NICE National Institute for Health and Care Excellence

Kidney Cancer

Consultation on draft guideline – deadline for comments 5pm, on Tuesday 28 October 2025 email: kidneycancer@nice.org.uk

Checklist for submitting comments

- Use this comments form and submit it as a **Word document (not a PDF)**.
- **Do not submit further attachments** such as research articles, or supplementary files. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline. You are welcome to include links to research articles or provide references to them
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 comments form from each organisation**.
- **Do not** paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; **do not** cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public with underlining and highlighting. Also, ensure you state in your email to NICE, and in the row below, that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate. Where comments contain confidential information, we will redact the relevant text, or may redact the entire comment as appropriate.

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

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	Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality and Health Inequalities Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.** 1. Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives. 2. Would implementation of any of the draft recommendations have significant cost implications? See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name (if you are responding as an individual rather than a registered stakeholder please specify).	Yorkshire Cancer Research
Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry).	N/A
Confidential comments (Do any of your comments contain confidential information?)	No
Name of person completing form	Rowan Ellis Hollins

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Comment number	Document [e.g. guideline, evidence review A, B, C etc., methods, EIA]	Page number 'General' for comments on whole document	Line number 'General' for comments on whole document	Comments • Insert each comment in a new row. • Do not paste other tables into this table, because your comments could get lost – type directly into this table. • Include section or recommendation number in this column.
Example	Guideline	016	045	Rec 1.3.4 – We are concerned that this recommendation may imply that ……..
Example	Guideline	017	023	Question 1: This recommendation will be a challenging change in practice because ……
Example	Guideline	037	016	This rationale states that…
Example	Evidence review C	057	032	There is evidence that …
Example	Evidence review C	063	012	CONFIDENTIAL: Our unpublished study has shown that [X] is more effective than [Y]
Example	Methods	034	010	The inclusion criteria …
Example	Algorithm	General	General	The algorithm seems to imply that …
Example	EIA	010	002	We agree with the barriers to access listed, and would also like to add ….
1	Guideline	006	1.1.7	There is evidence that the offer of stop smoking support could be strengthened by automatically enrolling people who smoke with renal cell carcinoma (RCC), as well as those with suspected RCC, into smoking cessation services. A suspected cancer diagnosis can act as a 'teachable moment', encouraging people to make positive lifestyle changes. Limiting stop smoking support to those already diagnosed risks missing this important opportunity for intervention. There is evidence from several settings that providing smoking cessation support on referral into cancer services is effective. For example, referral into smoking cessation services following head and neck urgent suspected cancer referral resulted in a 36% reported quit rate.[1] Moreover, evidence suggests that people who are referred to cancer specialists with suspected cancer are largely willing to accept advice on reducing their risk of future cancer.[2] This this willingness should be capitalised fully for people with suspected RCC. Additionally, people with diagnosed or suspected RCC should not simply be offered support to help to stop smoking. They should instead be automatically enrolled into smoking cessation support. Evidence from settings such as lung health checks, maternity care and hospital inpatient programmes, including from research and services funded by Yorkshire Cancer Research, shows that opt-out, fully integrated

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				approaches are effective.[3, 4] If logistics allow, this support should be co-located alongside the primary appointment for optimal impact. Opt-out approaches increase quit attempts and can play a meaningful role in reducing smoking prevalence. For example, the Yorkshire Enhanced Stop Smoking study (YESS) demonstrated that automatically enrolling people who smoke into smoking cessation support as part of their lung screening appointment on the same day is highly effective.[3] Of eligible participants in the YESS study, 89.0% agreed to see an advisor on the unit and 15.0% of all eligible people self-reported quitting after four weeks. This is a higher quit rate than is seen in lung screening units that do not provide such intensive intervention. For example, the UK Lung Screening Pilot provided standard smoking cessation advice leaflets and signposted participants to existing services.[5] At a similar time-point to the 4-week quit rate measured in the YESS study, 9.9% self-reported quitting. Opt-out, fully integrated support is designed and proven to capture people who smoke that may have ignored a leaflet or brief advice to quit by presenting smoking cessation as a standard element of the pathway rather than an optional extra. The CURE Project in Manchester and Yorkshire Cancer Research's QUIT programme further demonstrate that opt-out strategies lead to higher engagement and quit rates compared to traditional opt-in approaches.[6, 7] The QUIT programme automatically enrolled patients in hospitals who smoke into smoking cessation services as part of their routine care. During the period in which the charity co-funded the programme, 2,450 quits were achieved and following this initial funding the programme has been sustained as a key part of prevention work within the ICS, having the potential to save thousands of lives and hospital readmissions each year.
2	Guideline	1.3 – 1.5	009 - 015	These sections raise concerns around possible issues with variation in access. It is of course vital that different options are discussed with patients to ensure meaningful shared decision making. For this to be possible it is important to ensure that everyone has access to cancer care navigators so that options are presented and discussed in an appropriate manner to enable all patients to make informed decisions about their care.
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Insert extra rows as needed

Data protection
The information you submit on this form will be retained and used by NICE and its advisers for the purpose of developing its guidance and may be passed to other approved third parties. Please do not name or identify any individual patient or refer to their medical condition in your comments as all such data will be deleted or redacted. The information may appear on the NICE website in due course in which case all personal data will be removed in accordance with NICE policies.

By submitting your data via this form you are confirming that you have read and understood this statement.

For more information about how we process your data, please see our privacy notice.

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References

1. Tang MW, Oakley R, Dale C, Purushotham A, Møller H, Gallagher JE. *A surgeon led smoking cessation intervention in a head and neck cancer centre*. BMC Health Services Research. 2014;14:636.
2. E.C. Evans R, Watson H, Waller J, Nicholson BD, Round T, Gildea C, et al. *Advice after urgent suspected cancer referral when cancer is not found in England: Survey of patients' preferences and perceived acceptability*. Preventive Medicine Reports. 2024;43:102781.
3. Murray RL, Alexandris P, Baldwin D, Brain K, Britton J, Crosbie PAJ, et al. *Uptake and 4-week quit rates from an opt-out co-located smoking cessation service delivered alongside community-based low-dose computed tomography screening within the Yorkshire Lung Screening Trial*. European Respiratory Journal. 2024;63(4):2301768.
4. National Institute for Health and Care Excellence. *Tobacco: preventing uptake, promoting quitting and treating dependence.* 2025. Accessed: 02/05/2025. Available from: https://www.nice.org.uk/guidance/ng209
5. Brain K, Carter B, Lifford KJ, Burke O, Devaraj A, Baldwin DR, et al. *Impact of low-dose CT screening on smoking cessation among high-risk participants in the UK Lung Cancer Screening Trial*. Thorax. 2017;72(10):912-8.
6. Evison M, Pearse C, Howle F, Baugh M, Huddart H, Ashton E, et al. *Feasibility, uptake and impact of a hospital-wide tobacco addiction treatment pathway: Results from the CURE project pilot*. Clin Med (Lond). 2020;20(2):196-202.
7. Gillespie DB, Susan; Franklin, Matthew; Hock, Emma; Flight, Laura; Bright, Sophie; et al. *Evaluation of the QUIT hospital-based smoking cessation service: Interim report - covering the setup phase of the evaluation*. 2023.