Clinical practice guidelines for the prevention, early detection, and management of colorectal cancer: Population Screening. Appendix J.

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September 2023

Appendix J. Public consultation submissions summary

Public Consultation Submission Summary

Contents

Overview

A complete draft of the guidelines chapter updates were released for targeted expert consultation and public consultation over a period of 30 days from 17 April 2023 to 17 May 2023. The public consultation process complied with Section 14A of the NHMRC Act 1992 (Commonwealth) and accompanying regulations.

The draft guideline chapters were made publicly available on the CCA website during the public consultation period. The following organisations and individuals were specifically invited to provide feedback.

Organisations/Bodies:

- Cancer Australia
- Cancer Council NSW
- Cancer Council QLD
- Cancer Council SA
- Cancer Council TAS
- Cancer Council VIC
- Cancer Council WA
- Cancer Institute NSW
- Gastroenterological Society of Australia (GESA)
- National Aboriginal Community Controlled Health Organisation (NACCHO)

- Wellbeing South Australia

Individuals:
- Minister for Health
- Chief Health Officer NSW
- Chief Health Officer VIC
- Chief Health Officer QLD
- Chief Health Officer WA
- Chief Health Officer SA
- Chief Health Officer NT
- Chief Health Officer ACT
- Chief Health Officer TAS

Summary of Consultation

Date of consultation: April 17th 2023 – 17th May 2023

Total number of submissions received: # 17

Type of respondent:

- Individual respondent: # 2
- Organisational respondent: #15

Method of submission:

- Submissions received via REDCap: # 12
- Submissions received via Email: # 5

Demographic data of responders

ID	State/Territory	Postcode
1	[redacted on request]	[redacted on request]
2	New South Wales	2012
3	Queensland	4810
4	Queensland	4000
5	Canberra	2601

6	No response	Not provided
7	Queensland	4006
8	[redacted on request]	[redacted on request]
9	South Australia	5000
10	New South Wales	2113
11	Not applicable -Best Bowel Australia Alliance is a national research collaboration	Not provided
12	[redacted on request]	[redacted on request]
13	South Australia	5000
14	Tasmania	7000
15	[redacted on request]	[redacted on request]
16	Victoria	3065
17	South Australia	5001

Conflicts of interest

ID	**COI**	**Action taken**
1	No	
2	Cancer Australia has a representative – Vivienne Milch – on the Working Group who was involved in the preparation of the submission.	
3	No	
4	[response not provided by respondent]	
5	[response not provided by respondent]	
6	[response not provided by respondent]	
7	No	
8	No	
9	Yes -cancer council	
10	Yes- We work for a Colorectal declare Cancer Screening Business	
11	Mark Jenkins, Finlay Macrae, Jon Emery and Karen Canfell are all members of the Best Bowel Australia Alliance and members of the Guidelines review committee and therefore have a potential conflict of interest. However, none of the comments made in this submission were made by any of these four.	
12	No	

13	No	
14	No	
15	No	
16	Yes – I am an employee at Genetic Technologies	
17	[response not provided by respondent]	

General content and applicability of guidelines overall

ID	Comment	Project Team response	Action taken
1	I have been involved in several external meetings where members from academic institutions intend to lobby for an even lower screening age (40yrs) for citizens of Aboriginal and Torres Strait Islander origin based on published relatively weak modelling data showing benefit (these data are referenced in your guideline update). While the focus of these meetings championing equity have been admirable, and while I do believe that CRC outcomes for this population group is poor and that we should do better, I have been struck that these discussion have not been robust from an academic / scientific standpoint in my opinion.	Noted.	No action taken.
	I wish to make two points regarding this issue (in lieu of my opinion being potentially excluded from another submission): 1. While younger screening age may be indicated for the population as a whole when looked at from a singular focus of diagnosing colorectal cancer, in my opinion we do not have sufficient evidence that such a policy change would be feasible nor cost-effective in Australia. This is particularly the case given existing waitlist burdens and potential opportunity costs for symptomatic patients requiring a colonoscopy if these are further exacerbated. Nevertheless I agree with the framing in the guideline that the evidence be labelled as "Weak", but that the policy is supported.	Noted. The available evidence on feasibility has been summarised in the short review (Population screening - Appendix E7). The cost-effectiveness of CRC screening in alternative age ranges for the Australian population is also presented in the Population screening chapter - section 4.4.2, with the full technical report available in the Population screening Appendix E2. On the basis of this information, the recommendations and practice points have been developed.	No action taken.
	2. I do not think that an even lower starting age for Aboriginal and Torres Strait Islander people is indicated for colorectal cancer screening. I say this because the incidence of this cancer is higher in citizens of European origin than those with other ethnicities and, in general, disease screening is more effective targetted at populations with higher incidence of more indolent disease, rather than for populations of lower incidence of more aggressive disease (such as our indigenous population). I would suggest that if ethnicity based screening policy is to be pursued (and I'm not certain that it should be) funding and resource would be much better utilised targetting preventable diseases that are of higher prevalence in the Aboriginal and Torres Strait Islander population (such as cardiovascular disease for example, or other cancers).	Noted. The proposed recommendations and practice points do not differ based on ethnicity nor for Aboriginal and Torres Strait Islanders based on the current available evidence. Improving outreach and access is acknowledged and supported in the current draft for the Aboriginal and Torres Strait Islander communities.	No action taken.

	https://www.aihw.gov.au/news-media/media-releases/2021-1/october/indigenous-burden-of-disease Alternatively, improving outreach access and support for the existing screening initiative in more remote communities would be a more worthwhile thing to advocate for (i.e. attending to the geographic barrier).		
	Having worked in NZ for many years, I can tell you first hand that well meaning colonoscopy screening policy biasing in favour of the indigenous population has had the converse effect in practice, where the outcomes for that population has NOT improved, but the opportunity cost for symptomatic patients as a whole, in particular those with curable / preventable disease has arguably suffered due to waitlists being overwhelmed.	Noted.	No action required.
2	Cancer Australia commends the Daffodil Centre Project Team for conducting the update according to National Health and Medical Research Council (NHMRC) requirements and notes that the guidelines will be submitted to the NHMRC for approval.	Noted.	No action required
	Cancer Australia notes that a Working Party chaired by Professor Tim Price, including key experts in colorectal cancer from the majority of jurisdictions across Australia, consumer representatives, Aboriginal and Torres Strait Islander representatives and Cancer Australia's Medical Director, Prof Vivienne Milch, oversaw the update.	Noted.	
	In particular, it is pleasing that there has been close engagement with National Aboriginal Community Controlled Health Organisation (NACCHO), and that new practice points to support participation by Aboriginal and Torres Strait Islander people in bowel cancer screening have been co-developed with NACCHO.	Noted.	
3	Overall acceptable and applicable general content.	Noted.	General comment- no action required
4	Queensland notes the proposed updates to the Guidelines, including lowering the age recommended for biennial screening from 50 to 45 years. Given the community is accustomed to 50 being the age at which bowel screening begins, Queensland recommends consideration be given to a significant marketing campaign to alert health consumers of the updates to the Guidelines, particularly the change to the age cohort recommended for screening.	Noted and agreed. Awareness and marketing campaigns are implementation considerations for the National Bowel Cancer Screening Program. They are out of scope for the Guidelines which focus on the evidence available to guide clinical practice. These considerations will be put forward to the Department of Health and Aged Care.	Implementation issues have been collated and shared with the Department of Health and Aged Care, the National Bowel Cancer Screening Program.
	Consideration should also be given to engagement with the primary care sector to embed the updated Guidelines into health checks for people aged 45 to 49.	Noted and agreed. As above, these implementation issues will be put forward to the Department of Health and Aged Care.	Implementation issues have been collated and shared with the Department of Health and Aged Care, the National Bowel Cancer Screening Program.

5	***Language*** NACCHO notes and commends the inclusion of the plain language introductions to the draft chapters. To increase the reach of the guideline to all healthcare workers, minimal technical terminology should be employed across all components. The use of complex language reinforces inequities by ensuring only a select few can truly understand the evidence. **NACCHO recommends** ensuring all components of the document are clearly explained, with minimal technical terminology.	Noted. Where technical terminology is included, definitions and explanations have been provided to improve understanding. A medical editor has reviewed the text to improve clarity.	Copy editing has been conducted to improve clarity and ensure definitions are clear and acceptable.
	Intended audience NACCHO notes doctors are referred to as the intended, primary audience of the guideline. However, acknowledging the contribution to screening of the broader healthcare team, including Aboriginal Health Practitioners and Aboriginal Health Workers, is essential. **NACCHO recommends** extending the intended audience to capture all members of the healthcare team, including Aboriginal Health Practitioners and Aboriginal Health Workers.	Noted and agreed.	Statement added.
	Consumer engagement NACCHO is aware that the Cancer Council sought Aboriginal and Torres Strait Islander involvement in the chapter reviews. While Appendix 1 details much of the guideline development process, NACCHO is interested in gaining more insight into how Aboriginal and Torres Strait Islander consumers were engaged and consulted in developing the draft chapters. **NACCHO recommends** the inclusion of additional information on processes undertaken to optimise involvement of Aboriginal and Torres Strait Islander consumers and experts in the development of the draft chapters.	The project team worked to find interested, available and suitable consumer and expert representatives to be involved with the Working Group who could represent Aboriginal and Torres Strait Islander communities, consumers, and their experiences. Throughout this process Cancer Council Australia consulted with the following organisations and contacts - Wellbeing South Australia – through this process a suitable person was identified for the Working Party, however they were not able to take part in this project with their existing commitments. Another contact at Wellbeing SA was able to offer their support, to review the revised guideline chapters when they have been drafted during the public consultation process. - National Aboriginal Community Controlled Health Organisation (NACCHO) - Cancer Council's Cancer Screening Immunisation Committee (consisting of state and territory federation members) - South Australian Health & Medical Research Institute - Flinders University - Cancer Council NT	Additional text has been added to clarify the processes undertaken to optimise involvement of Aboriginal and Torres Strait Islander consumers and experts in the development of the guideline chapter updates. (Appendix A in the appendices documents for both chapters)

		- NT Health (contacts through the Guideline Working Party Chair, Prof Tim Price) - Cancer Council Queensland. There were also members of the Working Party, who do work with Aboriginal and Torres Strait Islander communities in their roles, and while they were not on the WP explicitly representing these views, they were able to share their insight based on their experiences. The project team also encouraged input and review of the recommendations and draft Guidelines from Aboriginal and Torres Strait Islander organisations and contacts as identified above, and other consumers through the public consultation process. Throughout this process, the Project Team have also been able to identify difference processes and structures may need to be considered in future to increase and maximise opportunities for consumer participation in guideline development and review.	
	Ensuring equity NACCHO acknowledges the efforts to highlight the importance of ensuring equitable access to, and participation in, CRC screening. Equity is an essential aspect of any population-based screening program. Specific guidance regarding how healthcare professionals, associations and other key stakeholders might ensure equity would be helpful. This guidance would be particularly beneficial in the context of a proposed reduction in the screening age, given this is likely to exacerbate inequities faced by Aboriginal and Torres Strait Islander peoples and other disadvantaged population groups. **NACCHO recommends** specific guidance on how healthcare professionals can ensure equity in CRC screening participation.	Noted and agreed. A section has been included in the text to outline equity issues as they relate to CRC screening. It is the view of the Working Group that addressing equitable participation with respect to the many stakeholders is a complex task beyond the scope of the guidelines. Despite this, the issue has been recognised and the Working Party acknowledge that on a broader level needs to be tackled.	An additional sub-section was added to implications section 9.8, page 72, highlighting key issues around equity that need to be addressed.
6	We are in agreement and support the recommendation to lower the screening age of people eligible for screening from 50 – 74 years to 45 -74 years. The balance of increasing health benefits and limiting increases to costs, resource demand and potential harms of screening are favourable and support extending the age of starting screening to 45 years.	Noted.	No action required.

	For Indigenous Australians bowel cancer is often diagnosed at an earlier age with more advanced disease and has a poorer long-term outcome. Lowering the screening age of Aboriginal and Torres Strait Islander communities should be considered to start at 40 years of age. This would increase equity to health care for Indigenous Australians An existing precedent is the Absolute Risk Assessment for cardiovascular disease which starts screening at age 30 for Indigenous Australians, and 45 for non-Indigenous Australians.	Noted. Modelling evaluations for Aboriginal and Torres Strait Islanders screening from a younger age are included in the guidelines. The results showed that lowering the age to 40 may be less favourable in terms of benefit-to-harm balance. Lowering the starting age may also exacerbate inequalities and the Working Group determined that the age range should be in line with the general population.	No action taken
	The development of a standardised family history data collection tool for cancer and bowel cancer, would be useful to primary care practitioners and give guidance on referral to familial cancer clinics for further testing. This would also provide consistent information for future guideline updates.	Noted. This is beyond the scope of the current update but has been noted as a future direction for risk based screening in the Risk and screening based on family history chapter - Section 9.4 p51.	No action required.
	To assist primary care practitioners to increase screening among patients, explore a link between the letter going to a participant to inform them the screening kit is on its way and their GP to endorse completion of the test. This may assist in increasing the completion and return of bowel cancer screening kits.	Several studies and trials are underway to inform implementation issues such as the use of GP endorsement letters and the impact on NBCSP participation. Their inclusion in the guidelines is out of scope.	No action required.
7	In the recently released Cancer in Adolescents and Young Adults in Australia 2023 Report released by the Australian Institute of Health and Welfare on 19 April 2023, the overall rate of new cancer diagnoses in young adults (aged 15-25 years) has actually declined over recent years, due to a reduction in melanoma and cervical cancer. However, this decline is masking a 370% increased risk of bowel cancer in the Adolescent and Young Adult (AYA) population which is the largest cancer 'growth' diagnosis for this age group. What is also alarming is that it is not yet known why this is happening - possibly delayed diagnosis, diet and lifestyle, genetics?	Noted. This is out of scope of the current guidelines which focus on population screening for colorectal cancer. While colorectal cancer incidence is increasing in people at younger ages, it is still relatively low.	No action required.
	The Queensland Cancer Clinical Network (QCaCN) and the Queensland Youth Cancer Service (QYCS) encourages the Cancer Council Australia to consider adjusting the existing 50-74 age cohort, particularly for those at risk based on family history, and also consider alternative screening techniques and marketing that brings awareness to the community and clinicians of a young person's increased risk of colorectal cancer.	Noted and agreed. The evidence presented in the guidelines support the potential adjustment in age cohort eligible for colorectal cancer screening in Australia.	No action required.

8	Support described recommendations and practice points.	Noted.	General comment- no action required
9	Our recommendations are to provide greater explanation of the grading system in terms of why recommendations are categorized by certain strength (i.e. N/A, weak, strong? etc.) Difficult to make our best assessment without the background content of the grading system.	Noted and agreed. An explanation has been added in the appendix A text explaining the development process of the recommendations and practice point. The table defining strength has been update for more detail.	This has now been clearly detailed as part of table 5 defining strength of recommendations, in Appendix A of the appendices documents for both chapters
10	[response not provided by respondent]		
11	1) Referencing other screening programs and guidelines These guidelines do not reference what other colorectal screening programs are implementing internationally, or reviews of other program guidelines.	The systematic reviews conducted to inform on the guidelines and recommendations have been detailed along with their evidence summaries in the Population screening chapter appendices E1, E3, E4 and E6. The reviews detail that 16 potentially relevant guidelines were identified, but only five were based on systematic review evidence. Hence these five were included in the systematic review and assessed for evidence.	No action required.
	2) Weak vs strong ratings In the 1c Population Screening Chapter it states that "Each EBR was assigned a grade (either strong or weak) by the expert Working Party, taking into account the certainty of the body of evidence for the 2023 update and the evidence base and consistency for the 2005 guidelines and 2017 update evidence, as well as the generalisability, applicability, acceptability, feasibility and clinical impact of the body of evidence using the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) methodology." It is not clear exactly how previous guidelines and current GRADE ratings were "taken into account", nor why these ratings were decided by the working party, rather than based on a quantitative aggregation of the GRADE scores - would this not be the most unbiased method?	Noted. This was an error in the former statement. This has been corrected to reflect the NHMRC evidence statement form was used	The Population screening chapter appendices and chapter text (section 1.7.5 p18) have been corrected to "…body of evidence using the NHMRC evidence statement form".

	We suggest more detail is needed regarding the algorithm or process applied to calculate/decide upon these ratings. The sentence at the end of the paragraph: "Where there is clear evidence of benefit, 'recommended', 'not recommended' and 'offer' is used." is not clear to us as we could not understand what these labels were referring to.	Agreed and noted.	Detailed definitions have been included of the strength of recommendations and practice points have been added to table 5, in Appendix A of the appendices documents for both chapters. The sentence “'recommended', 'not recommended' and 'offer' is used." has been removed as it is no longer relevant
	Why was the decision made to use dichotomous grading of evidence over a more precise scale? It is difficult to interpret and potentially leads to EBRs being over- or under-rated. Would the authors consider providing more information to help interpret these ratings such as a column stating why the evidence for that particular EBR was weak - given multiple factors went into the rating?	We used NHMRC evidence statement form which rates various aspects of evidence using 4 point scales. Based on these assessments the EBRs were rated strong or weak reflecting a shift to the dichotomous rating of recommendations . The definitions of strong and weak in Table 5 are based on GRADE processes for going from evidence to decision which we did not use. To link the definition of the ratings strong and weak more closely to the NHMRC evidence statement form.	Detailed definitions have been included of the strength of recommendations and practice points have been added to table 5, in Appendix A of the appendices documents for both chapters. The sentence “'recommended', 'not recommended' and 'offer' is used." has been removed as it is no longer relevant
	3) EBR vs Practice Points In the 1c Population Screening Chapter it states that "Practice points were developed where there were issues out of scope of a systematic review, or where the body of evidence was considered of low quality, or no evidence was available". We found this confusing because most of the EBRs are made based on "weak" evidence which in our minds is equivalent to "low"; at least semantically. We think more details is needed to explain the process for deciding what recommendations didn't have sufficient amount or quality of evidence behind them to be "evidence-based" recommendations. This would help distinguish the two types of recommendations.	Noted and agreed. An explanation has been added in the appendices A text explaining the development process of the recommendations and practice points. The table defining strength has been update for more detail.	Detailed definitions have been included to describe the strength of recommendations and practice points development and have been added to tables 3, 4 and 5, in Appendix A of the appendices

			documents for both chapters
	Similarly, it is not clear what "N/A" under study strength means? It appears to only relate to the recommendations about an age-range extension which we assume are based largely on modelling as opposed to systematic reviews -would this not make them practice points?	Noted. There is no current guidance available to assign “strength” to evidence provided using modelling. These recommendations are considered evidence-based but typically assigned a strength of N/A	This has now been clearly detailed as part of table 5 defining strength of recommendations, in the Population screening chapter appendices – Appendix A
12	Overall concerns that guidance to lower the age of participation to 45 is based on only a small number of studies. In addition, the barriers, enablers and participation rates of people aged 45-49 are unknown as this is not an age group that has been systematically offered population screening for colorectal cancer.	Noted. The available evidence identified with respect to age range was sought and summarised in the systematic review results. The evidence did not commonly report on individuals under the age of 50. Modelled evaluations were informed by available evidence and expert advice and are used, in line with the methodology used in international guidelines, to guide the age-range recommendations. Exploration of the enablers and barriers for those 45-49 years of age in population screening for colorectal cancer was not in scope for these guidelines. However, a short review was conducted to outline the evidence available on the feasibility and acceptability of population screening approaches for colorectal cancer (see section 7 and appendix E7).	No action required.

	The guidelines do not sufficiently reference the Alternative Access Model (AAM) for Kit Distribution. Healthcare providers can now bulk order and issue bowel screening kits directly to their eligible patients through the alternative access to kits model, in addition to the existing mail out model. This alternative way of giving kits to eligible patients will help remove barriers that prevent some people from participating in the National Bowel Cancer Screening Program. Patients are more likely to do the test when it has been discussed with a trusted health professional who can explain how to do the test and why it is important. The important role of the AAM in increasing participation for Aboriginal and Torres Strait Islander peoples should be included in the guidelines at a minimum.	Noted. The mechanisms used to deliver the National Bowel Cancer Screening Program, including the Alternative Access Model for kit distribution are not specifically nominated as they are implementation issues. The possibility of alternative methods and pathways of delivering population screening for colorectal cancer are covered in the current text (section 3 and section 8).	No action required.
13	[response not provided by respondent]		
14	The guidelines should recognise that the NBCSP Program Delivery Advisory Group (PDAG) to be provided with time to consider and respond to the change in screening recommendations	Noted. The mechanisms used to deliver the National Bowel Cancer Screening Program are out of scope for the Guidelines which focus on the evidence available to guide clinical practice. The recommendations put forward in the guidelines need to be considered by the Department of Health and Aged Care and their advisory groups before implementation.	Implementation issues have been collated and shared with the Department of Health and Aged Care, the National Bowel Cancer Screening Program.
	The timeframe for full review of the guideline should remain as 5 years, particularly in the context of emerging evidence regarding personalised screening and optimal screening strategies according to risk stratification	Noted. The timeframe for review has been updated to align with NHMRC requirements.	The text of the guidelines has been changed to reflect a 5 year timeframe for updating.
	State and Territory participant follow-up function (PFUF), who effectively fulfil the 'safety net' function for the NBCSP, should be acknowledged in the guidelines as a critical quality aspect of the screening program, including through supporting harm minimisation for participants with a positive screening test result (such as anxiety)	Noted. The mechanisms used to deliver the National Bowel Cancer Screening Program are out of scope for the Guidelines which focus on the evidence available to guide clinical practice. The role of the PFUF is acknowledged as important to quality and participation in the NBCSP.	Implementation issues have been collated and shared with the Department of Health and Aged Care, the National Bowel Cancer Screening Program.
	Similarly, State and Territory Health departments play a key role in promotion of key messaging, including relating to changes in practice, and in supporting overall success of the NBCSP	Noted. It is acknowledged that jurisdictional health departments play a key role in supporting the NBCSP. They are included in the guideline text as one of the key stakeholders involved in the process.	No action taken.
	Improved NBCSP data collection is recommended to be acknowledged as critical for the assessment of the effectiveness of the program and to inform future iterations of the guidelines	Noted. This is a factor included in Practice point #21 and also acknowledged in the implications.	No additional action required.

	• Further clinical guidance is required regarding the: O NBCSP skip round recommendation to inform screening policy development and compliance for: - When should NBCSP re-invitation occur when high-quality colonoscopy does not occur? - Definition of a 'negative' finding at colonoscopy: per Clinical practice guidelines for surveillance colonoscopy, patients with 1-2 diminutive (<6mm) low-risk adenomas should also be returned to the NBCSP after 4 years	Noted. This was discussed by the Working Group and determined that the practice point should be split into 2 separate practice points to more clearly address colonoscopies and colonoscopies with results that do not require follow-up. Additional guidance around specifics of colonoscopy findings are outlined in detail (and more appropriately) in the surveillance colonoscopy guidelines. This reference is included here in lieu of adding additional detail here.	Edits made in light of Working Group discussion: splitting of practice point 13 and adding detail in population screening chapter section 5.7.4.
	Population screening: • Further clinical guidance is required regarding the: O Provision of supplementary advice that an iFOBT does not require a patient cease or change current medications O Continuation of existing guidance on the: - Reference point for the 120-day timeframe - Urgent categorisation requirement for all patients with a positive iFOBT	The Working Group discussed these points at length, and agreed that no changes were needed to the practice point nor needed additional statements	No action taken, other than small rewording for clarity.
	High-level feedback Risk and screening based on family history: • The guidelines clearly identify the role and function of population screening for bowel cancer through the NBCSP (attachment 2b, p. 10). It is recommended that this same clarity is provided regarding the recommended approach to management of people with increased risk of bowel cancer based on family history of bowel cancer. For example, as per the definition in the Australian Population-Based Screening Framework (APBSF) (SCoS 2018, p. 18), targeted risk screening is defined as: O screening of selected high-risk groups. This can include genetic screening of people with a strong family history of certain cancers that may have a known genetic cause, or a group with specific exposures through environmental and occupational health factors, such as asbestos-exposed workers Inclusion of a definition will assist providers in discussion and educating patients regarding differences in clinical management pathways based on individual circumstance and ensure a shared language and understanding. Reference: Standing Committee on Screening (SCoS) 2018, Population Based Screening Framework, Australian Government Cth, viewed 12 May 2023, <https://www.health.gov.au/sites/default/files/documents/2019/09/population-based-screening-framework_0.pdf>.	Noted and agreed.	Text has been added outlining a definition of targeted risk screening in the risk and screening based on family history chapter (Introduction p13).
	High-level feedback Risk and screening based on family history:	Noted. No formal assessment of the harms vs the benefits of CT colonography has been conducted for the purposes of this review as	No action required.

	• Has there been an assessment of harms versus benefits in the context of the recommendation to offer CT (Computed Tomography) colonography if colonoscopy is contraindicated (attachment 2b, pp. 35, 38)? If an abnormality is detected at CT colonography, a colonoscopy may be required for further management, however, this may not be clinically appropriate.	an assessment of alternative technologies was out of scope.	
15	The general content and applicability of the guidelines on population screening and risk take into account expanded screening ages for those at average risk (40-85).		General comment- no action required
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Applicability of the recommendations to the Australian context

ID	Comment	Project Team response	Action taken
1	I would urge the guideline committee to focus on the scientific evidence pragmatically and without bias, and to be responsible stewards of this precious resource while advocating for equitable outcomes all Australian citizens including our indigenous population. The current guideline update appears to achieve this balance very well, and I hope this does not change.		General comment- no action required
2	The Australian Cancer Plan (ACP) has been developed as a future focused ten-year national framework that will accelerate world-class cancer outcomes and improve the lives of all Australians affected by cancer. The ACP has been delivered to the Minister for Health and Aged Care and is due for public release shortly. • The ACP sets priorities for reform for the next decade and beyond, with strategic objectives, ambitions, goals, and priority actions for cancer control. • Cancer Australia notes that the updated guidelines are consistent with the Strategic Objective 1: Maximising Cancer Prevention and Early Detection, which aims for a cancer control system that seeks to eliminate racism, proactively reduces cancer risk and supports all Australians to access personalised, evidence-based cancer prevention and early detection strategies. • In particular, this guideline update is consistent with actions to undertake ongoing assessment of the evidence for risk-based, cost-effective population cancer screening and that population screening activities should be co-designed and tailored to a range of settings.		General comment- no action required
3	Overall acceptable and applicable general content in the Australian context.		General comment- no action required
4	[response not provided by respondent]		

5	[response not provided by respondent]		
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	Colonoscopy services in the state and territory public health system are already at capacity and strained to meet demands of diagnostic colonoscopy following a positive screening result. A shift towards colonoscopy screening for people aged 40 to 50 years who are at moderately increased risk of colorectal cancer will put further strain on the system. In addition, changes to the guideline will have substantial impacts on primary care providers in promotion of screening, explanation of significance of positive screening test results, arranging colonoscopies, and interaction with the National Cancer Screening Register. Effective program modelling of impacts on primary care and acute workforce and service delivery is critical, prior to implementation of changes to the program eligibility.	Noted. The Working Group acknowledges the existing strain on colonoscopy services. Modelled evaluations of population screening for colorectal cancer via the NBCSP has shown that 10-14% of the current colonoscopies are generated by the program. The increase in age range would increase the number of NBCSP-related colonoscopies but would not contribute significantly to the overall demand. The demand, as outlined by Worthington et al 2022, are largely from colonoscopies not related to the NBCSP. Modelling of the impact on colonoscopy demand has been conducted and included in the guidelines. The impacts on primary care and acute workforce and service delivery is out of scope.	No action taken.
13	Please see comments in relation to Population Screening chapter, section 8.		General comment- no action required
14	Key Recommendations Population screening: • It is recommended that the inconsistent application of clinical practice guidelines regarding use of repeat/surveillance colonoscopy is acknowledged as an issue for clinical practice and resourcing in Australia (ACSQHC 2021) Reference: Australian Commission on Safety and Quality in Health Care (ACSQHC) 2021, Fourth Australian Atlas of Healthcare Variation - Gastrointestinal investigations, ACSQHC, viewed 16 May 2023, <https://www.safetyandquality.gov.au/sites/default/files/2021-04/fourth_atlas_2021_-_chapter_5._gastrointestinal_investigations_0.pdf>.	Noted. Recommendations and the clinical application of surveillance colonoscopies is out of scope of this update. These issues are covered by separate guidelines specific to Surveillance Colonoscopy.	No action taken.
	Key Recommendations Population screening: • It is recommended that there is opportunity for the NBCSP to support compliance with clinical practice guidelines through establishing pathways for	Noted. The mechanisms and pathways used to deliver the National Bowel Cancer Screening Program and maintain compliance are implementation issues and are out of scope.	Implementation issues have been collated and shared with the Department of Health and Aged

	re-invitation and return to screening in accordance with clinical recommendations. Reference: Australian Commission on Safety and Quality in Health Care (ACSQHC) 2021, Fourth Australian Atlas of Healthcare Variation - Gastrointestinal investigations, ACSQHC, viewed 16 May 2023, <https://www.safetyandquality.gov.au/sites/default/files/2021-04/fourth_atlas_2021_-_chapter_5._gastrointestinal_investigations_0.pdf>.		Care, the National Bowel Cancer Screening Program.
15	To ensure the NBCSP's (population screening) overarching goal of early detection is not undermined, there needs to be an ongoing commitment to invest in facilities to ensure adequate capacity to provide timely high quality colonoscopy. Extended delays in diagnosis have the potential to undermine the objective and success of population screening.	Noted. These are implementation issues that have been addressed in practice points #8 and #13. Their further expansion and/or instructions of this nature are out of scope.	Implementation issues have been collated and shared with the Department of Health and Aged Care, the National Bowel Cancer Screening Program.
	Colonoscopies need to be of a level that will enable good to excellent bowel preparation and ensure patients have an experience which will create confidence in the procedure.	Noted.	No action required.
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Population Screening: Plain language summary and 1. Introduction

ID	Comment		Project Team response	Action taken
1	[response not provided by respondent]			
2	[response not provided by respondent]			
3	[response not provided by respondent]			
4	[response not provided by respondent]			
5	Plain language summary	Suggest the guideline target a broader audience, not just focus on doctors. For example, primary health care workforce including nurse practitioners, Aboriginal health workers (AHW) and Aboriginal health practitioners (AHP). Change doctors to clinicians to look after people before they get bowel cancer. pg 10	Noted	Changes have been incorporated; "clinicians" used instead of "doctors"
	Plain language summary – who should have regular screening for bowel cancer?	Consider including sentence why asymptomatic people are only eligible i.e., that people with bowel cancer symptoms should discuss their symptoms with a GP to ensure appropriate investigation, follow up and support. Pg 11	Noted	Statement added

		Suggest including references to resources for Aboriginal and Torres Strait Islander people and Culturally and Linguistically Diverse populations. Pg 12	Noted. The Department of Health and Aged Care website provides comprehensive information regarding closing the gap in cancer screening with a focus on Aboriginal and Torres Strait Islander people and the resources they can access.	Link to resources have been added below the text after the plain language summary
	1.2 Intended users	Update the Plain language summary with the language in this paragraph as it's easier to read. Pg 12	Noted. The plain language summary has been reviewed by a copy editor and people with lived experience.	The plain language summary has been updated.
	1.3 Target populations	Consider simplifying the target population i.e. People 45-74 without symptoms of colorectal cancer. Pg 12 Remove the reference to Aboriginal and/or Torres Strait Islander people in the bullet points.	Noted.	The plain language summary has been updated.
	1.3 Target populations	Update sentence to 'people living with disabilities'. Pg 12	Noted.	The plain language summary has been updated.
	1.7 Guideline development process	Confirm who the Aboriginal and Torres Strait Islander representation in the Working Party refers to. If it is Dr Kate Armstrong, remove reference as it may not accurately reflect contribution or level of involvement of Aboriginal and Torres Strait Islander people in the working party. Pg 14	Noted.	This reference has been removed.
	1.7 Guideline development process – clinical questions	Separate the clinical questions so they are clearly articulated. Pg 14	Noted. The clinical questions are articulated as they were develoepd and approved by the Working Group.	No action has been taken.
	1.8 Scheduled review of these guidelines	Suggest including a specific revision date for the clinical guidelines i.e., before 2033. Pg 18	The guidelines include a revision time frame of 5 years.	No action has been taken.
6	[response not provided by respondent]			

7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	Chapter 1: Recommendation - We are open to consideration of the recommendation that the screening age for Aboriginal and Torres Strait Islander people be lowered to 40 years. As stated in your summary, starting screening at age 40 is not recommended for population screening because at this age range there is a less favourable benefits to burden balance for the whole Australian population, but what about for Aboriginal and Torres Strait Islander population?. referring this paper "https://www.sciencedirect.com/science/article/pii/S2213538322000042" that suggests extending NBCSP to 40-49 years is cost-effective and can save more lives	Modelling evaluations for Aboriginal and Torres Strait Islanders screening from a younger age are included in the guidelines. The results showed that lowering the age to 40 may be less favourable in terms of benefit-to-harm balance. Lowering the starting age may also exacerbate inequalities and the Working Group determined that the age range should be in line with the general population.	No action has been taken.
10	[response not provided by respondent]		
11	Plain language summary: Who should have regular screening for bowel cancer? Section: 'The NBCSP uses an iFOBT or the NBCSP kit' – this wording may erroneously suggest that the iFOBT is an alternative to the NBCSP kit, rather than the intended meaning of an alternative name.	The plain language summary states that the iFOBT is “also referred to as the NBCSP kit” to prevent confusion	No additional action taken.
	Also, we ask that you consider noting that the test is provided to the participant free of charge through the NBCSP.	Noted	This change has been made.
	Bowel Cancer in Australia section: Consider omitting the space after the comma in '5, 300'	Noted	This has been removed.
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	Recommend the guidelines acknowledge the requirement for the NBCSP Program Delivery Advisory Group (PDAG) to be provided with time to consider and respond to the change in screening recommendations: O The strain on health services struggling to meet existing demand of colonoscopy services is acknowledged (attachment 1b, pp. 39, 53). A reduction in screening age may further exacerbate this issue,	Noted. The mechanisms used to deliver the National Bowel Cancer	Implementation issues have been collated and shared with the

	particularly in the early stages when the proportion of positive results due to increased first-time screeners/new invitees is likely to be higher	Screening Program are out of scope for the Guidelines which focus on the evidence available to guide clinical practice. The recommendations put forward in the guidelines need to be considered by the Department of Health and Aged Care and their advisory groups before implementation.	Department of Health and Aged Care, the National Bowel Cancer Screening Program.
	• Recommend the guidelines acknowledge the requirement for the NBCSP Program Delivery Advisory Group (PDAG) to be provided with time to consider and respond to the change in screening recommendations: O The NBCSP will require time, via the NBCSP PDAG and at both Commonwealth and State and Territory Government levels, to respond to the operational implications arising from relevant updated recommendations, including modelling and preparing for the management of downstream impacts across the entirety of the screening pathway. This includes implications for recruitment and promotion, State and Territory participant follow-up for participants with a positive screening test, and access to GPs and diagnostic assessment (colonoscopy) services to ensure success of the age expansion, ability to respond to increased demand, and ensure harms are minimised		
	• Recommend the guidelines acknowledge the requirement for the NBCSP Program Delivery Advisory Group (PDAG) to be provided with time to consider and respond to the change in screening recommendations: O It is noted that the final guidelines are tentatively scheduled for publishing in September 2023 (attachment 1b, p. 17)		
	• Recommend the guidelines acknowledge the requirement for the NBCSP Program Delivery Advisory Group (PDAG) to be provided with time to consider and respond to the change in screening recommendations: O Change to the screening age for the NBCSP will be of strong interest to the public and it is imperative that expectations regarding timeframes for implementation are prioritised and achievable.		
	• A timeframe of 5 years for full review is recommended. This in accordance with the recommendation in the current guidelines: O The timeframe for review of this chapter is 10 years (attachment 1b, p. 17) O It is acknowledged that the chapter recognises that evidence will continue to be monitored in the interim.	This has been covered above, and the guidelines text suggest a full or partial review in light of strong new emerging evidence	
15	[response not provided by respondent]		
16	Request to add terminology to risk assess patient population to determine if a patient should be participating in population level screening or not.	Noted. The inclusion of a risk assessment tool is outside of the scope of population screening and is not included here. The Risk and screening based on family history addresses risk using	No action taken.

		the proxy measure of family history.	
17	[response not provided by respondent]		

Population Screening: 2. Summary of Recommendations

ID	Comment		Project Team response	Action taken
1	[response not provided by respondent]			
2	[response not provided by respondent]			
3	[response not provided by respondent]			
4	[response not provided by respondent]			
5	2. Summary of recommendations - colorectal cancer screening benefit	Every recommendation across both chapters has a weak strength rating. Consider addressing and defining the strength rating in both chapters. Define the implications of a weak rating and outline what recommendations could inform future research priorities and directions. Pg 19	Noted. The summary of recommendations is designed to provide the consolidated recommendation and practice points with the detail of each (including the definitions of strength) available in other parts of the document. In the final version of the guidelines there will be hyperlinks and alt text definitions available.	The definitions have been expanded on in the main text of the guidelines and in the appendices table 5. They are not included in the summary of recommendations but will be available via hyperlink in the final version.
	2. Summary of recommendations – practice point 13	Amend wording at the end of the paragraph to clarify intention of complete intubation (i.e. does the current wording suggest not complete intubation or complete intubation constitutes high quality) and incorporate plain language information about bowel preparation and intubation. Pg 21	Noted	Wording has been modified to improve clarity.
	Summary of recommendations – practice point 14	Review and consider removing the reference to ‘carries the risk of a misleading negative test result because of low levels of bleeding from a cancer or adenoma’ because this would lead to bowel cancer screening being irrelevant altogether. Pg 21	Noted. This was taken to the Working Group for further discussion, and it was determined that the text was important to state and was to remain.	No action taken.
	2. Summary of recommendations – practice point 15	Separate this point into two sentences i.e., place a full stop at the end of psychological harm and a new sentence with the statement that there is no evidence that prognosis is worsened within 120 days if cancer is present.	Noted. After a detailed discussion, the Working Group reworded the practice point to add clarity.	Clarity added to the practice point after discussion with the Working Group. Please note new numbering, this is now practice point “17”

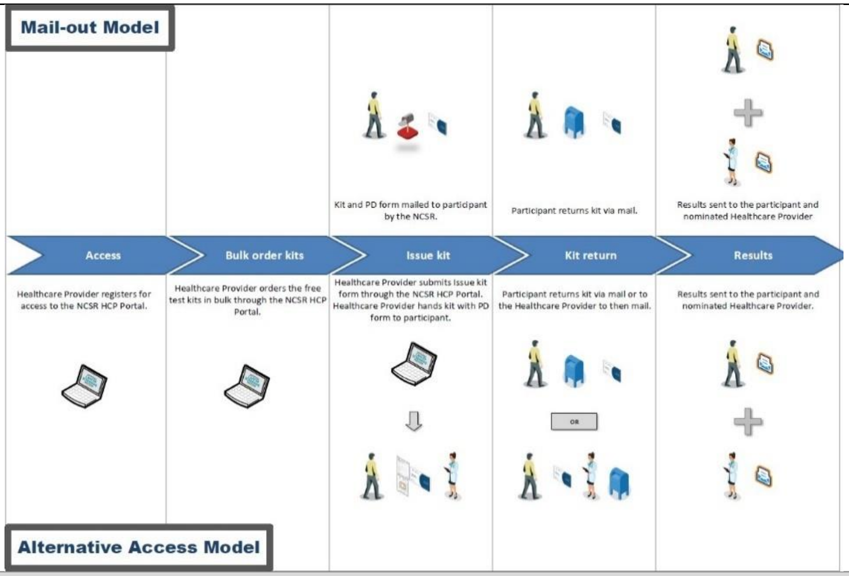
	2. Summary of recommendations – practice point 15	Consider if there is scope to include advice for health practitioners on how to support clients/ any action that can be taken where there is a long wait time for a colonoscopy. Pg 21	Noted. The Working Group agreed that colonoscopy wait times could be problematic. It was determined that is beyond the scope of the guidelines to provide additional advice given colonoscopy services vary depending on jurisdiction and geographic location.	No action taken.
	2. Summary of recommendations- practice point 16	Amend sentence to 'GP or clinic endorsement letters in advance of receiving a test kit, the use of recall and reminder systems'. Pg 22	Noted.	Practice point amended to add "clinic" to statement. Please note new numbering, this is now practice point "18"
	2. Summary of recommendations – practice point 18	This practice point is unclear. Perhaps separate the preferred method of screening and purpose of colonoscopy into two practice points pg 22	Noted. The Working Group views the two issues contingent on each other. They are best placed and read as one practice point. No change was made. n	No action taken.
	2. Summary of recommendations- practice point 19	Amend sentence to 'ongoing efforts to identify methods to improve 'colorectal cancer' screening participation'. Pg 22	Noted.	Practice point amended to add "colorectal cancer" to statement. Please note new numbering, this is now practice point "21"
	2. Summary of recommendations- practice point 22	Remove the reference to 'and increase' participation in the last sentence. Pg 23	Noted.	The practice point has been amended. Please note new numbering, this is now practice point "24"
6	[response not provided by respondent]			
7	[response not provided by respondent]			
8	[response not provided by respondent]			
9	[response not provided by respondent]			
10	[response not provided by respondent]			

11	1) Evidenced-based recommendation (EBR) 1: The focus of this statement is unclear. We eventually deduced that this was recommending changing the age at which population screening should commence. We think for clarity, it should be framed in this way rather than the current wording. These guidelines are intended to be used to guide clinician behaviour, so we are uncertain about why a population health recommendation, which is currently not in practice via the NBCSP (screen between 45 and 50 years) is included as a recommendation for practitioners unless the intention is for them to encourage people at this age to screen outside the program. It is also unclear whether this recommendation is based on cost-effectiveness modelling, or on other evidence.	Noted. This wording is consistent with previously used wording to summarise the scientific evidence. It does not determine how the NBCSP should be implemented.	No action taken.
	2) EBR 2: It is necessary to acknowledge that flexible sigmoidoscopy (FS) for population screening is beneficial from a colorectal cancer survival standpoint, with strong RCT evidence. The 'weak' EBR strength seems to contradict the RCT evidence, so other reasons why the EBR strength rating is 'weak' should be made clearer - e.g., by stating 'Modelling suggests it is not cost effective'. How was cost-effectiveness determined? It would be unusual if it was based on a single model, when there are RCTs available.	The determination of the EBR strength is outlined in the technical report available in Appendix E1, E3, E4, E6 where the available RCT evidence is summarised. Flexible sigmoidoscopy was not reevaluated for this Guideline as the modality of screening was not determined to be feasible or cost-effective in the 2017 Guidelines and the Working Group agreed that it would not be feasible as a population screening method at this time in Australia.	No action taken.
	3) Wording around strength of evidence What the 'strength' column in the 'colorectal cancer screening benefit' table means should be clarified. Does it mean strength of the EBR, strength of the evidence for the EBR, or strength of the evidence against the EBR? The use of the term "weak" with a negative statement is difficult to follow. E.g., Recommendation 2 says FS is not recommended and the evidence for this (to use FS or NOT to use FS?) is "weak". This potential confusion applies to a number of statements.	Noted. The use of strength in this way aligns with the NHRMC Guidelines for Guidelines and is presented as a requirement for NHRMC approval. This can also apply to negative statements or recommendations against an action. This process is outlined in Appendix A.	Clarity has been added to appendix A, table 5, to improve the clarity of the process.
	4) Typos Recommendation 5: delete "of" from the "less favourable (of) benefits to burden balance".	Noted.	Typo removed
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		

16	[response not provided by respondent]		
17	[response not provided by respondent]		

Population Screening: 3. Colorectal cancer in Australia

ID	Comment		Project Team response	Action taken
1	[response not provided by respondent]			
2	[response not provided by respondent]			
3	[response not provided by respondent]			
4	[response not provided by respondent]			
5	3.1.1 Population colorectal cancer screening	Amend the dot point or add a footnote to the '***Distribution of invitations and iFOBT kits primarily by mail'*** to acknowledge the Alternative Access Pathway has been scaled up to increase participation rates of Aboriginal and Torres Strait Islander people. Include referral to the Alternative Access Pathway section 3.1.3. pg 25	Noted. The Working Group agreed that alternative methods to distribute kits should be acknowledged. Specific nomination of the Alternative Access Model was not recommended. The currently used wording and model may not continue with this name nor as the "alternative". That is, it may be the main way of accessing kits in the future.	Additional text has been added to acknowledge alternative methods to distribute kits.
	Include additional figure of Alternative Access Pathway to compare against Figure 1. NBCSP population screening pathway pg 25		Noted. The Working Group agreed that alternative methods to distribute kits should be acknowledged. This diagram has not been included as it may be superseded or outdated in a short period of time. The Alternative Access Model to Kits is in the rollout phase and may undergo changes which would	No action taken.

		make this diagram incorrect.	
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	• Recommend the State and Territory participant follow-up function (PFUF) are acknowledged as a key element of the NBCSP (section 3.1.1 attachment 1b, p. 25): O In accordance with the Australian Population-Based Screening Framework, harm minimisation is a key criterion of a population screening program (Standing Committee on Screening 2018) O For the NBCSP, participant follow-up for those with a positive test result is the responsibility of States and Territories who effectively fulfil the 'safety net' function for the NBCSP. This ensures participants are supported across the entire screening pathway - and any harms (such as anxiety) from a positive screening test are minimised O The direct funding of states and territories through the PFUF model recognises the knowledge states and territories have at the local level about how usual care operates in their jurisdiction (Australian Government Department of Health and Aged Care 2017).	Agreed and noted	Statement added as part of NBCSP key elements in section 3.1.1: •the Participant Follow-up Function that compliments the NBCSP to follow-up and support of individuals with a positive iFOBT

	• 3.1.2 Recommend that the following comment is revised to include that the purpose of data collection for NBCSP is for monitoring, reporting, and evaluating effectiveness of the program and to inform future iterations of the clinical practice guidelines, per below: O Where provided by proceduralists, data are collected by the NBCSP for monitoring, reporting, and evaluating effectiveness of the program to inform training within the health care sector related to the quality of colonoscopy (attachment 1b, p. 27). O Robust and complete data collection to monitor and evaluate the NBCSP and its impact is also a requirement of the Australian Population-Based Screening Framework and critical for enabling monitoring the performance of the NBCSP in accordance with the Program aim of reducing the morbidity and mortality of bowel cancer in Australia through early detection and prevention of the disease. References: Australian Government Department of Health and Aged Care 2017, National Bowel Cancer Screening Program - Policy Framework, National Bowel Cancer Screening Program, viewed 12 May 2023, <https://www.health.gov.au/resources/publications/national-bowel-cancer-screening-program-policy-framework?language=en>, Standing Committee on Screening (SCoS) 2018, Population Based Screening Framework, Australian Government Cth, viewed 12 May 2023, <https://www.health.gov.au/sites/default/files/documents/2019/09/population-based-screening-framework_0.pdf>.	Noted	Additional statement has been added to section 3.1.2 to reflect: The purpose of data collection for NBCSP is for monitoring, reporting, and evaluating effectiveness and to inform future iterations of the clinical practice guidelines. Where data is provided by proceduralists, data are collected by the NBCSP for monitoring, reporting, and evaluating effectiveness of the program to inform training within the health care sector related to the quality of colonoscopy. Robust and complete data collection to monitor and evaluate the NBCSP and its impact is also a requirement of the Australian Population-Based Screening Framework and critical for enabling monitoring the performance of the NBCSP in accordance with the NBCSP aim of reducing the morbidity and mortality of bowel cancer in Australia through early detection and

			prevention of the disease
	• Recommend the below statement is retained from existing guidelines regarding primary aim of the NBCSP being: O ... (1) earlier detection of cancer and (2) prevention of cancer through detection and removal of pre-malignant adenomas.	Noted	The aim of the NBCSP in section 3.1.1 has been edited to include the following along with the existing dot point : •Enable earlier detection of colorectal cancer •Prevent cancer through detection and removal of pre-malignant adenomas
15	[response not provided by respondent]		
16	Suggest to add a sentence to describe risk assessment at the end of page 24. For example: "There is value in risk assessment in the population to determine who might benefit from continued or early screening."	Noted	A statement has been added at the end of the summary of recommendations section 2: Risk assessment methods to determine targeted screening strategies are addressed in the chapter on Risk and screening based on family history
17	[response not provided by respondent]		

Population Screening: 4. Colorectal cancer screening benefit

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	[response not provided by respondent]		

6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	We fully support adoption of recommendations 1,2 and 3		General comment- not action required
	Recommendations 4 and 5: These recommendations should include the option of screening outside the NBCSP for individuals between the age of 40-45 to allow access to non-invasive, low cost screening services and treatment (if applicable). Table 4 of appendix E2 for age range 40- 84 indicates increase in Health Benefits and possible cost effectiveness with screening. These benefits can then still be leveraged outside of the National program.	Noted. There recommendations have been made with close consideration of the benefits to harms/burden balance as well as the values, preferences alongside resource and other implications. These are outlined in the Guideline text. Practice points 6 and 7 have been intentionally included to provide guidance beyond the population screening age range where colorectal cancer screening may be provided outside of the NBCSP.	No action taken.
	This amendment will also align with practice points 6 and 7, encouraging healthcare practitioner involvement and ongoing assessment of treatment pathway	Noted.	No action taken.
	To ensure equity of access to safe healthcare and inclusion of regional areas of Australia that struggle with access to general practitioners, the reference to "General Practitioner" must be replaced with "Healthcare Practitioner" for practice points 6 and 7. The guidelines must include healthcare practitioners due to their expanding scopes of responsibility for patient assessment e.g. clinical nurses and pharmacists. The more appropriate term Healthcare practitioner would also align with section 1.5 purpose and scope of the clinical guidelines.	Noted.	"General practitioner" has been replaced with "health care professionals".
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	• Recommended edit to explanatory note regarding NBCSP follow-up for Practice points 6 and 7, for accuracy regarding program functions, as per below: O #Screening offered outside of the National Bowel Cancer Screening Program means that screening tests are provided by private pathology, screening status is not centrally recorded, and follow-up for patients with a positive screening test and future screening invitations are not centrally provided. Results of screening iFOBT conducted outside of the NBCSP are not taken into consideration regarding timeframes for invitation to re-screen.	Noted.	Explanatory note has been edited according to Working Group discussion incorporating suggestions from this comment

	• Equity of access and outcome across the entire screening pathway - from recruitment of the target population to diagnostic assessment for participants with a positive screening test result - is a critical tenet of population screening. Recommend amendment to Practice point 8 (attachment 1b, p. 20) to align with the Australian Population-Based Screening Framework, as per below: O Every effort should be pursued to ensure equitable participation and ongoing quality improvement initiatives in population screening for colorectal cancer in the target age group of 45-74 years and ensure equity of access to culturally safe health care, including to diagnostic assessment for NBCSP participants with a positive screening test.	Noted.	Practice point has been amended.
	• 4.7 Evidence to Decision, iv. (attachment 1b, p. 39): After a positive screen, further diagnostic assessment should occur in a timely fashion as there is a defined risk of bowel cancer in those with a positive screening test - and any harms (such as anxiety) from a positive screen should be minimised. This is an important quality indicator for the NBCSP. Has there been any modelling/assessment of the anticipated increase in colonoscopies required because of the change in clinical recommendation to increase the eligible NBCSP screening cohort to begin from 45 years? Recommend this is considered for inclusion.	Noted. The modelling evaluations in the appendices E2 technical report give details of the additional number of colonoscopies that could result from lowering the screening age range. Practice point #16 highlights the importance of prompt follow-up to reduce the possible harms.	No action taken
15	[response not provided by respondent]		
16	In reference for Practice point 4, page 20. There is evidence from us (Genetic Technologies) and others that risk assessment is a way for clinicians to identify the risk benefit ratio for people screening from age 40. Please refer to references at the end of the document. PC ID 16 Redcap 12	The inclusion of risk assessment was beyond the scope of the current chapter updates. We acknowledge the evidence, use of risk assessment instead of family-history as a proxy is a future consideration. This is covered in the chapter on risk and screening based on family history.	No action taken
	Suggestion to modify to the following: "For people aged 75-85 years who are fit, well and healthy, who request screening after being risk assessed to fully inform the benefits and potential harms of testing, general practitioners could offer an immunochemical faecal occult blood test outside of the National Bowel Cancer Screening Program#. Insert statement for clarification. Is it just the patient who requests, or should it be a joint decision-making discussion lead by the general practitioner?	Noted.	Practice point has been reworded for clarity.
17	[response not provided by respondent]		

Population Screening: 5. Colorectal cancer screening test accuracy

ID	Comment	Project Team response	Action taken

1	[response not provided by respondent]			
2	[response not provided by respondent]			
3	[response not provided by respondent]			
4	[response not provided by respondent]			
5	5.7 Evidence to decision – iv. Resources and other consideration	Amend wording to clarify intention of complete intubation (i.e., does the current wording suggest not complete intubation or complete intubation constitutes high quality) and incorporate plain language information about bowel preparation and intubation pg. 53	Noted. Clarity has been added to address confusion	Edit incorporated – the sentence now reads, pg 56: defined as adequate bowel preparation, complete intubation, and preferably ...
6	[response not provided by respondent]			
7	[response not provided by respondent]			
8	[response not provided by respondent]			
9	[response not provided by respondent]			
10	We fully support adoption of recommendations 9, 10, 11, 12, 13, 14 and 15			General comment- no action required
11	[response not provided by respondent]			
12	[response not provided by respondent]			
13	[response not provided by respondent]			
14	• Further clinical guidance is needed for Practice point 13 (attachment 1b, p. 41) regarding the recommended screening interval for NBCSP participants with a positive iFOBT who attend an incomplete colonoscopy (i.e. poor bowel preparation, incomplete intubation) to inform screening policy compliance and development: O Some participants may not proceed to complete a repeat colonoscopy which ensures high-quality assessment. Clinical recommendation for when re-invitation occur should occur is required in this setting. O A definition is required for 'negative' findings, noting that the Clinical practice guidelines for surveillance colonoscopy state that patients with 1-2 diminutive (<6mm) low-risk adenomas should also be returned to the NBCSP after 4 years.		Noted. Clarity has been added to address confusion	Edit incorporated – the sentence now reads, pg 56: defined as adequate bowel preparation, complete intubation, and preferably ...
	• Recommended addition to Practice point 14 (attachment 1b, p. 42) to support clinical management of patients on antiplatelet or anticoagulation medications who have a positive iFOBT: O Gastrointestinal bleeding is identified as one of the risks of antiplatelet or anticoagulation medications such as aspirin. This can create confusion with regards to the recommended clinical management in the context of the NBCSP and clinicians/participants have, on occasions, assumed alternate pathways which can result in unnecessary delays to timely diagnostic assessment O Recommend the practice point is updated to include: ...Completing the screening test does not require a patient to cease or change current medications...		Working Group discussed these comments. It was agreed that no addition is required to these statements. This medication would not impact the outcome of an iFOBT.	No action taken

	O This will be increasingly pertinent given the recommendation for aspirin use to prevent colorectal cancer for those aged 50-70 (attachment 2b). is the reference date. Recommend this is retained as part of the update.		
	• Recommend that clarity is provided regarding 120-day timeframe recommendation in Practice point 15 (attachment 1b, p. 42): O Confusion can occur regarding whether the 120-day timeframe is from the iFOBT date or from the first health care presentation after the positive iFOBT O Clarity is provided in section for Optimal maximum time from referral to diagnosis and treatment of the existing guidelines. This states that the date of the 'first healthcare presentation'	Noted.	Practice point has been amended for clarification. Note new numbering, this is now practice points "16" and "17".
	• Recommend Practice point 15 (attachment 1b, p. 42) is updated to include category 1 (most urgent) triaging requirement for participants with a positive iFOBT, as described in the existing guidelines (see Optimal maximum time from referral to diagnosis and treatment): O This is is a key quality indicator for the NBCSP that colonoscopy occurs within 30 calendar days of GP referral (Australian Government Department of Health 2016, p. 24). Reference: Australian Government Department of Health 2016, NBCSP Quality Framework - October 2016 Version 1.0, Australian Government Cth, viewed 15 May 2023, <https://www.health.gov.au/sites/default/files/documents/2019/10/national-bowel-cancer-screening-program-quality-framework.pdf>.	The Working Party discussed these implications and the wording practice point 17 (previously numbered "15"). Clarity was added through rewording for colonoscopy being performed with 120 days of a positive iFOBT, but within 120 days was agreed to be most appropriate. The practice point was not changed.	Clarification added to practice point that there is evidence that this should be done within 120 days from the day of the positive iFOBT".
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Population Screening: 6. Preferences for colorectal cancer screening modalities

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	Preferences for colorectal cancer screening modalities Explicitly reference evidence to justify the two-sample immunochemical faecal occult blood test (iFOBT) as opposed to one-sample test. International programs offer evidence of one sample colorectal screening programs with iFOBT and have significantly higher participation rates. Pg 54	Noted. There are limited studies directly comparing two-sample tests to one-sample tests. As such, there was limited information from which any determination to justify the change the number of samples used. This is an active area of	Additional information outlining the evidence on the number of iFOBT samples has been included in section 5.6

			research as outlined in section 5.5-5.7 and 6.	
	Preferences for colorectal cancer screening modalities	Amend the sentence that there is no clear preference for sample number. If there is evidence that patient preferences showed an indicative preference for a single sample test and some evidence of a higher uptake in screening for a single sample, this suggests one sample is preferred. Individuals will naturally prefer taking one sample instead of two. Pg 54	Noted. The statement included in the guidelines outlines that there is no consistent preference for number of samples presented in the scientific evidence. This is an accurate reflection of identified studies. It is acknowledged as an area of active research.	No action taken.
6	[response not provided by respondent]			
7	[response not provided by respondent]			
8	[response not provided by respondent]			
9	[response not provided by respondent]			
10	[response not provided by respondent]			
11	[response not provided by respondent]			
12	[response not provided by respondent]			
13	[response not provided by respondent]			
14	[response not provided by respondent]			
15	[response not provided by respondent]			
16	[response not provided by respondent]			
17	[response not provided by respondent]			

Population Screening: 7. Participation in the population screening for colorectal cancer

ID	**Comment**		**Project Team response**	**Action taken**
1	[response not provided by respondent]			
2	[response not provided by respondent]			
3	[response not provided by respondent]			
4	[response not provided by respondent]			
5	7. Participation in the population screening for colorectal cancer	Update language in the first paragraph to capture **all health practitioners** can facilitate participation ***including nurses, AHW and AHP***. Explicitly identify lifestyle factors that are associated with non-participation in NBCSP. Pg 55	Noted. Factors associated with non-participation were identified in the short review (Appendix E7) and have been	Clarification added to reflect that the referenced studies found that general practitioners endorsement can enhance participation. The first paragraph has now reads “Other reported facilitators include

			added.	individuals’ health status, family history, experiences with health services, good doctor–patient relationship, social support and awareness of CRC, including encouragement to participate by nurse, Aboriginal Health Workers, and Aboriginal Health Practitioners” and “These findings reinforced a the clear need to continue to support population screening, and NBCSP participation, through resourcing and encouragement in primary care by GPs, Aboriginal Health Workers, Aboriginal Health Practitioners, nurses and other health workers”
	7. Participation in the population screening for colorectal cancer	Amend the sentence to include clinic letters/reminders encouraging participation: ‘specifically in primary care, this may include GP *or* ***clinic*** endorsement letters in advance of receiving an invitation to participate in population screening, the use of GP *or* ***clinic*** reminders to encourage discussions of CRC screening’. Pg 56	Noted.	Clarification added in text, which now reads: Studies have reported that participation in population screening for colorectal cancer (CRC), through the National Bowel Cancer Screening Program (NBCSP), can be facilitated by general practitioners’ (GP) knowledge/awareness of screening, GP or clinic endorsement letters or reminders, simplicity of the test, perceived usefulness of screening or the screening test in the community
	7.1 recommendations and practice points - practice point 18	This practice point is unclear. Perhaps separate the preferred method of screening and purpose of colonoscopy into two practice points. Pg 56	Noted.	Clarification added in text, which now reads: Studies have reported that participation in population screening for colorectal cancer (CRC), through the National Bowel Cancer Screening Program (NBCSP), can be facilitated by general practitioners’ (GP) knowledge/awareness of screening, GP or clinic endorsement letters or reminders, simplicity of the test, perceived usefulness of screening or the screening test in the community
6	[response not provided by respondent]			
7	[response not provided by respondent]			
8	[response not provided by respondent]			
9	[response not provided by respondent]			

10	Practice point 16: The healthcare professional must not be limited to recommending the NBSCP but rather recommend the screening kit or product that will most align with the patient's needs. This recommendation should include assessment of the testing methodology and turn around time for results and accessibility. We fully support practice point 17, 18 and 19.	Noted. Note new numbering sequence, these practice points are now 19,20, 21	Clarification added in text, which now reads: Studies have reported that participation in population screening for colorectal cancer (CRC), through the National Bowel Cancer Screening Program (NBCSP), can be facilitated by general practitioners' (GP) knowledge/awareness of screening, GP or clinic endorsement letters or reminders, simplicity of the test, perceived usefulness of screening or the screening test in the community
11	[response not provided by respondent]		
12	Practice Points 16-19 should reference the Alternative Access Model (AAM) for Kit Distribution	Noted. Note new numbering sequence, these practice points are now 18-21	Clarification added in text, which now reads: Studies have reported that participation in population screening for colorectal cancer (CRC), through the National Bowel Cancer Screening Program (NBCSP), can be facilitated by general practitioners' (GP) knowledge/awareness of screening, GP or clinic endorsement letters or reminders, simplicity of the test, perceived usefulness of screening or the screening test in the community
13	[response not provided by respondent]		
14	• The expansion of health care providers to include Aboriginal Health Workers, Aboriginal Health Practitioners, nurses, and other primary health care providers is supported (practice points 16 and 17)	Noted.	Practice points have been amended. Note numbered now as "18" and "19".
	• State and Territory Health departments should also be acknowledged in practice points 16 and 17 as they play a key role in promotion and success of the NBCSP: O In Tasmania, this includes the appointment of screening recruitment and promotion staff and Registered Nurses who perform the follow-up of NBCSP participants with a positive screening test result and act as a local and specialised resource for the local community, and primary and tertiary providers	Noted.	Clarification added in text, which now reads: Studies have reported that participation in population screening for colorectal cancer (CRC), through the National Bowel Cancer Screening Program (NBCSP), can be facilitated by general practitioners' (GP) knowledge/awareness of screening, GP or clinic endorsement letters or reminders, simplicity of the test, perceived usefulness of screening or the screening test in the community
	• Recommended addition to Practice point 19 (attachment 1b, p. 56) to drive the need for improved outcome data to monitor, report, and evaluate the efficiency and effectiveness of the NBCSP, as per below:	Noted.	Practice point has been amended. Note new numbering, this is now practice point "21"

	O Ongoing efforts to identify methods to improve screening participation, modify testing strategies and evaluate new and existing population screening modalities are needed and should be informed by real-world data and other well-designed local and international research, as appropriate.		
	• Recommend that Practice points 20 and 21 (attachment 1b, p. 23) are also included in this section, as per below, to align with the Australian Population-Based Screening Framework principles of equity and access as fundamental elements of all screening programs, regardless of rurality, ethnicity, socio-economic status, or disadvantage status: O Local access to culturally safe, targeted advice and support relating to colorectal cancer screening, diagnostic services and treatment should be provided through trusted health professionals within communities and as close to home as possible. O Trusted health professionals must be adequately supported to provide culturally safe and sensitive information, verbally and in written form, about colorectal cancer screening and local services to promote engagement in the complete colorectal cancer screening pathway.	Noted. The Working Group adapted these comments and updated the related practice points.	Practice points has been amended. Note new numbering, this is now practice point “22” and “23”.
15	[response not provided by respondent]		
16	Suggest a sentence to be added to practice point 16 on page 22 in document 1b (suggestion in capital letters): "Encouragement by health care professionals (including general practitioners (GPs), Aboriginal Health Workers (AHWs), Aboriginal Health Practitioners (AHPs), nurses and other primary health care providers substantially boosts participation in colorectal cancer screening. HEALTH CARE PROFESSIONALS PLAY A KEY ROLE IN PROVIDING PATIENTS WITH RISK ASSESSMENT AND SCREENING ADVICE. GP endorsement letters in advance of receiving a test kit, the use of GP reminder systems, leadership of AHWs and AHPS in health promotion activities and practice audits can improve participation rates (Dodd et al 2019).	Noted. The Working Group adapted these comments and updated the related practice points.	Practice point has been amended. Note new numbering, this is now practice point “18”
17	[response not provided by respondent]		

Population Screening: 8. Colorectal cancer screening for Aboriginal and Torres Strait Islander peoples

ID	Comment	Project Team response	Action taken
1	The guidelines as currently written are perfectly pitched and balanced in my opinion.	Noted	No action required.
	Despite weak modelling data without a comparison group showing potential benenfit, I do not think that an even lower starting age for Aboriginal and Torres Strait Islander people is indicated for colorectal cancer screening. I say this because the incidence of this cancer is higher in citizens of European origin than those with other ethnicities and, in general, disease screening is more effective targetted at populations with higher incidence of more indolent disease, rather than for populations of lower incidence of	Noted.	No action required.

	more aggressive disease (such as our indigenous population). I would suggest that if ethnicity based screening policy is to be pursued (and I'm not certain that it should be) funding and resource would be much better utilised targetting preventable diseases that are of higher prevalence in the Aboriginal and Torres Strait Islander population (such as cardiovascular disease for example, or other cancers). https://www.aihw.gov.au/news-media/media-releases/2021-1/october/indigenous-burden-of-disease		
	Alternatively, improving outreach access and support for the existing screening initiative in more remote communities would be a more worthwhile thing to advocate for (i.e. attending to the geographic barrier).	Noted.	No action required.
2	Cancer Australia commends the inclusion of new practice points in relation to Aboriginal and Torres Strait Islander people, which were codeveloped with NACCHO. These points underpin the importance of embedding culturally safe care within cancer-related services for Aboriginal and Torres Strait Islander people.	Noted.	No action required.
	• Cancer Australia also commends the idenitification of the importance of encouragement by Aboriginal Health Workers (AHWs), Aboriginal Health Practitioners (AHPs), in addition to general practitioners (GPs), nurses and other primary health care providers, in boosting participation in colorectal cancer screening and managing the interface between population screening and personalised care	Noted.	No action required.
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	***Reductions in the screening age*** NACCHO acknowledges the modelling study by Lew et al.4 found that reductions in the screening start age may result in cost-effective improvements in cancer detection and reductions in CRC incidence and mortality among Aboriginal and Torres Strait Islander peoples. However, the modelled increased participation rates for Aboriginal and Torres Strait Islander people (equal to those observed across the general population) would be associated with even greater reductions in CRC incidence and mortality, with even greater cost-effectiveness margins. Increased participation rates would achieve these reductions without a substantial change in the incremental number needed to colonoscope. There is little evidence to support the acceptability of a reduction in the CRC screening start age among Aboriginal and Torres Strait Islander people. Conversely, culturally informed, place-based approaches to increase participation rates, such as the National Indigenous Bowel Screening Pilot,5 (also known as the Alternative Access Model) have been shown to be effective with adequate support and funding. All initiatives to increase participation must consider the local and cultural contexts in which they are taking place. The recent national roll-out of the Alternative Access Model to primary care providers, including ACCHOs, is an important step in increasing screening participation for eligible Aboriginal and Torres Strait Islander people.	Noted. The points raised by NACCHO are important in relation to: 1. The consistency in the screening age range between Aboriginal and Torres Strait Islanders and the general population 2. The emphasis on improving participation and access to screening and early detection services, including using alternative pathways to access kits 3. Reducing the barriers to the screening, and 4. Monitoring screening uptake.	These points have been emphasised and highlighted in the chapter text. 1. Modelling outcomes were highlighted in section 8 2. Emphasis on alternative accept pathways have been made in section 8 3. Suggestion to removing barriers to screening and improving equity have been added in sections 9.7.3, 9.8 and 10.1. 4. This has been emphasised in practice point 21 about real-world data and in section 9.8.

	There is scope to strengthen participation in the NBCSP by optimising existing national systems and processes and implementing key learnings from trials and implementation in place must be trialled and tested on the ground for usability and must promote easy access. For example, NACCHO has received feedback from many ACCHOs that ordering and issuing screening kits through the National Cancer Screening Register is challenging. This presents a significant barrier to participating in the NBCSP. **NACCHO recommends** focusing on the importance of early detection, improving participation rates in screening, access to early colonoscopy in the public system and ensuring there are culturally appropriate pathways and communication materials to raise awareness about bowel cancer for Aboriginal and Torres Strait Islander people. **NACCHO recommends** a review into the usability of the National Cancer Screening Register, including adequate consultation with the community-controlled sector to ensure all barriers to using the register are addressed and removed.		
	Single test screening Single immunochemical faecal occult blood testing (iFOBT) is utilised quite broadly as a CRC screening modality in other countries, as outlined in the update. There is some evidence emerging that single test screening is preferred and may result in higher participation rates.6 As two-test screening remains the preferred protocol in this update, explanation of the rationale for this continuance should be strengthened. NACCHO strongly advocates for the exploration of single-test screening as a means of improving participation rates, especially given the barriers faced by, and potential benefits to, Aboriginal and Torres Strait Islander peoples. **NACCHO recommends** immediate investigation and consideration into the feasibility of single test screening as a method to reducing barriers to screening for Aboriginal and Torres Strait Islander people.	Noted. The existing evidence comparing 1-sample vs 2-sample is not sufficient at this point to evaluate the impact such a change in the Australian context. This is an area of exploration and is outlined in the chapter text.	This has been raised and, in the chapter, and further clarifications have been made in section 6.

	Hot zone approaches While the importance of the *hot zone policy* is acknowledged, it is known that individuals and communities impacted by this policy are more likely to be living in rural or remote areas, with a higher proportion of Aboriginal and Torres Strait Islander people affected.7 There are multiple communities across northern and central Australia classified as a hot zone all year round, and many more affected for more than six months each year. Given this, careful consideration and nuancing of the messaging and options to promote around participation in the NBCSP is required to enhance screening participation whilst maintaining viability of samples. Targeted health-promoting initiatives run by the community-controlled sector are more likely to be effective in such *hot zones*. These initiatives should be explored further, and options considered for supporting communities that might otherwise be disadvantaged by the *hot zone policy.* **NACCHO recommends** exploring pragmatic approaches to encouraging participation in the NBCSP for areas affected by the hot zone policy.	Noted.	This has been clarified in the text.
	First paragraph: ● Update sentence to cancer ***is the leading cause*** of death for Aboriginal and Torres Strait Islander people and ***structural barriers that impact the social and cultural determinants of health result in*** Aboriginal and Torres Strait Islander people experiencing inequitable health outcomes. ● Amend sentence to Aboriginal and Torres Strait Islanders ***people experience inequitable*** health outcomes and lower life expectancy than non-Indigenous Australians. Amend sentence to once diagnosed with ***bowel cancer*** there are disparities in outcomes for Aboriginal and Torres Strait Islander peoples including: ***earlier age of cancer onset.*** *Pg 57*	Noted.	Changes have been made in the text
	Second paragraph: ● Remove ***'current'*** and add comparative participation rate for non-Indigenous Australians to first sentence. ● Add comparative figure for non-Indigenous Australians number-needed-to-colonoscope (NNC) to make figure for Aboriginal and Torres Strait Islander NNC more meaningful. ● Amend sentence to 'lowering the screening start age to 40 or 45 years was ***predicted*** *to* further reduce CRC incidence and CRC mortality by 7–11 and 4–5 percentage points'. Acknowledging only one consultation with Aboriginal and Torres Strait Islander community in South Australia has been conducted on acceptability of lowering the age, therefore this is not a reflection of all Aboriginal and Torres Strait Islander communities and to date there has been no broader	Noted.	Changes have been made in the text

	consultation Pg 58		
	Third paragraph: The recommendation to lower the screening age to 45 contradicts the review of the barriers and facilitators to the NBCSP in reference 115. It is hard to understand how lowering the age will increase participation. Suggest updating as this may be misleading to readers.	Noted. The recommendation to lower the population screening start age was based on the systematic review and modelling evaluation results detailed in Appendices E. The modelling evaluations allow for the changing incidence trends in the Australian context and also include sensitivity analyses to model for differing participation rates in screening. Section 7 in the guidelines text acknowledges that there are barriers to participation and efforts to address these have been highlighted in the section recommendations and practice point. This acknowledges that little is known about participation in people under 50 years of age. Using this information, the Working Group determined the recommendation for population screening.	Emphasis on the comments has been elaborated in sections 7 and 10.1, other unresolved issues. Further emphasis on equity in population screening has been added in a new section 9.8, page 72.
	Fourth paragraph: Provide more information to highlight the inequities and barriers for Aboriginal and Torres Strait Islander people accessing colonoscopies.	Noted. More information regarding the specific barriers Aboriginal and Torres Strait Islander people face in accessing colonoscopies have been highlighted.	Changes have been made in the text
	It is also unclear how lowering the screening age to 45 will increase participation given these barriers.	Noted. As acknowledged in the guidelines text, little is known about the impact of lowering the screening start age on participation. This has been addressed in Section 7 and Section 10.1.	Clarifying text has been added to Section 7 and Section 10.1.
	Include a recommendation with stronger language relating to inequities associated with Aboriginal and Torres Strait Islander people accessing colonoscopies, particularly in rural and remote areas.	Noted. This was discussed with the Working Group the practice points were updated to emphasise equity. Furthermore a new section 9.8 was	Practice points were reworded, a new section 9.8 addressing equity implications was added.

		added specifically addressing possible equity issues.	
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	Practice point 20: The healthcare professional should not be limited to recommending the NBSCP but rather the screening kit that will most align with the patient's needs.	Noted. The practice point references colorectal cancer screening without reference to the NBCSP.	No action taken.
	Practice point 21: We fully support this practice point and believe this engagement and support of healthcare professionals should be further extend to all members of the rural and remote communities.	Noted. Practice point was amended in light of Working Group discussion.	Practice point has been amended. Note new numbering, this is now practice point “23”
	Practice point 22: We fully support this practice point.	Noted.	No action taken.
11	[response not provided by respondent]		
12	Practice Point 21 should reference the Alternative Access Model (AAM) for Kit Distribution	The Working Group discussed this suggestion and concluded that it was difficult to determine whether the AAM terminology will be used in the longer term. The guideline text refers to alternative pathways for accessing kits as “most appropriate avenue of kit distribution” be used. This allows for the possibility that other pathways or avenues may be developed and may become mainstream. This change was incorporated in practice point 18.	Practice point has been amended. Note new numbering, this is now practice point “23”
13	Based on the current evidence and the need to reduce inequalities in health, Wellbeing SA (WBSA) requests that the recommended screening age for Aboriginal and Torres Strait Islander people of 40 - 74 years be considered in the updated Clinical practice guidelines. The study quoted in this section (reference number 7) was commissioned by WBSA and the modelling indicated that lowering the screening age for Aboriginal and Torres Strait Islander peoples to 40 years would further reduce colorectal cancer incidence and mortality by 7-11 percentage points and be cost effective. WBSA believes greater emphasis and special measures need to be placed on redressing the equity imbalance for Aboriginal and Torres Strait Islander people in relation to the	Noted. Modelling evaluations for Aboriginal and Torres Strait Islanders screening from a younger age are included in the guidelines. The results showed that lowering the age to 40 may be less favourable in terms of benefit-to-harm balance. Lowering the starting age may also exacerbate inequalities and the Working Group	No action taken

	National Bowel Cancer Screening Program (NBCSP). Sustained effort and multiple approaches to overcoming the barriers and facilitating participation are required. The alternative access model for kits is highly likely to increase participation in the NBCSP and should be combined with lowering the screening age to 40 years for Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander people are diagnosed with bowel cancer at a younger age and later stage than the rest of the population and have poorer outcomes. This means that they are more likely to benefit to an equivalent extent than the non-Aboriginal NBCSP cohort if they screen from an earlier age. The BreastScreen Australia program is an existing precedent where women aged 40 to 49 years are able to access breast screening but are not actively invited to screen. Aboriginal and Torres Strait Islander women are well placed to benefit from this expansion of the access criteria. A study by David Banham et al found that under-exposure to screening and treatment of Aboriginal women with breast cancers contributed to excess cancer deaths.[1] This supports the concept that earlier cancer diagnosis at a younger age improves survival for Aboriginal and Torres Strait Islander people. [1] Banham D, Roder D, Keefe D, Farshid G, Eckert M, Howard N, Canuto K, Brown A; CanDAD Aboriginal Community Reference Group and other CanDAD investigators. Disparities in breast screening, stage at diagnosis, cancer treatment and the subsequent risk of cancer death: a retrospective, matched cohort of aboriginal and non-aboriginal women with breast cancer. BMC Health Serv Res. 2019 Jun 14;19(1):387. doi: 10.1186/s12913-019-4147-5. PMID: 31200700; PMCID: PMC6570827.	determined that the age range should be in line with the general population.	
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	The South Australian Health and Medical Research Institute, through the Aboriginal Health Equity Research Theme, the Health Policy Centre and Cancer Epidemiology and Population Health are concerned that the guidelines currently recommend that organised screening be implemented for all people aged 45-74 years, presumably irrespective of Aboriginal and Torres Strait Islander status (chapter 18, pp.57-58): The recommended strategy in the guidelines for population screening in Australia, directed at those at average risk of colorectal cancer and without relevant symptoms, is immunochemical faecal occult blood testing every two years, starting at age 45 years and continuing to age 74 years.	Noted.	No action required.

	We recommend to lower the bowel screening entry age for Aboriginal and Torres Strait Islander people to 40 years. Considering the disproportionate burden of chronic disease and earlier onset, as well as the later stage cancer diagnosis in Aboriginal and Torres Strait Islander populations, it is critically important to target the population for screening at a younger age. Otherwise, equity in screening reach for colorectal cancers will not be achieved, nor equity in outcomes.	Noted. Modelling evaluations for Aboriginal and Torres Strait Islanders screening from a younger age are included in the guidelines. The results showed that lowering the age to 40 may be less favourable in terms of benefit-to-harm balance. Lowering the starting age may also exacerbate inequalities and the Working Group determined that the age range should be in line with the general population.	No action taken
	Modelling from Lew et al. 20221 assessed the cost-effectiveness of tailored screening for Aboriginal communities to reduce bowel cancer mortality. The paper highlights that increasing participation in bowel cancer screening can reduce mortality, and a wider reach, that includes more Aboriginal and Torres Strait Islander people through lowering the age eligibility criteria is therefore likely to save more lives. The paper furthermore reported that 'lowering the National Bowel Cancer Screening Program start age for Aboriginal and Torres Strait Islander peoples…will further reduce colorectal cancer incidence and mortality' and potentially be cost-effective.	Noted.	No action required.

Population Screening: 9. Population screening: Implications

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	• Cancer Australia notes that some changes in the updated guidelines will have resource implications, which need to be carefully managed to ensure delivery of an effective cancer screening program which is underpinned by equity. • In particular lowering the screening age for population screening to 45 years will increase the number of colonoscopies required as follow-up investigation of positive Faecal Occult Blood Tests identified through screening.	Noted. The resourcing implications have been noted in the chapter text.	No action required.
	The guidelines note that colonoscopy services in the public health system are already at capacity and strained to meet demands of diagnostic colonoscopy following a positive screening result. Whilst the guidelines state that the National Bowel Cancer Screening Program is estimated to generate only a fraction of	Noted.	No action required.

	Australian colonoscopy demand, any increase in colonoscopies will risk unacceptable delay in follow-up of positive screening tests. This will need to be closely monitored to ensure equity of access to follow-up investigations and management.		
	It is noted that the guideline commentary states that for average-risk Australians, prioritising population screening through the NBCSP can help reduce colonoscopy service demand which is already under considerable strain. Updated booking systems to manage demand within a model of care that give priority to these and other high-risk groups are being explored e.g. Direct Access Colonoscopy Services, and have shown promising results in terms of reduced waiting times for colonoscopies and reduced direct costs to patients.	Noted.	No action required.
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	It is not clear how the modelling evaluation and recommendation relates to Aboriginal and Torres Strait Islander people.	Noted. The modelling evaluation for CRC screening for Aboriginal and Torres Strait Islander is outlined in section 8. Based on this information, the Working Group determined that the screening age range should be consistent for the general population and Aboriginal and Torres Strait Islanders. Practice Points relating to Aboriginal and Torres Strait Islanders are found in section 8.	The text has been reworded for clarity, page 62-63
	Other feedback in this section: It is unclear how the earlier starting age is more beneficial than the current screening age. The modelling evaluation summary compares the 'higher' benefits and 'lower' harms of earlier screening strategies (45-74) with a later finishing age (50-79).	Noted.	Clarification has been added in text,
	It is unclear if the 'higher' benefits and 'lower' colonoscopy burden from an earlier starting age was found at all three modelled levels of participation (40%, 60%, 100%). A participation rate of 40% is realistically the only screening scenario relevant to the current policy context (given the current national participation rate).	Noted	Clarification has been added in text, page 62-63
	Remove the ***'with'*** from 'favourable benefits-and-harms balance, compared with strategies ~~with~~ that stopped screening at a later age'.	Noted.	This has been done.

	Tidy the paragraph (and other relevant sections in both Chapters) by removing all the spelt-out abbreviations of commonly used terms i.e., immunochemical faecal occult blood test (iFOBT), National Bowel Cancer Screening Program (NBCSP) and colorectal cancer (CRC). These are acronyms in previous pages and in the glossary.	Noted. Basic editing rules have been applied to the chapter text. All abbreviations are spelled out at the beginning of each chapter as a standard rule. This is based on the assumption that the guidelines will not be read in their entirety but section by section, based on the readers interest.	The final version of the guidelines will be reviewed for abbreviations and glossary before being uploaded on MagicApp
	The analysis of the screening age range at 45-74 and 40-74 indicates a small increase in lifetime colonoscopy utilisation. Has the impact on colonoscopy services in the public system (as noted on page 39 are at capacity) been considered? Pg 60	Lowering screening start age to 40 or 45 years were predicted to increase the lifetime NBCSP-related colonoscopy (include those performed to follow-up positive iFOBT results and the downstream surveillance) used by 12-15% and 27-33%, respectively. A recent study (ref. Worthington et al 2023 https://pubmed.ncbi.nlm.nih.gov/36477980/) estimated that the NBCSP-related colonoscopies utilisation contributed to small proportion of total MBS-funded colonoscopies in Australia (10-14%). Therefore, the increase in the colonoscopy utilisation due to starting screening earlier from the age of 40 or 45 years is not expected to have significant impact on the colonoscopy service in the public system.	This information was included in the chapter text along with the reference to Worthington et al 2023. No further action was required.
	Increasing the age range may deepen existing inequities experienced by Aboriginal and Torres Strait Islander people outweighing the harms and benefits balance. Pg 61	Noted. The Working Party discussed the existing inequities in screening and the potential for further inequities given the lower screening start age.	A new section 9.8 was added to further emphasise on implication with respect to equity, page 72
	Explicitly identify actions how health care professionals, professional associations, not for profit organisations and other key stakeholders can ensure equitable participation and ongoing quality improvement initiatives in population screening for colorectal cancer. This is stated throughout the guidelines on multiple occasions, but it is not clear how this translates into practical actions or recommendations.	Noted. Equity is an important issue. The Working Party consider it beyond the scope of clinical guidelines to comprehensively address practice implementation issues. The role of the Australian Cancer Plan in supporting these issues has been acknowledged and the text has been modified to acknowledge this point.	A new section 9.8 was added to further emphasise on implication with respect to equity, page 72
	Consider the ethical implications of expanding age range for screening before barriers to participation are addressed i.e., diverting funds to increase the age range versus increasing participation of those currently not engaging. Pg 62	Noted. This aspect was discussed with the Working Party. There are also ethical implications to disadvantaging younger	A new section 9.8 was added to further emphasise on

		people by not broadening the age range, if appropriate. The balance between these two priorities is important and a matter for implementation rather than clinical guidelines.	implication with respect to equity.
	Add additional dot point to include ***Investment in efforts to promote equitable participation and support CQI initiatives in this regard (as per recommendation on page 62) pg 65***	Noted. Specific investments are not outlined in the clinical guidelines and are considered out of scope. This is an implementation issue and will be shared with Department of Health and Aged Care for consideration.	No action taken.
	Expand '***simplifying the method of stool sampling'*** to include more information on single samples and, refer reader to 10.1. pg 66	Noted.	Additional detail on 1 vs 2 sample stool tests has been added to section 6 as it relates to preferences for screening modalities, page 58
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	• 9.3: Harms and benefits-and burden balance (attachment 1b, p.60): It is recommended that State and Territory NBCSP PFUF are acknowledged in the discussion regarding support for participants with a positive screening test which ensures and any harms (such as anxiety) from a positive screening test are minimised (see recommendation regarding 3.1.1).	Noted. The PFUF is part of the Quality Framework for the NBSCP. The NBCSP determines the implementation of the guidelines and detail of the future arrangements are out of scope of the current guidelines. The PFUF has been acknowledged in the background section and briefly in the implications section.	The PFUF has been added to the key elements of the NBCSP – page 28 – as well as in section 9.3.
	• 9.5 Choice of testing interval for population screening: there is opportunity for the NBCSP to support compliance with clinical practice guidelines through establishing pathways for re-invitation and return to screening in accordance with clinical recommendations.	Noted. Pathways for re-invitation and return to screening are out of scope of these guidelines. They covered either by the Clinical practice guidelines for surveillance colonoscopy or are part of the implementation of the NBCSP led by the Department of Health and Aged Care.	No change was made.

	• Recommend the following paragraph is more relevant to section 9.7.2 Resourcing: O The NBCSP is estimated to generate only a fraction of Australian colonoscopy demand (54)...	Noted. This section is relevant to clinical practice and remains in its previous position.	No action taken.
	• 9.7 Health system implications of the recommendations: as recognised by the Fourth Australian Atlas of Healthcare Variation, it is recommended that the use of repeat/surveillance colonoscopy is acknowledged as an issue for clinical practice and resourcing. The Atlas identifies that: O There is a pattern of repeat colonoscopy use that is not consistent with the prevalence of disease, indicating possible overuse in some areas and underuse in others. - Repeating the procedure in people who are unlikely to benefit puts them at risk of procedural harms and may reduce opportunities for people who are at high risk of bowel cancer and more in need of the procedure. It also results in inconvenience, cost and confusion to the individual and the health system - The low rates of short-interval repeat colonoscopies in disadvantaged remote areas are concerning, because they suggest that people at high risk of bowel cancer could be missing out on appropriate surveillance. O If guidelines are followed, a small proportion of people who have an initial colonoscopy might be expected to need a repeat within three years O A focus on driving implementation of national guidelines and the Colonoscopy Clinical Care Standard is needed (ACSQHC 2021).	Noted. Health system implications are outlined in the guidelines as they relate to population screening only. The provision of low-value colonoscopies (I.e. unnecessary repeat colonoscopies) or access to colonoscopies are not explored in detail and are largely out of scope for the clinical guidelines. These are important implementation issues.	Additional clarification has been added to the Health system implications text (section 9.7).
	• 9.7.2: Resourcing: Recommend the role of the NBCSP in the implementation of the updated screening age recommendation is acknowledged (attachment 1b, p. 64). Reference: Australian Commission on Safety and Quality in Health Care (ACSQHC) 2021, Fourth Australian Atlas of Healthcare Variation - Gastrointestinal investigations, ACSQHC, viewed 16 May 2023, <https://www.safetyandquality.gov.au/sites/default/files/2021-04/fourth_atlas_2021_-_chapter_5._gastrointestinal_investigations_0.pdf>.	Noted. The role of the NBCSP in the implementation of the guidelines has been acknowledged as appropriate.	No change was made.
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Population Screening: 10. Population Screening: Discussion

ID	Comment	Project Team response	Action taken

1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	Add a dot point to include: ***The ethical implications of expanding age range for screening before barriers to participation for those with inequitable participation rates have been addressed.***	Noted	The text has been clarified, added to section 10.1
	Consider amending the first dot point because the diagnostic performance of iFOBT using one stool sample vs two stool samples could be available by looking at the evidence from international programs and their diagnostic performance. Pg 67	Noted. The international evidence has been reviewed and is not sufficient to drive a change in the Australian context. Local evidence is required and is an active area of research.	No action taken.
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Population Screening: Appendices

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	[response not provided by respondent]		
6	[response not provided by respondent]		

7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Risk and screening based on family history: Plain language summary and 1. Introduction

ID	**Comment**	**Project Team response**	**Action taken**
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	Suggest the purpose of the guideline target a broader audience, not just focus on doctors. For example, primary health care workforce including nurse practitioners, Aboriginal health workers (AHW) and Aboriginal health practitioners (AHP). Change doctors to ***clinicians*** to look after people before they get bowel cancer. Pg 9	This wording is used in the plain language summary which has been written and simplified so that it is understood and accessible to a wider audience. The introduction provides further clarity on this (i.e. 'These guideline chapters are intended for health professionals caring for people without symptoms or signs of CRC and with a family history of CRC to whom screening applies p13.)	No action taken.
	Suggest using a different term to 'lifestyle factors' i.e., risk factors. Lifestyle factors implies chosen behaviours. Pg 9	Noted.	This wording has been updated to the term 'risk factors' throughout the chapter.

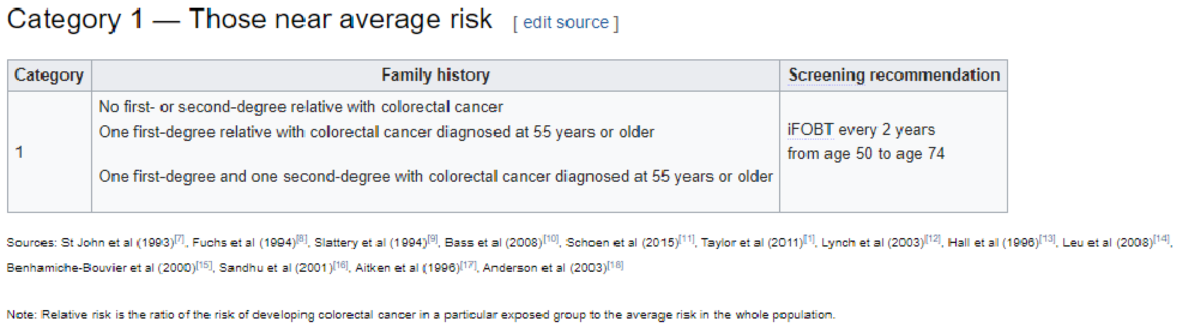
	Provide evidence why people at risk or with a family history of bowel cancer should consider taking aspirin daily. Consider including a reference to support the evidence. Pg 10	This wording is used in the plain language summary which has been written and simplified so that it is understood and accessible to a wider audience. References are not used in a plain language summary. A link to further clarity and evidence around aspirin is provided in the guidelines chapter. (p43)	No action taken.
	Amend sentence to: In Australia people aged 45-74 ***who have no family history of bowel cancer*** are considered at average risk of getting bowel cancer, and ***it is recommended these*** *people* take part in population screening, which is offered as part of the National Bowel Cancer Screening Program (NBCSP). Pg 10	Noted.	This sentence has been amended to '*Everyone aged 45–74 years in Australia should have bowel cancer screening through the National Bowel Cancer Screening Program (NBCSP).' (Plain Language Summary, p11)*
	Amend paragraph to: People with a family history of bowel cancer ***are recommended*** *to* ***undertake different screening*** **to** people who take part in population screening through the National Bowel Cancer Screening Program. They ***need*** different screening tests to find bowel cancer early. This will depend on the ***details of their family history – for example***, whether or not someone has had a first degree relative (i.e., mother, father, sister, brother) and/or second degree relative (i.e. grandparent, aunt, uncle) who had bowel cancer and the age they were when they were first diagnosed. Pg 10	Noted.	This paragraph has been rewritten for clarity. (*Plain Language Summary, p11)*
	Suggest including references to resources for Aboriginal and Torres Strait Islander people and Culturally and Linguistically Diverse populations pg 11	Noted.	Reference resources have been added. (Plain language summary – Where to find information about bowel cancer and bowel cancer treatment? p12)
	Update to people ***living*** with disabilities pg 13	Agreed.	This has been updated. (Section 1,3 Target populations, p14)
	Confirm who the Aboriginal and Torres Strait Islander representation in the Working Party refers to. If it is Dr Kate Armstrong, remove reference as it may not accurately reflect contribution or level of involvement in the working party. Pg 14	Noted.	This reference has been removed. (Section 1.7.1 Contributors, p15)
	Clarify if the two points are questions. If so, consider restructuring to: Clinical Question**s**: i) What is the strength of association between family history and colorectal cancer (CRC) risk? ii) What screening strategies should be used for people with a family history based on age, sex, number and relatedness of relatives with CRC? Pg 14	Agreed.	This has been restructured. (Section 1.7.2 Clinical questions p15)

	Fifth paragraph: Remove duplicated final sentence ***the choice of recommendation and wording reflects the certainty of evidence. Pg 14***	Agreed.	This duplication has been removed. (Section 1.7.5 p16)
	Confirm if the final guidelines will be published in September 2023, otherwise remove the month/year and leave as date to be confirmed. Pg 16	Noted.	This date has been removed. (Section 1.7.7 p18)
	Suggest including a specific revision date the clinical guidelines i.e., before 2033. Pg 17	The guidelines include a revision time frame of 5 years.	No action taken.
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Risk and screening based on family history: 2. Summary of recommendations

ID	**Comment**	**Project Team response**	**Action taken**
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	Amend sentence to: These people may have no symptoms that might indicate CRC but their family history may **indicate** increasing risk so that preventative measures or early treatment may be offered to improve health outcomes. Pg 18	Noted.	This sentence has been re-written for clarity. (Section 2. Summary of recommendations p19)

<table>
<tr>
<td></td>
<td>
Consider including definitions of categories, for example: pg 18

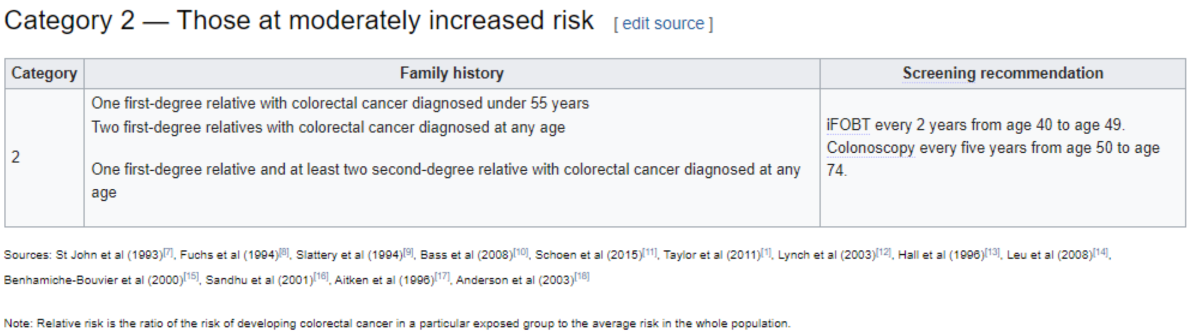


Category 1 — Those near average risk [edit source]

<table>
<tr><th>Category</th><th>Family history</th><th>Screening recommendation</th></tr>
<tr><td>1</td><td>No first- or second-degree relative with colorectal cancer
One first-degree relative with colorectal cancer diagnosed at 55 years or older
One first-degree and one second-degree with colorectal cancer diagnosed at 55 years or older</td><td>iFOBT every 2 years from age 50 to age 74</td></tr>
</table>

Sources: St John et al (1993)[7], Fuchs et al (1994)[8], Slattery et al (1994)[9], Bass et al (2008)[10], Schoen et al (2015)[11], Taylor et al (2011)[1], Lynch et al (2003)[12], Hall et al (1996)[13], Leu et al (2008)[14], Benhamiche-Bouvier et al (2000)[15], Sandhu et al (2001)[16], Aitken et al (1996)[17], Anderson et al (2003)[18]

Note: Relative risk is the ratio of the risk of developing colorectal cancer in a particular exposed group to the average risk in the whole population.



Category 2 — Those at moderately increased risk [edit source]

<table>
<tr><th>Category</th><th>Family history</th><th>Screening recommendation</th></tr>
<tr><td>2</td><td>One first-degree relative with colorectal cancer diagnosed under 55 years
Two first-degree relatives with colorectal cancer diagnosed at any age
One first-degree relative and at least two second-degree relative with colorectal cancer diagnosed at any age</td><td>iFOBT every 2 years from age 40 to age 49.
Colonoscopy every five years from age 50 to age 74.</td></tr>
</table>

Sources: St John et al (1993)[7], Fuchs et al (1994)[8], Slattery et al (1994)[9], Bass et al (2008)[10], Schoen et al (2015)[11], Taylor et al (2011)[1], Lynch et al (2003)[12], Hall et al (1996)[13], Leu et al (2008)[14], Benhamiche-Bouvier et al (2000)[15], Sandhu et al (2001)[16], Aitken et al (1996)[17], Anderson et al (2003)[18]

Note: Relative risk is the ratio of the risk of developing colorectal cancer in a particular exposed group to the average risk in the whole population.

Category 3 — those at potentially high risk [edit source]

<table>
<tr><th>Category</th><th>Family history</th><th>Screening recommendation</th></tr>
<tr><td>3</td><td>At least three first-degree or second-degree relatives with colorectal cancer, with at least one diagnosed under 55 years
At least three first-degree relatives with colorectal cancer diagnosed at any age</td><td>iFOBT every 2 years from age 35 to age 44.
Colonoscopy every five years from age 45 to age 74.</td></tr>
</table>

Sources: St John et al (1993)[7], Fuchs et al (1994)[8], Slattery et al (1994)[9], Bass et al (2008)[10], Schoen et al (2015)[11], Taylor et al (2011)[1], Lynch et al (2003)[12], Hall et al (1996)[13], Leu et al (2008)[14], Benhamiche-Bouvier et al (2000)[15], Sandhu et al (2001)[16], Aitken et al (1996)[17], Anderson et al (2003)[18]

Note: Relative risk is the ratio of the risk of developing colorectal cancer in a particular exposed group to the average risk in the whole population.

The following images have been sourced from https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/Screening_based_on_family_history)
</td>
<td>These categories are defined and outlined in recommendations 1-3 and the associated screening recommendations for each category are outline in practice points 15-17.</td>
<td>No action taken.</td>
</tr>
</table>

	Unclear on where to locate definition of categories of risk in this paper.	Noted. The categories of risk are defined in Chapter 3. The categories are also defined and outlined in recommendations 1-3 .	No action taken.
	Every recommendation across both chapters has a strength rating of weak. Addressing and define this rating in both chapters including what are the implications of the weak rating and outline what recommendations could inform future research priorities and directions.	Noted.	The grading of the recommendations, description of the grading and the criteria have been updated and further clarified in Table 5 in both Appendices documents.
	Suggest more detail is provided and a reference to support the statement "*this excludes anyone known to have a genetic syndrome or related to someone known to have a genetic syndrome." Pg 19*	Noted. This suggestion was brought to the working group for discussion and consideration.	This statement in recommendations 1-3 has been updated and clarification around the term 'genetic syndrome' has been added.
	Pp #4: This practice point is also relevant for people who are not connected to their family history (eg: Stolen Generation or people raised in out of home care). Consider providing advice and support for practitioners caring for people in these circumstances. There must be sensitivity given circumstances where people do not have access to family history.	Noted. This suggestion was brought to the working group for discussion and consideration.	Practice point 4 has been updated to highlight that family history may be unknown and individuals may not be connected to their family history.
	Pp #5: This practice point is also relevant for people who are not connected to their family history (eg: Stolen Generation or people raised in out of home care). Consider providing advice and support for practitioners caring for people in these circumstances. There must be sensitivity given in circumstances where people do not have access to family history.	Noted. This suggestion was brought to the working group for	Practice point 5 has been updated to highlight that family history may be unknown and

		discussion and consideration.	individuals may not be connected to their family history.
	Pp #10-17: Define what is a category 1, 2 or 3 in respective practice points.	Noted. These definitions are provided in EBR 1-3 and will be hyperlinked in the final version of the guidelines.	No action taken.
	Pp #13: Amend start of sentence to: Category 2 ***Criteria*** can be met	Noted. This suggestion was brought to the working group for discussion and consideration.	Practice point 13 has been split into three points for clarity and the suggested wording has been incorporated.
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Risk and screening based on family history: 3. Risk based on family history of colorectal cancer

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		

4	[response not provided by respondent]		
5	Amend sentence: These genetic disorders have ***either*** an autosomal-dominant mode of transmission (mismatch repair genes and APC) or autosomal-recessive mode of transmission (*MUTYH*) within Families pg 24	Agreed.	This sentence has been amended. (Section 3. Risk based on family history of colorectal cancer p24)
	Third paragraph: Are there studies relevant to Aboriginal and Torres Strait Islander people that could be included here.	No studies relevant to Aboriginal and Torres Strait Islander people identified for inclusion here.	The limited information on Aboriginal and Torres Strait Islander peoples has been acknowledged in the text. No further action was taken.
	Fifth paragraph: Amend sentence: For the 2023 update, a systematic review of cohort and nested case-control studies since ***1 January 2016. Pg 25***	Agreed.	This sentence has been amended. (Section 3.1, p25)
	If available, include data relevant to Aboriginal and Torres Strait Islander people. If there is a gap in the evidence, this would be good to acknowledge. Pg 27	Noted.	A sentence has been added to clarify the gap in evidence for data relevant to Aboriginal and Torres Strait Islander people (section 3.4 p27).
	Include the table, and at least the first two columns, at the start of the document. Pg 29	The categories included in this table are defined and outlined in recommendations 1-3 and the associated screening recommendations for each category are outline in practice points 15-17.	No action taken.
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Risk and screening based on family history: 4. Defining the population with risk based on family history

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	Update section to acknowledge cultural factors (for instance, Aboriginal and Torres Strait Islander concepts of "family" may be different to biomedical concepts). Topic may also be associated with trauma and should be approached sensitively. Culturally safe and competent approach to family history is essential. Pg 33	Noted and agreed.	Text has been added to acknowledge cultural factors for Aboriginal and Torres Strait Islander people and emphasise the importance of culturally safe and sensitive care provision. (Section 4.1, p34)
	Update section to acknowledge that cultural understandings of 'family' may vary for Aboriginal and Torres Strait Islander people and should be considered in context of history taking. Pg 34	Noted and agreed.	Text has been added to acknowledge cultural factors for Aboriginal and Torres Strait Islander people and emphasise the importance of culturally safe and sensitive care provision. (Section 4.1, p34)
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	Suggest a reword for practice point 5 to make it clearer: "Accurate risk prediction for an individual is critical. Every effort should be made to collect reliable information. Knowledge of family history may also change over time."	Noted. This suggestion was brought to the working group for discussion and consideration. A decision was made to leave the wording as is.	The suggested wording was not incorporated, however, practice point 5 has been updated to highlight that family history may be unknown and individuals may not be connected to their family history.

17	[response not provided by respondent]		

Risk and screening based on family history: 5. Screening modalities and timing

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	Colorectal cancer screening modalities and timing Practice point 11 "Screening recommendations specify that screening should be offered at 10 years younger than the age of first diagnosis of colorectal cancer in a first-degree relative or 50 years of age, whichever is earlier, to age 74." Comment: I would recommend to amend as follows: "..... should be offered at 10 years younger than the age of first diagnosis of colorectal cancer in a first-degree relative or 40 years of age, whichever is earlier..." based on published data and international guidelines.	Noted. This suggestion was brought to the working group for discussion and consideration. A decision was made to update the wording based on current evidence.	Practice point 11 has been updated to focus on the evidence to offer screening at 10 years younger than the age of first diagnosis of colorectal cancer in a first-degree relative.
4	[response not provided by respondent]		
5	[response not provided by respondent]		
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	We fully support practice point 10 and 11.	Noted.	No action required.
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Risk and screening based on family history: 6 Further testing and referrals

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		

4	[response not provided by respondent]		
5	Amend sentence in first paragraph to: This may be hampered by ***reduced*** community ***health literacy*** and symptom awareness, ***delayed presentation to primary health care***, ***prolonged wait times for specialist*** **referrals**, or limited access to ***culturally safe*** colonoscopy services. Consider updating section to include a broader range of barriers and challenges. Pg 37	Agreed.	This sentence has been updated to include the suggested range of barriers (Section 6, p38).
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	Whilst we support the intention of practice point #12 we believe clarity around the point should be considered, including: Screening is by definition for asymptomatic people. If people have symptoms, they should be investigated appropriately because they are not candidates for a screening program.	Noted. This suggestion was brought to the working group for discussion and consideration.	Practice point 12 has been amended and re-worded for clarity.
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Risk and screening based on family history: 7 Determining screening strategies for risk categories

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	Practice point 15,16 and 17: "Low-dose (100mg) aspirin daily should be considered from age 50 to 70". Comment: I would recommend to amend as follows: "Low-dose (100mg) aspirin daily can be considered from age 50 to 70".	Noted. This suggestion was brought to the working group for discussion and consideration. A decision was made to leave the wording as is in order to accurately convey the information in the practice point.	No action required.
	Practice point 16 and 17: "Colonoscopy should be performed every five years starting at 10 years younger than the age of first diagnosis of colorectal cancer in a first-degree relative or 50 years of age, whichever is earlier, to age 74. Low-dose (100 mg) aspirin	Noted. This suggestion was brought to the working group for discussion and consideration. A decision was made to	No action taken for practice point 16.

	daily should be considered from age 50 to 70." Comment: I would recommend to amend as follows: "...every five years starting at 10 years younger than the age of first diagnosis of colorectal cancer in a first-degree relative or 40 years of age...".	leave the starting age at 50 years for those in category 2 (practice point 16) and reduce the starting age to 40 years for those in category 3 (practice point 17) due to the associated higher risk for category 3 individuals.	Practice point 17 has been amended to incorporate a younger colonoscopy screening start age.
4	[response not provided by respondent]		
5	Suggest clarifying if people with Category 2 risk of colorectal cancer are required to participate in biennial screening in addition to 5 yearly colonoscopies. If 5 yearly colonoscopies alone are sufficient, state this clearly. Pg 40-41	Noted. This suggestion was brought to the working group for discussion and consideration. It was agreed that prior to requiring colonoscopy based on these criteria, people with Category 2 risk should screen via population screening programs.	Text has been added to section 7.2, p42 to clarify suggested screening strategies for those in category 2.
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	We fully support practice point 15. Practice points 16 and 17: We note that the option of IFOBT has been removed from recommendations and believe these practice points should instead be aligned with the RACGP recommendations of: Category 2 - IFOBT every 2 years from ages 40-49 With colonoscopy every 5 years from 50-74 years Category 3 - IFOBT every 2 years from ages 35 -44 With Colonoscopy every five years from 45 to 74 years. We also note, removing IFOBT as part of the practice point for category 2 and 3 patients would limit a clinician's ability to tailor an investigation and consequent treatment plan to the individual. This may also lead a higher number of unnecessary and invasive colonoscopies when a patient may have been ruled out via a simple non-invasive IFOBT.	Noted. This suggestion was brought to the working group for discussion and consideration. A decision was made to leave the starting age at 50 years for those in category 2 (practice point 16) and reduce the starting age to 40 years for those in category 3 (practice point 17) due to the associated higher risk for category 3 individuals. A minimal increase in colonoscopies is anticipated due to the small percentage of those in category 2 and 3.	No action taken for practice point 16. Practice point 17 has been amended to incorporate a younger colonoscopy screening start age.
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Risk and screening based on family history: 8. Risk and screening based on family history: Implications

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	Cancer Australia notes that some changes in the updated guidelines will have resource implications, which need to be carefully managed to ensure delivery of an effective cancer screening program which is underpinned by equity. • In addition, updated practice points in relation to screening strategies for people assessed at increased risk based on family history, will also result in a requirement for more colonoscopies, although this is a small subset of the whole population.	Noted. This is acknowledged in the guidelines chapter (p33).	No action required.
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	Consider including a reference to cultural considerations in relation to determining family history for Aboriginal and Torres Strait Islander people. Pg 42	Noted.	Text has been added to acknowledge cultural factors for Aboriginal and Torres Strait Islander people and emphasise the importance of culturally safe and sensitive care provision. (section 8.1.1, p45)
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Risk based on family history: 9. Risk based on family history: Discussion

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	Given the pervasive impacts of colonisation, racism and intergenerational trauma,8 cultural safety should be emphasised as a key aspect of asking about and assessing CRC risk based on family history among Aboriginal and Torres Strait Islander people. As this chapter is based on risk and risk categorisation, definitions of each risk category must be clearly articulated. As noted in both chapters, there is minimal evidence regarding Aboriginal and Torres Strait Islander people and CRC risk and outcomes. As such, consideration should be given to further highlighting the uncertainties in stratifying individual CRC risk among such populations. This is particularly relevant as previous studies have found that a family history of cancer was identified as a barrier to participating in CRC screening for Aboriginal and Torres Strait Islander people.9,10 These studies further highlight the importance of education by, and engagement with, trusted healthcare professionals. **NACCHO recommends** sensitivity and cultural safety employed when discussing family history and risk with Aboriginal and Torres Strait Islander people.	Noted.	Text has been added to acknowledge cultural factors for Aboriginal and Torres Strait Islander people and emphasise the importance of culturally safe and sensitive care provision. (section 8.1.1, p45)
	If there are no studies relevant to Aboriginal and Torres Strait Islander people, add a note that there is no evidence specific to Aboriginal and Torres Strait Islander people. Pg 45	Noted.	A sentence has been added to clarify the gap in evidence for data relevant to Aboriginal and Torres Strait Islander people (section 9.2 p48).
	Add that co-designing of future research with Aboriginal and Torres Strait Islander people is a priority pg 46	Noted.	Text has been added to highlight the priority of future research with Aboriginal and Torres Strait Islander people. (section 9.4 p49
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		

14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Risk and screening based on family history: Appendices

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	[response not provided by respondent]		
3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	[response not provided by respondent]		
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	[response not provided by respondent]		
9	[response not provided by respondent]		
10	[response not provided by respondent]		
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	[response not provided by respondent]		
17	[response not provided by respondent]		

Other comments

ID	Comment	Project Team response	Action taken
1	[response not provided by respondent]		
2	Given the rigour of the guidelines development, the appropriate involvement of key stakeholders and co-development of practice points with Aboriginal and Torres Strait Islander people, Cancer Australia is pleased to support the chapter updates to the clinical practice guidelines for the prevention, early detection, and management of colorectal cancer, noting the resource implications highlighted above.	Noted.	No action required.

3	[response not provided by respondent]		
4	[response not provided by respondent]		
5	Specific amendments To reflect the commitment to equity, it is important that the language and framing of the draft chapters consistently demonstrates a culturally appropriate, person-centred, strengths-based approach. In Appendix A, NACCHO has outlined specific language and content amendments suggested for consideration to strengthen the cultural appropriateness and clarity of the draft chapters. Please note that these changes may not be required if the Working Party elects to simplify the language throughout the draft documents to improve accessibility and make it more reader friendly. NACCHO would welcome the opportunity to discuss these proposed amendments in more detail. **NACCHO recommends** updating the draft chapters to reflect the amendments listed in Appendix A.	Noted.	The chapters have been updated to incorporate the suggested amendments, where feasible.
	Conclusion To close the gap, there is an urgent need for tangible improvements in the cancer outcomes for Aboriginal and Torres Strait Islander people. There is opportunity to recognise and build on and scale the existing work and successes of the Aboriginal Community Controlled Health Sector to achieve such change. Initiatives must be firmly aligned with the Four Priority Reform Areas of the National Agreement on Closing the Gap, led by Aboriginal and Torres Strait Islander people. Equity must be at the centre of all initiatives. The draft chapters could be strengthened to better address the needs of Aboriginal and Torres Strait Islander people. Ongoing efforts to ensure meaningful involvement of Aboriginal and Torres Strait Islander people at all stages of future guideline development will strengthen future guidelines. Without such involvement and change there is a risk that current and future guidelines will continue to exacerbate the inequities faced by Aboriginal and Torres Strait Islander people and other priority population groups. Aboriginal health belongs in Aboriginal hands.	Noted and agreed.	The chapters have been updated to incorporate the suggested changes where feasible, which we hope will strengthen the guidelines.
6	[response not provided by respondent]		
7	[response not provided by respondent]		
8	Modeling for the impact on endoscopy services in response to extending age range is required in advance of recommendation being implemented. A national communications plan will be required in advance of implementation to support primary care practitioners and other relevant clinicians, and the general population to understand the changes and new criteria.	Noted. This has been acknowledged in the implications section and the dissemination report.	No action required.
9	[response not provided by respondent]		

10	These guidelines should not advocate primarily for the national program (as evidenced by increasing and repeated references to the "NBCSP") to the exclusion of other iFOBT products available to patients in Australia. These guidelines should align with what is clinically in the patient's best interests for screening test type and potential treatment pathway (including risk category alignment) rather than substantially champion the national program in what may be considered an anti-competitive manner. [The Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. 9th edn, updated. East Melbourne, Vic: RACGP, 2018.]	Noted. The guidelines do not advocate for the NBCSP, they focus on the evidence for population screening. The guidelines appropriately explain the context of population screening in Australia, which includes the NBCSP alongside the possibility of screening outside of the NBCSP.	Changes have been made to the text to ensure the NBCSP is referenced appropriately at all times.
11	[response not provided by respondent]		
12	[response not provided by respondent]		
13	[response not provided by respondent]		
14	[response not provided by respondent]		
15	[response not provided by respondent]		
16	The new guidelines do not reference a percentage as the risk threshold, as in the RACGP guidelines that would indicate a high-risk individual based on a 10-year risk score. Can a sentence be included that unifies guidelines from the RACGP and the cancer council to some degree as this would help with conversations with GPs for bowel cancer screening and guide GPs on the guidelines.	Noted. The current RACGP advice may need to be revised pending the finalisation and endorsement of the Guidelines. The Guideline Developers will work with the RACGP to ensure that consistent advice and guidance is provided.	No action required.
	Furthermore, it looks like you have done away with previous cancer council lifetime risk thresholds of 10% (to age 75), and focused more on relative risk. We do think this is a helpful step to be able to focus on short term risk as opposed to lifetime risk, even for those with hereditary risk because the risk-reduction of polypectomy can be calculated over a short-time frame, or a relative risk that is constantly in flux.	Noted.	No action required.
	An effort to tie back to RACGP recommendations would be helpful for general practitioners to navigate guidelines. The RACGP summarises risk based on 10-year risk scores as well as relative risk. Creating a summary statement to help GP instead of further confusing them would be helpful.	Noted. The current RACGP advice may need to be revised pending the finalisation and endorsement of the Guidelines. The Guideline Developers will work with the RACGP to ensure that consistent advice and guidance is provided.	No action required.
17	[response not provided by respondent]		