

# Suspected cancer

Quality standard

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[www.nice.org.uk/guidance/qs124](http://www.nice.org.uk/guidance/qs124)

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This standard is based on NG12 and DG30.

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

## Introduction

This quality standard covers recognition of suspected cancer in adults, young people and children, and referral to specialist services. For more information see the suspected cancer [topic overview](#).

### *Why this quality standard is needed*

Cancer is a condition in which cells in a specific part of the body grow and reproduce uncontrollably. Cancerous cells can invade and destroy surrounding tissue, including internal organs. There are over 200 types of cancer, many of which have different methods for diagnosis and treatment.

Cancer has an enormous impact, both in terms of the number of people affected by it and the impact it has on people with cancer and those close to them. Approximately one-third of the population will develop a cancer in their lifetime and more than 300,000 new cancers (excluding skin cancers) are diagnosed annually in the UK. Each cancer type can have different presenting features, though they sometimes overlap. There is considerable variation in referral and testing rates for suspected cancer, which cannot be fully explained by variation in the population.

The identification of people with suspected cancer usually happens in primary care, because most people first present to a primary care health professional. Some investigations for suspected cancer can be performed in primary care, for example, blood tests such as prostate-specific antigen tests for prostate cancer or CA125 tests for ovarian cancer. Imaging investigations, such as chest X-rays or ultrasound, are generally available by direct access<sup>[1]</sup> from GPs. However, some investigations, such as colonoscopy and biopsy, can be accessed only through secondary care and so need formal referral.

This quality standard is expected to contribute to improvements in the following outcomes:

- time to cancer diagnosis
- cancer diagnosed at stage 1 or 2

- cancer-related morbidity
- cancer-related mortality.

### *How this quality standard supports delivery of outcome frameworks*

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – safety, experience and effectiveness of care – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2015–16](#)
- [Public Health Outcomes Framework 2013–16](#).

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

**Table 1 [NHS Outcomes Framework 2015–16](#)**

Domain	Overarching indicators and improvement areas
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<p>1 Preventing people from dying prematurely</p>	<p><b>Overarching indicators</b></p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults ii Children and young people</p> <p>1b Life expectancy at 75</p> <p>i Males ii Females</p> <p><b>Improvement areas</b></p> <p><b>Reducing premature mortality from the major causes of death</b></p> <p>1.4 Under 75 mortality rate from cancer* (PHOF 4.5)</p> <p>i One- and ii Five-year survival from all cancers</p> <p>iii One- and iv Five-year survival from breast, lung and colorectal cancer</p> <p>v One- and vi Five-year survival from cancers diagnosed at stage 1 &amp; 2** (PHOF 2.19)</p>
<p>4 Ensuring that people have a positive experience of care</p>	<p><b>Overarching indicator</b></p> <p>4a Patient experience of primary care</p> <p>i GP services</p> <p><i>4d Patient experience characterised as poor or worse</i></p> <p><i>i. Primary care</i></p> <p><b>Improvement areas</b></p> <p><b>Improving access to primary care services</b></p> <p>4.4 Access to i GP services</p> <p><b>Improving people's experience of integrated care</b></p> <p><i>4.9 People's experience of integrated care**</i></p>
<p><b>Alignment across the health and social care system</b></p> <p>* Indicator is shared.</p> <p>** Indicator is complementary.</p> <p>Indicators in italics in development.</p>	

**Table 2 Public health outcomes framework for England, 2013–16**

Domain	Objectives and indicators
2 Health improvement	<p><b>Objective</b></p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p><b>Indicators</b></p> <p>2.19 Cancer diagnosed at stage 1 and 2** (NHSOF 1.4) 2.20 Cancer screening coverage</p>
4 Healthcare public health and preventing premature mortality	<p><b>Objective</b></p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities</p> <p><b>Indicators</b></p> <p>4.3 Mortality rate from causes considered preventable ** (NHSOF 1a)</p> <p>4.5 Under 75 mortality rate from cancer*</p>
<p><b>Alignment across the health and social care system</b></p> <p>* Indicator is shared.</p> <p>** Indicator is complementary.</p>	

### *Safety and people's experience of care*

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to suspected cancer.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to people using services. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the

topic are considered during quality statement development.

## *Coordinated services*

The quality standard for suspected cancer specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole cancer care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with suspected cancer.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality cancer service are listed in [related quality standards](#).

## **Training and competencies**

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing and referring people with suspected cancer should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

## **Role of families and carers**

Quality standards recognise the important role families and carers have in supporting people with suspected cancer. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

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<sup>[1]</sup> Please note that direct access may also be called "straight to test" or similar.



## 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*

#### **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 service providers, healthcare professionals and commissioners*

**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.

### *What the quality statement means for patients and carers.*

**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 (2015) NICE guideline NG12, recommendations 1.2.1 and 1.2.7

### *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 Suspected cancer: recognition and referral (NICE guideline NG12)]

## 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*

#### **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 service providers, healthcare professionals and commissioners*

**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.

### *What the quality statement means for patients and carers*

**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 (2015) NICE guideline NG12, 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 [Suspected cancer: recognition and referral](#) (NICE guideline NG12)]

### **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 [Suspected cancer: recognition and referral](#) (NICE guideline NG12)]

## **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 [Suspected cancer: recognition and referral](#) (NICE guideline NG12) 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*

#### **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 service providers, healthcare professionals and commissioners*

**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.

### *What the quality statement means for patients and carers*

**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*

[Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care](#) (2017) NICE diagnostics guidance DG30

### *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 [Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care](#) (NICE diagnostics guidance DG30) and [Suspected cancer: recognition and referral](#) (NICE guideline NG12) recommendations 1.3.1 and 1.3.3]

## 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.

[[Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care](#) (NICE diagnostics guidance DG30)]

## 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*

#### **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 service providers, healthcare professionals and commissioners***

**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.

### ***What the quality statement means for patients, service users and carers***

**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** (2015) NICE guideline NG12, 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 [Suspected cancer: recognition and referral](#) (NICE guideline NG12) 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.

## Using the quality standard

### *Quality measures*

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

For further information, including guidance on using quality measures, please see [how to use quality standards](#).

### *Levels of achievement*

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, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's [quality standard service improvement template](#) helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement. This tool is updated monthly to include new quality standards.

### *Using other national guidance and policy documents*

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#).

## Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between health, public health and social care practitioners and people with suspected cancer is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with suspected cancer should have access to an interpreter or advocate if needed.

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.

## Development sources

### *Evidence sources*

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care](#) (2017) NICE diagnostics guidance DG30
- [Suspected cancer: recognition and referral](#) (2015) NICE guideline NG12

### *Policy context*

It is important that the quality standard is considered alongside current policy documents, including:

- NHS England (2014) [Waiting times for suspected and diagnosed cancer patients 2013–2014](#)
- <https://www.england.nhs.uk/statistics/2014/07/25/cancer-waiting-times-annual-report-2013-14/> Department of Health (2013) [2010 to 2015 government policy: cancer research and treatment](#)
- Department of Health (2013) [National cancer strategy: impact assessment](#)
- Department of Health (2012) [Direct access to diagnostic tests for cancer: best practice referral pathways for general practitioners](#)
- Department of Health (2012) [Cancer early diagnosis campaigns outlined](#)
- Department of Health (2012) [National campaign to promote awareness and earlier diagnosis of lung cancer](#)
- Department of Health (2011) [Be Clear on Cancer: national campaign to promote earlier diagnosis of bowel cancer](#)
- Department of Health (2011)
- Department of Health (2011) [The national cancer strategy](#)
- The King's Fund (2011) [Referral management: lessons for success](#)

- Royal College of General Practitioners (2011)
- National Cancer Action Team and Royal College of General Practitioners (2010) Primary care cancer audit



## Related NICE quality standards

- [Haematological cancers](#) (2017) NICE quality standard 150
- [Head and neck cancer](#) (2017) NICE quality standard 146
- [Skin cancer](#) (2016) NICE quality standard 130
- [Breast cancer](#) (2011, updated 2016) NICE quality standard 12
- [Bladder cancer](#) (2015) NICE quality standard 106
- [Dyspepsia and gastro-oesophageal reflux disease in adults](#) (2015) NICE quality standard 96
- [Prostate cancer](#) (2015) NICE quality standard 91
- [Sarcoma](#) (2015) NICE quality standard 78
- [Metastatic spinal cord compression in adults](#) (2014) NICE quality standard 56
- [Cancer services for children and young people](#) (2014) NICE quality standard 55
- [Colorectal cancer](#) (2012) NICE quality standard 20
- [Ovarian cancer](#) (2012) NICE quality standard 18
- [Lung cancer in adults](#) (2012) NICE quality standard 17
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15

The full list of quality standard topics referred to NICE is available from the [quality standard topic library](#) on the NICE website.

## Quality Standards Advisory Committee and NICE project team

### *Quality Standards Advisory Committee*

This quality standard has been developed by Quality Standards Advisory Committee 1. Membership of this committee is as follows:

**Dr Ivan Benett**

Clinical Director, Central Manchester Clinical Commissioning Group

**Dr Gita Bhutani**

Associate Director for Psychological Professions, Lancashire Care NHS Foundation Trust

**Mrs Jennifer Bostock**

Lay member

**Dr Helen Bromley**

Consultant in Public Health, Cheshire West and Chester Council

**Ms Amanda de la Motte**

Deputy Chief Nurse, South Lincolnshire Clinical Commissioning Group

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Psychiatric Liaison Team Manager, West London Mental Health Trust

**Ms Phyllis Dunn**

Clinical Lead Nurse, University Hospital of North Staffordshire

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Head of Measures Development, National Peer Review Programme, NHS England

**Mr Gavin Maxwell**

Lay member

**Ms Teresa Middleton**

Deputy Director of Quality, NHS Gloucestershire Clinical Commissioning Group

**Mrs Juliette Millard**

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**Hazel Trender**

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Director of Public Health, NHS Highland

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Consultant and Senior Clinical Lecturer in Palliative Medicine, Oxford University Hospitals NHS Trust and Oxford University

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Programme Head for Clinical Audit, Health and Social Care Information Centre

**Ms Jane Worsley**

Chief Operating Officer, Options Group, Alcester Heath, Warwickshire

**Dr Arnold Zermansky**

GP, Leeds

The following specialist members joined the committee to develop this quality standard:

**Dr Steve Hajioff**

Director of Public Health, London Borough of Hillingdon

**Professor Willie Hamilton**

Professor of Primary Care Diagnostics, Peninsula College of Medicine and Dentistry, Plymouth

**Mr Stephen Langton**

Consultant Maxillofacial Surgeon, East Lancashire Hospitals NHS Trust

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GP, Greater Glasgow & Clyde Health Board

**Dr Liliana Risi**

GP, East London Foundation Trust

**Diana Robinson**

Lay member

### *NICE project team*

**Nick Baillie**

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**Karen Slade**

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Programme Manager

**Stephanie Birtles**

Technical Adviser

**Roshni Joshi**

Lead Technical Analyst

**Jenny Mills**

Project Manager

**Julia Sus**

Coordinator

## Update information

**December 2017:** The definitions and source guidance sections in statement 3 were updated to ensure alignment with NICE 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.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathway on [suspected cancer recognition and referral](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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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](#)

- Royal College of Obstetricians and Gynaecologists
- Faculty of General Dental Practice