SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification	NHS Tameside and Glossop Community Based Lung Health Checks
Service	Phased Extension of the National Lung Health Checks within NHS Tameside and Glossop Clinical Commissioning Group (T&G CCG)
Commissioner Lead	NHS Tameside and Glossop Clinical Commissioning Group T&G CCG)
Provider Lead	Manchester Foundation Trust
Period	March 2021 to March 2024
Date of Review	

1. Population Needs

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The Targeted Lung Health Check (TLHC) service which is being commissioned involves identifying people between the ages of 55 – 74 and 364 days who have ever smoked. These people will be invited for a lung health check and a low dose CT scan (where necessary) for the earlier detection and treatment of lung cancer and earlier identification of other respiratory disease. The service fits with Domains 1, 2, 4, and 5 of the NHS Outcomes Framework.

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

2.2 Locally Defined Outcomes

The objective of the programme is to achieve the requirements outlined in the Targeted Lung Health Checks Standard Protocol https://www.england.nhs.uk/wp-content/uploads/2019/02/targeted-lung-health-checks-standard-protocol-v1.pdf , Quality Standards https://www.england.nhs.uk/wp-content/uploads/2019/02/targeted-screening-for-lung-cancer-quality-assurance-standard.pdf and addendum issued due to COVID-19 www.england.nhs.uk/.../2019/02/C0699-tlhc-pathway-addendum.pdf covers the following areas:

- Early diagnosis and treatment of lung cancer improving current staging diagnosis and improving survival rates.
- Reduction in lung mortality rate
- Early detection and diagnosis of other incidental findings such as cardiac, pulmonary disease as identified through previous lung health check pilots
- Patient monitoring /call back for participants with suspicious lung nodules
- Proactive promotion of participant self-management and smoking cessation
- Increase the number of people who quit smoking
- Reduction in A&E attendances and hospital admissions in future years

2.3 Data Collection Requirements

The service provider will be responsible for the collation and submission of TLHC data in line with the minimum dataset (attached) which sits within the Standard Protocol. Data will be submitted to the Commissioner each month. Data will also be submitted to IPSOS MORI as part of a robust evaluation. The provider will ensure they complete the most recent versions, when available.


Copy of V03 TLHC Clinical Dataset Proc


Copy of TLHC Evaluation Dataset F

The Provider will work with the NHS Strategy Unit https://www.strategyunitwm.nhs.uk/ who will support the service evaluation. To support this the Provider will be expected to build quality monitoring assessment tools into the programme.

The lung health check is a service for the GP registered population of T&G CCG who meet the service criteria. The provision of the lung health check service will improve health outcomes and quality of life by enabling more people to be identified at an earlier stage for serious respiratory disease, with a better chance of putting in place positive ways to substantially reduce the risk of respiratory disease morbidity, premature death or disability. The lung health check service is not just a diagnostic service but is part of a wider process that should ensure that people with respiratory problems gain an accurate diagnosis and appropriate treatment and support, including, if they are smokers, support to help them quit.

The Provider will be expected to update the Commissioner on the performance of the service against the service outcomes on a quarterly basis through the agreed governance process.

3. Scope

3.1 Aims and Objectives of the Service

The primary aim of the service is to reduce mortality from lung cancer. The Provider will ensure that a lung health check is offered to people who smoke or who have been previous smokers, aged 55 to 74 and 364 days in line with the standard protocol. The service will also aim to:

- Increase the number of people diagnosed with lung cancer at an early stage by accurately identifying people at an elevated risk of lung cancer who would benefit from having a low dose CT scan
- Increase the number of people registered at their GP with a correct diagnosis of COPD and in receipt of appropriate treatment
- Increased recognition of the number of people at risk of cardiovascular event in the next 10 years, who may benefit from intervention
- Reduce smoking in people within the targeted age group

The service objectives are:

- Correctly inform participants about the lung health check process and the need for a CT scan if lung cancer risk is equal to or above the set risk threshold
- Accurately calculate the lung cancer risk score of all participants
- Provide a high quality baseline Spirometry test to people at high risk of lung health problems (not required while addendum in place due to COVID-19 restrictions)
- Correctly assess people's lung health and refer them to the most appropriate service/s based on their diagnosis.
- Provide support and advice about lung health, in particular, the importance of not smoking and encourage people that express any interest in quitting to access smoking cessation therapy, counsellors services or their GP
- Provide a user friendly service to a diverse population of smokers and ex-smokers aged 55-74 and 364 days that results in high levels of customer satisfaction
- Offer all service participant a lung health check which is convenient and accessible
- Ensure that all participants are seen with the timescale set by T&G CCG & NHSE

The programme scope covers residents who are registered with a GP in T&G CCG.

The Provider will work collaboratively to agree and establish local pathways for all eligible patients to ensure they access the right care, at the right time to meet the person's needs.

3.2 Inclusion Criteria:

- Age range from 55 to 74 and 364 days
- Willing and able to undergo LDCT; and
- PLCOm2012 risk of ≥1.51% over 6 years and LLPver2 5-year risk of ≥2.5%

3.3 Exclusion Criteria:

- Participant does not have capacity to give consent (standard criteria for assessing capacity apply)
- Full thoracic CT scan within the last 12 months or planned, for clinical reasons, in the next 3 months (Note, may still be included if CT essentially equates to a baseline scan and there are no other exclusion criteria)
- Weight exceeds restrictions for scanner (>200kg)
- Participant unable to lie flat; or
- Poor physical fitness such that treatment with curative intent would be contraindicated; this may require a second opinion or advice from the local lung cancer MDT
- Patients suspected of cancer (should be referred on the two week wait pathway)
- Patients on the Gold Standard Framework end of life register
- Patients who have had a lung cancer diagnosis within the last five years

3.4. Service Set Up & Delivery

The Provider will work with the Primary Care Network / GP Practices to ensure they invite the targeted population as per the agreed data quality search (attached below). Practices are able to run a search on their GP system to share with the Provider/s (in accordance with the data sharing agreement).

LHC Data Quality Search - v30-09-202

Insert DPIA

The planned service start date is 01st February 2021. Planned trajectories need to take into account the complex interdependencies across Greater Manchester and take into account capacity at the tertiary centres.

The Provider/s will be required to implement robust booking, scheduling and administration processes and ensure that LHC minimum data requirements are collected across different systems or organisations and stored and transferred securely.

The Provider/s of the lung health check service will set up a system in line with the Standard protocol to provide CT scanning and reporting provision or work in partnership with a CT scan provider. The Provider will set up a process to transfer reports and CT images to Tameside & Glossop ICFT radiology system where necessary. This process will be agreed through the discussion and production of clinical pathways between the provider/s and the T&G CCG. The time scale for image reporting is two weeks from the date of scan. A time frame for the transfer of images and reports will be discussed and agreed with the Commissioner and included in the appropriate service operation procedure.

It is essential that the Provider builds good working relationships with other LHC providers, primary care and tertiary centres across GM. Clinical pathways will need to be developed and agreed to ensure seamless referral and treatment processes between service providers.

3.5 Service Preparation

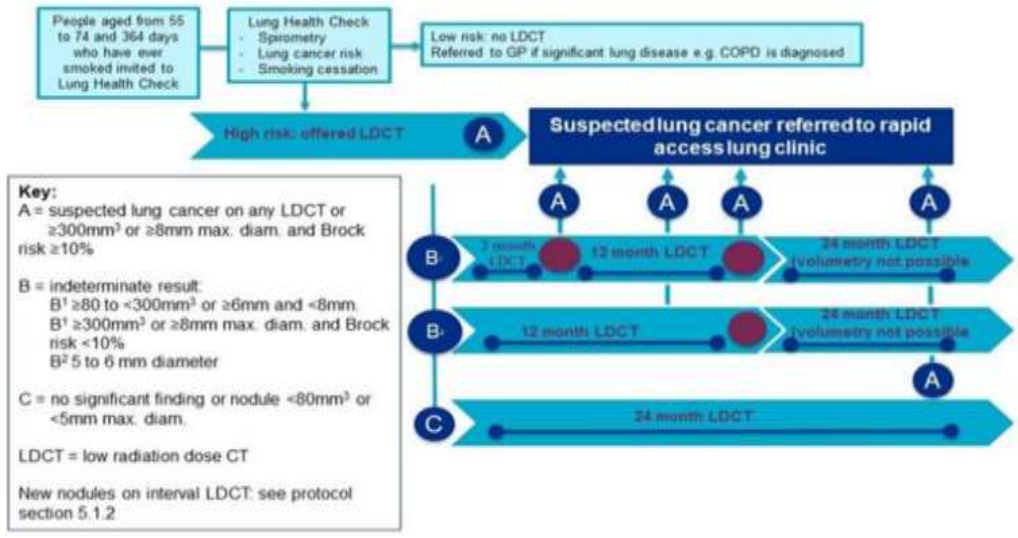
The Provider must ensure a full understanding of the Targeted Lung Health Check Service Protocol and ensure that the protocol is fully adhered to (please note that the protocol may be subject to change as the service evolves). Areas of concern which must be addressed to ensure excellent service uptake are:

- Participant address is checked as correct
- Process for changing appointments is easy and straight forward
- Follow up process for contacting non-attenders
- Participant is not deceased
- Participant is not an in-patient (participant should be contacted at a later date)
- Participant has not had a thoracic CT within the last 12 months or planned for clinical reasons in the next 3 months

The initial invitation process will be as follows: Please note that GP's may send the initial invite letter (DPO to advise SCO)

1. Participants aged between 55 and 74 and 364 days of age at the date of the first low dose CT scan (LDCT), registered with a Tameside & Glossop GP practice who have ever smoked will be invited for a Lung Health Check. Those who attend (maybe virtual refer to addendum to National Standard Protocol) will be assessed to calculate their individual risk of developing lung cancer.
2. Invitation to attend for an assessment for suitability for LDCT may be by correspondence or telephone via primary or secondary care, or by offering assessment in a mobile setting in high-risk areas, as part of a Lung Health Check.
3. Individuals will be assessed for eligibility criteria by confirming medical, social and employment history and risk factors for lung cancer. Validated lung cancer risk assessment tools may be used to better quantify risk.
4. Where necessary, reasonable changes should be made to the approach to ensure the service is accessible to all, including those with physical and learning disability and mental illness e.g. easy read documentation, engaging key worker in invitation.
5. NHS translation services should be available where required for individuals without adequate English language skills.
6. Participants who have difficulty understanding the purpose of the programme should be able to access the programme.

The participant journey for both those assessed at the Lung Health Check as low risk of developing lung cancer and those at high risk is shown in the diagram below (Appendix A of the Standard Protocol provides a more detailed clinical pathway).



3.6 Capacity & Infrastructure

There should be sufficient capacity and infrastructure to deliver the programme including:

- Community facilities for siting of mobile CT scanners
- Primary care facilities for supporting assessments for eligibility and health checks
- Scanning capacity
- Radiology reporting
- Clinical service for work up of referred participants
- Clinical service for treatment of participants
- Smoking cessation support and advice with robust links back to local smoking cessation services in Tameside & Glossop
- Administrative support for the programme including data collection, collation and submission

The implementation of the programme should be aligned with local services. This will involve working with regional and local healthcare management including:

- Regional Office, NHS England
- Cancer Alliances
- Sustainability and Transformation Partnerships (STPs)
- CCGs
- Local NHS Trusts
- Local Authorities
- Third Sector
- Voluntary Providers
- Social Prescribers

3.7 Overview of the Lung Health Check Assessment

The lung health check assessment is an opportunity for people to consider their lung health. Each person qualifying for a lung health check will have a basic examination focusing on lung symptoms, baseline spirometry (not required while addendum in place), Qrisk2 score and have their risk of lung cancer calculated. Those calculated to have a risk of lung cancer above or equal to a set threshold of ≥1.51% will be eligible to enter the low dose CT scan service. Atrial Fibrillation may also be included but is not mandated within the contract.

A nurse will interpret the results of the lung health check and use clinical judgment to decide whether or not the participant should visit their GP practice or be signposted elsewhere. The nurse will give reassurance and advice as required and put the patient in touch with on-site smoking cessation intervention as appropriate. The smoking cessation advisor will ensure robust links with Be Well Tameside and Live Life Better Derbyshire along with social prescribing providers. The Provider will be responsible for ensuring that results from the lung health check are shared with GPs in the form of a letter sent electronically via secure email advising next steps.

The success of the service will depend upon:

- Attendance at the lung health check
- Correct assessment of lung health & Qrisk2
- Appropriate referral to CT scan
- Structured reporting of CT scans to identify lung cancer, emphysema or coronary disease etc.

3.8 Expected Patient Numbers

The expected number of service participants is shown in the table below. The data is based on Tameside & Glossop Demand Modelling taken from primary care data from 09th October 2020. The data search will need to be re-run as the service moves to different localities/neighbourhoods to take into account the service age range of 55 – 74 and 364 days.

Use yellow cells to input your eligible population and ever smoking rates 09.10.2020

Data refreshed with SNOMED codes and revised exclusion criteria

Stage	No.	%	Comment
Total eligible population	58,121	100.0%	Aged 55-74/364
Ever smoked	36,248	62%	Of Total eligible population (excludes Palliative/Lung Cancer and Severely Frail)
Appointments booked	18,124	50.0%	Of Ever Smoked
Non attendees	1,450	8.0%	Of Appointments Booked
LHC's performed	16,674	92.0%	Of Appointments Booked
Positive LHC's	9,337	56.0%	Of LHC's analysed
Excluded from CT scan	280	3.0%	Of Positive LHC's
Initial CT scans performed	9,057	97.0%	Of Positive LHC's
Indeterminate - require second scan	1,286	14.2%	Of Initial CT Scans performed
Negative CT Scan - 24 months follow-up	7,481	82.6%	Of Initial CT Scans performed
Total CT	19,111		

Activity Impact of Cancers Identified

Findings	No.	%	Comment
Patients needing clinical investigation (following first scan, three months follow-up and 12 months follow-up)	534	5.9%	Of Initial CT Scans performed (including patients requiring investigation after second scan)
Cancers found	271	50.8%	Of Needing clinic investigation
24 months follow-up	7,481	82.6%	Of Initial CT Scans performed
Patient needing clinical investigation following 24 month scan	180	2.4%	Of 24 month scans
Cancers found at 24 months follow-up	118	65.5%	Of Needing clinic investigation
Total cancers found	389	N/A	Including those found at initial, 3, 12 and 24 months scans
Surgery	198	51.0%	Of Cancers found
Stereotactic Body Radiation Therapy (SABR)	47	12.2%	Of Cancers found
Chemo-Radiation	35	9.1%	Of Cancers found
Radiation treatment (XRT)	35	9.1%	Of Cancers found
Surgery and Adj Chemo	30	7.7%	Of Cancers found
No Treatment	18	4.6%	Of Cancers found
Chemo	18	4.6%	Of Cancers found
Best Standard Care	6	1.5%	Of Cancers found
Grade I&II Cancers Detected	362	4.0%	Of initial scanned
Grade III&IV Cancers Detected	91	1.0%	Of initial scanned
Nodules Detected	815	9.0%	Of initial scanned
Nodules doubling at 12 months (NELSON)	19	2.3%	Of Nodules Detected
Other Significant Incidental findings NIHR	543	6.0%	Of initial scanned

The expected number of CT scans over the four year project period is estimated at:

Total demand Values inputted from "TLHC" tab

Detail	Number	%	% of . . .
LHC's booked (appts booked)	18,124	50.0%	of the Ever smokers
Initial CT scans performed (baseline scans)	9,057	97%	Of Positive LHCs
3 month repeat scan booked (if indeterminate results)	1,286	14.2%	of initial CTs
12 month follow-up scan (if had 3 month repeat scan)	1,286	100%	of 3 month repeat scan
24 month follow-up scan (if first round of scans clear)	7,481	82.6%	of initial CTs

All eligible participants will need to be seen, scanned and followed up (where appropriate) as per the participant pathway above by the end of March 2024. Please note that a process will need to be in place for communicating CT results back to participants. **Results will not go directly back to the GP for management**. This will need to be organised in partnership with the provider undertaking the lung health check assessments. Patients with incidental findings will need to be referred to the most appropriate service. Incidental findings mapping has already taken place (and will align to the Quality Assurance Standards).

The allocation and booking of LHC appointments will be monitored through weekly NHS T&G mobilising contract meetings (moving to monthly as the service is established). The Provider will communicate and advise the Commissioner on the number and proportion of slots booked along with any potential for additional capacity. Contingency plans for overbooking will be developed and agreed based on the business case contingency amount (TBC by finance lead).

The proposed service trajectory for booking the initial Lung Health appointments within 34 weeks (to be agreed)must ensure that all patients receive a Follow UP CT scan within the specified time period is shown in **Appendix A** in accordance with National timeframes and financial framework. The time period may change depending on possible service impact on tertiary providers. The Provider will continually link with the GM Cancer Alliance to ensure that the service dovetails with other services across GM and is provided at a safe and manageable pace. The Provider will update the Commissioner on service roll out progress and identify and communicate service issues well in advance of them becoming unmanageable.

3.9 Initial Contact

The provider will work with Practices to identify patients in the appropriate age range of 55-74 and 364 days registered with a T&G CCG GP practice. The Provider will identify the name, date of birth, home address and contact details whilst taking into account the inclusion and exclusion criteria within the standard protocol. Patients will then be invited to contact the booking service to agree an appointment for a community based lung health check (mat be virtual due to COVID-19 restrictions).

The initial invitation letters and booking of any appointments will be managed by the Provider who will manage the end to end process for this service i.e. booking appointments to patient follow up and treatment if required. This will enable control over the whole pathway and mitigate any issues with onward referral.

3.10 Set up at Community Locations

The Provider will engage with Primary Care throughout the service planning and scheduling stage. The provider will identify suitable service locations that adequately cover the Tameside & Glossop footprint. The service is expected to be delivered in 3-4 locations and will target participants across a number of GP practices in the surrounding area (COVID-19 safe sites may limit options available). Practices will be informed well in advance of when their patients will be invited. This will give them time to prepare and run their data download and encourage participants to attend.

The provider will agree locations and duration on site with T&G CCG as the Commissioner. The locations for service delivery will be selected so that they are convenient for the GP practice patients to attend. The Provider will work with the Commissioner and in partnership with the CT scan service to agree suitable locations. The final locations at which the service will be delivered will be agreed with the Provider at least six weeks before commencement of the service.

The Provider will make all necessary assessments to ensure that a high quality lung health check service can be delivered safely and securely at the agreed locations. The Provider will work with the Commissioner to agree the schedule of service delivery and ensure that the service is ready to begin delivery at the agreed locations at the agreed times, on the agreed dates.

The Provider will work with the Commissioner and in partnership with the provider of the CT scan service to agree the times and days that the lung health check one stop service will operate.

3.11 Service Opening Hours

The LHC service must be available at convenient times for participants i.e.

- Over 6 days
- Early starts 8am
- Late finishes 8pm
- Weekend working i.e. Saturday morning/afternoon

3.12 Pathway Planning

The Provider will work in partnership with the CT scanner provider to deliver a welcoming, seamless and easily accessible pathway from LHC to CT scan through a one stop service (may not be possible due to COVID-19 restrictions, may require virtual LHCs). Participants meetings the criteria for a low dose CT scan will be guided through this process with the intention of minimising any worries or concerns.

The Provider will work closely with GM Cancer Alliance and tertiary providers to plan service roll out so that the service is launched in a safe and methodical manner to prevent overburden and saturation of the full lung pathway. The service must not impact on local and GM cancer targets in line with National Cancer Waiting Times Monitoring Guidance V.10. The schedule will be discussed with the Commissioner and agreed with the NHS England National Team.

The Provider will produce service operational procedures (SOPs) covering all aspects of the LHC pathway both in and out of the service and will also cover all incidental findings pathways (in accordance with the Quality Assurance standards) to include:

- Chronic Obstructive Pulmonary Disease (COPD)

- Emphysema
- Bronchiectasis
- Cardiovascular conditions
- Gastrointestinal conditions
- Cancers

Less Frequent

- Thyroid disorders
- Adrenal nodules
- Hepatic lesions
- Renal masses
- Bone Lesions
- Gastric Conditions
- Lymphadenopathy

The SOPs will be shared with the Commissioner to provide assurance. Where possible patients should have the option to choose providers closer to home using existing pathways and local providers. In addition pathways will be established to supporting services for examples Psychological support or social prescribing.

3.13 Patient Literature

Patient literature should be available by request in a number of different formats i.e. braille, different languages, video with subtitles etc. Draft literature must be shared with patient groups and primary care for comments and co-production. Literature must include their rights under the Data Protection Act 2018, describe what information is being shared, how it is used, and the location of the Privacy Notice.

The Provider will ensure maximum uptake by implementing a booking process consisting of:

- Invite letter explain the service and why the patient has been invited
- Appointment confirmation letter and service leaflet explaining LHC process including CT scan
- Reminder letter/phone call if participant does not attend
- Telephone call or text reminder on the day of the LHC

3.14 Arrival for Lung Health Check

- Participants will be warmly welcomed in a non-judgmental way
- Participants will be offered a high quality effective service
- There will be a process in place for dealing with participants who may have a physical or mental disability
- Only participants with a pre-booked appointment will be seen
- A person asking for a lung health check who does not have an appointment should be signposted to the booking service, if eligible
- Adequate staffing must be in place to cover the service appointment schedule
- Waiting times must be kept to a minimum (no longer than 30 minutes)
- The participant waiting area will be comfortable and restroom facilities provided

3.15 Content of the Lung Health Check & Low Dose CT Consultation

The Provider will deliver a lung health check to each participant in line with the Standard Protocol (which may be subject to change as the service evolves) in an electronic format ensuring that all aspects of the minimum dataset are covered. The data will be shared electronically with the Commissioner on a monthly basis.

The LHC will consist of:

- Explanation of the LHC process
- Explanation of low dose CT scan and risk (if required)
- Consent for CT scan (if required)

- If a participant decides not to have a scan this should be recorded
- Consent to share data for service evaluation purposes
- A person that does not consent to their data being used for evaluation purposes is still eligible to have a lung health check but their decision for their data not to be shared must be clearly recorded
- Heart & lung symptom questionnaire
- Calculation of lung cancer risk score*
- Calculation of QRisk2 score for CVD
- Quality assured spirometry
- Brief consultation with respiratory nurse (including smoking cessation advice) to discuss findings and next steps
- Referral to a smoking cessation counsellor on the mobile unit or an appointment will be made prior to leaving

*Assessment of risk of lung cancer is essential to maximise the cost effectiveness of the intervention. There are a number of methods and further research may identify which is the best. This will form part of the evaluation of the Targeted Lung Health Check Programme.

Incidentals finding pathway v11.docx

Draft incidental findings pathway

3.16 Staff Training & Competence

Before commencement of the service the Provider will ensure that all staff providing the service are fully trained and competent. It is also advisable to offer shadowing to the Respiratory Nurses covering the areas highlighted in the pilot for incidental findings (See section 4.8 above). There would be a benefit from additional enhanced training to ensure that staff are confident to relay sensitive information to participants.

Training must be provided in line with the Standard Protocol and is available via the Cancer Alliance Portal https://future.nhs.uk/connect.ti/canc/view?objectID=13365584 (registration required) and https://www.roycastle.org/for-healthcare-professionals/targeted-lung-health-checks/training/

The Lead Radiologist and Reading Radiologist/s will be required to provide the following information to the NHSE National Team & T&G ICFT before they are permitted to report for the T&G LHC service:

- How often they attend the lung nodule MDT
- How many other MDTs they attend (e.g. general chest) and how often
- Any specific interests (e.g. chest, GI, neuro)
- If BTS guidelines are used in clinical practice for incidental nodules
- If volumetry is used in clinical practice for incidental nodules
- The volumetry software used

The NHSE minimum standards and the LHC key performance outcomes framework in **Appendix B** must be adhered to by the Lung Health Check Nurses and The Lung Cancer Reading Radiologists and compliance must be overseen by the Responsible Assessor as per the Standard Protocol.

3.17 Equipment for LHC

Equipment used for the LHC must be calibrated (where necessary) to collect accurate readings i.e.

- Weighing scales (record in kilograms)
- Blood pressure equipment (recorded in mmHg in patient's right arm, where possible)
- Height (recorded in metres)

The nurse will assess the participants pulse and record regular / irregular. If irregular, and atrial fibrillation not known, follow up with formal diagnosis (and inform GP). Include AF used in the calculation of Qrisk2 score.

3.18 Respiratory Health Questions

The Provider will use a symptom questionnaire covering relevant aspects of the minimum dataset. The Provider will be responsible for ensuring that the answers to each question are recorded electronically on the structured data collection template and this information should flow or interface into primary care IT systems and the relevant Tameside and Glossop ICFT IT systems. Systems must be put in place for easy referral and appropriate transfer of data to third sector and social prescribing service.

3.19 Referrals to Smoking Cessation Services

The Provider will ensure that smoking cessation is an integral part of the service and will work with the subcontracted provider to ensure that the relevant aspects of the minimum dataset are recorded i.e. number of referrals verses number of quits. Smoking cessation will record the LHC data electronically and separately from all of their other data. This data will be provided electronically to the Commissioner on a monthly basis.

3.20 Low Dose CT Scan

The low dose CT scan will be provided as part of an integral one stop mobile service (subject to addendum). The scanner will comply with the CT equipment and volumetry software requirements and the CT image acquisition within the Standard Protocol.

3.21 Administrative Follow-up

The Provider will ensure:

- A robust record of attendance and outcomes is maintained for all people receiving a lung health check
- Keep a secure database which feeds into the production of reports regarding attendance and a participant's lung health check
- Brief activity report covering each month's activity as a routine electronic data return
- The return will include the number of lung health checks provided, non-attendance and the outcome of the health check
- This information will be presented to the T&G CCG contracting team using an agreed electronic format

3.22. Security

The Provider will be responsible for the security of the mobile unit/s and will work with the subcontracted provider to plan security measures day and night. The security agreement will be agreed and documented in the tender agreement and contract.

4. Transfer of Data

The results of the lung health check will be captured on a data collection template that has been developed by NHSE. For those participants receiving a CT scan, the report and image must be transferred to Tameside & Glossop ICFT radiology system electronically and stored in NHS PACS systems. Data sharing agreements must be in place covering all data sharing and transfer processes across all service providers. The data sharing agreements must be written clearly and unambiguous.

The Provider will develop a reporting framework utilising NHS consultant radiologists (or international equivalents) and use a structured report to categorise the presence or absence of pulmonary nodules, coronary artery disease, emphysema or significant additional findings (NHSE in the process of drafting templates).

There should be sufficient radiology reporting capacity to ensure that reports are available within 14 calendar days of initial scan. Where possible Radiologists should be employed by the service or have the role built into

their existing job plans. The reporting of pulmonary nodules will utilise volumetry, computer aided detection software and a nodule management algorithm based on British Thoracic Society (BTS) guidelines.

The Strategic Commission will develop a quality assurance programme for reporting and providing reports to the Commissioner.

All data flows must be recorded by the Provider and include the data items being transferred, technology processing these flows, legal consent, and the location of the database.

5. Clinical Protocols & Pathways

Clinical protocols and pathways will be developed by the Provider in collaboration with appropriate colleagues (a sub-group of GPs, respiratory physicians, lung nurses, and radiologists). These will be in place before the commencement of the service.

Patients with a positive scan will be upgraded to the suspected lung cancer pathway within 1 working day of receipt of CT report for diagnostic work up. Patients with significant additional unexpected findings will be referred to an appropriate clinician in accordance with agreed pathways and protocols with the Commissioner. The Provider will ensure a process is in place for notifying the patient's GP of the action taken.

The Provider will arrange telephone clinic appointments for participants with abnormal findings to fully explain the results and possible actions. These appointments will be followed by a patient letter, and a letter to the participants GP. Where possible standardised GP and patient template letters will be utilised to convey the results and actions of the nurse led LHC and CT scan as appropriate (NHSE templates are available).

6. Communication & Engagement

The provider will be responsible and accountable for the communication & engagement plan that will be developed and implemented in collaboration with the Strategic Commission. It is recognised that the success of this service is supported by a robust engagement strategy across all associated NHS providers, third sector, voluntary services and the local population.

Lung Health Check Communications Str

Draft Communication plan

Approach:
The key messages and benefits of the lung health check:

- One stop service (or Virtual LHC subject to COVID-19 restructions) – everything in one place and CT scan being available immediately
- Accessible and very convenient

The Provider will use patient experience statistics to promote or improve uptake of the service, to include:

- Care and treatment, waiting time, location and communications of the Lung Health Check (LHC)
- Communications prior to CT scan
- Facilities at the LHC
- Would you recommend the service to a friend or family member?

Co-designed well researched patient information will be developed (align with NHSE materials) to include:

- GP invite letter
- Lung Health Check and LDCT scan leaflets (supplemented with NHSE COVID-19 letter)
- Online resource portal for practices and patients to access information and resources about the services
- Information video about the lung health check process

6.1 Community engagement:

Co-ordinate community events to include:

- Community networks
- Leafleting and Macmillan bus
- Awareness sessions e.g. Breathe Easy groups
- Bookmakers, Vape/E-Cig shops
- Posters in community venues

6.2 GP Engagement:

GP practices play a pivotal role in communicating and engaging with patients. GP practice staff should proactively talk to their patients encouraging attendance and answering questions about the service.

- Briefing sessions/ staff encouragement
- Waiting room posters
- Messages on prescriptions
- Practice staff answering queries
- Training module to support practices prior to go-live

6.3 Media and advertising

The lung health check has already received a significant amount of local and national media attention. This provides a strong base of recognition from which to continue to promote the service.

- Local video
- Press release, Local radio and TV
- Social media
- Patient stories

7. NHS Patient Experience & Satisfaction Survey

The Provider will ensure that an appropriate Patient Satisfaction Survey is undertaken, asking a minimum of 20% of participants selected at random from each site location. The survey should be in line with Picker Institute Healthcare Commission standardised patient experience questionnaires. https://www.picker.org/wp-content/uploads/2014/10/Discussion-paper-...-hospital-outpatients.pdf

A robust complaints procedure must be in place so that participants understand the process. The provider will be expected to log complaints, respond swiftly and identify recurring issues that must be addressed. The provider must follow the procedure outlines in the NHS Constitution for England (2015). https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Patient feedback must be considered and appropriate improvements put in place where necessary.

The NHS Evaluation Team will requires access to patient identifiable information for a small number of participants / patients. They will be contacted directly and asked to give their opinion of the service. This process has yet to be agreed as data sharing agreements will need to be put in place.

8. Equality


LHC EIA 21.10.20


LHC Quality Impact Assessment Oct 202

Data Requirements

The service will be monitored on the collection of data as per the lung health check minimum dataset.

9. Finance

The national team has allocated funding 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 T&G CCG population of 55 to 74-year and 364 days.

Fixed funding:

- Each CCG has funding for core staffing and clinical leadership for the 4-year programme
- CCGs with populations over 55,000 have received additional funding for project and
- programme management posts
- Funding allocated will ensure the projects have the resources to deliver the clinical service

The financial model uses three nationally agreed averages:

1. 54% of the eligible population of 55 to 74-year olds and 364 days, smoke or have smoked
2. 50% of those who smoke or have smoked, will take up the offer of a lung health check
3. 56% of those who attend a lung health check are at risk and offered a low dose CT

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

Fixed funding:

The table below provides a breakdown of suggested roles based on NHSE assumptions:

Post	Band	WTE	Notes
Clinical posts	Medical consultant	1 wte	10 pa sessions/ week
Specialist lung health check nurse	Band 6	1 wte	
Practice nurse	Band 6	1 wte	Not required in yrs. 3 & 4
PACS support	Band 4	2 wte	
Administrator	Band 3	1 wte	
Project manager	Band 8a	1 wte	
Additional fixed funding for single CCGs with target population over 55,000			
Project manager	Band 8a	1 wte	Tameside & Glossop Doncaster Newcastle Gateshead
Programme manager	Band 8d	1 wte	Newcastle Gateshead

The finances associated with the programme is shown in schedule 3 of the contract. – to be inserted

10. Applicable Service Standards

10.1 Applicable national standards (e.g. NICE)

The Provider will deliver a lung health check to the adult population of T&G CCG in accordance with the requirements as set out in this specification, in accordance with the National Standard Protocol, current guidelines and legislation.

Good Practice Standards

The Provider will comply with:

- Good clinical industry practice which will include but is not limited to: standards for better health, relevant NICE guidance, for example guidance supporting interventions to help people stop smoking
- The baseline spirometry will be undertaken in accordance with the guidance from the Association for Respiratory Technology and Physiology

http://www.artp.org.uk/en/professional/artp-standards/index.cfm/Quality%20Assured%20Spirometry

Time Standards

The Provider will:

- Ensure that for all people arriving before or on time for their appointment the lung health check begins within 30 minutes of the scheduled appointment time.

- Provide details of the daily attendance at the lung health check service to the weekly (moving to monthly as service develops) T&G CCG contract meeting
- Provide outcome of the nurse led LHC +/- LD-CT within 14 calendar days to the participants GP; but aim to move to real time reporting in the future.

Information Management & Technology (IM&T) Requirements

The Provider will

- Enable referral information and reports to be received and delivered in electronic format, as outlined by the Commissioner.
- Comply with the Information Governance requirements of T&G CCG and the NHS for personal identifiable data.
- All new information assets and changes to service must be approved via the Change Control Advisory Board at T&G ICFT.

Clinical Safety and Medical Emergency Measures

The Provider will ensure that:

- They operate within a clinically safe environment ensuring safe practice and adequate levels of equipment to deal effectively with medical emergencies.
- All staff are appropriately trained and accredited including having a Life Support certificate which meets the standards set out by the Resuscitation Council (www.resus.org.uk)

Quality Requirements of Activity Outputs

The Provider will ensure the participant's GP receives the result of the lung health check to agreed or mandated timescales or in line with clinical appropriateness.

The Provider will communicate any unusual, unexpected, urgent, or clinically significant findings that may require immediate or urgent clinical decisions in accordance with the locally agreed protocol.

Contract Specification - Standards and Equipment

The Provider will ensure that equipment is provided and maintained to an adequate minimum level to fulfill the standards outlined within this specification.

The Provider will carry out daily quality assurance and quality control checks on equipment to ensure minimum standards of operations are maintained in line with legal, professional, industry and manufacturers specifications.

The Provider should use:

- A spirometer which meets the ISO standard 267823
- One-way mouthpieces and nose clips
- Bacterial and viral filters (as indicated in selected patients)
- Height measure and weighing scales – calibrated according to manufacturer's instructions.

Training and Education

The Provider will deliver education and training for all staff to attain competence and maintain those standards including the provision of professional registration requirements.

Quality Assurance

Undertake quality assurance of the Spirometry equipment in line with assured diagnostic spirometry (ARTP) guidance. This will include quality control checks at least weekly to ensure reliability and reproducibility of results.

Operating Manual

The Provider will have and adhere to an Operating Manual that contains effective policies and procedures covering service specific standards and any regulatory and legislative requirements.

11. Performance Monitoring

Key Performance Indicators from Business Case

In the process of being developed in line with the Standard Protocol. To be updated

Draft KPI's.docx

12. Location of Provider Premises

The Provider's premises are to be located at agreed community locations. The service will be delivered from suitable mobile units. The locations for service delivery will be convenient for the GP practice's patients to attend and must also be able to accommodate the size and other requirements of the mobile units, and the participants attending the service (COVID-19 safe setting while under current restrictions). Car parking facilities must be available for participants.

Please refer to the Indicative Activity Plan at Schedule 2B for the breakdown of activity (outline draft plan below). The time scales are still in the process of being agreed.

Updated service modelling to be inserted here when agreed. Dates below to be amended when agreed.

Dates	Activity
February 2021 to March 2022	LHC and Initial CT scans performed
May 2021 to February 2022	3 month repeat scan booked (if intermediary results)
February 2022 to July 2023	12 month follow-up scan (if had 3 month repeat scan)
October 2022 to March 2024	24 month follow-up scan (if first round of scans clear)

Appendix A

T&G TLHC trajectories Oct 20 (

MFT Modelling to be replaced with revised baseline data

T&G Estimates _for LR_NHSE.xlsx

Additional Findings.pdf

Appendix 2 - Smoking Prevalence

Appendix 3 - Diagnostic Impact (v

Appendix B Minimum Standards

targeted-scree