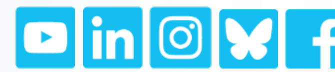
# Hampshire and the Isle of Wight Primary Care Cancer Conference

Novotel Southampton
Thursday 26th February 2026

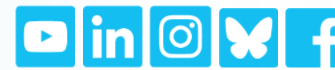
# Housekeeping

- No planned fire alarms today – however, in the event of a fire, exits are located at the front of the room and through the building entrance.
- There will be three breaks during the day for refreshments; mid-morning and lunch and early afternoon. Please do help yourself to refreshments throughout the day.
- We will be taking some photos of the day – please do flag to the team if there are any issues.
- If you have any queries, please ask a WCA team member (look out for a white lanyard!)
- Remember to enter your registration number on the panels in reception.



# Wi-Fi Code

Select ‘Novotel’ in your Wi-fi settings and press connect.



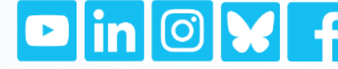
# Agenda

| Time | Topic/Activity | Lead |
|---|---|---|
| 10:00am | **Welcome** | Dr Richard Roope |
| 10:10am | **Beyond Screening: Ann's Story** | Ann Brown |
| 10:30am | **Lung Cancer Screening Programme** | Abi Desouza/Rachel Hardstaff |
| 11:00am | **Workshop Session 1** | ALL |
| 11:45am | Refreshment break | |
| 12:00pm | **When FIT is positive: Derek's Story**<br>**Bowel Cancer Pilots – what have we learned** | Dr Richard Roope / Guest speakers |
| 12:45pm | Lunch | |
| 1:30pm | **Looking ahead to 26/27 - Facilitated round table discussions** | ALL |
| 2.15pm | **Workshop Session 2** | ALL |
| 3:00pm | Refreshment break | |
| 3:15pm | **Panel Discussion** | ALL |
| 4:00pm | **Close** | |

Cancer Matters Wessex

# Improving Cancer Outcomes

How big is Cancer?:



# Improving Cancer Outcomes

Cancer:

- Largest cause of Premature (<75) deaths[1] (more than cardiovascular, respiratory and liver causes combined.)

1. https://digital.nhs.uk/data-and-information/publications/statistical/compendium-mortality/current/years-of-life-lost

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- Largest cause of Loss of Life Years[4]
- Largest cause of All Deaths[5].


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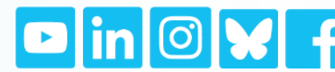
Cancer Matters Wessex

# Improving Cancer Outcomes

By how much did the cancer premature (<75) death rate fall in England between 2011 and 2024?



# Improving Cancer Outcomes

By how much did the cancer premature (<75) death rate fall in England between 2011 and 2024?

1. 5.6%
2. 10.6%
3. 15.6%
4. 20.6%
5. 25.6%

Show of hands...

# Improving Cancer Outcomes

By how much did the cancer premature (<75) death rate fall in England between 2011 and 2024?

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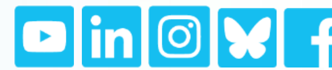

# Improving Cancer Outcomes

Cancer <75 preventable death rate

70.0
65.0
60.0
55.0
50.0
45.0
40.0

2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024

# Improving Cancer Outcomes

Smoking

# Improving Cancer Outcomes

Smoking

- Across England by how much did the adult smoking prevalence fall between 2011 and 2024?

1. 27.5%
2. 32.5%
3. 37.5%
4. 42.5%
5. 47.5%

# Improving Cancer Outcomes

Smoking

- Across England by how much did the adult smoking prevalence fall between 2011 and 2024?

1. 27.5%
2. 32.5%
3. 37.5%
4. 42.5%
5. 47.5%

# Improving Cancer Outcomes

Smoking

| | England | Wales | Scotland | Northern Ireland | UK |
|---|---|---|---|---|---|
| 2011 | 19.8% | 22.3% | 23.4% | 18.9% | 20.2% |
| 2012 | 19.3% | 21.0% | 21.7% | 19.2% | 19.6% |
| 2013 | 18.4% | 20.2% | 21.5% | 18.5% | 18.8% |
| 2014 | 17.8% | 19.4% | 20.3% | 18.0% | 18.1% |
| 2015 | 16.9% | 18.1% | 19.1% | 19.0% | 17.2% |
| 2016 | 15.5% | 16.9% | 17.7% | 18.1% | 15.8% |
| 2017 | 14.9% | 16.1% | 16.3% | 16.5% | 15.1% |
| 2018 | 14.4% | 15.9% | 16.3% | 15.5% | 14.7% |
| 2019 | 13.9% | 15.5% | 15.4% | 15.6% | 14.1% |
| 2020 | 13.8% | 15.1% | 16.0% | 14.7% | 14.0% |
| 2021 | 13.0% | 14.1% | 14.8% | 13.8% | 13.3% |
| 2022 | 12.7% | 14.1% | 13.9% | 14.0% | 12.9% |
| 2023 | 11.6% | 12.6% | 13.5% | 13.3% | 11.9% |
| 2024 | 10.4% | 11.4% | 12.0% | 10.5% | 10.6% |
| | | | | | |
| Drop | -47.5% | -48.9% | -48.7% | -44.4% | -47.5% |

# Improving Cancer Outcomes

UK Smoking prevalence

25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035

# Improving Cancer Outcomes

Cancer:

- Largest cause of Premature (<75) deaths[1] (more than cardiovascular, respiratory and liver causes combined.)
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Cancer Matters Wessex

Lung
Cancer
Screening

Ann Brown
Lived experience representative

# Lung Cancer Screening across Wessex

Abigail Desouza, Programme Manager, WCA
Rachel Hardstaff, Responsible Assessor for the Hampshire Hospital LCS Programme

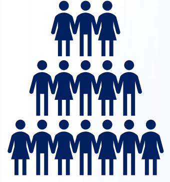
# Proportion of new lung cancer diagnosis in Wessex, by stage – Pre TLHC/LCS

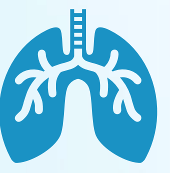
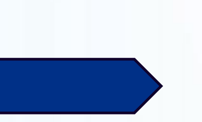
100%
80%
60%
40%
20%
0%

2018 2019 2020

Early detection rate ~25%

# Lung Cancer Screening pathway



**Identify**

- 55-74yrs
- Smoking history

**Invite**

- Informed choice on screening

**Risk assess**

- Determine risk of lung cancer in next 5-6yrs
- Smoking cessation support

**LDCT**

- Low-dose CT performed locally

**Outcome**

- Manage output of LDCT:
  - Referral to secondary care
  - Nodule surveillance
  - Negative finding – routine screening

# Rollout across Wessex

# Rollout across Wessex

# Rollout across Wessex

%

80000
70000
60000
50000
40000
30000
20000
10000
0

80
70
60
50
40
30
20
10
0

19/20 20/21 21/22 22/23 23/24 24/25 25/26 26/27 27/28 28/29

Invitations Uptake rate

# Clinical outcomes post LDCT

# Clinical outcomes post LDCT

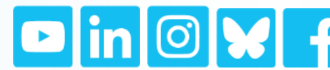
| Outcome | n (%) |
| --- | --- |
| Coronary artery calcification | **15,408 (27%)** |
| Other | **10,386 (18%)** |
| Emphysema | **8,233 (14%)** |
| Aortic valve calcification | **757 (1.3%)** |
| Other cancers | **197* (0.3%)** |

N = 57,360

# Clinical outcomes post LDCT

**A closer look this year at incidental cancer findings within LCS**

- Thyroid
- Breast
- Lymphoma
- Myeloma
- Sarcoma
- Spinal
- Liver & Pancreatic (HPB)
- Renal
- Adrenal
- GI
- Gynae
- Other



# Collaborative working: North and Mid Hants LCS Incidental finding pathway

## Significant Findings

- Significant incidental findings are managed by Lung Cancer Screening (LCS) Team
- Review at LCS MDT
- Contacted by Responsible Assessor and letter sent to patient (and CC GP)
- Appropriate bloods and imaging requested as agreed with speciality
- Referrals made to appropriate speciality

| | | | | |
|---|---|---|---|---|
| Tuberculosis | Aortic Valve Calcification | Cholecystitis | Hyperdense/Complex Renal Cyst | Lytic and sclerotic lesions |
| Mediastinal Mass | Pericardial Effusion | Bile Duct Dilatation | Hydronephrosis | Osteoporotic fractures |
| Interstitial Lung Disease | Cardiomegaly | Pancreatic Cysts | Adrenal Lesion | Oesophageal dilatation/Mass/Lesion |
| Infective Consolidation | Breast Mass/Lesion | Pancreatic Mass/Lesion | Thyroid Mass/Goitre | Sarcoma |
| Pleural Effusion | Liver Mass/Lesion | Renal Mass/Lesion | Thoracic Aneurysm | Suspected Lymphoma |
| Pulmonary Nodules | Liver Cirrhosis | Non obstructive calculi | Abdominal Aortic Aneurysm | Suspected myeloma |

# Collaborative working: North and Mid Hants LCS Incidental finding pathway

## Coronary Artery Calcification

- Only reported if moderate or severe

- Patient advised of finding via outcome letter (and CC to GP)

"Your low dose CT scan has shown coronary artery calcification, which is caused by a build-up of calcium in the blood vessels that supply your heart. You may not be experiencing any symptoms. You may already be on medication for this such as a statin, this will be a bespoke treatment for you and does not need changing. If you are not on a statin the treatment for this as agreed with the cardiology team at Hampshire Hospitals is 40mg of Atorvastatin, if not contraindicated. Please contact your primary care team to arrange a health check and to find out if a statin is a suitable treatment for you.  Your primary care team will consider whether you have had a previous vascular event (such as heart attack or stroke) and, if not, treat accordingly to the primary prevention guidelines."

- GP Management

➢ If the patient is already on a statin, this can be continued and dose adjusted to get the LDL to target. If not on a statin please consider starting 40mg atorvastatin. This is due to the objective evidence of coronary artery calcification on LDCT scan.

➢ Manage as per the primary prevention guidelines aiming for >40% reduction in LDL

➢ Provide lifestyle advice such as diet and exercise and aim for optimal management of BP

# Collaborative working: North and Mid Hants LCS Incidental finding pathway

## Emphysema

- Only reported is moderate or severe

- Patient advised of finding via outcome letter (and CC to GP)

"Your low dose CT scan has shown emphysema, which is change in the lung usually caused by smoking. You may not be experiencing any symptoms. The best treatment is to stop smoking. If you have symptoms such as breathlessness, please arrange a health check with your GP. They may arrange lung function tests locally or via the clinic diagnostics centre (CDC)."

- GP Management

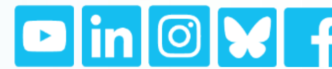
➢ Emphysema is a radiological finding on CT imaging.
➢ Emphysema reported as moderate to severe is likely to infer COPD but can only be diagnosed with spirometry (GOLD Guidelines)
➢ Smoking cessation is essential – all patients would have been offered this during the LCS pathway.
➢ Follow Hampshire and Isle of Wight COPD Management and prescribing Guidelines to review symptoms and confirm diagnosis

CS54999_HIOWICB_COPD_Guidelines_update_PRF4.pdf

# Collaborative working: North and Mid Hants LCS Incidental finding pathway

## Case Study

- 72-year-old male
- Lung Health Check
  - Smoker referred to smoking cessation
  - Reports breathless of strenuous exercise
- LDCT Scan
  - 40mm Solid Left Lower Lobe Lung Nodule
- Discussed in LCS MDT
  - PET
  - PFTS
  - Bloods
  - Referral to lung cancer clinic
- Patient contacted by Responsible Assessor
  - advised of outcome and plan
  - tests requested
  - letter sent to patient and GP
  - Referred to Lung Cancer Clinic



# Collaborative working: North and Mid Hants LCS Incidental finding pathway

## Case Study

- Review in Lung Cancer Clinic
  - Performance status 0
  - PET Moderately avid LLL nodule concerning for lung cancer
- For Surgical resection
  - stopped smoking prior to surgery
- Left lower lobectomy
  - adenocarcinoma T1b N0 M0
- 1 month post surgery
  - Well,
  - no significant shortness of breath,
  - walks 2.5miles daily with no difficulty
  - No post op adjuvant treatment needed
- 4 months post surgery
  - remains well,
  - still not smoking but now vapes
- Coronary artery calcification treatment commenced by GP
- Emphysema no symptoms post surgery- life style advice provided

# Collaborative working: North and Mid Hants LCS Incidental finding pathway

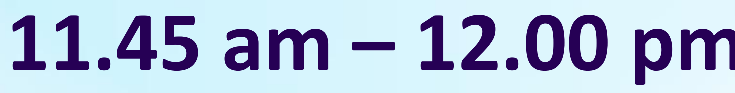
**Resources & contacts – Please visit the delegate webpage for details**

- Primary Care Guidance for Incidental Findings
- HHFT Lung Cancer Screening Awareness Posters
- HHFT Lung Cancer Screening Leaflets
- HHFT Internet Lung Cancer Screening: Hampshire Hospitals
- Practice Level awareness events – face to face or virtual

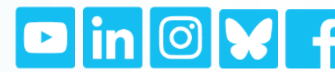
# Workshop Session 1

| Workshop Name | Breakout Room |
|---|---|
| Bladder Cancer and managing non-visible haematuria | Main Conference Room |
| Making the most of social media | CHERBOURG |
| MSK presentations of cancer | DIEPPE |

# Refreshment break

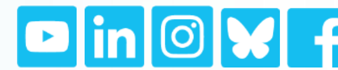


# When FIT Is Positive: Derek’s Story

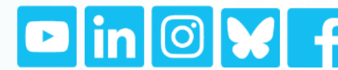


# Bowel Cancer Pilots

- Burgess Road Surgery/Sea City PCN – Community Engagement
- One Wight Health – Your Loo Could Save you
- Meon Health Practice – Bowel Screening pilot.
- Bowel Cancer case finding round up.



# BURGESS ROAD SURGERY / SEA CITY PCN– Community Engagement



# Improving the Uptake of Bowel Cancer Screening, focusing on our South Asian Population

Lisa Lucas

Practice Nurse

Burgess Road Surgery

1/9/24 – 31/8/25

Jill Ghanouni

Community Involvement Lead

Sea City Partnership

# PROJECT OVERVIEW

In England there are health inequalities between ethnic minority and white groups. These are driven by socio-economic deprivation, environmental and health-related behaviours. Screening rates are lower among women from ethnic minority groups. Poorer awareness of risk factors, and socio-cultural and language barriers, contribute to lower screening rates among ethnic minority groups. Research suggests that culturally adapted personalised interventions can improve participation in cancer screening.

In 2023/4, Burgess Road Surgery's uptake of bowel screening was 62.4%, which is lower than HIOW (76.2%) and England (71.8%).

17% of Burgess Road Surgery's population are South Asian.

The objectives of this project were to increase the uptake of bowel cancer screening, focusing on our South Asian population. These patients were sent a text and video in their first language, with information of how to re-order and complete a kit. All other patients were contacted by telephone.

Community leaders of local Gurdwaras, temples and mosques, enabled the delivery of educational sessions, to increase awareness of bowel cancer screening and provide general health advice.

# KEY ACCOMPLISHMENTS

192 patients did not return their bowel screening kit. They were all sent a reminder letter in their first language. Translated video links were sent to all South Asian patients.

Of these 192 patients, 19 patients completed their screening (either the kit they were sent, they ordered a kit, or I ordered one on their behalf).

Of these 19 patients, 4 were South Asian – just over 20%.

Of these 19 patients, 18 results were negative. 1 was positive, but the patient chose not to have further investigations.

Project goals were met, as we had a 10% increase in uptake.

Positive feedback from the community (verbally and written). Certificate presented by the local Temple, to the Surgery for our input in a Wellbeing day. Bunch of flowers given by local community after giving a talk.

Practice protocol updated. All patients are sent a letter or text in their first language.

# CHALLENGES FACED

Translated texts sent to patients who don't read the language – they only speak it. Text resent in requested language.

Very difficult to engage with the community. Many emails sent to religious leaders, but no reply. I started attending the Friendship lunches and made some contacts there. Also liaised with other nurses/surgery staff, who offered contacts and invited me to community health and wellbeing sessions. The Inclusion and Involvement lead at WCA was also very helpful, inviting me to webinars and introducing me to the wider community.

Unable to contact patients on the phone. Safety netted by sending a letter.

Feedback forms were translated into different languages, but it was often not an appropriate venue/time for them to be completed. However, all completed feedback forms were positive.

Patients not wanting to complete the test (too busy at work/on holiday, I feel ok, I don't have blood in my stools, I haven't received a kit, I don't want to do it – no reason given, I haven't got round to it, I hate waiting for results – health anxiety, I don't believe cancer can be cured, If I get it, I get it, I'd rather not know, I have recently done a FIT test, wrong address on SystmOne, I would be physically sick if I did it, I had a full body scan this year). After explaining the test in more detail, some agreed to complete the test.

# LESSONS LEARNED

## 01

Patience and perseverance!! It took many months to gain trust from community leaders.  The first community event took place nearly 6 months into the project.

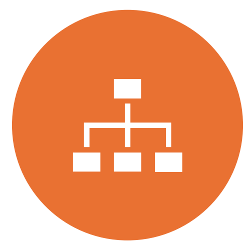
## 02

Although patient may have first language documented in their notes, they may not be able to read that language.

## 03

Questionnaires were not very helpful, as difficult to hand them out or get them completed.

# RECOMMENDATIONS



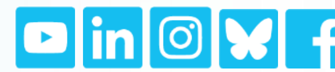
WCA CONTACTS TO BE SHARED AT THE BEGINNING OF THE PROJECT – I WAS SEVERAL MONTHS INTO THE PROJECT BEFORE I MET SUE NEWELL.

INDIVIDUAL SURGERIES WERE CONTACTING THE SAME PERSON TO ORGANISE CANCER TALKS. COULD HAVE BEEN PUT IN CONTACT WITH THE OTHER SURGERIES SOONER.

CHECK PATIENT'S FIRST LANGUAGE AND WHETHER THEY CAN SPEAK THAT LANGUAGE, WHEN REGISTERING.

TRANSLATED TEXTS AND VIDEOS WERE FORWARDED TO WCA, TO SHARE WITH ALL SURGERIES.

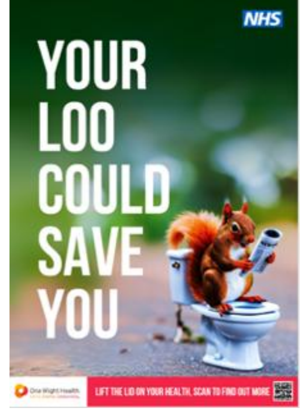
# ONE WIGHT HEALTH – Your Loo Could Save You Project



# Campaign concept & Launch activity

# Our artists' loos

# Campaign collateral & Community/Business Engagement



Bowel cancer can affect adults of any age, but it is treatable if caught early.

KNOW THE SIGNS AND SYMPTOMS:

- Change in your bowel habits
- Bleeding from your bottom
- Blood in your poo
- Losing weight without trying
- Frequent pain/lump in your tummy
- Feeling breathless
- Feeling a lot more tired than usual

Most people with these symptoms will not have bowel cancer, but it's still important to get checked if you spot these signs.

Don't delay, contact your GP practice today!

Plus - if you're over 50, and have received a home poo testing kit, take the test and put your mind at rest. If you've lost your kit, contact 0800 707 60 60.

SCAN TO FIND OUT MORE

## Getting to the bottom of bowel cancer awareness

Isle of Wight organisations are being encouraged to support their employees' health with the launch of a new business toolkit designed to raise awareness of the symptoms of bowel cancer in the workplace. Developed by One Wight Health as part of the impactful Your Loo Could Save You campaign, the toolkit gives Island employers a simple and effective way to share life-saving information with staff.

Backed by the IW Chamber of Commerce, the campaign was officially launched at the Isle of Wight Chamber Business Expo. Members of the campaign team met representatives from local businesses and answered questions about a subject that all too often gets flushed aside.

The free toolkit includes:

- A ready-to-use PowerPoint presentation for team briefings or staff meetings
- Digital posters and flyers for noticeboards or internal communications
- An article for staff newsletters
- A pre-written email to send to employees
- A short awareness film featuring local GP Dr David Isaac on recognising the symptoms of bowel cancer

Dr Isaac said, "Bowel cancer is one of the most common types of cancer, yet it's still a subject many people feel uncomfortable discussing. This campaign is about breaking that silence, and the workplace is a great place to start."

# Advertising, Social Media & Website

## Your loo could save you

Island businesses are being encouraged to raise awareness of bowel cancer symptoms in the workplace, with the launch of a new campaign toolkit.

The free resource, developed by One Wight Health as part of its 'Your Loo Could Save You' campaign, offers a simple way for employers to share life-saving information with staff. It includes a presentation, digital posters, newsletter content, an awareness video, featuring Island GP, Dr David Isaac, and a pre-written email for employees.

The initiative was officially launched at the IW Chamber of Commerce Business Expo, held at Ryde School on Wednesday, July 9, and is being backed by the Chamber.

Dr Isaac said: "Bowel cancer is one of the most common types of cancer, yet many people still feel uncomfortable discussing it. This campaign is about breaking that silence and the workplace is a great place to start."

Steven Holbrook, IW Chamber CEO, added: "We're very pleased to support this creative and impactful campaign. We encourage Island businesses to download the toolkit and help raise awareness among their staff."

The campaign first drew attention in May, when decorated toilets appeared unexpectedly around the Island to spark conversation about bowel cancer and the importance of early diagnosis.

The toolkit aims to help Island businesses play a role in encouraging earlier detection, particularly among people of working age.

# Meon Health Practice – Bowel Screening Pilot

Dr Jenny Rattray, Dr Jill Choudhury, and Darah McGrath (Care Navigator)

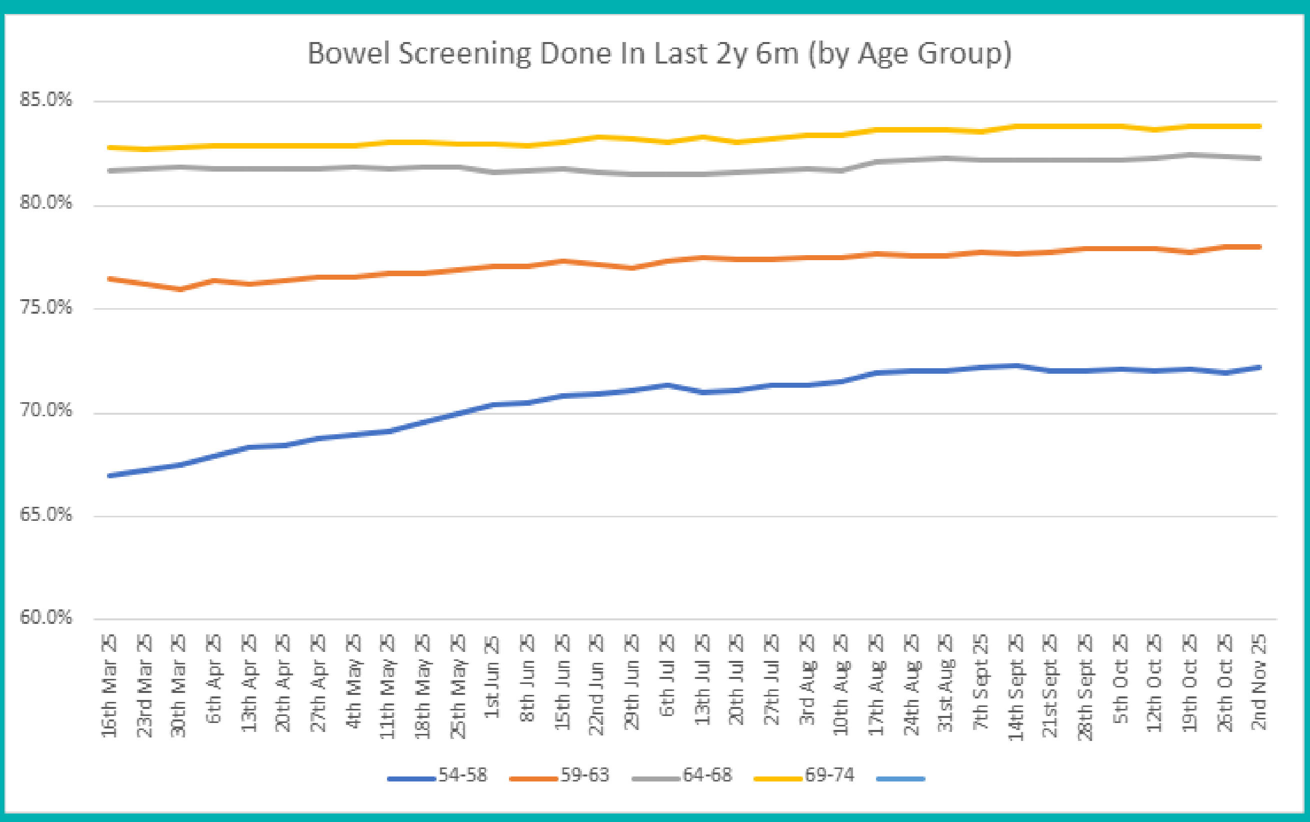
# Aim and method of project

- Aim - Increase overall uptake of bowel screening with specific targeting of our non-responding patients using telephone-based education
- Method
  - Care Navigator educated on the bowel screening programme and trained in using a telephone script
  - Cohorts of non-responders developed using searches categorised by age/gender/deprivation
  - Named GP allocated to answer queries in a timely way
  - Care Navigator used EMIS template to document consultations
  - Email sent to BCSP on behalf of patient to request replacement kit if consent given
  - For patients who didn’t answer calls Accurx Florey was sent offering callback or re-ordering of kit to increase reach of project
  - Patients were sent follow-up text 2 weeks later to remind them to complete test

  - Ran alongside patient and staff engagement campaign to raise awareness of screening and symptoms of cancer

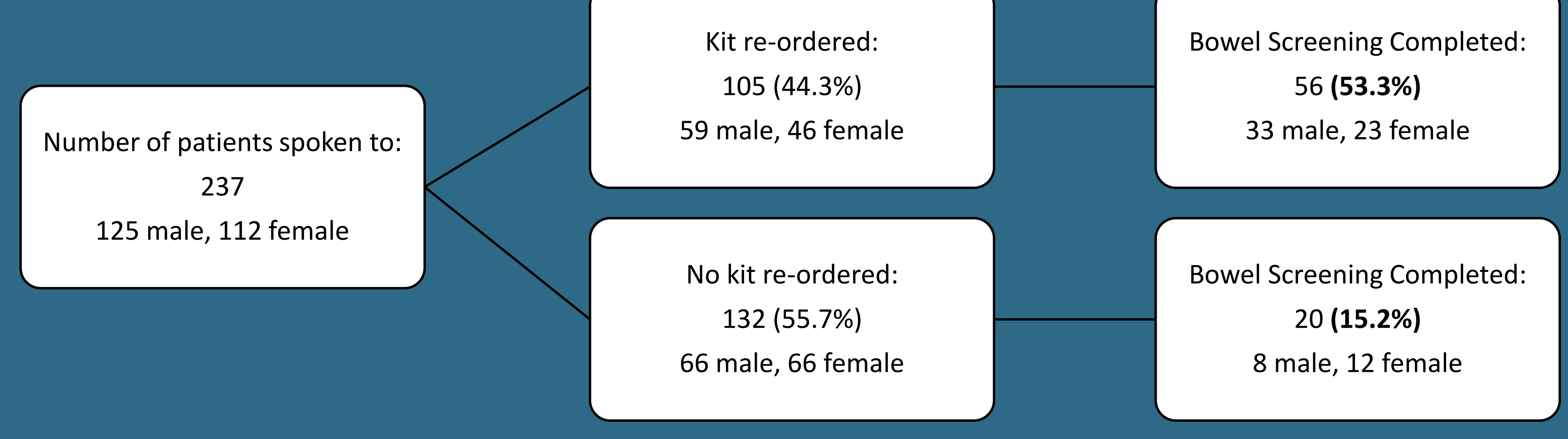
# Results

- 237 phone calls taking on average 15 minutes
- Accurx florey sent to further 212 patients
- Overall bowel screening uptake increased from 76.3% to 78.7%
- The biggest increase was seen in our younger patients with an increase of 5.2% in the 54-58 age bracket

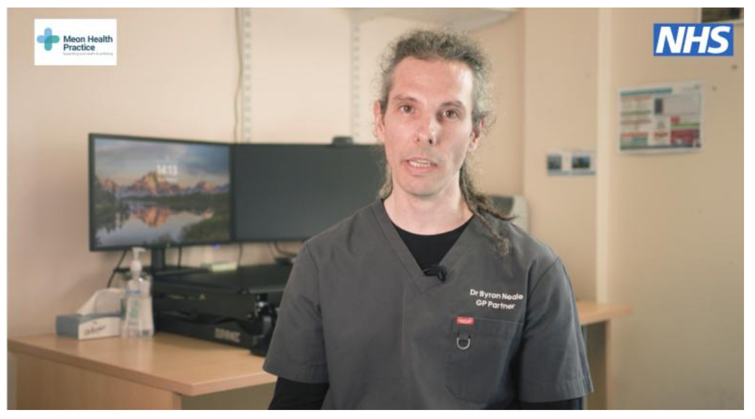


# Learning points

- Better screening uptake when **called** vs. text (32.1% vs. 10.8%)
- Better screening uptake when **called & kit re-ordered** vs. called & no kit re-ordered (53.3% vs. 15.2%)
- Additional benefits from phone calls – Smoking cessation advice, arranging cervical screening, arranging GP review for symptomatic patients



# Sustainability




- Personalised input from practice most beneficial
- Time constraints to telephoning
- Younger male patients had the lowest screening uptake but highest benefit from targeted intervention

- Created screening information video with WCA with younger male GP
  - Texted to all non-responders and patients approaching screening age at 49 years and 10 months
  - https://www.meonhealthpractice.co.uk/2025/10/17/our-dr-byron-neale-talks-about-spotting-the-signs-of-bowel-cancer-early-through-bowel-screening-kits-for-people-aged-50-74/

# Primary Care Bowel Cancer Case Finding Pilots

# Primary Care Bowel Cancer Case Finding

## Searches

The four projects chose slightly different criteria to identify patients but all excluded patients who had a recent FIT result.
The vague symptoms of bowel cancer meant that initial searches identified a large number of patients and therefore needed to be refined further.

Initial system searches included:
**Patients with no FIT result and**:-
- Raised platelets >400
- Change in bowel habit
- New diagnosis of IBS
- New prescription of Mebeverine
- Rectal bleeding

- X30Bj – Bleeding per rectum
- J573011 – Rectal bleeding
- J573.11 – Bleeding PR
- XaJuy – Painless rectal bleeding
- J5730 – Rectal haemorrhage
- XaJuu – Painful rectal bleeding
- J5731 – Anal haemorrhage
- J573012 – PRB - Rectal bleeding
- 196.. – Type of gastrointestinal tract pain
- 197.. – Site of gastrointestinal tract pain
- R090. – [D] Abdominal pain
- 9. – Abdominal pain
- XaA06 – Nonspecific abdominal pain
- XE0qb – Abnormal weight loss
- R032. – [D] Abnormal loss of weight
- XaQgK – Unexplained weight loss
- XaXTs – Unintentional weight loss
- X76CA – Weight loss

- Reassuringly most projects found relatively low numbers of patients where a FIT had not been offered or was not clinically appropriate.
- Variation in practice related to the management of elevated platelets was identified by one project.
- One project created custom searches to interrogate digital triage data for patients presenting with symptoms consistent with NICE NG12 suspected lower GI cancer guidance.

Cancer Matters Wessex

# Primary Care Bowel Cancer Case Finding

## Interventions

- Patients identified through the case finding were reviewed by a clinical member of staff to ensure they were appropriate for further diagnostics.
- Patients were contacted by email, SMS or phone to discuss ongoing symptoms and prompt them to complete a FIT or request a new test.
- Where necessary patients were invited in for additional history and exam.
- One project reported requesting CXR/Ca125/Pelvic USS for a small number of patients where appropriate.
- Projects reported a significant amount of time taken to review patients records and contact patients/clinicians.

# Primary Care Bowel Cancer Case Finding

## Results

| | Search | Number of patients identified | Results | Cancer found |
|---|---|---|---|---|
| **Pilot project 1** | Patients with no FIT and **platelet >400** over a 4-month period | 56 patients | Symptoms resolved: 20<br>Other cause/longstanding: 21<br>Outstanding investigations: 10<br>Onward referral: 6 (10%) - RIS (2) Resp (1) Gynae (1) Lower GI (1) Upper GI (1) | No bowel cancer identified. One diagnosis of pancreatic cancer. |
| **Pilot project 2** | Patients >50 years with no FIT and **IBS** diagnosed in last year | 53 patients | 10 patients completed a FIT | No bowel cancer identified. |
| **Pilot project 3** | Patients with no FIT and<br>i) **rectal bleeding**<br>ii) **IBS** | 72 patients | 30 patients completed a FIT. | No bowel cancer identified |
| **Pilot project 4** | Patients with no FIT presenting with **symptoms consistent with NICE NG12 suspected lower GI cancer guidance** | 472 patients | 183 patients completed a FIT.<br>21 patients (11.5% of completed tests) had a positive FIT result. | •12 patients remain under investigation<br>•5 patients have undergone investigations and are awaiting biopsy or final results. |

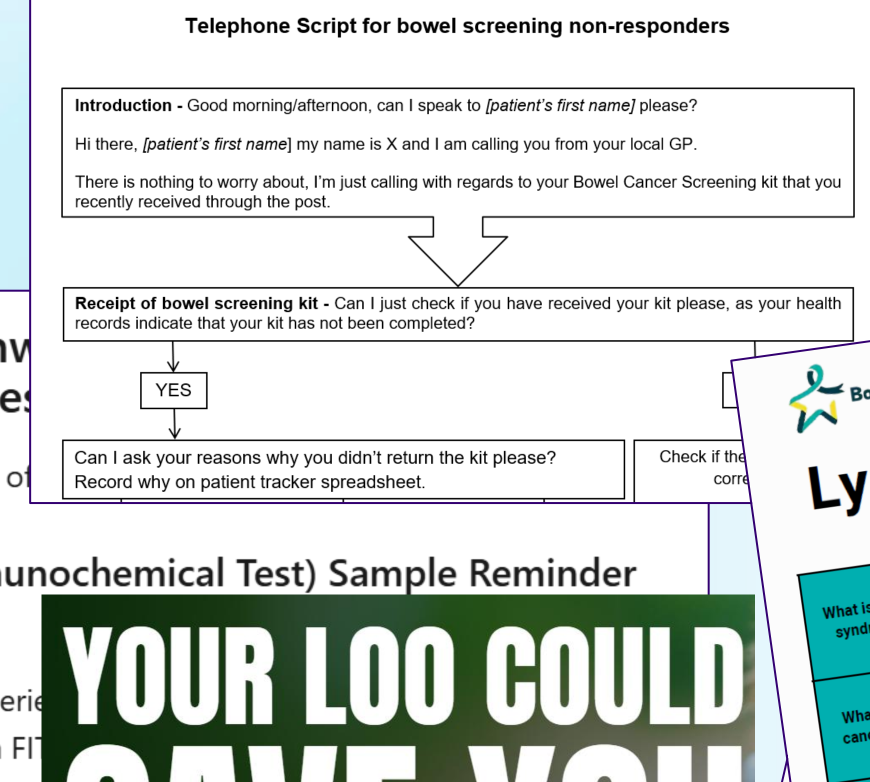
# Primary Care Bowel Cancer Case Finding

## Learning

- Projects reported that due to the time-consuming nature of the case finding including clinical review of patient records and contacting patients, it was **not possible to make this work sustainable** and embed as part of regular practice without additional funding.
- **Use of digital triage data** by one project to identify patients yielded meaningful results and may be worth exploring further.
- Through the case finding one PCN identified a need for education for clinicians around the **link between elevated platelets and the LEGO-C(O) cancers**. GP trainees undertook a leadership project to address this and raise awareness among colleagues. A practice protocol was subsequently developed.
- One PCN was reassured by the process, finding very few patients had not been offered a FIT however they did identify **variation and gaps with regards to tracking and reminding patients to return FITs**. A new process and practice education have been put in place.
- Projects found **retrospective education for clinicians** useful as they were reminded of the need for symptomatic FIT in relation to new IBS and rectal bleeding.
- One PCN found the main reason for low patient engagement with the process was due to a **lack of perceived relevance** to the patient. There was limited evidence that fear of cancer was a major barrier.

# Primary Care Bowel Cancer Projects - Resources

**Many useful resources were identified or developed over the course of the projects – these will be available on the WCA website shortly**



**Telephone Script for bowel screening non-responders**

**Introduction -** Good morning/afternoon, can I speak to *[patient's first name]* please?

Hi there, *[patient's first name]* my name is X and I am calling you from your local GP.

There is nothing to worry about, I'm just calling with regards to your Bowel Cancer Screening kit that you recently received through the post.

**Receipt of bowel screening kit -** Can I just check if you have received your kit please, as your health records indicate that your kit has not been completed?

YES

Can I ask your reasons why you didn't return the kit please? Record why on patient tracker spreadsheet.

Check if the ... corre...

FIT Sample Reminder Pathw...
Sample Reminder message...

Pathways allow you to schedule a series of...

What is the FIT (Faecal Immunochemical Test) Sample Reminder Pathway?

The FIT Sample Reminder Pathway is a serie... patients who have been provided with a FIT...

- Message 1 asks the patient to complet... it via a CRUK link
- Message 2 is automatically sent 3 days...

For step-by-step instructions ... watch the video or follow the steps below

YOUR LOO COULD SAVE YOU

LIFT THE LID ON YOUR HEALTH

Bowel Cancer UK
Meon Health Practice Wellbeing Team
Bowel Cancer screening
Facts fo... ...ans

Bowel Cancer UK
Meon Health Practice Wellbeing Team
LISTEN • EXPLORE • CONNECT • EMPOWER

## Lynch syndrome & cancer

| | |
|---|---|
| What is Lynch syndrome? | Lynch syndrome is an autosomal dominant condition associated with an increased risk of certain cancers. It affects 1 in 400 of the general population, but only about 5% are aware. |
| What are the cancer risks? | **Highest risk**: colorectal and endometrial. **Increased risk**: ovarian, urinary tract, gastric, small intestine, hepato-biliary, pancreatic, sebaceous gland, CNS. |
| What can we do in primary care? | **Check they are on bowel cancer screening programme**: they will receive 2-yearly colonoscopy<br>**Prescribe low-dose aspirin**: 50% risk reduction of colorectal cancer<br>**Regular gynae review**: check for symptoms & discuss risk-reducing surgery when family complete/around age 40<br>**H pylori testing and eradication**<br>**Ensure family members offered genetic testing** |

# HIOW Primary Care Colorectal Cancer Audit

Dr Helen Platts

WCA GP Advisor, RIS Specialist GP, Lung cancer screening Medic Dorset

# HIOW Primary care Colorectal Cancer(CRC) Audit: Headline Findings

- 1,008 CRC cases

<u>Predominantly older adults</u>

- Largest groups aged 75+ and 60–74
- Small but important cohort diagnosed under 50

<u>Clinical features</u>

- Anaemia present in 24.5%

<u>Vulnerable groups</u>

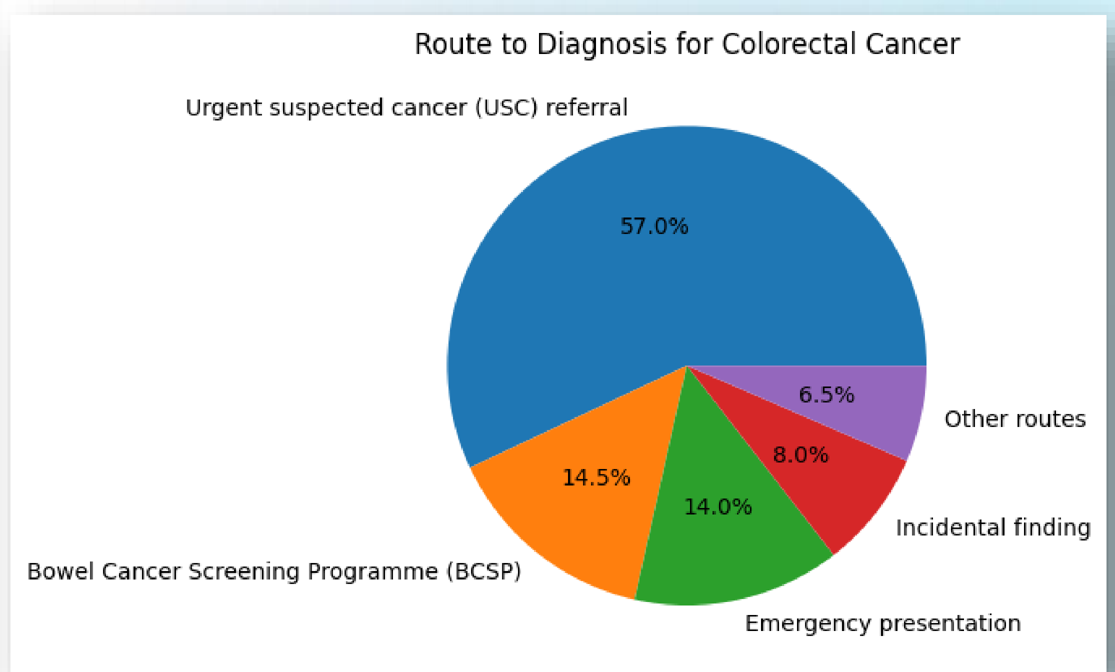
- 5.1% with SMI recorded
- <1% learning disability coded

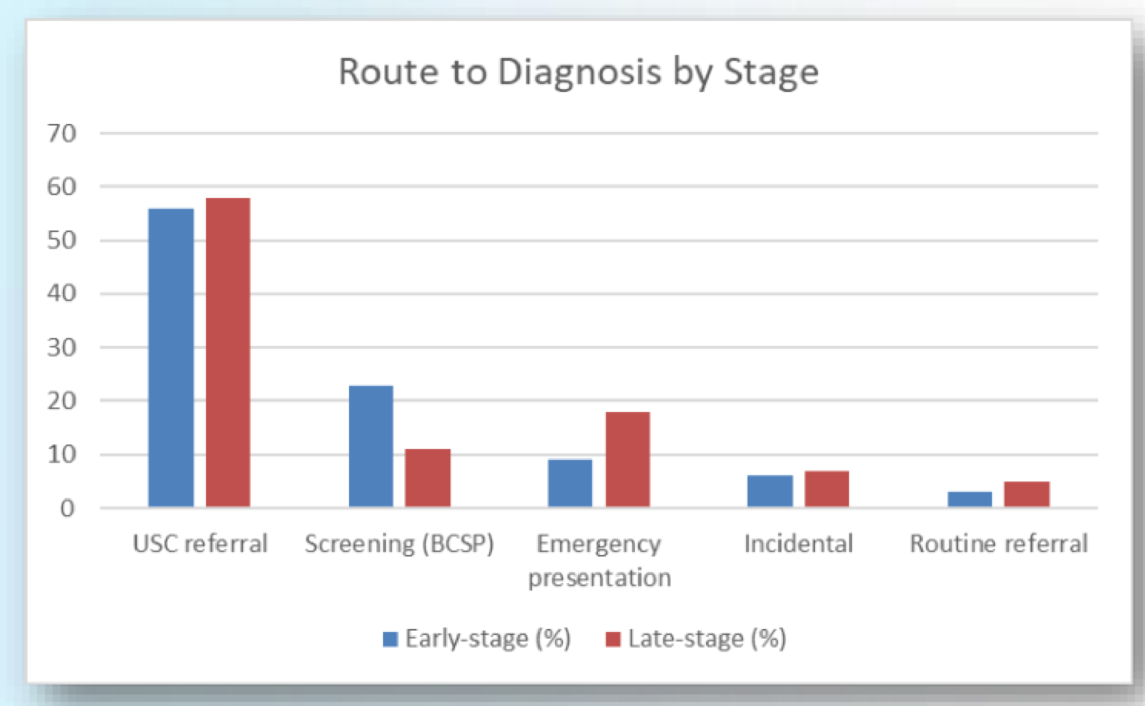
# Risk Profile of Cohort

- 5% IBD
- 1% Lynch syndrome
- 19.9% prior polyps
- 17.1% previous cancer

- >50% smoking history
- High overweight/obesity prevalence

# Route to Diagnosis



# Presentation

Most patients had *multiple* symptoms

| Change in Bowel Habit | Rectal Bleeding | Abdominal Pain | Weight Loss | Tiredness |
|---|---|---|---|---|
| 44.6% | 33.7% | 29.7% | 19.8% | 15.5% |

*Non-specific ≠ Low risk*

# Baseline Assessment Gaps

- 26% no abdominal exam
- 34% no DRE
- 27% no bloods at referral

- Limits effective triage

Baseline Assessments Often Missed

26% No Abdominal Exam

34% No DRE

27% No Blood Tests

*Gaps in early assessment*

# Time from First Clinical Contact to First Referral

| Referral interval | Patients (n) | % of cohort |
|---|---|---|
| **≤ 2 weeks** | 433 | **43.0%** |
| **2–4 weeks** | 121 | **12.0%** |
| **1–3 months** | 81 | 8.0% |
| **3–6 months** | 19 | 1.9% |
| **> 6 months** | 20 | 2.0% |

# Analysis of primary care delays

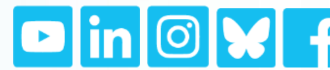
| Delay factor | Patients (n) |
|---|---|
| Delay accessing face-to-face GP appointment | 5 |
| Multiple consultations prior to referral | 6 |
| Delay in primary care investigations | 15 |
| Routine referral instead of USC | 1 |
| Referred to alternative tumour pathway | 5 |
| Treated for haemorrhoids prior to referral | 8 |
| Chronic anaemia / iron deficiency not investigated | 14 |

**Patient-Related Contributors to Diagnostic Delay**

| Delay factor | Patients (n) |
|---|---|
| Declined further investigation | 4 |
| Patient-related delay (missed appointments, relocation, not following up results, declined screening) | 9 |

# Primary Care Delays

- Face-to-face appointment not available
- Multiple different consultations
- Delays in Primary Care Investigations
  - Often with patients presenting with vague/unspecific symptoms
  - Waiting time for bloods
- Wrong referral type (routine vs USC)
- Referred to alternative tumour groups USC pathway (UGI, gynae and urology)



# FIT Pathway Delay Themes

| Issue identified | Number of patients (n) |
|---|---|
| No FIT requested / FIT delayed | 17 |
| Positive FIT with delayed referral | 10 |
| Delay in returning FIT kit | 6 |
| FIT unlabelled | 5 |
| Lab delay in FIT result | 2 |

# Iron Deficiency Anaemia

- 14 anaemia related delays in primary care and 16 in secondary care
  - 8–10% CRC yield in new IDA [1]
  - Longstanding or recurrent IDA following prior negative gastrointestinal investigations is associated with a lower, but clinically significant, CRC yield (2-5%) [2]
  - IDA should override negative FIT
  - All patients who presented as an emergency had IDA at the time of admission

1. Pengelly et al., 2013; Snook et al., 2021.
2. Ayres et al., 2019; Pengelly et al., 2013.

# Haemorrhoids & Diagnostic Overshadowing

- 8 cases
- All reported rectal bleeding
- In 75% of cases there were additional red flags present
- In 75% the DRE examination was absent or misleading

# Multiple Contacts & Continuity

- 12% ≥3 contacts before referral
- 7.6% saw ≥3 clinicians
- Jess's Rule relevance
- Escalation triggers needed

# Analysis of secondary care delays

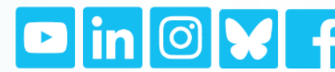
| Category of delay | Number of cases |
| --- | --- |
| Endoscopy capacity & scheduling delays | 26 |
| Presentation with IDA / anaemia contributing to delay | 16 |
| Breakdown in follow-up, safety-netting & communication | 14 |
| Diagnostic fragmentation across multiple specialties | 10 |
| Incorrect referral routing / rejection of 2WW referrals | 9 |
| Patient-related or unavoidable delays | 9 |
| Failures in inpatient pathways & missed opportunities | 7 |
| Failure to act on FIT results / FIT not done in secondary care | 6 |

# Secondary Care Learning

- 26 colonoscopy delays – endoscopy capacity
- referral downgrades based on negative FIT
- Interface ownership issues
  - sent back to primary care, visibility of results
- Overlapping theme of IDA/anaemia contributing to delay
- Patient factors
  - relocation, declined further investigations etc

# Primary Care Bowel Cancer Audit - Conference Recommendations

- Audit-identified delay themes
  - Targeted escalation behaviours — including diagnostic overshadowing
  - Education + safety-netting + pathway alignment

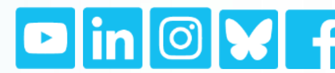


# 1. Strengthen FIT Use & Messaging

- FIT at first presentation for red flag or NSS symptoms
- Embed FIT <10 repeat-testing pathway
- 48-hour actioning of positive FIT
- Clarify screening vs symptomatic thresholds – FIT>10 vs FIT@120/80

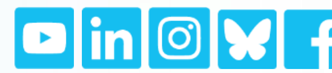
# 2. Iron Deficiency Anaemia Safety Strategy

- IDA overrides negative FIT
- Hb drop alerts (>20 g/L) in clinical systems
- GI investigation bundle within ICE
- Re-investigate recurrent IDA appropriately



# 3. Diagnostic Overshadowing & Haemorrhoids

- Do not diagnose haemorrhoids in isolation
  - Mandatory DRE documentation for rectal bleeding
  - Escalate persistent bleeding despite presumed haemorrhoids
  - Avoid repeating positive FIT due to presumed benign cause
  - Consider anal cancer in bleeding + pain/leakage cases



# 4. Standardise Baseline Assessment

- FIT, DRE (+Abdominal exam) + FBC and Ferritin at referral
  - 4 Fs – FIT, Finger, FBC and Ferritin
- Avoid telephone-only management of red flags
- Use ≥3-contact escalation trigger or passive risk assessments (Jess's Rule)
- Structured recording of risk factors

# 5. Safety-Netting Standardisation

- 7-day FIT chase policy
- Documented patient advice for FIT <10
  - *Updated support to be released from WCA FIT<10 management*
- Structured review triggers for non-specific symptoms (e.g add FIT to TATT panel on ICE)
- Automated alerts for ≥3 consultations & Hb drop >20 g/L

# 6. Secondary Care Interface Alignment

- Do not downgrade referral based on FIT alone
- Clear ownership when redirecting referrals
- Direct specialty-to-specialty 2WW pathways (with safety netting in place)
- Access for secondary care to CHIE so all investigations are available to support appropriate triage
- Align capacity with risk stratification – FIT>100, IDA + FIT>10

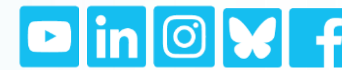
# Possible Future Action for Cancer Champions

- Deliver local teaching on rectal bleeding & IDA
- Review haemorrhoid management against audit findings
- Monitor FIT & escalation compliance
- Embed escalation standards into routine practice

*More to information to come regarding - Screening FIT@80, FIT<10, ColoFIT and 26/7 LIS in the post lunch session*

# Thank you for all the hard work from gathering the data in this audit

# We will have the opportunity for further discussion, questions and comments in the post lunch session



DID SOMEONE SAY FOOD

# Lunch

12.45 pm – 1.30 pm

# Earlier Diagnosis of Bowel Cancer – Looking ahead and 26/27 planning

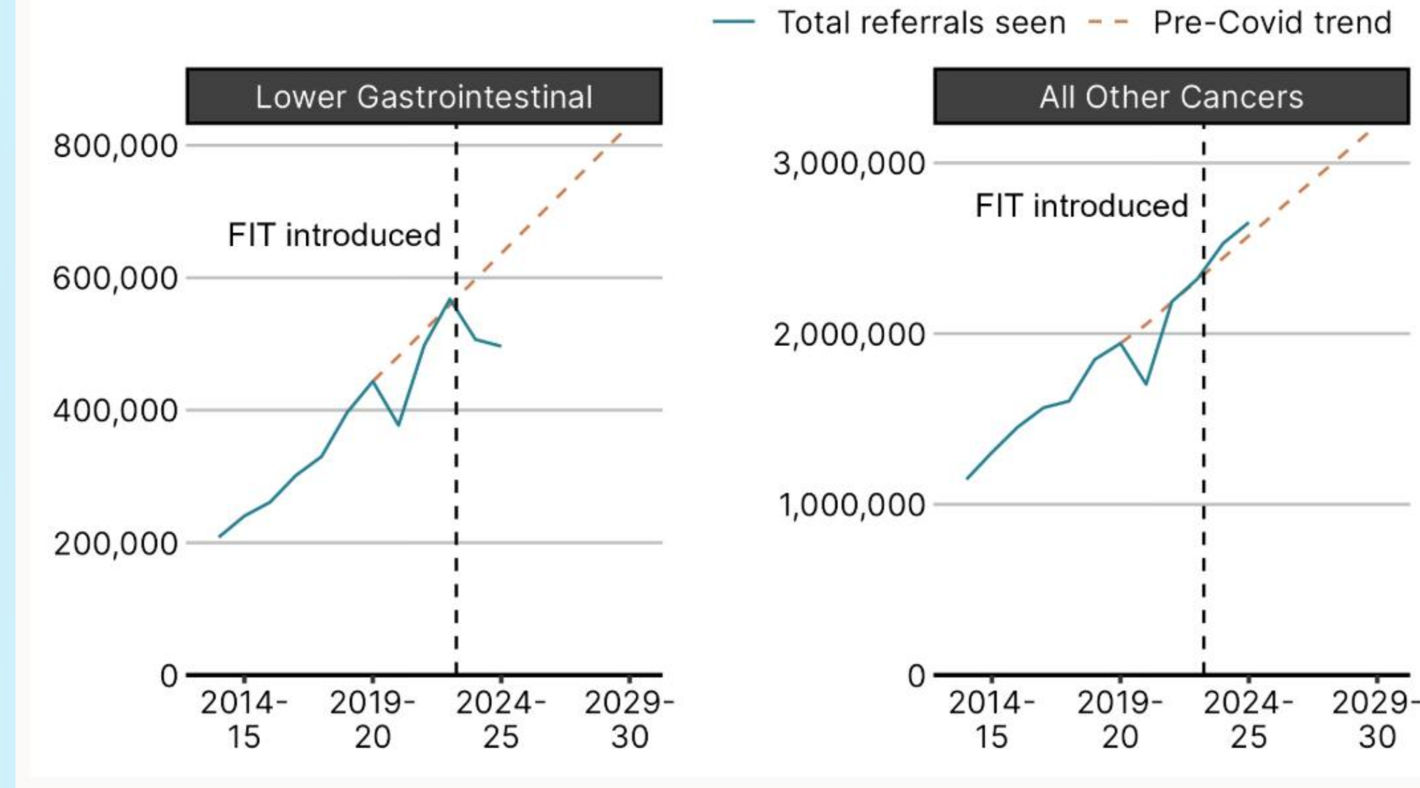
# Impact of FIT in the Symptomatic LGI Pathway

- FIT has been widely adopted in primary care
- 81.5% Wessex Lower GI suspected cancer referrals accompanied by a FIT in 25/26

- National data shows referrals for suspected bowel cancer have declined as referrals for all other cancers combined continue to rise.

- The number of cancers detected has remained stable, suggesting the test is successfully identifying patients who need urgent investigation.

- However no improvement has been seen in the proportion of bowel cancers diagnosed early at Stage 1 or 2 (currently 49.4% in Wessex)

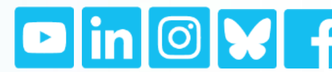



[Simple home test prevents thousands of unnecessary bowel cancer referrals | NICE]

# NHS to increase sensitivity of bowel cancer screening in England

NHS England is lowering the bowel cancer screening FIT threshold from **120 to 80 micrograms of haemoglobin per gram of faeces** g Hb/g), with full rollout by March 2028. This increased sensitivity will detect approximately 600 more cancers annually and 2,000 more high-risk polyps.

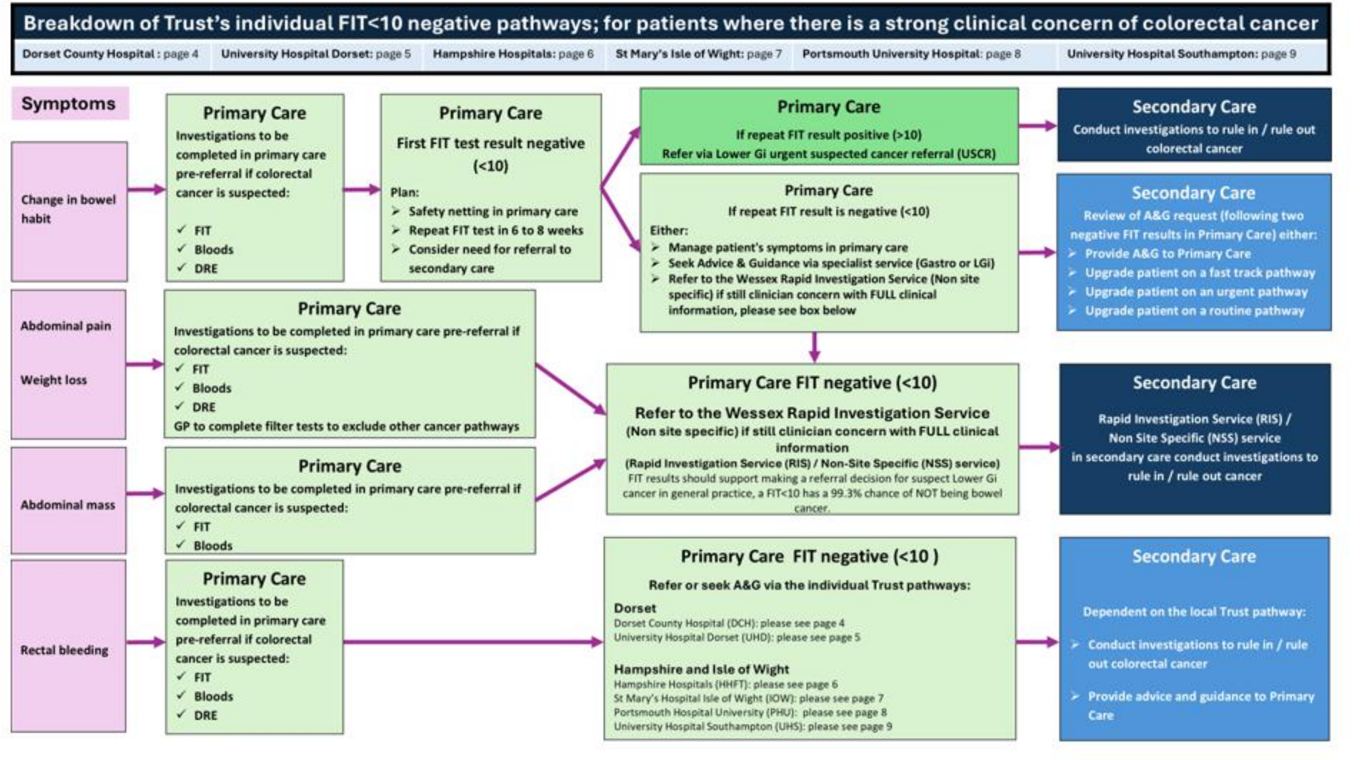
The NHS estimates that this change will lead to **35% more screening colonoscopies** each year in England.



# Making the best use of the resource we have

## New FIT <10 Pathway Guidance

FIT negative (<10) patient pathways with ongoing symptoms suggestive of colorectal cancer




### Hampshire Hospitals Foundation Trust (HHFT)

| Service | Patient cohort | Refer via | | Waiting times | Reviewed by |
|---|---|---|---|---|---|
| **Change in bowel habit referral pathways for patients with TWO negative FIT<10 results - Hampshire Hospitals Foundation Trust (HHFT)** | | | | | |
| **Colorectal pathways** | | | | | |
| Colorectal A&G, urgent and routine referrals<br>Basingstoke | Bowel symptoms.<br>For advice and guidance, urgent and routine referrals. | ERS | 'Colorectal Surgery-General Triage Service - Basingstoke' | Triaged: Daily.<br>Routine OPA: 6-7 months at BNHH.<br>Routine STT investigation: 21 weeks.<br>Urgent OPA: 3 months.<br>Urgent STT investigation: 6 weeks. | Colorectal Consultant |
| Colorectal A&G, urgent and routine referrals<br>Winchester | Bowel symptoms.<br>For advice and guidance, urgent and routine referrals. | ERS | 'Colorectal Triage Service - Winchester' | Triaged: Daily.<br>Routine OPA: 12 months at RHCH.<br>Routine STT investigation: 21 weeks.<br>Urgent OPA: 3 months.<br>Urgent STT investigation: 6 weeks. | Colorectal Consultant |
| Colorectal A&G, urgent and routine referrals<br>Andover | Bowel symptoms.<br>For advice and guidance, urgent and routine referrals. | ERS | 'Colorectal Triage Service - Andover' | Triaged: Daily.<br>Routine OPA: 12 months.<br>Routine STT investigation: 21 weeks.<br>Urgent OPA: 3 months.<br>Urgent STT investigation: 6 weeks. | Colorectal Consultant |
| **Gastroenterology pathways** | | | | | |
| Gastroenterology A&G, urgent and routine referrals Basingstoke | Gastroenterology symptoms.<br>Gi and Liver (Medicine and Surgery). | ERS | 'Gastroenterology - Advice & Guidance - Adult Service - Basingstoke - HHFT RN5' | Triaged: Daily.<br>Routine OPA: 11 months.<br>Routine STT investigation: 11 months.<br>Urgent OPA: 6 weeks.<br>Urgent STT investigation: 6 weeks. | Gastro Consultant |
| Gastroenterology A&G, urgent and routine referrals Winchester & Andover | Gastroenterology symptoms.<br>Gi and Liver (Medicine and Surgery). | ERS | 'Gastroenterology - Advice & Guidance - Adult Service - Winchester & Andover - HHFT RN5' | Triaged: Daily.<br>Routine OPA: 11 months.<br>Routine STT investigation: 11 months.<br>Urgent OPA: 6 weeks.<br>Urgent STT investigation: 6 weeks. | Gastro Consultant |
| Gastroenterology A&G, urgent and routine referrals Alton | Gastroenterology symptoms.<br>Gi and Liver (Medicine and Surgery). | ERS | 'Gastroenterology - Advice & Guidance - Adult Service - Alton - HHFT RN5' | Triaged: Daily.<br>Routine OPA: 11 months.<br>Routine STT investigation: 11 months.<br>Urgent OPA: 6 weeks.<br>Urgent STT investigation: 6 weeks. | Gastro Consultant |
| **Rectal bleeding with FIT<10 pathway - Hampshire Hospitals Foundation Trust (HHFT)** | | | | | |
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# Coming soon… Further risk stratification in the LGI Pathway

A risk-based algorithm combining FIT results with patient data including age, sex and blood tests (MCV, Platelets) to predict cancer risk.

- Validation of the algorithm has shown it is more effective than using FIT alone for detecting colorectal cancer (CRC).
- Using ColoFIT can reduce unnecessary colonoscopies by approx 20% while maintaining high diagnostic accuracy.
- The proposal is to embed the algorithm into laboratory systems to provide primary care with a risk score to guide referral decisions.

# Ensuring no one is disadvantaged

- Rising CRC incidence in the under 50s
- Represent a small proportion of overall cases BUT more likely to be diagnosed at Stage 3 or 4

- Some people may have difficulties completing a FIT
- Ensure information is offered in different formats, languages, consider accessibility

**% Change in CRC incidence in younger adults**

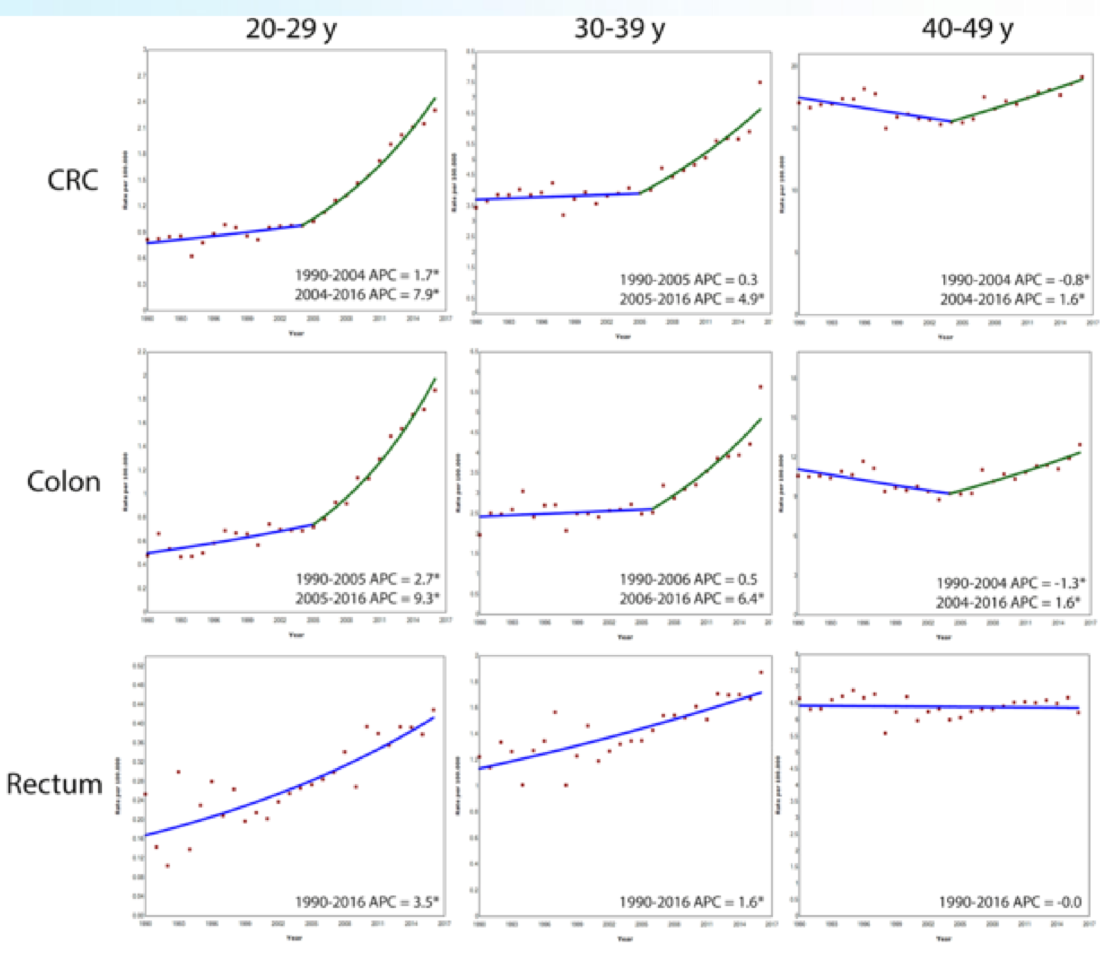



**Figure 2** Annual percent change (APC) in age-specific colorectal cancer (CRC), colon cancer and rectal cancer incidence rates in Europe, 1990–2016.
*Indicates that APC is statistically significant different from zero.

Cancer Matters Wessex

# Wessex Cancer Alliance 26/27 Bowel Cancer Early Diagnosis Plans
# - Building on learning from the bowel pilots and audit

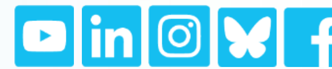
26/27 Primary Care Local Improvement Scheme:

- Bowel Cancer Awareness Campaign
- Bowel Cancer Screening – Practice led follow up of non-responders aged 50-59
- LGI Pathway Practice Education 'Train the Trainer' model

Other projects:

- FIT Safety Netting Pilot tbc
- Pilot to reduce the proportion of bowel cancer screening positive non-responders

# Now over to you…



# Activity

Step 1: Pick one of the three service improvement scenarios for your table. Briefly discuss what you would like to achieve and the route you'd take to get there.

Step 2: Consider 2-3 of the 'potential barriers' (separate A4 sheet). Discuss how you would work around these issues.

Step 3: You have a magic wand – what key factors would enable this work to be a success?

## Scenarios

1. Patients at your practice are overdue their surveillance appointment on the bowel screening programme.
What steps would you take to support patients to engage with the surveillance programme? Who would you involve?

2. You identify that a group of patients at your practice have had a positive bowel screening result (>120ug/g) but they don't respond to the invitation to attend a follow-up appointment.
How could you engage these patients? What processes would need to be in place?

3. An audit shows that some symptomatic patients in your practice are being referred on a Lower GI urgent suspected cancer pathway without the relevant diagnostics e.g. FIT, full blood count and physical exam.
How could you improve the proportion of referrals that include this essential information?

# Workshop Session 2

| Workshop Name | Breakout Room |
|---|---|
| Safety Netting & Jess's Rule | CHERBOURG |
| Late Effects – Living with and beyond | MAIN ROOM |
| Lynch Syndrome | DIEPPE |
| Learning Disabilities | BAYEUX |

# Refreshment break

3.00 pm – 3.15 pm

# The National Cancer Plan for England

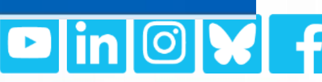
## Delivering World Class Cancer Care

Peter Johnson

# The National Cancer Plan takes the 10 Year Health Plan's 3 shifts and new care model and hardwires it into cancer pathways

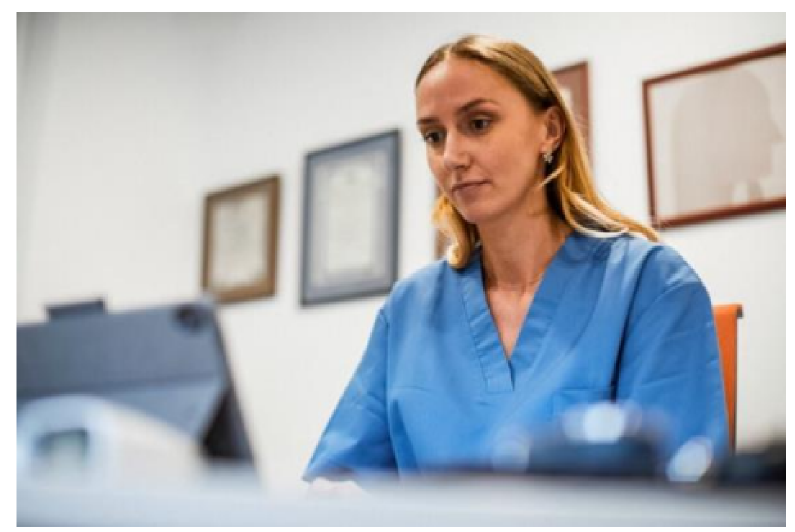
The three big shifts will transform how we deliver cancer services:

- **Analogue to digital:** harnessing new technology to improve access, efficiency and outcomes
- **Sickness to prevention:** accelerating work on primary prevention and early diagnosis
- **Hospital to community:** improving support to people before, during and after treatment, and for people living with and beyond cancer



# Over 11,000 people responded to our call for evidence

- Respondents included:
  - 7,000 people **living with** or who've **experienced cancer**
  - 2,000 people **caring for people** with cancer
- People with lived experience of cancer participated in a series of **Expert Reference Groups**, providing key insights for the plan
- **Clinicians, charities, Royal Colleges** and **industry** representatives provided key evidence and ideas which shaped the plan



**The message was clear: we must do better**

# Our commitments for the next 10 years

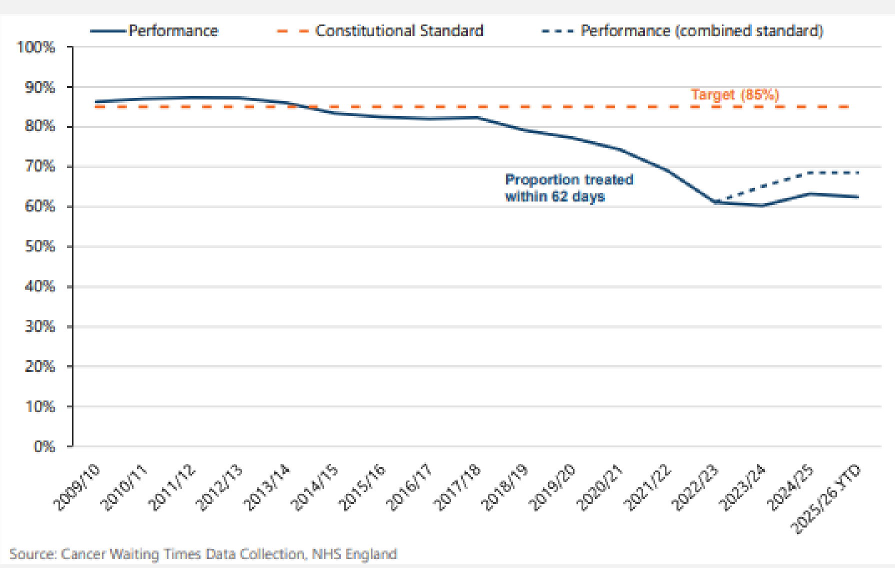
| | | |
|---|---|---|
| Meeting Cancer Waiting Time Standards | Becoming a global leader on cancer survival | Improving quality of life for people with cancer |
| Accelerating research, development, and innovation | Tackling cancer in children and young people | Prioritising rare and less common cancers |

**Delivering on these commitments will make England a global leader in cancer care**

# 1. Driving up NHS Cancer Performance

*"Right at the beginning of this, is faster, accurate diagnosis, is absolutely key. Then, being able to get as much of your diagnosis and treatment happening in one place, at one time, will greatly help people."* Patient and Public Voice Forum member

Since 2014, the NHS has consistently missed its key target to start treating 85% of people within 62 days of an urgent referral for suspected cancer.



Source: Cancer Waiting Times Data Collection, NHS England

We will:

- Harness **innovative tech and use of data** to make sure we offer patients the right services, enable at-home tests, and prioritise care for those at highest risk
- **Transform outpatients** by doing more tests at the outset to improve patient care and free up clinical capacity
- **Expand diagnostic capacity** by ensuring that, where possible, all Community Diagnostic Centres are fully operational 12 hours a day, 7 days a week
- **Increase throughput of imaging tests** by investing in digital diagnostics and AI to ensure 98% of histology results are back within 10 days of the sample being taken
- **Make better use of hospital beds** through increased use of surgical hubs to increase available capacity
- **Streamline** MDT meetings, increasing efficiency

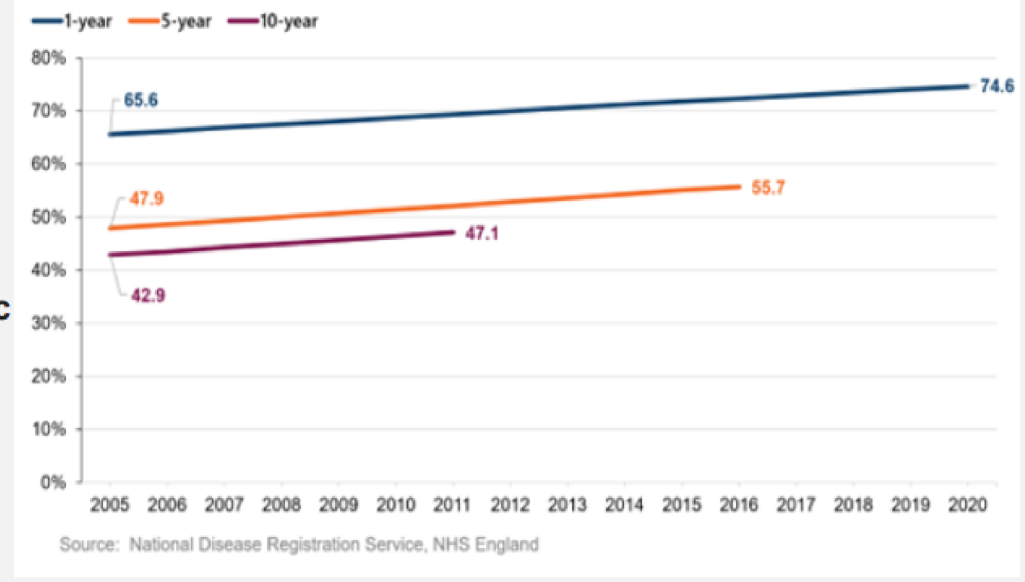
**We will meet all cancer waiting time standards by 2029**

# 2. Improving cancer outcomes

*"I really feel that early diagnosis is crucial. Absolutely crucial. The quicker we get in there, we know that it gives people better life chances."* Patient and Public Voice Forum member

We will:

- Roll out **lung cancer screening** nationally by 2030 and lower the sensitivity of bowel cancer screening
- Enable cancer patients to manage screening invitations, appointments, and treatment plans using the **NHS App** by 2028
- Develop and deliver more proactive approaches to identifying people at risk of cancer through **symptomatic case finding**, additional support for GPs, and **genomic testing**
- Provide greater access to **specialist cancer treatment centres,** and improve approaches to quality monitoring
- Establish clear **quality standards** for cancer delivery through **cancer manuals**, published by tumour type
- Proactively prepare for **Multi-Cancer Early Detection tests** and similar breakthroughs




**3 out of 4 people diagnosed with cancer in 2035 should be cancer-free, or living well with cancer, after 5 years**

# 3. Designing cancer care around people's lives

*"There is often too much focus on the actual treatment itself and not enough taking into account the person and the wider impact on their life and wellbeing, particularly as a younger patient."* Patient and Public Voice Forum member

We will:

- Provide a **named neighbourhood cancer lead** for each patient, to coordinate post-treatment care, by 2035
- Support patients to **stay in and return to work**
- Enable patients to provide real-time feedback to clinicians, through **digital Patient Reported Outcome Measures**
- Roll out a **national digital first prehabilitation offer** to support patients before they start treatment
- Provide every cancer patient with a **Holistic Needs Assessment** and a **Personal Care Plan**, to support their physical, mental, and social needs and employment support
- Where safe, value for money, and better for patient care, deliver cancer care at home

**Our Neighbourhood Health Service will mean that cancer patients are not just passive recipients of care, but rather active partners in its delivery - with real say and choice.**

# 4. Delivering world class cancer care through world class research

*"[…] The most important priority for me as a brain tumour patient is for the government to invest in research into rarer cancers to ensure we develop kinder more effective treatments to give patients equality of hope for more time with a higher quality of life."* Call for evidence respondent

We will:

- **Expand access** to trials by improving digital trial-finding tools and using genomic testing to open up personalised treatment options
- Ensure **faster and fairer access** to trials, cutting set-up times from 250 to 150 days and launching a Cancer Trials Accelerator Programme
- Speed up adoption of proven innovations through a **clear cancer innovation pathway and the National HealthTech Access programme** – including four new diagnostic technologies by 2027
- Set clear national cancer research priorities, applying **data, AI, genomics, wearables and robotics** to accelerate progress
- By 2030, up to **10,000 cancer immunotherapies** will be delivered via the Cancer Vaccine Launch Pad and Vaccine Innovation Pathway

**This National Cancer Plan will ensure that we are a world leader on cancer research and innovation**

# 5. Tackling Children and Young People's Cancer

*"It is common for survivors of cancer to realise the trauma experienced several years, post-treatment."* Children and Young People's Patient Experience Panel Member

We will:

- Improve experiences of care by providing **up to £10m per year for travel** costs, and ensuring child-friendly hospital food and play/youth support
- **Improve early detection and diagnosis,** ensuring primary and emergency care clinicians can access paediatric advice for suspected cancer cases
- Advance neighbourhood care by providing a **lead paediatrician in every Neighbourhood MDT** for children
- Speed up diagnosis by ensuring imaging for suspected cancer is reported, or reviewed, by a **paediatric radiologist**
- **Strengthen psychosocial and long-term support** by standardising access to psychological care, improving surveillance for late effects, and providing neurorehabilitation keyworkers for children with CNS tumours
- **Ensure equitable access to genomics and research** by making CYP genomics a core NHS Genomic Medicine Service deliverable and tackling age-related barriers to clinical trials for 16 to 24-year-olds

**By 2035, every child and young person with cancer should receive earlier support, fair access to the latest treatments and trials, and care that protects their long-term health and quality of life**

# 6. Prioritising rarer and less common cancers

*"My mum was diagnosed with pancreatic cancer in A&E - I tried to reassure her that published survival rates must be out of date as progress must have been made. But I was so very wrong! [...] My mum died just 7 months after diagnosis in 2020."* Call for evidence respondent

We will:

- **Diagnose rarer cancers earlier** by reducing emergency diagnoses and expanding proactive case-finding in primary care
- **Improve access to specialist treatments** by developing specialist multi-provider MDTs and prioritising genomic testing
- Expand access to clinical trials by **implementing the Rare Cancers Bill from 2026** and using AI tools to match patients to studies
- Give rarer cancers parity by appointing a **National Specialty Lead for Rare Cancers** by 2026
- **Improve data and transparency** by expanding NDRS Get Data Out publications and defining recurrent cancers by 2027
- **Accelerate research and innovation through novel procurement routes,** increased research funding and mission-led models

**Everyone with a rarer cancer should have timely diagnosis, access to specialist care, and opportunities to join innovative trials**

# 7. Reducing health inequalities is integral to the delivery of the National Cancer Plan

*"I think the dangers of tobacco are well documented and smokers are fully aware of the risks to cancer. However, I think the general public still isn't aware of the dangers of physical inactivity, alcohol and obesity in relation to cancer." Call for evidence respondent*

We will:

- Continue to roll out cancer screening and surveillance programmes which can specifically benefit those in underserved communities, including **lung cancer screening** and **community liver health checks**
- Develop locally targeted campaigns to improve the awareness of cancer **risk factors**, reduce the gap in **screening uptake** and address barriers to **early diagnosis** in underserved communities
- Roll out adjustments to existing screening programmes to improve take up in underserved communities such as **self-testing for cervical screening** and **mammography machines** that are accessible to people with physical disabilities
- Create an **equal playing field on health literacy** utilising AI tools on the NHS App to make care less dependent on personal knowledge of health
- Publish regular data and assess our performance to ensure we are **reducing the gap in rates of early diagnosis** between the most and least deprived areas

# Digital priorities for National Cancer Plan

## We will meet the Cancer Waiting Time standards by the end of this Parliament

- Scale the use of **single patient tracking lists** across local providers - develop functionality in the FDP, including booking and scheduling systems, to roll them out more widely
- Expect all providers to use the FDP or equivalent technology to **improve operational performance** from 2026/27
- Cancer will be a priority for **NHS Online**, beginning with virtual hospital pathways for PSA testing for prostate cancer

## We will become a global leader on cancer survival – 75% people surviving cancer for 5 years or more by 2035

- Explore how we use digital tools to introduce a more **risk stratified approach for screening programmes,** beginning with bowel cancer screening
- Give every patient **personalised insights into their cancer risk**, drawing on NHS, genomic, lifestyle, demographic and wearable data
- The **NHS App will be** the primary access point for cancer care by 2028 :
    - integrated management of screening invitations;
    - appointment booking and care navigation;
    - tailored prevention and support

## We will drive up quality of life for people living with cancer - designing cancer care around people's lives

- Cancer will be the first pathway to fully embed new digital **patient reported outcome and experience measures** (PROMS/PREMS) through the NHS App
- Deliver a universal, **digital first prehabilitation offer** for all cancer patients through the NHS App and other digital channels
- **Diagnosis Connect** will help patients with cancer and other long-term conditions get the support and knowledge they need

# 10Year Cancer Plan & Panel Discussion

Three strategic shifts

2 Analogue ↓ Digital

3 Treatment ↓ Prevention

In 1948 a Labour government founded the NHS. My job now is to make it fit for the future

Wes Streeting

Our 10-year plan, backed by an extra £29bn, will transform the service through AI and neighbourhood care - and hand power back to patients

Wes Streeting is secretary of state for health and social care

Do not edit
How to change the design

# Audience Q&A

ⓘ The Slido app must be installed on every computer you're presenting from

# Before you go, let us know….

# Hampshire and the Isle of Wight Primary Care Cancer Conference

Novotel Southampton
Thursday 26th February 2026

Cancer Matters Wessex