Colorectal cancer

Quality standard
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Introduction and overview

This quality standard covers the diagnosis and management of adults (18 years and older) with newly diagnosed and recurring adenocarcinoma of the colon and rectum. It includes diagnosis of suspected colorectal cancer, staging of the disease, management of both local and metastatic disease, and follow-up and regular surveillance for those free from disease after treatment. For more information see the scope for this quality standard.

Introduction

Colorectal cancer covers cancerous growths in the colon (colon cancer) and rectum (rectal cancer). Most colorectal cancers arise from adenomatous polyps. These neoplasms are usually benign, but some develop into cancer over time. The occurrence of colorectal cancer is strongly related to age, with 83% of cases arising in people who are 60 years or older.

This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for people with colorectal cancer in the following ways:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill health or following injury.
- Ensuring that people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

These overarching outcomes are from The NHS Outcomes Framework 2012/13.

Overview

The quality standard for colorectal cancer requires that services should be commissioned from and
coordinated across all relevant agencies encompassing the whole colorectal cancer care pathway. An integrated approach to provision of services is fundamental to the delivery of high-quality care to adults with colorectal cancer.
List of quality statements

**Statement 1.** People with suspected colorectal cancer without major comorbidity are offered diagnostic colonoscopy.

**Statement 2.** People with colon cancer are offered contrast-enhanced computed tomography (CT) of the chest, abdomen and pelvis to determine the stage of the disease.

**Statement 3.** People with rectal cancer are offered contrast-enhanced computed tomography (CT) of the chest, abdomen and pelvis to determine the stage of the disease, and pelvic magnetic resonance imaging (MRI) to assess the risk of local recurrence.

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

**Statement 5.** People with locally excised, pathologically confirmed stage I colorectal cancer whose tumour had involved resection margins (less than 1 mm) are offered further surgery or active monitoring.

**Statement 6.** People with a contrast-enhanced computed tomography (CT) of the chest, abdomen and pelvis suggesting liver metastatic colorectal cancer have their scans reviewed by the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for surgery.

**Statement 7.** People with locally advanced or metastatic colorectal cancer whose disease progresses after first-line systemic anticancer therapy are offered second-line systemic anticancer therapy if they are able to tolerate it.

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

In addition, quality standards that should also be considered when commissioning and providing a high-quality colorectal cancer service are listed in [Related NICE quality standards](https://www.nice.org.uk/terms-and-conditions#notice-of-rights).
Quality statement 1: Colonoscopy

Quality statement

People with suspected colorectal cancer without major comorbidity are offered diagnostic colonoscopy.

Quality measure

Structure: Evidence of local arrangements to ensure people with suspected colorectal cancer without major comorbidity are offered diagnostic colonoscopy.

Process: Proportion of people with suspected colorectal cancer without major comorbidity who receive diagnostic colonoscopy.

Numerator – the number of people in the denominator who receive diagnostic colonoscopy.

Denominator – the number of people with suspected colorectal cancer without major comorbidity.

What the quality statement means for each audience

Service providers ensure systems are in place for people with suspected colorectal cancer without major comorbidity to be offered diagnostic colonoscopy.

Healthcare professionals ensure they offer diagnostic colonoscopy to people with suspected colorectal cancer without major comorbidity.

Commissioners ensure they commission services for people with suspected colorectal cancer without major comorbidity that offer diagnostic colonoscopy.

People with suspected colorectal cancer without any other significant diseases are offered a procedure called colonoscopy, which allows the large bowel to be viewed through a camera on the end of a flexible tube, to establish the diagnosis.

Source guidance

NICE clinical guideline 131 recommendations 1.1.1.2 (key priority for implementation) and 1.1.1.
Data source

Structure: Local data collection.

Process: Local data collection. The National Bowel Cancer Audit records colonoscopy results, classified as abnormal (cancer detected whether complete examination or not), inadequate (no cancer detected but incomplete examination), not done or not known. The NHS Bowel Cancer Screening Programme’s Quality assurance guidelines for colonoscopy suggest indicators based on data returns, including:

- minimum number of screening colonoscopies
- bowel preparation
- response rate (acceptance rate) for colonoscopy (index and surveillance)
- surveillance colonoscopy attendance rate
- consent
- safe sedation and comfort
- caecal intubation rate
- neoplasia detection rates
- withdrawal time in negative colonoscopies
- polyp recovery.

Also contained within NICE audit support for colorectal cancer (NICE clinical guideline 131): Diagnosis, criteria 1 and 2.

Definitions

NICE clinical guideline 131 (full version) concludes that colonoscopy is the most effective investigation for diagnosis of colorectal tumours. It also allows immediate biopsy confirmation of colorectal cancer and removal of adenomas during the same procedure. Therefore, the guideline recommends colonoscopy as the first investigation for the diagnosis of colorectal tumours.

NICE clinical guideline 131 (full version) recognises it may not be possible to perform complete colonoscopy in some patients. Also, patients with serious cardiorespiratory or neurological
comorbidity may be at high risk from potential complications of colonoscopy (for example colonic perforation or the effects of sedation). Such patients might be better served by alternative investigations.
Quality statement 2: Staging (colon cancer)

Quality statement

People with colon cancer are offered contrast-enhanced computed tomography (CT) of the chest, abdomen and pelvis to determine the stage of the disease.

Quality measure

Structure: Evidence of local arrangements to ensure people with colon cancer are offered contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease.

Process: Proportion of people with colon cancer who receive contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease.

Numerator – the number of people in the denominator who receive contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease.

Denominator – the number of people with colon cancer without contraindications to contrast-enhanced CT of the chest, abdomen and pelvis.

What the quality statement means for each audience

Service providers ensure systems are in place for people with colon cancer to be offered contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease.

Healthcare professionals offer people with colon cancer contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease.

Commissioners ensure they commission services that offer people with colon cancer contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease.

People with colon cancer are offered a CT scan of the chest, abdomen and pelvis to estimate the spread of the disease.

Source guidance

NICE clinical guideline 131 recommendation 1.1.2.1 (key priority for implementation).
Data source

Structure: Local data collection.

Process: Local data collection. The National Bowel Cancer Audit records CT scan results, classified as normal liver, liver metastases or liver uncertain. Also contained within NICE audit support for colorectal cancer (NICE clinical guideline 131): Staging, criterion 1.
Quality statement 3: Staging (rectal cancer)

Quality statement

People with rectal cancer are offered contrast-enhanced computed tomography (CT) of the chest, abdomen and pelvis to determine the stage of the disease, and pelvic magnetic resonance imaging (MRI) to assess the risk of local recurrence.

Quality measure

Structure: Evidence of local arrangements to ensure people with colorectal cancer are offered contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease, and pelvic MRI to assess the risk of local recurrence.

Process: Proportion of people with rectal cancer who receive contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease, and pelvic MRI to assess the risk of local recurrence.

Numerator – the number of people in the denominator who receive contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease, and pelvic MRI to assess the risk of local recurrence.

Denominator – the number of people with rectal cancer without contraindications to CT of the chest, abdomen and pelvis or pelvic MRI.

What the quality statement means for each audience

Service providers ensure systems are in place for people with rectal cancer to be offered contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease, and pelvic MRI to assess the risk of local recurrence.

Healthcare professionals ensure they offer people with rectal cancer contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease, and pelvic MRI to assess the risk of local recurrence.

Commissioners ensure they commission services that offer people with rectal cancer contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease, and pelvic MRI to assess the risk of local recurrence.
People with rectal cancer are offered a CT scan of the chest, abdomen and pelvis to estimate the spread of the disease, and an MRI scan to assess the risk of the cancer returning.

Source guidance

NICE clinical guideline 131 recommendations 1.1.2.1 and 1.1.2.2 (key priorities for implementation).

Data source

Structure: Local data collection.

Process: Local data collection. The National Bowel Cancer Audit records CT scan results, classified as normal liver, liver metastases or liver uncertain, and also records MRI scans. Also contained within NICE audit support for colorectal cancer (NICE clinical guideline 131): Staging, criteria 1 and 2.
Quality statement 4: Preoperative treatment of rectal cancer

**Quality statement**

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

**Quality measure**

**Structure:** Evidence of local arrangements, including written clinical protocols, to ensure people with rectal cancer are offered a preoperative treatment strategy appropriate to their risk of local disease recurrence.

**Process:**

a) Proportion of people with low-risk operable rectal cancer who do not receive short-course preoperative radiotherapy or chemoradiotherapy unless as part of a clinical trial.

Numerator – the number of people in the denominator who do not receive short-course preoperative radiotherapy or chemoradiotherapy, unless as part of a clinical trial.

Denominator – the number of people with low-risk operable rectal cancer.

b) Proportion of people with high-risk operable rectal cancer who receive preoperative chemoradiotherapy with a suitable interval before surgery to allow tumour response and shrinkage.

Numerator – the number of people in the denominator who receive preoperative chemoradiotherapy with a suitable interval before surgery to allow tumour response and shrinkage.

Denominator – the number of people with high-risk operable rectal cancer.

c) Proportion of people with high-risk locally advanced rectal cancer who receive preoperative chemoradiotherapy with a suitable interval before surgery to allow tumour response and shrinkage.

Numerator – the number of people in the denominator who receive preoperative
chemoradiotherapy with a suitable interval before surgery to allow tumour response and shrinkage.

Denominator – the number of people with high-risk locally advanced rectal cancer.

Outcome:

a) Local recurrence.

b) Circumferential resection margin.

What the quality statement means for each audience

Service providers ensure systems are in place for people with rectal cancer to be offered a preoperative treatment strategy appropriate to their risk of local disease recurrence.

Healthcare professionals offer people with rectal cancer a preoperative treatment strategy appropriate to their risk of local disease recurrence.

Commissioners ensure they commission services that offer people with rectal cancer a preoperative treatment strategy appropriate to their risk of local disease recurrence.

People with rectal cancer are offered treatment before surgery that takes into account the likelihood of the cancer returning.

Source guidance

NICE clinical guideline 131 recommendations 1.2.1.2 (key priority for implementation), 1.2.1.3, 1.2.1.4, 1.2.1.6 and 1.2.1.7.

Data source

Structure: Local data collection.

Process: a), b) and c) The National Bowel Cancer Audit records preoperative radiotherapy.

a) Local data collection. Contained within NICE audit support for colorectal cancer (NICE clinical guideline 131): Management of local disease – preoperative management of the primary tumour,
criterion 2.


c) Local data collection. Contained within NICE audit support for colorectal cancer (NICE clinical guideline 131): Management of local disease – preoperative management of the primary tumour, criterion 5.

Outcome:

a) Local data collection.

b) The National Bowel Cancer Audit records whether the circumferential margin was involved, not involved or not known. It also records the distance between the cancer and the circumferential margins.

Definitions

NICE clinical guideline 131 uses the following categorisations of risk of local disease recurrence:

- High – a threatened (less than 1 mm) or breached resection margin; or low tumours encroaching onto the inter-sphincteric plane or with levator involvement.

- Moderate – any cT3b or greater, in which the potential surgical margin is not threatened; or any suspicious lymph node not threatening the surgical resection margin; or the presence of extramural vascular invasion (this feature is also associated with high risk of systemic recurrence).

- Low – cT1, cT2 or cT3a and no lymph node involvement.

NICE clinical guideline 131 also uses the following categorisations:

- Low-risk operable rectal cancer – primary rectal tumours which appear resectable at presentation.

- High-risk operable rectal cancer – primary rectal tumours which appear resectable at presentation.
- High-risk locally advanced rectal cancer – primary rectal tumours which appear unresectable or borderline resectable.
Quality statement 5: Stage I colorectal cancer treatment

**Quality statement**

People with locally excised, pathologically confirmed stage I colorectal cancer whose tumour had involved resection margins (less than 1 mm) are offered further surgery or active monitoring.

**Quality measure**

**Structure:** Evidence of local arrangements, including written clinical protocols, to ensure people with locally excised, pathologically confirmed stage I colorectal cancer whose tumour had involved resection margins (less than 1 mm), are offered further surgery or active monitoring.

**Process:** Proportion of people with locally excised, pathologically confirmed stage I colorectal cancer whose tumour had involved resection margins (less than 1 mm), who receive further surgery or active monitoring.

Numerator – the number of people in the denominator who receive further surgery or active monitoring.

Denominator – the number of people with locally excised, pathologically confirmed stage I colorectal cancer whose tumour had involved resection margins (less than 1 mm).

**What the quality statement means for each audience**

**Service providers** ensure systems are in place for people with locally excised, pathologically confirmed stage I colorectal cancer whose tumour had involved resection margins (less than 1 mm) to be offered further surgery or active monitoring.

**Healthcare professionals** ensure people with locally excised, pathologically confirmed stage I colorectal cancer whose tumour had involved resection margins (less than 1 mm) are offered further surgery or active monitoring.

**Commissioners** ensure they commission services where people with locally excised, pathologically confirmed stage I colorectal cancer whose tumour had involved resection margins (less than 1 mm) are offered further surgery or active monitoring.

People with colorectal cancer that has not spread beyond the original tumour (stage I), as
Confirmed by examining the tumour once it is removed, are offered further surgery or active monitoring if the healthy tissue around the tumour is thought to contain cancer cells.

Source guidance

NICE clinical guideline 131 recommendations 1.2.3.1 (key priority for implementation) and 1.2.3.2.

Data source

Structure: Local data collection.

Process: Local data collection. The National Bowel Cancer Audit reports on whether the circumferential margin was involved, not involved or not known. It also records the distance between the cancer and the circumferential margins.

Definitions

NICE clinical guideline 131 (full version) states that although it is extremely important for patients with involved resection margins to be offered further treatment, there was not enough evidence to recommend specific treatments. Therefore the decision on which further treatment to use should be made locally by the appropriate multidisciplinary team.

NICE clinical guideline 131 states that the colorectal multidisciplinary team should take into account pathological characteristics of the lesion, imaging results and previous treatments when deciding whether to offer further treatment.

The Topic Expert Group who developed the quality standard felt that the choice between surgery and active monitoring would be dependent on clinical judgement on the risks of surgery (taking into account factors such as age and comorbidities) and the risk of disease recurrence.

Involved resection margins (less than 1 mm) refer to the distance from tumour to nearest surgical margin.
Quality statement 6: Imaging hepatic metastases

**Quality statement**

People with a contrast-enhanced computed tomography (CT) of the chest, abdomen and pelvis suggesting liver metastatic colorectal cancer have their scans reviewed by the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for surgery.

**Quality measure**

**Structure:** Evidence of local arrangements to ensure people with a contrast-enhanced CT of the chest, abdomen and pelvis suggesting liver metastatic colorectal cancer have their scans reviewed by the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for surgery.

**Process:** Proportion of people with a contrast-enhanced CT of the chest, abdomen and pelvis suggesting liver metastatic colorectal cancer who have their scans reviewed by the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for surgery.

Numerator – the number of people in the denominator who have their scans reviewed by the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for surgery.

Denominator – the number of people with a contrast-enhanced CT of the chest, abdomen and pelvis suggesting liver metastatic colorectal cancer.

**What the quality statement means for each audience**

**Service providers** ensure systems are in place for people with a contrast-enhanced CT of the chest, abdomen and pelvis suggesting liver metastatic colorectal cancer to have their scans reviewed by the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for surgery.

**Healthcare professionals** ensure people with a contrast-enhanced CT of the chest, abdomen and pelvis suggesting liver metastatic colorectal cancer have their scans reviewed by the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for surgery.
Commissioners ensure they commission services for people with a contrast-enhanced CT of the chest, abdomen and pelvis suggesting liver metastatic colorectal cancer to have their scans reviewed by the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for surgery.

People with colorectal cancer that may have spread to the liver have their CT scans reviewed by the hepatobiliary multidisciplinary team to decide if further scans are needed to guide the choice of treatment.

Source guidance

NICE clinical guideline 131 recommendation 1.3.2.1 (key priority for implementation).

Data source

Structure: Local data collection.

Process: Local data collection. The National Bowel Cancer Audit records CT scan results, classified as normal liver, liver metastases or liver uncertain. Also contained within NICE audit support for colorectal cancer (NICE clinical guideline 131): Management of metastatic disease, criterion 2.

Definitions

NICE clinical guideline 131 (full version) finds that the available evidence is unclear about which form of imaging should be used after a CT scan to confirm if the patient with liver metastases is suitable for surgery. Therefore, the guideline recommends that the opinion of a hepatobiliary MDT is sought. This would allow a specialist to make the decision on what additional imaging to use, striking a balance between missing patients with resectable disease and excessive inappropriate laparotomies.
Quality statement 7: Systemic anticancer therapy

**Quality statement**

People with locally advanced or metastatic colorectal cancer whose disease progresses after first-line systemic anticancer therapy are offered second-line systemic anticancer therapy if they are able to tolerate it.

**Quality measure**

**Structure:** Evidence of local arrangements, including written clinical protocols, to ensure people with locally advanced or metastatic colorectal cancer whose disease progresses after first-line systemic anticancer therapy are offered second-line systemic anticancer therapy if they are able to tolerate it.

**Process:** Proportion of people with locally advanced or metastatic colorectal cancer whose disease progresses after first-line systemic anticancer therapy who are offered second-line systemic anticancer therapy if they are able to tolerate it.

Numerator – the number of people in the denominator who receive second-line systemic anticancer therapy.

Denominator – the number of people with locally advanced or metastatic colorectal cancer whose disease progresses after first-line systemic anticancer therapy who are able to tolerate second-line systemic anticancer therapy.

**Outcome:**

a) 1-year survival.

b) 2-year survival.

**What the quality statement means for each audience**

**Service providers** ensure systems are in place for people with locally advanced or metastatic colorectal cancer whose disease progresses after first-line systemic anticancer therapy to be offered second-line systemic anticancer therapy if they are able to tolerate it.
Healthcare professionals offer second-line systemic anticancer therapy to people with locally advanced or metastatic colorectal cancer whose disease progresses after first-line systemic anticancer therapy if they are able to tolerate it.

Commissioners ensure they commission services for people with locally advanced or metastatic colorectal cancer whose disease progresses after first-line systemic anticancer therapy that offer second-line systemic anticancer therapy if they are able to tolerate it.

People with colorectal cancer that has spread to other parts of the body and continues to spread after initial chemotherapy are offered additional chemotherapy and/or treatment with a type of drug called a biological therapy (which may help the body to control the growth of cancer cells) if they are fit and able enough.

Source guidance

NICE clinical guideline 131 recommendations 1.3.4.1 (key priority for implementation), 1.3.4.2, 1.3.4.3 and 1.3.4.5.

Data source

Structure: Local data collection.

Process: Local data collection. The National Bowel Cancer Audit records drug treatment intent classified as palliative, adjuvant, neo-adjuvant or other. The Systemic Anti-Cancer Therapy (SACT) dataset will record clinical management information on patients undergoing chemotherapy in (or funded by) the NHS in England, and will have a staged implementation of national collection of the dataset, which began April 2012 and will have full data collection from April 2014. Also contained within NICE audit support for colorectal cancer (NICE clinical guideline 131): chemotherapy for advanced and metastatic colorectal cancer criteria 1–5.

Outcome:

a) Local data collection. The Health and Social Care Information Centre's Indicator Portal records 1-year relative survival following diagnosis of colon cancer.

b) Local data collection.
Definitions

Systemic anticancer therapy includes the use of chemotherapy and biological agents. NICE clinical guideline 131, section 1.3.4 contains recommendations on chemotherapy regimens and biological agents, including references to several NICE technology appraisals, and highlights that any decision should only be made after full discussion of the side effects and the patient's preferences.
Quality statement 8: Follow-up and regular surveillance

Quality statement

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

Quality measure

Structure: Evidence of local arrangements to ensure people free from disease after treatment for colorectal cancer, are offered regular surveillance.

Process:

a) Proportion of people free from disease after treatment for colorectal cancer who receive 6-monthly blood carcinoembryonic antigen estimation (CEA) for 3 years after treatment.

Numerator – the number of people in the denominator who received CEA estimation no more than 6 months ago.

Denominator – the number of people who have been free from disease for 3 years or less after treatment for colorectal cancer.

b) Proportion of people free from disease after treatment for colorectal cancer who receive at least 2 CT scans of the chest, abdomen and pelvis within 3 years of treatment for colorectal cancer.

Numerator – the number of people in the denominator who received at least 2 CT scans of the chest, abdomen and pelvis within 3 years of completion of treatment.

Denominator – the number of people who have had colorectal cancer who have been disease free for 3 years or more after completion of treatment.

c) Proportion of people free from disease after treatment for colorectal cancer who receive surveillance colonoscopy 1 year after treatment.

Numerator – the number of people in the denominator who receive surveillance colonoscopy 1 year after treatment.

Denominator: the number of people free from disease for 1 year after treatment for colorectal cancer.
What the quality statement means for each audience

Service providers ensure systems are in place for people free from disease after treatment for colorectal cancer to be offered regular surveillance.

Healthcare professionals offer regular surveillance to people free from disease after treatment for colorectal cancer.

Commissioners ensure they commission services for people free from disease after treatment for colorectal cancer that offers regular surveillance.

People with colorectal cancer who are disease free after treatment are offered regular check-ups and investigations to check for any signs of the disease returning.

Source guidance

NICE clinical guideline 131 recommendations 1.4.1.2 (key priority for implementation), 1.4.1.1, 1.4.1.3, 1.4.1.4 and 1.4.1.5.

Data source

Structure: Local data collection.

Process:

a), b) and c) The National Bowel Cancer Audit records data on follow-up, however these data are not currently included in the annual reports.

a) and b) Local data collection. Contained within NICE audit support for colorectal cancer (NICE clinical guideline 131): ongoing care and support, criterion 2.

c) Local data collection. Contained within NICE audit support for colorectal cancer (NICE clinical guideline 131): ongoing care and support, criterion 3.
Using the quality standard

It is important that the quality standard is considered alongside current policy and guidance documents listed in the evidence sources section, including *Improving outcomes in colorectal cancers* (NICE cancer service guidance, 2004) and the *Manual for cancer services: colorectal measures* (National Cancer Peer Review Programme, 2010).

NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard. Full guides for commissioners on colorectal cancer that support the local implementation of NICE guidance are also available. Information for patients on using the quality standard, is available on the NICE website.

The quality measures accompanying the quality standard, aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. As quality standards are intended to drive up the quality of care, achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, we recognise that this may not always be appropriate in practice, taking into account patient safety, patient choice and clinical judgement, and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist to measure the quality statement. National indicators include those developed by the NHS Information Centre through their *Indicators for Quality Improvement Programme*. For statements where national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

Further information about NICE quality standards, including guidance on using quality measures, is available on the NICE website.

*Diversity, equality and language*

During the development of this quality standard, equality issues have been considered and equality assessments (developed at the first, second and third meetings of the Topic Expert Group) are published on the NICE website.
Good communication between health and social care professionals and people with colorectal cancer is essential. Treatment and care, 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 colorectal cancer should have access to an interpreter or advocate if needed.
Development sources

Evidence sources

The document below contains clinical guideline recommendations or other recommendations that
were used by the Topic Expert Group to develop the quality standard statements and measures.

Colorectal cancer: the diagnosis and management of colorectal cancer. NICE clinical guideline 131
(2011; NHS Evidence accredited).

Policy context

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


Improving outcomes in colorectal cancers. NICE cancer service guidance (2004; NICE accredited).


Definitions and data sources for the quality measures

References included within in the definitions and data sources sections:

Chemotherapy Intelligence Unit Systemic Anti-Cancer Therapy (SACT).

Health and Social Care Information Centre Bowel cancer.

Health and Social Care Information Centre Indicator portal.

NHS Bowel Cancer Screening Programme (2011) Quality assurance guidelines for colonoscopy.
Related NICE quality standards

Patient experience in adult NHS services. NICE quality standard 15 (2012).

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Changes after publication

May 2015: Minor maintenance.

April 2015: Minor maintenance.

February 2015: Reference to NICE audit support for colorectal cancer (NICE clinical guideline 131): Management of local disease – stage I colorectal cancer, criterion 1 has been removed from the data source section of statement 5.
About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the healthcare quality standards process guide.

This quality standard has been incorporated into the NICE pathway for colorectal cancer.

We have produced a summary for patients and carers.

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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.

- Society and College of Radiographers
- Royal College of Nursing
- Royal College of Physicians