National Institute for Health and Care Excellence

Colorectal cancer update

Consultation on draft quality standard – deadline for comments 5pm on 11/10/2021

Please email your completed form to: QSconsultations@nice.org.uk

Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly.

Use the form to comment on the content of the quality standard (i.e. the statements and other sections e.g. rationale, measures etc.), as well as answer the following questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

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.

4. For draft quality statement 3: Draft quality statement 3 includes the term ‘node-positive or locally advanced rectal cancer’ to refer to rectal cancer at stage cT1 T2, cN1 N2, M0, or cT3 T4, any cN, M0. Is this an accurate term to refer to rectal cancer at these stages?

5. For draft quality statement 5: Process measure b) measures at least 2 CT scans done in the first 3 years after potentially curative surgery based on NICE’s guideline on colorectal cancer, evidence review E1. Could there be any unintended consequences from specifying this number as a minimum?

6. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form.

Organisation details

Organisation name (if you are responding as an individual rather than a registered stakeholder please leave blank)	**Royal College of Physicians and Surgeons of Glasgow**
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	**None**
Name of person completing form	**Dr Richard Hull, Honorary Secretary with the aid of experts in the field**
Supporting the quality standard Would your organisation like to express an interest in formally supporting this quality standard? More information.	**Yes**
Type	**[Office use only]**

Comments on the draft quality standard

Comment number	**Statement or question number** Or 'general' for comments on the whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table because your comments could get lost – type directly into this table.
Example 1	*Statement 1*	*This statement may be hard to measure because…*
1	General	The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the UK. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments.

		The College welcomes this draft quality standard on Colorectal Cancer. It is noted that Scotland adheres to similar guidelines (SIGN) and Scottish Colorectal Units submit outcomes data to the Scottish Colorectal Cancer Network.
2	Question 1	Our reviewers considered that the QS reflected the current areas for Quality improvement in the field including Lynch syndrome testing, early and advanced rectal cancer, metastatic colorectal cancer and follow up of patients after curative surgery for non-metastatic colorectal cancer. One considered the focus on locally advanced colorectal cancer and the use of neoadjuvant therapy was worthy of mention to patients in that position with large trials suggesting that chemotherapy may improve post-operative complication rate including anastomotic leak rate and resection margin status. The concept of considering early rectal cancer separately is important. It is important to emphasise that there are still clinical trials in this area to determine the role of minimally invasive surgical procedures and the best candidates for this treatment. The definition given seems appropriate. Locally advanced rectal cancer should include low rectal tumours that when downstaged may permit maintenance of intestinal continuity. Additionally, the concept of complete clinical response should be introduced, as we know now that this can be sustained and “watch and wait” protocols are options for patients. This should involve fully informed and consented patients. The guideline should consider the excellent results with SCRT in the Rapido trial when drawing its conclusions. Additionally, patients with locally advanced rectal cancer with invasion of other organs should be discussed with an MDT routinely treating and operating in locally advanced disease/pelvic exenteration prior to institution of neoadjuvant therapy to permit surgical planning and review.
3	Question 2	Given the legal obligation to submit outcomes cancer data, all hospitals in the UK have systems and structures in place to collect data for these proposed quality measures. However, the addition of further data collection may put a strain on the already overstretched local audit departments. Extra funding may be needed by a number of units in order to meet the demand of additional data collection and patient follow up.
4	Question 3	Resources for routine genetic testing would be welcome and required.

		As mentioned in 3 above, some local audit units may struggle to meet the demand of additional data collection and patient follow up. Extra funding may be necessary for the improvement and upgrade of the hardware and software, and for employing the appropriate number of clerical staff and patient pathway co-ordinators.
5	Question 4	This definition could be developed further. In quality statement 3, low rectal cancers and any cancers potentially involving the circumferential resection margin should be included in those that should be considered for neoadjuvant therapy. Most surgeons would consider T3a/b N0 tumours to be resectable without neoadjuvant therapy. Node-positive rectal cancer is any T stage with N1 or N2. Locally advanced rectal cancer is T3 and T4 with any N stage. The addition of EMVI (extramural vascular invasion) to the staging as a marker of locally advanced cancer should be considered.
6	Question 5	Our reviewers considered that two CT scans in three years was appropriate as a minimum. Specifying a minimum of scans ensures that there is an evidence-based standard that all hospitals should aim for in order to continually improve the quality of care. However, this standard should make allowance for exceptions, as for example patients who are too frail to undergo any follow up. Therefore, the denominator should read “The number of adults who had potentially curative surgery for non-metastatic colorectal cancer and who are fit for follow up investigations”.
7	Question 6	No
8	Statement 1	It is agreed that adults with a new diagnosis of colorectal cancer should have testing for Lynch syndrome. A registry should be kept of these patients, who would also be tested for other cancers, for example, ovary in females. A registry, set up with the collaboration of the local Genetics Unit, will also help to identify first and second degree relatives who may be at risk. Widespread testing for Lynch syndrome (as experienced in Scotland) will put additional strain on the pathology laboratory services. The appropriate resources and funding should therefore be put in place.
9	Statement 2	Adults with early rectal cancer should be given the full opportunity to discuss their diagnosis and the various ways to treat (local excision eg TART, TAMIS, TEM; radical resection; chemoradiotherapy (only if part of a trial)). A discussion should also be made with regard to participation in the relevant prospective trials.
10	Statement 3	Pre-operative radiotherapy or chemoradiotherapy should be available for adults with node positive or locally advanced cancer, and not just for patients with margin-threatening cancer only. This implies that the local oncology unit will have to be prepared to meet an increased demand on its services.

11	Statement 4	This statement is agreed. In the UK, oncologists routinely request testing for RAS and other mutations prior to instituting treatment. Standardising this testing will ensure uniformity across all units. An increased demand on pathology laboratories is is to be expected.
12	Statement 5	Adults who had curative surgical resection for colorectal cancer should have at least three years' follow up, with the relevant investigations carried out. This is done in the majority of hospitals. Provided that robust protocols are in place, follow up does not need to be carried out by a consultant surgeon. A nurse-led colorectal cancer clinic is most useful and efficient use of resources.

Insert more rows as needed

Checklist for submitting comments

- Use this form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use

Please return to QSconsultations@nice.org.uk

NICE reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of NICE, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.

Comments received from registered stakeholders and respondents during our stakeholder engagements are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.