NICE National Institute for Health and Care Excellence

# Appendix B: Stakeholder consultation comments table

## 2022 surveillance of Suspected Cancer: Recognition and Referral (2015)

Consultation dates: 11th to 24th May 2022

**1. Do you agree with the proposal to resume the paused diagnostic assessment (GID-DG10036), followed by the update of NICE Guideline NG12 (after the publication of the resumed diagnostic assessment)?**

**Please could let us know if you agree or disagree (yes/no) and provide with your comments.**

| Stakeholder | Overall response | Comments | NICE response |
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| BSG colorectal committee & Endoscopy Section Committee | No | Thank you for the opportunity to respond to this consultation<br><br>The BSG and ACPGBI have completed this week a guideline about the use of FIT for symptomatic patients with a suspected colorectal cancer diagnosis which will be in the public domain in the next few weeks<br><br>As BSG guidelines are NICE accredited we have followed NICE methodology, using AGREEII, GRADE etc, and have included 92 individuals from around the UK in a broad | Thank you for your comment and information on the BSG-ACPGBI guideline. We will consider this information during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. The diagnostic assessment will include cost effectiveness evaluation, which does not routinely feature in the BSG-ACPGBI guideline. However, NICE is keen to build on the evidence synthesis done by BSG in developing future recommendations in the area. |

*Comments received in the course of consultations carried out by NICE 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 submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees*

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| | | Delphi to ensure that voices have been heard and the many relevant stakeholders have participated from primary, secondary care, patient groups and charities. The guideline development group included representation from the major studies of FIT in the symptomatic population, including NICE FIT, QFIT and other key leaders.<br><br>The scope of the BSG/ACP guideline is broader than the NICE consultation, including a broader range of symptoms of suspected CRC. We would suggest that any NICE guideline broaden its scope in line with this, which is supported by emerging evidence (i.e. not just change in bowel habit and abdominal pain)<br><br>The systematic review from the BSG guideline incorporates the evidence outlined in the consultation document, for example from NICE FIT, and much more besides (including 'grey literature'), which have contributed directly to the formulation of the guideline recommendations. There is an ongoing HTA NIHR programme which will publish in approximately a year from now, and it would be a more appropriate time to consider reopening the NICE guidelines process at this point. We would respectfully ask that NICE support the BSG/ACP guideline in the interim, and offer clinicians advice that it may be used in place of DG30/NG12 guidelines until further new evidence is published which can inform a future guideline update.' | |

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| The Association of Coloproctology of Great Britain & Ireland | | Thank you for inviting the Association of Coloproctology of Great Britain & Ireland to comment on this consultation re NICE Guideline NG12.<br><br>The ACPGBI and BSG have completed this week a guideline regarding the use of FIT for symptomatic patients with a suspected Colorectal Cancer which will be in the public domain in the next few weeks.<br><br>This Guideline is an up to date, comprehensive evaluation of this important area and includes the most recent literature. It has been developed by a multidisciplinary Guideline Development Group which included representatives from the major population based studies of FIT in symptomatic patients (including the NICE-FIT study). The Guideline Development has had input from all the relevant stakeholders, with 92 individuals from Primary Care, Secondary Care (Colorectal Surgery (ACPGBI), Gastroenterology (BSG), Radiology (BSGAR), Nursing, Biochemistry, Epidemiology, Patient Representatives and Charities. BSG Guidelines are NICE Accredited and NICE Methodology has been followed including use of AGREEII and GRADE.<br><br>The scope of the ACPGBI-BSG Guideline is broader than that of this NICE Consultation, including a wider range of symptoms of a suspected CRC, which is supported by emerging evidence and we would suggest that a future NICE Guideline should include these aspects.<br><br>The ACPGBI-BSG Guideline includes a comprehensive systematic review of the most up to date evidence which | Thank you for your comment and information on the BSG-ACPGBI guideline. We will consider this information during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. The diagnostic assessment will include cost effectiveness evaluation, which does not routinely feature in the BSG-ACPGBI guideline. However, NICE is keen to build on the evidence synthesis done by BSG in developing future recommendations in the area. |

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| | | includes the NICE-FIT study referred to in this consultation but also a many other relevant, recent studies. These have all been evaluated in the synthesis of the guideline recommendations. There is a current HTA NIHR programme which is due to report in 1 year's time, we would suggest that this would be an appropriate time to resume the paused diagnostic assessment (GID-DG10036). We would therefore respectfully ask if NICE would consider supporting this Joint ACPGBI-BSG Guideline in the interim, and offer clinicians advice that it may be used in place of DG30/NG12 guidelines until further, new evidence is published which can inform a future NICE Guideline update. | |
| The Village Medical Centre | Yes | Yes<br>Resuming this assessment would allow progress to be made on using FIT as a triage tool in primary care as a rule out test for colorectal cancer in selected groups of patients. This enables capacity to be created in secondary care (both in endoscopy and within surgical services), empowers primary care teams to make evidence-based decisions about patient care and importantly allows us to be able to rapidly reassure patients that the symptoms they have presented with are NOT that of colorectal cancer. This will reduce anxiety for patients and allow primary care to move on to exploring other diagnoses for the patient and hopefully help to resolve their symptoms faster. | Thank you for your comment. |
| Royal College of Paediatrics and Child Health | Yes | Yes. In the document there is an error - it refers to the NICE-FIT study but the study was funded by NHS England not NICE and this should be clarified.<br><br>Yes. This seems a sensible adoptions but consideration | Thank you for your comments.<br>The “NICE-FIT” study is the name of the study, quoted by the authors in their publications. It is not referring to the funding source. We have added additional reference in the surveillance report. |

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| | | should be given to making clear of it's relevance to the adult population and lack of checking in paediatrics. | We will ensure the scope of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12 will be explicit about which populations will be covered. |
| Royal College of General Practitioners | Yes | We welcome the introduction of any test that is accurate, sensitive and useful in clinical practice, especially where it can supersede a needless invasive procedure. It appears that from the submission FIT testing, if used, would reduce the number of people requiring colonoscopy.<br>Though there is a good rationale developing for use of FIT testing in primary care in the context of carcinoma of the colon and rectum – we did not identify in the proposal a recognition that a palpable mass (on rectal examination) would not necessitate a delay in referral by arranging a FIT test and waiting for a result – this type of scenario should ensure fast tracking. One problem that members identify is that many of the referrals are screened by inexperienced clinicians or administrators, and the importance of an ability to refer outside the " guidance" which we accept is inherent in NICE documentation is not often delivered in that way at a working level.<br>There needs to be clear and succinct guidance produced to help clinicians and patients understand the difference between a screening FIT and a FIT used in the symptomatic context.<br>We believe it would be useful to adapt any current national early diagnosis of cancer guidance on the basis of relevant findings. | Thank you for your comment and information. We will consider this information during scoping of the diagnostic assessment (GID-DG10036). Palpable mass is currently in recommendation 1.3.2 in NG12. The referral pathway and the use of FIT in this population will be evaluated in the diagnostic assessment (GID-DG10036), followed by any subsequent update of NG12 if required. |
| Royal College of Physicians | Yes | Yes.<br>Especially in the early post-COVID era (with overloaded systems) accurate referrals and excellent triaging using simple tests with approved safety need to be | Thank you for your comment and information. We will consider this information during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. We will register |

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| | | implemented.<br>In the near future, video capsule (colonic) endoscopy may play a role in patients with low positive results of quantitative FIT tests (10-50mcg/g) instead of colonoscopy, however more data is required for its implementation.<br><br>RMP strongly endorses the proposal to resume the paused diagnosis assessment and subsequent NICE update around the FIT test. It will be particularly important to see proper account being taken of the NICE-FIT data generated by the RMP-funded study. Our understanding is that FIT testing in primary care has so far not led to any reduction in GP referral and subsequent colonoscopy, so clearly there is work to do. | the issue of emerging evidence on the use of video capsule endoscopy to our issue log, and will monitor the research in this area. |
| Lancashire & South Cumbria Cancer Alliance | Yes | Yes in agreement;<br><br>1. If significant alternations to patient pathways are to be made based on FIT testing, it is essential that there is a high level of confidence in the test. The LSC data https://bmjopen.bmj.com/content/12/4/e059940 shows a very strong negative predictive value for FIT with 2 FIT tests but cancers were detected in patients with one negative and one positive FIT test which could potentially have been missed with a single FIT test. We therefore suggest consideration of dual FIT testing as the national standard for guidelines.<br>2. The very small number of patients with negative FIT tests who had a colorectal cancer in the LSC series all had Iron Deficiency anaemia and most had large tumours. We therefore endorse the recommendations of Professor Johnson and Dr Logan published 10 Aug 2020 regarding | Thank you for your comment and information. We will consider this information, including populations, FIT thresholds and definition for iron deficiency anaemia during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |

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| | | exceptions to removing patients from Rapid Diagnostic Pathways based on negative FIT tests.<br>3. Assuming that patients with Iron Deficiency anaemia will be excepted from step down from Rapid diagnostic Pathways based on Negative FIT tests, it is vital that the criteria for Iron deficiency anaemia are well defined and agreed across primary care, secondary care and diagnostic services. The current NICE guidelines on Iron deficiency anaemia are subject to differing interpretations. We would urge NICE to consider a robust algorithm for the definition of Iron Deficiency Anaemia that can be used in primary care in the context of NG12 referrals. In the current absence of this, LSCCA are currently in the process of setting up a working group to define local guidelines, but we would welcome this being addressed by NICE.<br>4. We have identified that there are patients who do not meet either NG12 or DG30 criteria who are referred to the rapid access colorectal cancer clinic on the basis of a +ve FIT test at the 10ug/g threshold. A preliminary data analysis suggests that this accounts for around 10% of colorectal rapid access referrals. We are currently analysing the FIT levels and cancer incidence in these patients. The assumption would be that, given these patients do not have high risk symptoms, there pre-test probability of cancer would be lower and consequently the cancer risk associated with a +ve FIT test at the 10ug/g threshold would also be lower. We note that, even in patients over 60, BSCP has elected to use a a FIT threshold of 110ug/g for patients without colorectal symptoms and feel that further consideration is needed as the appropriate FIT threshold for rapid access referral in patients not meeting the NG12 or DG30 | |

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| | | criteria. (Consider current biomarkers) FCP to be considered | |
| NICE Quality Standards Team | Yes | Yes. Stakeholders commented on the importance of quantitative FIT (qFIT) testing during the update to NICE's quality standard on colorectal cancer which was published in February 2022. Stakeholders noted the role of qFIT in referral of people with suspected cancer and the potential to support efficient use of resources ensuring colonoscopy is prioritised for those at highest risk of cancer. Stakeholders noted NHSE clinical guidance on triaging lower GI referrals using FIT. Use of qFIT was subject to comments at consultation for QS20, specifically around the use of qFIT in patients not currently addressed in DG30. The quality standards advisory committee discussed the use of FIT in high risk populations as a result of the pandemic and noted BSG guidance in development. Stakeholders noted an additional study that doesn't appear to have been included in your review (BD Nicolson et al, 2020 available at: https://onlinelibrary.wiley.com/doi/full/10.1111/apt.15969) | Thank you for your comment and information. We will consider this information during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12.<br>For the purpose of surveillance, we had to apply restrictive inclusion criteria for the literature review, with the aim to assess whether there is sufficient new evidence to warrant an update. Consequently, the Nicolson 2020 study is excluded in this surveillance review due to not all study populations having received the reference standard (colonoscopy). Separate systematic searches will be conducted for the evidence reviews for diagnostic assessment (GID-DG10036). |
| National Health Service England & National Health Service Improvement | Yes | Yes, we agree with the proposal to resume the paused diagnostic. However, it is essential that the guidance is informed by the COLOFIT study which is due to publish this calendar year. The purpose of the COLOFIT study is to evaluate the evidence and develop a risk-based algorithm for implementation of a FIT-based strategy for patients with possible colorectal cancer (CRC) symptoms presenting to primary care. | Thank you for your comment and suggestions. We will consider these suggestions during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. We are aware of the COLOFIT study, and we are tracking its publication. All relevant evidence will be considered in the diagnostic assessment and any subsequent update of NG12. |

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| | | The original review of NG12 re FIT was paused following discussions between NICE and NHSEI regarding the best way to manage CRC referrals using FIT. An agreement was reached that additional research was needed to test whether a single lower FIT threshold for CRC urgent referral would be appropriate in light of other risk factors such as age, sex and family history. The COLOFIT study was initiated to meet this need.<br>We also recommend that while the review of NG12 takes place, NICE adopts the Clinical guidance on triaging lower GI referrals which has recently been updated by NHSEI and submitted to NICE for approval. This and the Delphi review of FIT recently undertaken by the British Society of Gastroenterology and the Association of Colo-Proctologists of Great Britain and Ireland will act as an important bridge until the updated NG12 guidance is published following the conclusion of the COLOFIT study.<br>We further recommend that all guidance on FIT be contained within NG12 and DG30 be retired. The evidence suggests that the diagnostic accuracy of FIT is the same in both high and low risk symptomatic patients irrespective of the lower threshold used for onward referral. The current overlapping guidance on FIT alongside the NHS Bowel Cancer Screening programme of 120ug/gm is causing significant confusion among physicians in the field. Therefore, one piece of guidance for symptomatic patients would be highly recommended and we would expect this approach to lead to more consistent implementation of FIT and better management of endoscopy resource.<br>Finally, we strongly recommend that the diagnostic assessment considers the impact of a low FIT threshold (2ug/gm) for CRC urgent referral on endoscopy capacity | A decision will be made regarding the status of DG30 once the scope of the diagnostic assessment (GID-DG10036) is confirmed. |

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| | | and makes a pragmatic decision, informed by the BSG/ACPGBI Delphi review, on what cut off is appropriate. This review must consider the ongoing pressure on endoscopy services and the current low cancer conversion rates of the procedure which could be further negatively impacted by introduction of low FIT threshold for referral of 2ug/gm. | |
| Cheshire & Merseyside Cancer Alliance | Yes | Agree that this is re-commenced. It feels as though it would be appropriate to review the use of FIT with all LGI symptoms, including IDA. Specifically, these are as follows:<br>• Unexplained weight loss<br>• Unexplained rectal bleeding<br>• IDA<br>• People with rectal or abdominal mass<br>• Combinations of symptoms e.g. Rectal bleeding AND WITH abdominal pain/CBH/weight loss/IDA<br>FIT is vital in informing triage of patients with LGI symptoms, it would be important to understand NICE position with regards to utilisation of this in Primary Care. Clinical Teams are bought in to this as a test and need further NICE Guidance to give confidence. There is a need for clarity on what to do with patients who are FIT negative and do not have IDA, for example. Similarly, it is key to understand the effectiveness of FIT in individuals who do have IDA i.e. does FIT aid with clinical prioritisation, for example.<br>There are also areas who carry out duplicate FIT tests and is key to understand the cost/benefit of doing this at a system-level.<br>All of these points will hopefully be included within the expected guidance from the British Society of | Thank you for your comment and information. We will consider this information during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |

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| | | Gastroenterology however, NICE guidance that compliments this would be welcomed. | |
| Bowel Cancer UK | Yes | Yes, Bowel Cancer UK agree with the proposal. However, we believe it would be prudent to resume this assessment after the completion of the ongoing National Institute for Health and Care Research's Health Technology Assessment on 'Faecal immunochemical test (FIT) based tools to triage patients in primary care' due to be published at the end of 2022. This assessment is considering the use of FIT by GPs for all patients with possible colorectal cancer (with possible exceptions such as severe Iron deficiency anaemia/rectal masses) and incorporates important variables including age, sex, full blood count results. It will also offer a health-economic analysis of the use of FIT in this cohort.<br><br>In addition, the British Society of Gastroenterology (BSG) and the Association of Coloproctology of Great Britain and Ireland (ACGBI) are due to publish new guidance on the use of FIT in patients with signs or symptoms raising suspicion of colorectal cancer imminently. The development of this guidance included a systematic evidence review incorporating the evidence highlighted within the NICE proposal (i.e. NICE FIT) and was developed using NICE methodology. As such, the scope of the NICE proposal should be broader and include anaemia and other bowel symptoms and the additional evidence collected through the Health Technology Assessment should be taken into consideration. | Thank you for your comment and information. We will consider this information during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. We are aware of the COLOFIT study and are monitoring its publication. All relevant studies, including the COLOFIT study will be considered by the diagnostic assessment (GID-DG10036) and any subsequent update of NG12.<br><br>We are aware of the forthcoming publication of the BSG-ACPGBI full guideline, and the publication of its headline report. We are liaising with BSG to explore possible collaboration in developing future recommendations in the area. |

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| Cancer Research UK | Yes | Yes<br><br>· We are aware the diagnostic assessment for using FIT in patients with abdominal pain/change in bowel habit was already under review before the pandemic. Since the pandemic, national guidance was published in response to COVID-19, recommending the use of FIT to triage patients, including in those who meet the urgent referral criteria (and may have abdominal pain or change in bowel habit). Throughout the pandemic our insight suggests that the implementation of FIT has accelerated, including shifts towards use in higher risk patients.<br><br>· The CRUK GP Omnibus survey [1] has been used to ask GPs in the UK if/how they were using FIT in June 2020, and again in March 2021 and Nov 2021. The results showed an increase in the proportion of GPs reporting that they are using FIT to some capacity in primary care (June 2020: 60%, March 2021: 76%, November 2021: 87%). There was also a shift in the proportion of GPs reporting using FIT for low-risk patients, which reduced over time, whereas for high risk, the proportion increased. For England where regional breakdowns were available, we saw a large variation in how FIT was being used. As these data indicate that FIT is being used in 'high risk' patients, an evidence-based recommendation for health professionals may be helpful.<br><br>· Overall, it seems timely and beneficial to provide follow-up guidance to that published in response to COVID-19, which can now be informed by the research undertaken prior to this which has since been published, and by evaluations from the areas which implemented FIT in | Thank you for your comment and information. We will consider this information during scoping of the diagnostic assessment (GID-DG10036). NG12 may be updated subsequently pending on the outcomes of the diagnostic assessment. The diagnostic assessment will include cost effectiveness evaluation, which does not routinely feature in the BSG-ACPGBI guideline. However, NICE is keen to build on the evidence synthesis done by BSG in developing future recommendations in the area. |

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| | | high-risk patients.<br><br>· There should be clarity about how any new NICE guidelines and NG12 updates fit in with the upcoming BSG/ACPGBI guidance.<br><br>Reference<br><br>1. Cancer Research UK GP Omnibus survey (2020-2021) Unpublished findings. Data collected by medeConnect who interview 1000 regionally representative UK GPs online. medeConnect is a division of Doctors.net.uk | |
| Royal College of Nursing | No comment | We do not have any comments to add on this. Many thanks for the opportunity to contribute. | Thank you. |

**2. Are you aware of any acceptability issues from specific groups around the use of FIT, particularly on collecting stool sample?**

**If yes, please provide us details.**

| Stakeholder | Overall response | Comments | NICE response |
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| BSG colorectal committee & Endoscopy Section Committee | Yes | See comment for question 1 | Thank you for providing this information. |

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| The Village Medical Centre | Yes | Elderly patients and those patients who have problems with manual dexterity may find the process of using the FIT kit more challenging and anecdotally men are less likely to return their FIT kits. However, the alternative of having a colonoscopy is far more invasive and generally less acceptable to patients. | Thank you for providing this useful information. We will log this information to the Equalities Impact Assessment.<br>We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |
| The Association of Coloproctology of Great Britain & Ireland | | The Joint ACPGBI-BSG Guideline on the use of FIT in patients with symptoms of suspected colorectal cancer contains a systematic review of the most current literature regarding the acceptability of FIT testing for patients and clinicians. There is limited published data on this area but on the basis of this limited information there is no evidence which identifies that there are acceptability issues from either patients or clinicians with the use of FIT. It is also important to note that FIT testing is already widely used in bowel screening patients as well as more recent use in symptomatic patients and acceptability issues have not been identified. | Thank you for providing this information. We are aware of the Delisle (2022) study on 'Faecal immunochemical test for suspected colorectal cancer symptoms: patient survey of usability and acceptability'. We will consider this information in the diagnostic assessment and any subsequent update of NG12. |
| Royal College of Paediatrics and Child Health | No | No. The decision to end the need to conduct colonoscopies on often health people is a wise one. The paper in GUT speaks for itself.<br><br>Yes. Lack of investigation into the use of it in children - in this setting 'rule out bowel cancer' would leave a wide range of other gastrointestinal illnesses which need colonoscopy and is a clinically incorrect question. | Thank you for providing this information.<br>The diagnostic assessment (GID-DG10036) and NG12 cover children and young people. We will consider all relevant evidence on this sub-group and will address this sub-group issue where possible. |

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| Royal College of General Practitioners | No | We have not seen any expressed acceptability issues. | Thank you for your comment. |
| Royal College of Physicians | | No – if patients receive appropriate guidance and importance about the outcome is provided / explained.<br><br>As regards acceptability , our experts would like to highlight a published piece of work on this: https://bjgpopen.org/content/6/1/BJGPO.2021.0102<br><br>Overall there was a high degree of acceptability, particularly in those aged over 65. Over 90% of individuals had no problem with faecal collection. | Thank you for providing this useful information.<br>We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |
| Lancashire & South Cumbria Cancer Alliance | Yes | See comment for question 1 | Thank you for providing this information. |
| NICE Quality Standards Team | No | No | Thank you. |
| National Health Service England & National Health Service Improvement | No | We are not aware of any acceptability issues. | Thank you. |
| Cheshire & Merseyside Cancer Alliance | Yes | Comprehensive patient experience evaluations in our two original pilot sites have found the following:<br><br>a. Site 1<br>i. Positive feedback on the pathway was received from | Thank you for providing this useful information.<br>We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |

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| | | patients, consultants, and primary care colleagues. GPs comments included that FIT was “easy to navigate with simple written guidance … fast turnaround”.<br>ii. Further opportunities were identified to improve FIT for patients as part of a study carried out by University College London. The study found that while FIT is highly acceptable, the symptomatic FIT pathway could be improved by; 1) ensuring the purpose of the test is explained (during the GP consultation), 2) providing clearer kit instructions/wider sample tubes and, 3) always providing the patient with the test result. In terms of future work, this study found that satisfaction with the GP consultation and the way the results are delivered are lower in the more socioeconomically deprived parts of Cheshire and Merseyside.<br>b. Site 2 – patient experience survey<br>i. 77% surveyed believe they received clear GP communication regarding the FIT test.<br>ii. 86% surveyed felt that they test instructions were clear and helpful<br>iii. 95% surveyed said completing the test did not add to any anxiety they had<br>iv. 68% said they would not have preferred to go straight to the hospital for a colonoscopy.<br>v. 94% said that completing the test was easy.<br>vi. 75% say they had an overall positive experience | |
| Bowel Cancer UK | | New guidance on the use of FIT in patients with signs or symptoms raising suspicion of colorectal cancer by British Society of Gastroenterology (BSG) and the Association of Coloproctology of Great Britain and Ireland (ACGBI ), due to published imminently, reviewed the acceptability of | Thank you for providing this useful information. |

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| | | FIT in patients with suspected colorectal cancer symptoms. In summary, all of the papers that reported the uptake of FIT in its study sample demonstrate an uptake of between 78.9% and 94%. There was some suggestion that younger age groups found the FIT kits less acceptable to complete which may need explored in more detail and addressed. These results suggest that the test has a high degree of acceptability. Patients prefer the non-invasive FIT kits over colonoscopy as long as its accuracy is comparable. Thresholds can be used to highlight high-risk patients and so that a rapid response can be initiated.<br><br>However, while the review recommended that FIT is an acceptable test for this patient cohort, the grade of evidence is very low. In addition, there is insufficient evidence of significant barriers to the use of FIT related to acceptability of the test by clinicians or patients. It is recommended that services should consider ways of promoting a high proportion of patients to return a FIT kits. | We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |
| Cancer Research UK | Yes | Yes<br><br>The February 2022 CRUK GP Omnibus survey [1] asked GPs in the UK about barriers to using FIT in primary care for the investigation and diagnosis of people who present with colorectal symptoms. The top 3 barriers reported by GP respondents were:<br><br>· The patient's not returning the test (51%)<br><br>· The patient being asked to redo the FIT test as it has | Thank you for providing this useful information. We will log this information in the Equalities Impact Assessment.<br>We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |

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| | | been rejected i.e., spoilt, labelled wrong (41%)<br><br>· The patient not wanting to do the test (28%)<br><br>Further to this, in a CRUK public survey of more than 4,000 people across the UK, conducted by YouGov Feb-Mar 2022, we asked respondents whether they would do a FIT if they had bowel symptoms and their GP or health professional had asked them to do the test [2]. Overall, the majority responded, 'yes definitely' or 'yes, probably' (62% and 22%, respectively). However, there were groups who were significantly less likely ($p<0.05$) to say 'yes definitely', including:<br><br>· Men<br><br>· Younger age groups - those aged 18-34<br><br>· Those living in London versus UK average<br><br>· Those who are more deprived (social grade C2DE)<br><br>· Those who are of Black, Asian, and Minority Ethnic (BAME) ethnicity – particularly Black and Asian people<br><br>Men, and those living in London only were significantly less likely to say 'net yes' (yes, definitely or yes, probably).<br><br>These survey findings are consistent with findings in the evidence base, specifically, from the NICE FIT study patient survey which found willingness to do FIT again was stronger in patients from white compared with other | |

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| | | non-white groups, and in those outside London [3]. Additionally, preference for FIT over colonoscopy was weaker in younger age groups (those 40-64 compared to those >65). The researchers did not have ethics approval to collect demographic data on patients who declined to return a FIT, so could not comment on whether some people are more or less likely to return a FIT when asked to. This information is not routinely reported in research and evaluations as far as we are aware, but we would be keen to see this addressed in the future.<br><br>Insights from bowel screening<br><br>FIT is now used in the bowel screening programmes across all UK nations. We regularly seek to understand attitudes and beliefs around bowel screening in our CRUK Cancer Awareness Measure (CAM) [4]. While the question focuses on screening, and therefore asymptomatic rather than symptomatic use of FIT, there may be some interesting parallels and insights to draw. In our most recent CRUK CAM survey (Feb 2022, unpublished data), people of black and minority ethnic origin were more likely to report that a barrier to them taking part in bowel screening last time they were invited was 'I found it too messy to complete the poo test kit' (11% versus 4%).<br><br>References<br><br>1. Cancer Research UK GP Omnibus survey (2022) Unpublished findings. Data collected by medeConnect who interview 1000 regionally representative UK GPs online. medeConnect is a division of Doctors.net.uk | |

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| | | 2. Cancer Research UK (2022). Public polling. Unpublished findings. Data collected by YouGov Plc, 22nd Feb - 7th March.<br><br>3. Georgiou Delisle, Theo, Nigel D'Souza, Bethan Davies, Sally Benton, Michelle Chen, Helen Ward, and Muti Abulafi. "Faecal Immunochemical Test for Suspected Colorectal Cancer Symptoms: Patient Survey of Usability and Acceptability." BJGP Open 6, no. 1 (2022): BJGPO.2021.0102. 4. Cancer Research UK's Cancer Awareness Measure survey (February 2022) Unpublished finding. Data collected by YouGov Plc. | |
| Royal College of Nursing | No comment | We do not have any comments to add on this. Many thanks for the opportunity to contribute. | Thank you. |

**3. Are you aware of any other health inequalities issues?**

**If yes, please provide us details.**

| Stakeholder | Overall response | Comments | NICE response |
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| BSG colorectal committee & Endoscopy Section Committee | Yes | See comment for question 1 | Thank you for providing this information.<br>We will pass this information to the developer who will update the guidance. |

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| The Village Medical Centre | No | No | Thank you. |
| The Association of Coloproctology of Great Britain & Ireland | Yes | The Joint ACPGBI-BSG Guideline has reviewed the most current literature regarding this area. There is very limited evidence regarding this area but it is recommended that clinicians focus on equity of access and application to all patients with lower GI symptoms to actively prevent the risk of inequality or discrimination. | Thank you for providing this useful information.<br>We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |
| Royal College of Paediatrics and Child Health | No | No. One might consider literacy as an obstacle or lack thereof. | Thank you for providing this information. |
| Royal College of General Practitioners | No | We are not aware of any other health inequalities issues. | Thank you. |
| Royal College of Physicians | No | No<br><br>In the aforementioned study, comparing acceptability and willingness to repeat FIT testing between white and no-white groups, this was higher in the white population. | Thank you for providing this information. |
| Lancashire & South Cumbria Cancer Alliance | Yes | See comment for question 1 | Thank you for providing this information. |
| NICE Quality Standards Team | Yes | qFIT was suggested by stakeholders as an area for quality improvement during topic engagement for development of QS20 in February 2022. Variation in provision of FIT testing was noted, and comments suggested that different CCGs were using different approaches to | Thank you for providing this information. |

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| | | implementation. This could have an impact on health inequalities. | |
| National Health Service England & National Health Service Improvement | | We will be monitoring the impact of inequalities closely through the data we will be getting through the Primary Care Network Investment and Impact Fund incentive showing how many two week wait referrals are accompanied by a FIT at PCN level. Cancer Alliances have been set the objective of identifying and acting on health inequalities in relation to FIT and funding has been transferred to the Transforming Care Services Team in London to specifically address uptake issues in the Bangladeshi community.<br>Cancer Research UK has created materials to support patients to undertake a FIT which NHSEI has published through the Primary Care Network DES. | Thank you for providing this useful information.<br>We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |
| Cheshire & Merseyside Cancer Alliance | Yes | The University College London study found that satisfaction with the GP consultation and the way the results are delivered are lower in the more socioeconomically deprived parts of Cheshire and Merseyside.<br>Additionally, it is important for patient instruction leaflets and information to be reviewed by reader groups to reflect all ages and readability. For example, the reading age in some parts of Cheshire & Merseyside is 7 years old.<br>Evaluations have shown that the elements that are essential to contribute to a successful equitable FIT service are as follows:<br>• Comprehensive Primary Care education and awareness of pathways and criteria/method of ordering a FIT.<br>• Appropriate and timely distribution to patients. | Thank you for providing this useful information.<br>We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |

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| | | • Optimal understanding of FIT by patients to promote completion of the test.<br>• Appropriate and timely analysis of FIT by pathology, utilising Medical Laboratory Assistants to support this process.<br>• Employment of an Early Diagnosis Support Worker (EDSW) to work with existing LGI EDSWs and support robust safety netting of patients throughout the pathway, including timely referral by Primary Care.<br>• Development and use of Tracking Dashboards to support safety netting, test tracking and timely referral.<br>• Clear evidence-based guidance to support Primary and Secondary Care clinicians to triage patients effectively and ensure appropriate follow-up investigation and onward referral.<br>• Clear Primary and Secondary Care processes to ensure that FIT test results inform the LGI triage process.<br>• Appropriate clinical and operational oversight of FIT within a Trust with clear incorporation in to the LGI suspected cancer pathway as part of the colorectal service. | |
| Bowel Cancer UK | | Data on the role of underutilization of CRC screening among certain racial and ethnic minorities, age groups, and among persons with lower socioeconomic status in the screening literature are well reported. However, data on differences in utilization for FIT testing in symptomatic patients is very limited. As such, active efforts should be made to avoid discrimination as symptomatic FIT testing is rolled out, with a clear emphasis on equity of access and application. | Thank you for providing this useful information.<br>We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |

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| Cancer Research UK | | We would like to take this opportunity to raise the importance of clear public/patient comms and engagement around the different indications for FIT, particularly in the screening-eligible population. There are important differences between screening and symptomatic indications, and it is essential that people who have (recently) undertaken a screening FIT do not think that a symptomatic FIT is not indicated, if that is what a GP suggests on the basis of their symptomatology, and vice versa. GPs and other primary care staff have an important part to play in supporting their patients to engage with FIT and it is essential that they have the time and resources that allow them to do this optimally.<br><br>The public/patient's understanding of FIT symptomatic compared to FIT for screening purposes could be a helpful topic to build insight on. Investigating how perceptions might vary across different groups could support more tailored approaches to supporting individuals in the future. | Thank you for providing this information.<br>We will ensure this information is considered during scoping of the diagnostic assessment (GID-DG10036) and any subsequent update of NG12. |
| Royal College of Nursing | No comment | We do not have any comments to add on this. Many thanks for the opportunity to contribute. | Thank you. |