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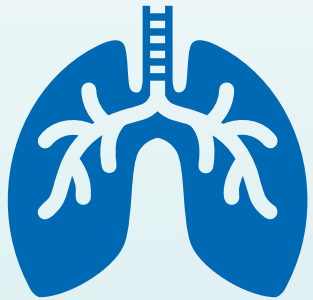
Working together to improve cancer care across the North East and North Cumbria

NHS

Moving a Pathway into the Community



Dr Ruth Sharrock

Lung Cancer, Health Inequalities, Smokefree Clinical Lead

- Community
- Neighbourhood

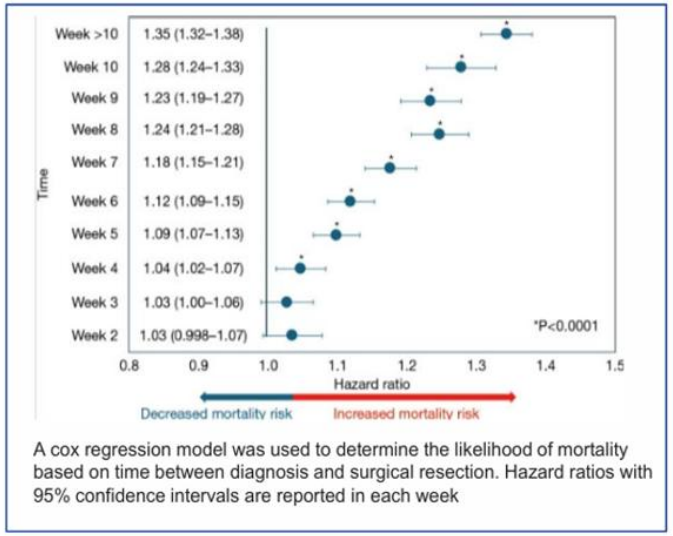
- Missingness
- Case finding
- Assertive outreach
- Support to engage with diagnostic pathways
- Partnership working in our communities

- What is community?

Why do we need to 'move' our lung cancer pathway towards our community?

CANCER RESEARCH UK

- **<u>It matters:</u> Prognosis**
- Lung Cancer is the leading cause of cancer death
- **<u>It is unfair</u>: Cancer death rates almost 60% higher in UKs most deprived areas**
- Lung cancer historically presented in late stages (75% five years ago)



A cox regression model was used to determine the likelihood of mortality based on time between diagnosis and surgical resection. Hazard ratios with 95% confidence intervals are reported in each week

Wait times between lung cancer diagnosis and surgery: national trends, disparities, and impact on long-term survival

Claire Perez [1], Andrew R Brownlee [1], Lucas Weiser [1], Justin J J Watson [1], Kellie Knabe [1], Charles Fuller [1], Shruthi Nammalwar [1], Qiudong Chen [1], Raffaele Rocco [1], Harmik J Soukiasian [1]

Affiliations + expand

PMID: 40950869 PMCID: PMC12433072 DOI: 10.21037/jtd-2024-2002

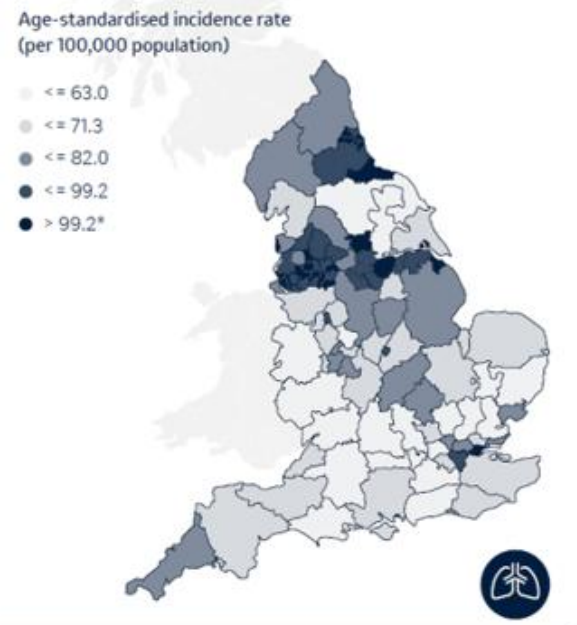


Figure 1 | Lung cancer

C33-C34 = malignant neoplasm of trachea, bronchus and lung

39,990 people were diagnosed with lung cancer in 2019 and the overall age-standardised incidence rate was 74.9 per 100,000. **Across CCGs, age-standardised incidence rates ranged from 50.0 per 100,000 to 160.7 per 100,000 (a difference of 110.7 people per 100,000).**[23]

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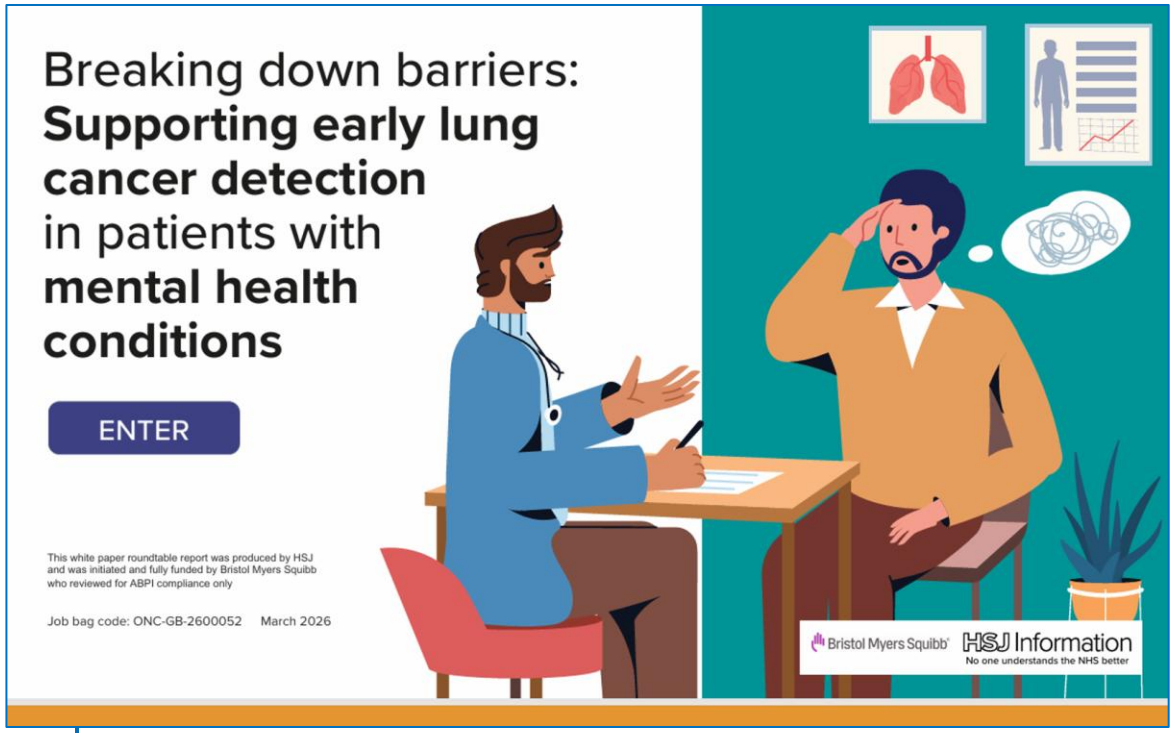
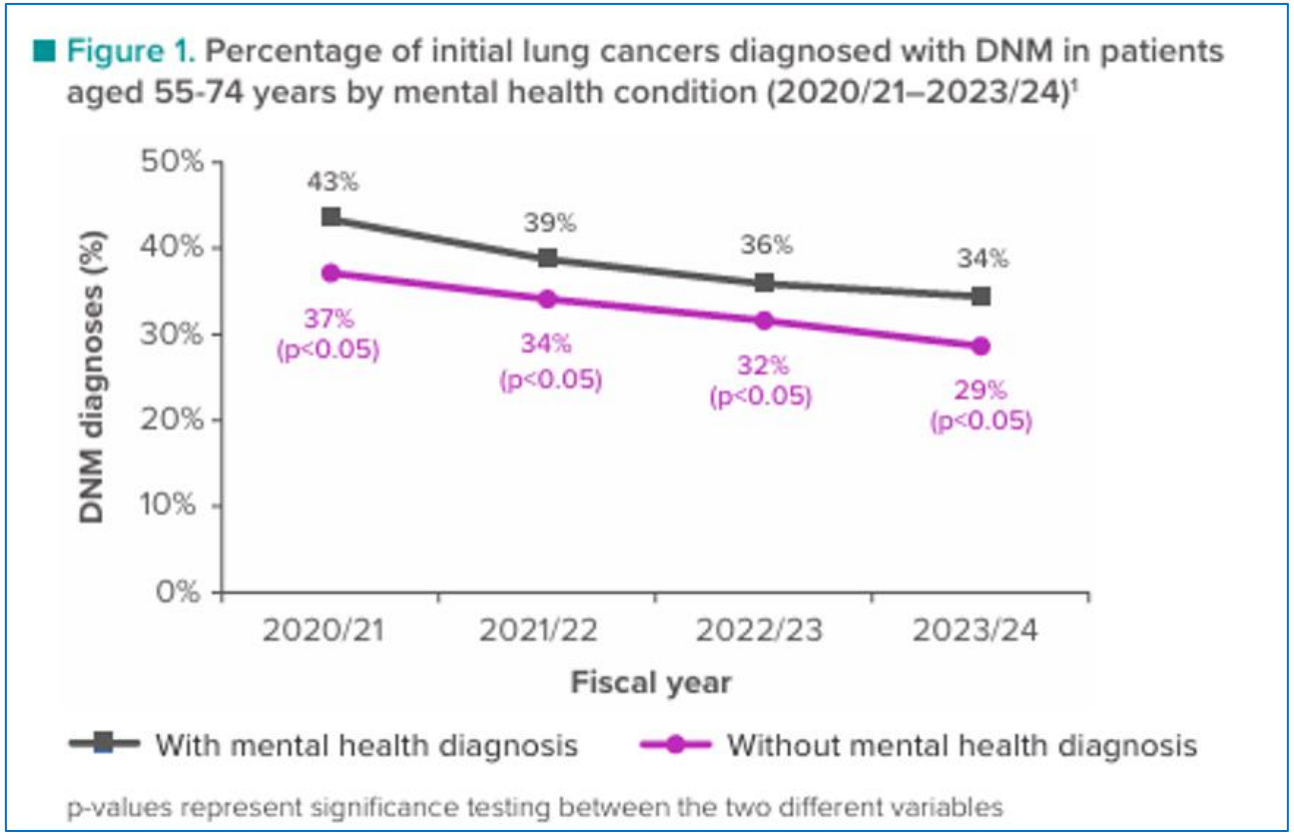
Within our communities there are even greater inequities

SMI and Lung Cancer White Paper





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Inverse Care Law in our pathways

- Take up screening invite
- Recognise symptoms
- Regular contact with GP
- Referred for assessment
- Diagnostics requested
- *Able to self advocate*

- Attend diagnostics
- Comply prehab, fit for treatment
- Stay in prolonged follow up period, best poised for new treatment strategies and optimisation opportunities
- Be offered access to 1'/ 2' preventative services (i.e. smoking cessation)

Good outcomes

Unable to engage in planned contact with primary or secondary care

- Little to no contact with GP

- **Reduced screening uptake in highest risk grps**
- **OOH presentations – 'wrong door'**
- **Cancers identified during intercurrent illness**
- **Miss opportunities for planned and preventative care**
- **Discharged for 'non engagement'**

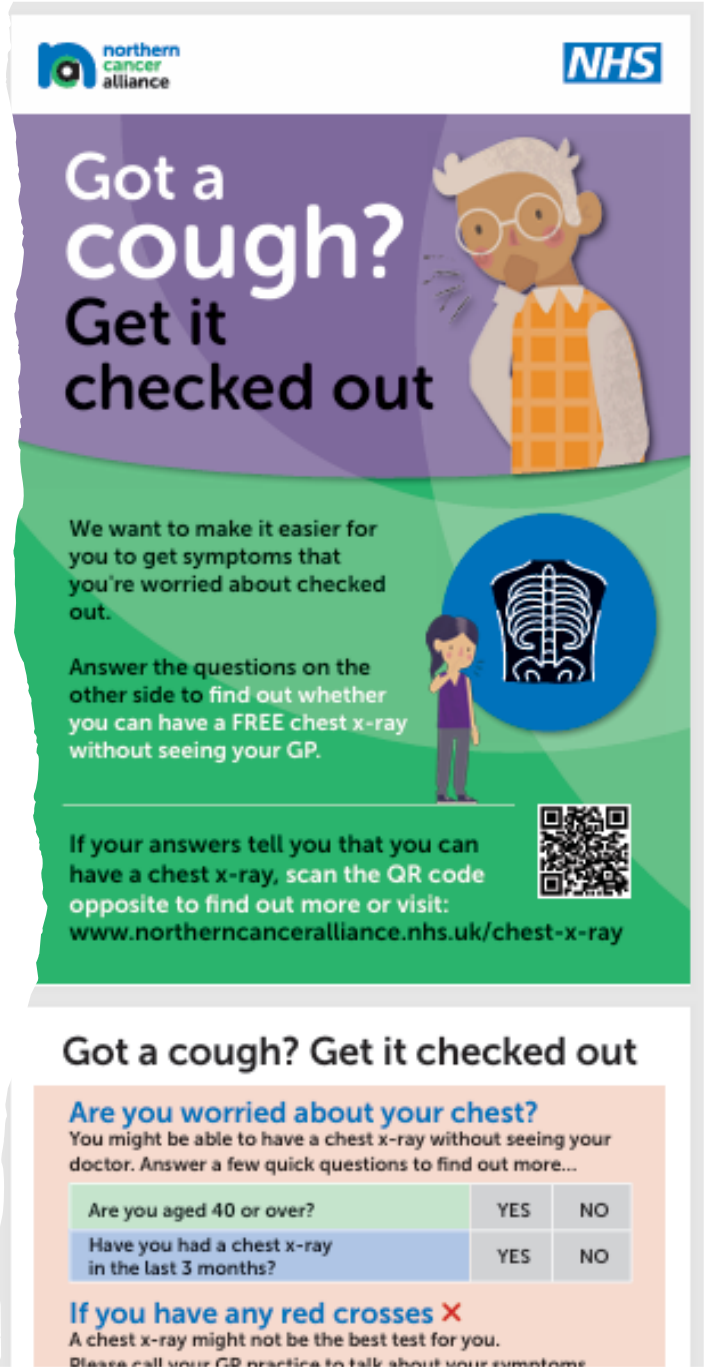
Poorer, inequitable outcomes

Missingness

Missingness – a targeted approach

- Who doesn't take up screening?
- Who doesn't present with early symptoms?
- Who doesn't get referred with early symptoms?
- Who doesn't attend when referred?

Why?



Screening – moving into communities

- Data informed roll out
- Health equity focus
- Maximise engagement with most marginalised groups using:
  - health literacy as standard
  - reducing process barriers
  - behavioural psychology
  - considered locations
  - trauma informed care
  - embedded prevention

Lung Cancer Screening

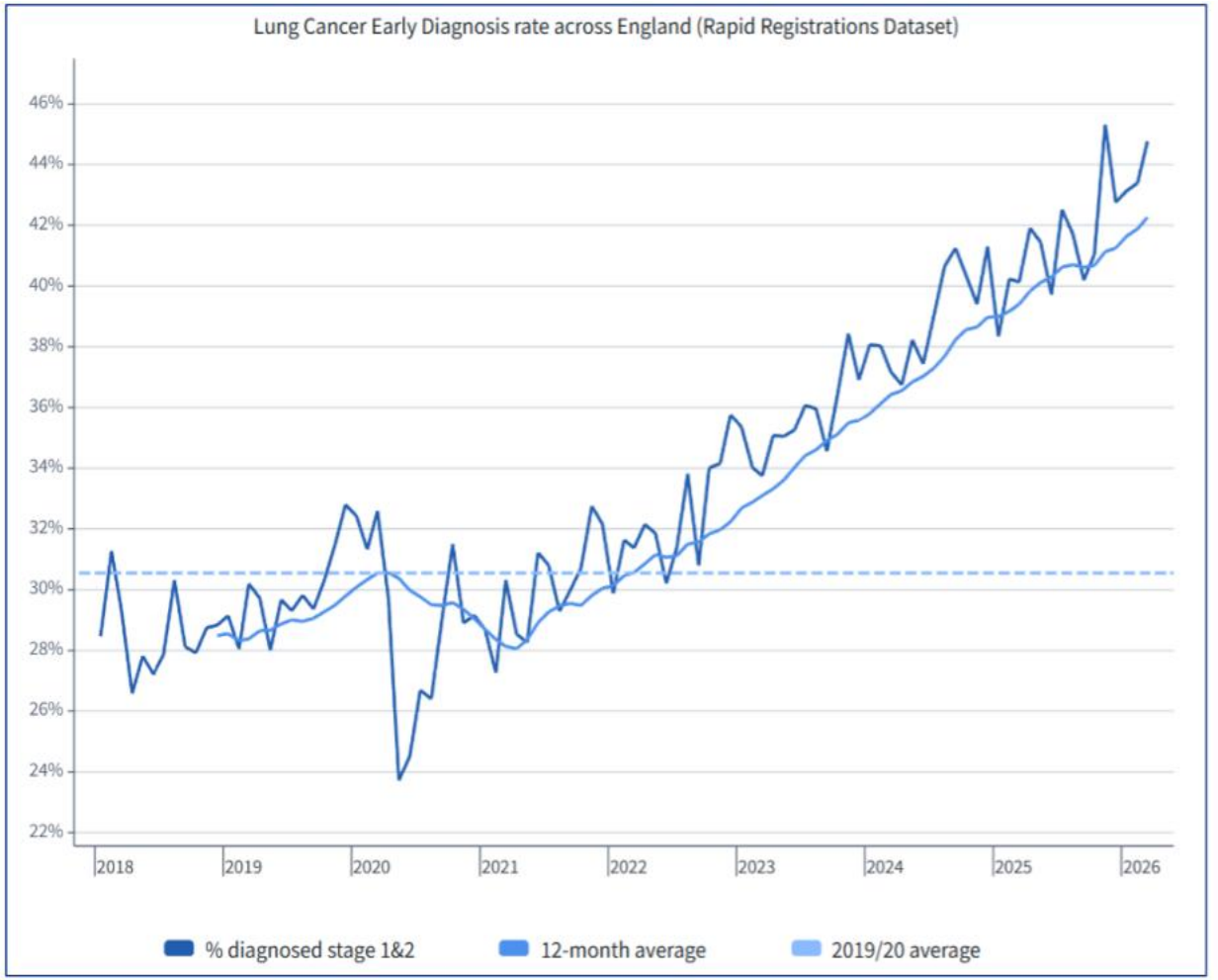
- Proportionate universalism approach
  - **Mental health inpatients**
  - **Prison population**
  - **Routine and manual workers in our anchor institutions**
  - **Armed Forces**

Impact of a roll out of a screening program targeted to greatest need

Nationally, lung cancer is experiencing the stage shift towards earlier diagnosis faster than other tumour groups

Muti- layered approach:

- Governmental prioritisation to lung
- England pilot sites based on inequity
- Local roll out targeted to highest incidence
- Inclusion groups prioritised



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Screening – moving into communities

Assertive outreach for screening and prevention (pilot)

- Small team working across one PCN in Gateshead
- Identifying those who might be smokers, who are age eligible but have not taken up screening
- Proactive phone calls, enhanced offer of tobacco support and support into screening

Bridges Medical Practice

This learning could inform our approach to Neighbourhood Health

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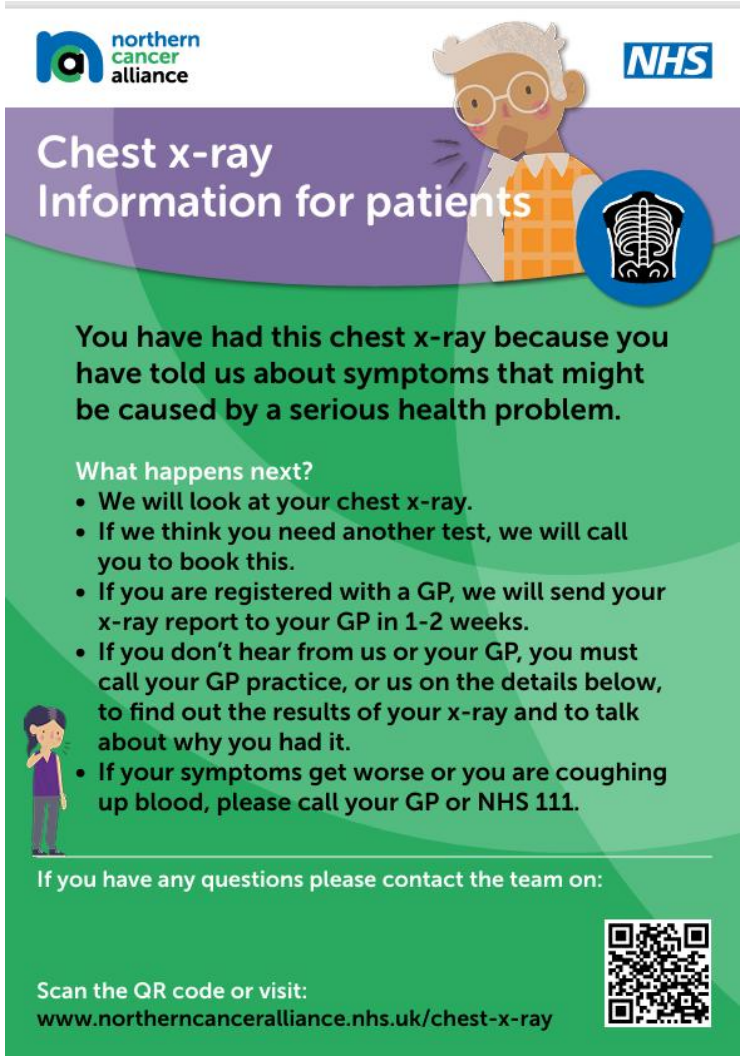
Symptomatic pathways into communities

Symptomatic self referral for chest x-ray

Projects developing across NCA, different models

- Newcastle
- Gateshead
- Northumbria
- Durham and Darlington
- North Cumbria



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Self referral – case study

Symptomatic self referral for chest x-ray

49M smoker, persistent cough, ?related to welding, drop-in (self referral) clinic at DAS

- never accessed SSS, tried a vape, safety concerns
- stable on methadone programme
- unable to access primary care appointments
- loss of income if time away from work a concern

- vape, patches, evening CXR with SMS support
- new lung mass = small cell lung cancer

- **Undergoing concurrent chemo radiotherapy – fitness improved by smoking cessation – eligible for radical treatment**

asked us to see his partner, smoker, who hasn't accessed health care because of fear of judgement over very poor dentition - cough plus breast lump, abnormal vaginal bleeding

Making symptomatic pathways accessible to our communities

Healthier and Fairer Programme

HIVE GATESHEAD

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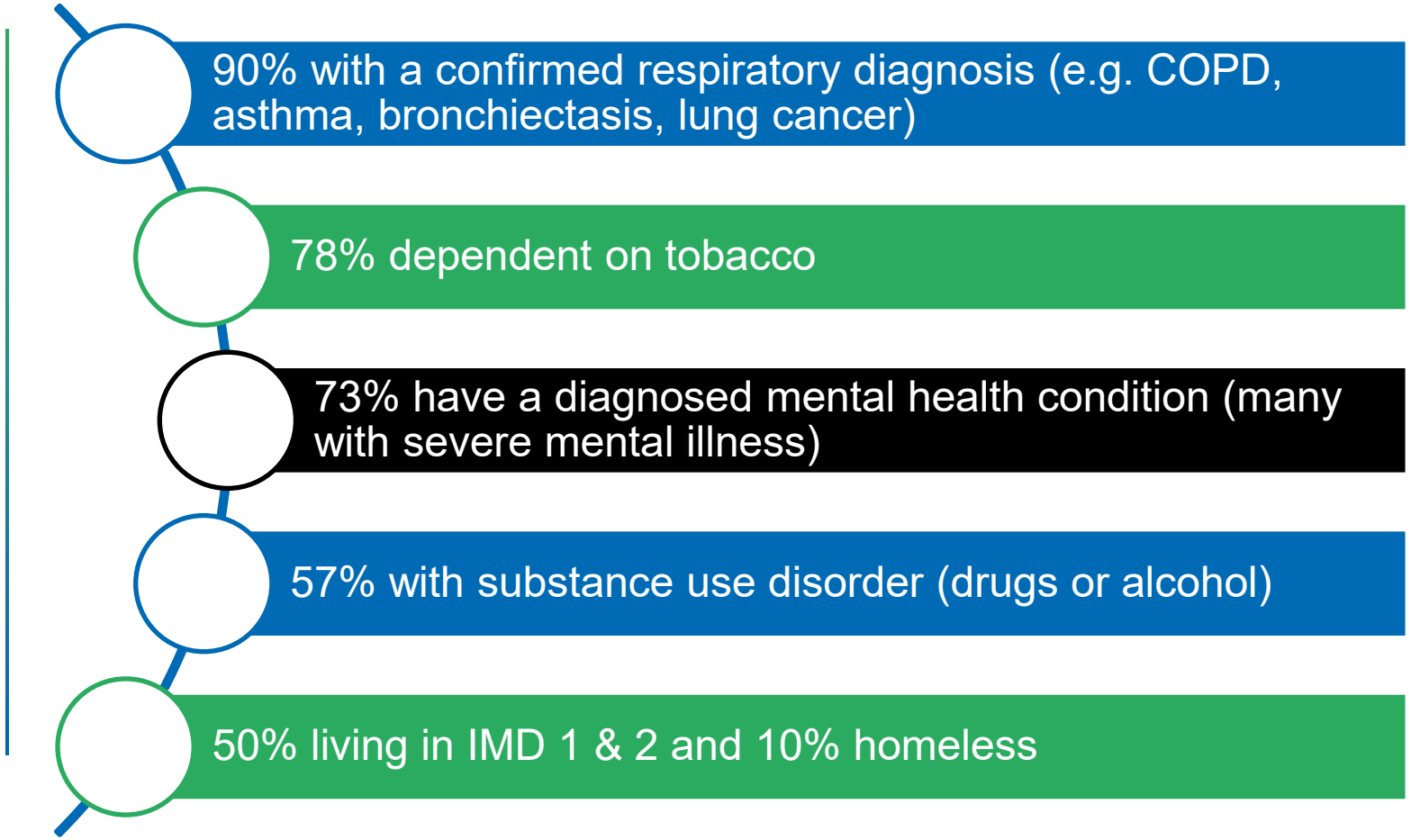
Learning: who are the missing in our community?

- a population with layered complexity



Yet, with an appropriate support team,(HIVE), **98.7%** of those referred were helped to engage with the pathway

Moving pathways into communities

Consider prevention, screening and symptomatic pathways together

Data led approach

Embed Health Literacy in the approach

Look for the missingness in the data

Understand specific barriers – ie not just distance but transport/ practicalities

Assertive outreach, self referral, co - location with key service

Practical and personal support to engage with complex pathways

What is community?

- Familiar
- Friendly
- Personal
- Accessibility
- Safe
- Reliable
- Honest
- Valued