

Quality measures

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

Structure

Evidence of local direct access pathways to ensure that people presenting in primary care with symptoms that suggest oesophageal or stomach cancer have an urgent direct access upper gastrointestinal endoscopy.

Data source: Local data collection.

Process

Proportion of people with symptoms that suggest oesophageal or stomach cancer who

have an urgent direct access upper gastrointestinal endoscopy.

Numerator – the number in the denominator who have an urgent direct access upper gastrointestinal endoscopy.

Denominator – the number of people with symptoms that suggest oesophageal or stomach cancer sent for an urgent direct access upper gastrointestinal endoscopy at the time of presentation at their GP.

Data source: Local data collection.

Outcome

a) Time to oesophageal cancer diagnosis.

Data source: Local data collection.

b) Time to stomach cancer diagnosis.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (primary care services and endoscopy services) ensure that systems are in place for GPs to send people who present at primary care with symptoms that suggest oesophageal or stomach cancer for an urgent direct access upper gastrointestinal endoscopy.

Healthcare professionals (GPs or practice nurses) send people with symptoms that suggest oesophageal or stomach cancer for an urgent direct access upper gastrointestinal endoscopy.

Commissioners (clinical commissioning groups and NHS England) ensure services use urgent direct access to send people who present in primary care with symptoms that suggest oesophageal or stomach cancer for an urgent direct access upper gastrointestinal endoscopy.

People who have certain symptoms that might be caused by cancer of the oesophagus (the throat) or stomach and who go to their GP are offered a hospital procedure to look inside the throat and stomach (called an endoscopy). This is carried out and the results sent back within 2 weeks of seeing their GP.

Source guidance

Suspected cancer: recognition and referral. NICE guideline NG12 (2015, updated 2021), recommendations 1.2.1 and 1.2.7

Definitions of terms used in this quality statement

Direct access

When a person is sent directly by their GP for a test in a specialist service, such as imaging or endoscopy, and the GP retains responsibility for the person's care, including following up and acting on the results. [Adapted from NICE's guideline on suspected cancer]

Urgent

The test should be performed and results returned within 2 weeks. When a person is sent for an urgent direct access test by their GP, the test (for example, an endoscopy) is performed and results returned within 2 weeks. [Adapted from NICE's guideline on suspected cancer]

Symptoms that suggest oesophageal or stomach cancer

People should be referred for an urgent direct access upper gastrointestinal endoscopy (performed within 2 weeks) to assess for oesophageal or stomach cancer if they:

- have dysphagia **or**

- are aged 55 and over with weight loss **and** any of the following:
  - upper abdominal pain
  - reflux
  - dyspepsia.

[Adapted from NICE's guideline on suspected cancer, recommendations 1.2.1 and 1.2.7]

Quality statement 3: Testing for blood in faeces

Quality statement

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.

Rationale

Many colorectal cancers leak blood into the bowel intermittently. Tests for the presence of blood in faeces are relatively easy, inexpensive and safe, and help to identify people at higher risk of having colorectal cancer. People at higher risk can then receive definitive investigation sooner, resulting in earlier treatment for those diagnosed with cancer.

Quality measures

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

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults presenting in primary care with symptoms that suggest colorectal cancer who do not meet the referral pathway criteria, have a test for blood in faeces.

Data source: Local data collection.

Process

Proportion of presentations of adults with symptoms that suggest colorectal cancer, without visible rectal bleeding, in which the person has a test for blood in faeces.

Numerator – the number in the denominator resulting in a test for blood in faeces.

Denominator – the number of presentations of adults with symptoms that suggest colorectal cancer who do not meet the referral pathway criteria.

Data source: Local data collection.

Outcome

a) Stage of colorectal cancer at diagnosis.

Data source: Local data collection.

b) Colorectal cancer-related mortality.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (primary care services) ensure that systems are in place for adults with symptoms that suggest colorectal cancer, who do not meet the referral pathway criteria, to have a test for blood in their faeces.

Healthcare professionals (GPs, specialists and practice nurses) ensure they offer a test for blood in their faeces to adults presenting in primary care with symptoms that suggest colorectal cancer who do not meet the referral pathway criteria.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services in which people 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.

Adults who have certain symptoms that might be caused by cancer of the colon or rectum, should be offered a test to check for traces of blood in their faeces. This will check if the person is at risk of cancer, and may help to diagnose it early.

Source guidance

- Suspected cancer: recognition and referral. NICE guideline NG12 (2015, updated 2021), recommendation 1.3.4
- Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care. NICE diagnostics guidance 30 (2017)

Definitions of terms used in this quality statement

Adults with symptoms that suggest colorectal cancer who do not need an urgent referral

Adults with unexplained symptoms of colorectal cancer (for example, weight loss, abdominal pain, iron-deficiency anaemia and changes in bowel habit) who do not have rectal bleeding and do not meet the criteria for a suspected cancer pathway referral outlined in NICE's guideline on suspected cancer (recommendations 1.3.1 to 1.3.3). [Adapted from NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care and NICE's guideline on suspected cancer, recommendation 1.3.4]

Test for blood in faeces

A chemical test that can pick up the presence of tiny traces of blood in faeces. NICE recommends OC Sensor, HM-JACKarc and FOB Gold quantitative faecal immunochemical tests for adoption in primary care. [NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care]

Quality statement 4: Encouraging attendance at cancer services

Quality statement

People with suspected cancer who are referred to a cancer service are given written information encouraging them to attend.

Rationale

Providing information to help people with suspected cancer to understand the importance of attending their appointment is critical to avoid delay due to missed appointments and ensure early diagnosis. People should be reassured that most people who are referred will not be diagnosed with cancer. This should help to alleviate any fears or concerns people may have about the referral.

Quality measures

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

Structure

Evidence of local arrangements to ensure that people with suspected cancer who are referred to a cancer service are given written information to encourage them to attend.

Data source: Local data collection.

Process

Proportion of referrals of people with suspected cancer to a cancer service for which there is a recorded discussion when they are offered the referral about information to encourage attendance.

Numerator – the number in the denominator for which there is a record of a discussion when the referral was offered about information to encourage attendance.

Denominator – the number of referrals of people with suspected cancer to a cancer service.

Data source: Local data collection.

Outcome

a) Number of missed appointments.

Data source: Local data collection.

b) Patient satisfaction with information provided.

Data source: Local data collection.

c) Time to cancer diagnosis.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (primary care, secondary care and cancer services) ensure that systems are in place for people with suspected cancer who are referred to a cancer service to be given written information to encourage attendance when they are offered the referral.

Healthcare professionals (such as GPs or practice nurses) give people with suspected cancer written information when they are referred to a cancer service, to encourage them to attend and understand the need to do so.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services that provide written information to encourage attendance when referrals to cancer services are made for people with suspected cancer.

People with suspected cancer are given written information when they are offered an appointment with a cancer specialist that explains what the appointment is for, what tests they might have and why, and what the results could mean. Giving people information will help to reassure them and encourage them to attend their appointment.

Source guidance

Suspected cancer: recognition and referral. NICE guideline NG12 (2015, updated 2021), recommendations 1.14.1, 1.14.3 and 1.14.5

Definitions of terms used in this quality statement

Information to encourage attendance to cancer services

People who are given a referral are provided with information about:

- where they are being referred
- how to get further information about the type of cancer
- potential test outcomes
- alternative diagnoses
- 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.

[Adapted from NICE's guideline on suspected cancer, recommendations 1.14.1, 1.14.3 and 1.14.5]

Equality and diversity considerations

Information given to a person with suspected cancer should be appropriate in terms of language and culture, because there may be different cultural meanings associated with

the possibility of cancer.

Update information

Minor changes since publication

July 2021: The source guidance for statement 3 was amended in line with the updated NICE guideline on suspected cancer: recognition and referral.

December 2017: The definitions and source guidance sections in statement 3 were updated to ensure alignment with NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care.

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 is available from the NICE website.

See our webpage on quality standard advisory committees 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.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

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

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the resource impact statement for the source guidance to help estimate local costs.

Diversity, equality and language

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

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

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Endorsing organisation

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

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Association of British Neurologists (ABN)
- Royal College of Obstetricians and Gynaecologists
- College of General Dentistry