NHS Rotherham Clinical Commissioning Group
(NHS Rotherham CCG)

Operational Executive – 30 July 2021

Strategic Clinical Executive - 04 August 2021

Governing Body – 01 September 2021

Lung Health Checks

Lead Executive:	Ian Atkinson, Executive Place Director, RCCG
Lead Officer:	Becci Chadburn, Senior Contracts and Delivery Manager, RCCG
Lead GP:	Dr Jason Page, SCE GP

Purpose:

To provide a report detailing the proposed implementation of the Lung Health Checks Programme in Rotherham in conjunction with the South Yorkshire and Bassetlaw Cancer Alliance.

To note the requirements for delivery of the programme from April 2022.

Background:

The Targeted Lung Health Checks (TLHC) programme offers the opportunity for early diagnosis to those most at risk of lung cancer (ever smokers) in areas with among the highest lung cancer mortality rates in England. The programme is also a flagship contributor to the Long-Term Plan ambition to diagnose 75% of cancers at an early stage by 2028.

There are 23 places around England with a current TLHC project, Doncaster is one of those areas. Trial data suggest that TLHCs can substantially increase early diagnosis of lung cancer. Over the course of a four-year programme around 6,100 cancers will be diagnosed from the existing 23 TLHC projects, with around 4,500 (66%) diagnosed at either stage 1 or stage 2. This compares to 28.9% of lung cancers diagnosed at stage 1 or 2 in 2018. Data from the initial small pilots in Manchester suggest the early diagnosis figure could be as high as 80%.

Analysis of key issues and of risks

NHS England and Improvement has identified Rotherham as a 'Priority' area for the expansion of the Lung Health Checks Programme due to lung cancer mortality. Rotherham CCG is currently ranked 21 highest in the country for lung mortality based on a total of 265 lung cancer deaths (55- 74, 2016-2018) against a population of 185,085.

TLHCs work by inviting those between 55 years and 74 years 364 days who have ever smoked to an appointment where lung cancer risk is assessed. If the individual is at higher risk of lung cancer, the participant is offered a low-dose CT scan, which aims to identify lung cancers at an earlier stage. This is followed up with subsequent scans, based on the participants' individual risk and the offer of smoking cessation support.

The TLHC has produced a standard protocol which outlines the four clinical roles each project has in place to ensure the effective delivery of care and clinical governance of the programme. The Clinical Director of Programme will work with the Responsible Assessor, Responsible Radiologist and Responsible Clinician to implement and monitor the programme and ensure compliance with the expected quality standards.

Dr. Jason Page, SCE GP and GP Cancer Lead will be the Clinical Director for the Rotherham TLHC programme and is also the Clinical Director for the Doncaster TLHC Programme.

Rotherham CCG in conjunction with the Cancer Alliance has submitted an initial template to NHS England which will be utilised to assess the feasibility of an area delivering a TLHC project. The

next stage is to discuss the responses included in this template during a feasibility discussion with the national team. See Appendix A.

Within this template it describes the Rotherham approach to the TLHC programme and identifies that we would look to replicate the service currently in place as part of the Doncaster TLHC pathway.

In addition, Doncaster CCG has procured an end-to end package from an external supplier to deliver their TLHC service. SYB ICS Cancer Alliance would look to replicate that service model across the other CCGs including Rotherham as part of the roll out. We would need to take procurement and legal advice first to ensure the correct procurement and/or contract extension procedures are followed.

Rotherham CCG has access to community smoking cessation services. Discussions with the provider will take place to identify a process and capacity for referrals from TLHC.

Patient, Public and Stakeholder Involvement:

Following confirmation from the national team that Rotherham can progress as area for the expansion of the Lung Health Checks Programme, a communications and engagement plan for further engagement will be developed in line with the programme plan.

Equality Impact:

The criteria for the Targeted Lung Health Check service are set nationally as per the national protocol. The criteria are based on national and international evidence for the effectiveness and impact on health outcomes of a health check and screening programme. This is a time-limited service for Rotherham meaning that a defined cohort of residents will be invited to the service. NHSE will evaluate the service to determine if the TLHC service has the intended impact and if it will be supported further after 2024. The communication of this programme will highlight the time-limited and targeted nature of the service.

Financial Implications:

The TLHC programme is funded by NHSE and project funding is allocated through a two-cost model:

- A **fixed** amount for each project to cover the cost of the core programme.
- A **variable** amount calculated on the national reported size of the CCG population of 55 to 74-year and 364 days.

The allocation for Rotherham is still to be confirmed as this is subject to Rotherham being confirmed as area for the expansion of the Lung Health Checks Programme and being a Phase 3 site. If approval is given, it is anticipated that funding agreements and a memorandum of understanding will be in place during August 2021 once NHSEi have fully confirmed Rotherham as a Phase 3 site.

Fixed funding

Each CCG has funding for core staffing and clinical leadership for the 4-year programme.

Variable funding

Funding allocated will ensure projects have the resources to deliver the clinical service. The financial model uses three nationally agreed averages:

- 54% of the eligible population of 55 to 74-year olds and 364 days, smoke or have smoked.
- 50% of those who smoke or have smoked, will take up the offer of a lung health check.
- and 56% of those who attend a lung health check are at risk and offered a low dose CT.

Each project will receive **£264** per CT scan to cover variable costs such as:

- CT scanning including the cost of providing mobile capacity.
- Teleradiology.
- Consumable costs associated with the lung health check.
- Travel and other costs including legal.

The variable funding mechanism is in place to enable funding to be flexed, based on project activity. For example, if during the year the project carries out more scans than estimated at the start of the year, additional funds will be paid to the project to cover activity. If the project carries out fewer scans than anticipated, funds will be recouped from the project.

As TLHC project funding only covers up to the point of LDCT scan reporting, consideration will be given to any potential impacts on TRFT services with regards to increased referrals following the outcome of scans and associated activity. Work will be undertaken with the Trust to understand the potential impact once Rotherham has been finally confirmed as Phase 3 site.

Human Resource Implications:

A null statement.

Procurement Advice:

ICS Cancer Alliance would look to replicate the end-to end package that is in place in Doncaster across the other CCGs including Rotherham. SYB ICS Cancer Alliance are currently seeking procurement and legal advice to ensure the correct procurement and/or contract extension procedures are followed.

Data Protection Impact Assessment:

A DPIA will be completed for the front end of the process i.e. the identification of eligible patients by GP practices and the invitation process. A further DPIA may need to be completed by the supplier dependent on the final agreed service model.

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Approval history:

Operational Executive noted and supported the content of this paper on 30 July 2021.

Recommendations:

Governing Body are asked to:

- note the proposed implementation of the Lung Health Checks Programme in Rotherham in conjunction with the South Yorkshire and Bassetlaw Cancer Alliance.
- note the requirements for delivery of the programme from April 2022 including the associated funding.

Paper is for Noting

TLHC Onboarding Template and Timeline

This document is part of the Phase 3 expansion of the Targeted Lung Health Checks (TLHC) programme. It is designed to give an overview of the information and plans Cancer Alliances and CCGs will need in order for new Targeted Lung Health Check projects to be confirmed and become operational. It is divided into stages up to March 2022 with information, milestones and suggested timeframes for each of the stages.

Some of the information milestones across stages are duplicative. It is worth considering all of the information requirements across all stages at the outset. In many cases, it is possible to gather necessary information for later stages much earlier than the deadline. For example, Stage 4 includes elements of a detailed project delivery plan which are less urgent to complete, but would still benefit from early consideration.

Resources

Specific resources on the NHS Futures Workspace are linked throughout the document. But these broader resources should also be referred to:

- Project Support Pack [Available in NHS Futures; Link to be updated]
- The Standard Protocol and Quality Assurance Standards

If you have suggested amendments to develop any of the resources or you feel additional resources would be useful, then please let the National Team know.

Stage 1 Template (to be completed by July 9th 2021)

The stage 1 template aims to support Cancer Alliances to assess the feasibility of individual CCGs launching a TLHC project. It may be helpful to schedule a meeting between the Cancer Alliance and the CCG to talk through this template. The National Team is able to support this process and attend these meetings. Where possible, it may be also helpful to invite the Project Lead or SRO of neighbouring TLHC programmes to join the discussion.

	Cancer Alliance:	**CCG:**
1.	**People**	
1.1	**Who are the lead contacts for this project from the Cancer Alliance and CCG?**	
	Cancer Alliance: Julia Jessop	**Rotherham CCG:** Jacqui Tuffnell, Head of Commissioning
1.2	**Can senior members of staff be identified to fill the following roles? If so, who? If not, will they need to be recruited through secondment/externally?**	
1.2.1	**Clinical Director of Programme**	
	There should be a single clinical director who takes overall responsibility for the safety of patients involved in the programme, including verifying the procedures for selection, scanning, acting on findings and communicating with participants. These procedures should include	

	failsafe mechanisms to ensure that decisions to recall participants for assessment are actioned, including reminders for individuals who fail to attend.
	Dr. Jason Page, GP; Clinical Director, Doncaster TLHC Programme
1.2.2	**Responsible Assessor**
	There should be a named clinician who is responsible for the leadership of the process to select and assess the individual cases for entry into the programme, the lung health check and the risk assessment for lung cancer. The clinician can be a doctor, nurse or other professional with the appropriate clinical authority and accountability, from either the local primary or secondary care team. They will continually oversee and monitor the clinical programme, the management of participants and provide day to day leadership of the clinical service.
	TBC
1.2.3	**Responsible Radiologist**
	There should be a named radiologist who is responsible for the LDCT in individual cases and will normally be the first-read radiologist. The radiologist should urgently refer either direct to the rapid access lung clinic/ named consultant or via other urgent pathways in secondary care. The radiologist will accurately monitor reporting performance, and act on these results to support governance, training and improve quality. They will be responsible for data entry relating to the LDCT report and ensure findings are communicated for action.
	Dr Sue Matthews, Consultant Radiologist, Sheffield Teaching Hospitals; Responsible Radiologist for Doncaster TLHC programme. *Dr Matthews is currently considering how she can be involved with the expansion within SYB. She will help with recruitment to the roles she is unable to fulfil.*
1.2.4	**Responsible Clinician**
	There should be a named secondary care respiratory physician who is responsible for managing the referrals into the rapid access lung clinic and coordinating the clinical work up of participants in secondary care. This will normally be the respiratory physician who works in the lung cancer service and who receives referrals from the programme.
	Dr Vicky Athey, Consultant Respiratory Physician, Rotherham NHS Foundation Trust has been approached to discuss the role. She is considering the role but needs to understand further details/contractual arrangements etc.
2.	**Resources & outsourcing arrangements**
2.1	**What current smoking cessation intervention and services are offered in the CCG and who delivers them? Is it possible that these would be available for TLHCs, or do additional services need to be procured?**
	As part of a Lung Health Check, both eligible and ineligible participants should be advised on smoking cessation. Smoking cessation advice should be incorporated into written correspondence and should be face-to-face where participants attend. Enhanced smoking cessation interventions are also encouraged including the use of pharmacotherapy. There are NICE Guidelines on 'stop smoking interventions and services'.
	Rotherham CCG has access to community smoking cessation services. Discussions with the provider will take place to identify a process and capacity for referrals from TLHC. We would look to replicate the service currently in place as part of the Doncaster TLHC pathway i.e. TLHC nurses offer brief advice on smoking cessation to patients and then refer to Yorkshire Smokefree Doncaster for

	ongoing smoking cessation support in the community. This is working well and approx. 41% of eligible LHC participants i.e. current smokers, are taking up the opportunity of ongoing smoking cessation support.
2.2	**Do you have any initial thoughts on how necessary CT capacity would be procured?**
	So far, projects have primarily procured additional mobile CT capacity. This has helped with accessibility, including setting up scans in the local community. Procurement can take 3 to 8 months so it will be important to think about early. (see Resources).
	We would work on a system-wide level with the other CCGs in the Cancer Alliance to explore the procurement of additional CT capacity with the provider for Doncaster TLHC service. We would seek procurement and legal advice initially, working with the ICS.
2.3	**Is there another CCG in the Cancer Alliance happy to help support the new CCG to become operational?**
	We will work closely with Doncaster CCG who are currently delivering a TLHC service.
2.3.1	**Is there an opportunity to share any resources with existing neighbouring TLHC projects?**
	For example, sharing a Project Manager, staffing support or CT capacity.
	As per 2.3. Shared resource – Clinical Director; CT capacity Additional project management and admin support would be required to ensure all the planning is completed and the programme is ready to go live.
2.4	**Is it intended that any parts of the service are outsourced, or will any contract need putting in place with primary care teams to deliver the service?**
	For example, this may include part of the service - mobile CT capacity (CT scanner & reporting only), or much of the resource associated with the Lung Health Check – e.g. a procured end-to-end package (including booking system, staff, CT scanner, reporting)
	Doncaster CCG has procured an end-to end package from Alliance Medical to deliver their TLHC service. SYB ICS Cancer Alliance would look to replicate that service model across the other CCGs as part of the roll out. We would need to take procurement and legal advice first to ensure the correct procurement and/or contract extension procedures are followed.
3.	**Governance**
3.1	**Are key local stakeholders supportive of a local TLHC programme in the area?**
	e.g. Medical Director, key clinical colleagues including radiology leads, primary care colleagues and GPs.
	Paper to be submitted to RCCG Exec Team for sign-off/approval. Sign-off by Trust Board also required.
3.2	**What local sign-off requirements are necessary?**
	Are there any Trust or CCG Boards that will be required to sign off the programme or elements of it? For example, CT procurement or Data Protection Impact Assessments. Will consultation be required? How quickly can a TLC project be provisionally agreed locally?
	SYB ICS Cancer Alliance Board has agreed in principle to the expansion of the TLHC programme to Rotherham, Barnsley and Bassetlaw.

	Proposal for expansion to other areas within SYB is to be presented to Directors of Commissioning and Accountable Officers in July/August. Agreement for roll out in Rotherham and any financial impact would be required by Rotherham CCG Executive Team and TRFT Board? Any IG / privacy assessments would need sign off by the appropriate committee and governance lead. Procurement is via a shared team based in Sheffield.
4.	**Population**
4.1	**Can you give an estimate of the eligible population to receive TLHC in your CCG?**
	The eligible population is the number of adults between 55 years and 74 years and 364 days who have ever smoked. (see Resources).
	Age 55 to 74years, ever-smoked = 25,949
4.2	**It is likely that participation in each area will initially be capped at an eligible population of 50,000 participants. If your population is greater than 50,000 can you give an indication of how you might limit the eligible population to 50,000?**
	For example, decisions may be made to limit the number of GP practices that are covered by the programme, and to prioritise those practices covering areas with higher smoking rates.
	NA
4.3	**Are there any local preferences for how the local population would be targeted? E.g. selection of particular geographical areas within the Cancer Alliance/ CCG boundary or phasing up to a number of identified GP practices?**
	We would use local data and work with the PCNs to identify and prioritise areas for roll out of the service.
5.	**Other**
5.1	**Are there any existing early diagnosis innovations or research trials related to lung cancer taking place in the CCG which might align/ conflict with a TLHC project (e.g. Oncimmune, research trials)?**
	No
5.2	**Please give an initial assessment on the feasibility of your identified CCG(s) delivering a TLHC programme, and any anticipated barriers or difficulties.**
	Potential barriers: • If we have to procure a service from scratch, this will take time and resource • Capacity issues at TRFT, including radiology • Recruitment to key posts

	• Funding
5.3	**Please highlight any enablers that might place your identified localities at an advantage in delivering TLHCs**
	Doncaster TLHC Clinical Director is a GP in Rotherham. Doncaster CCG has already launched their TLHC programme and will offer valuable insight and experience. Proposal to work as a system across SYB to ensure knowledge and experience is shared.
5.4	**Are there any support or resources you feel would be particularly helpful in getting the TLHC programme operational locally?**
	Early permission to recruit to posts and confirmation of funding will be key to enable the start date of April 2022 to be met.
5.5	**Please let us know if you have any further comments or feedback.**

Stage 2 Key milestones (due by end of July 2021)
Stage 3 Key milestones
Stage 4 Key milestones
Stage 5 Key milestones