Welcome to the 9th NHS Oncology Conference!

07th October 2025
Leonardo Hotel, Milton Keynes, Midsummer Boulevard Milton Keynes, MK9 2HP

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Chair Opening Address

Mr Chris Sleight MSc BSc FIBMS
Ex Diagnostics Leader within the NHS

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Keynote Presentation

Alastair Greystoke
Professor of Precision Oncology
Newcastle University, Newcastle upon Tyne Hospitals NHS Trust

Embedding Liquid Biopsy in Clinical Practice: lessons learnt from the NHSE Lung Cancer Pilot

Alastair Greystoke
Professor of Precision Oncology
Honorary Consultant in Medical Oncology

Email; alastair.greystoke@newcastle.ac.uk

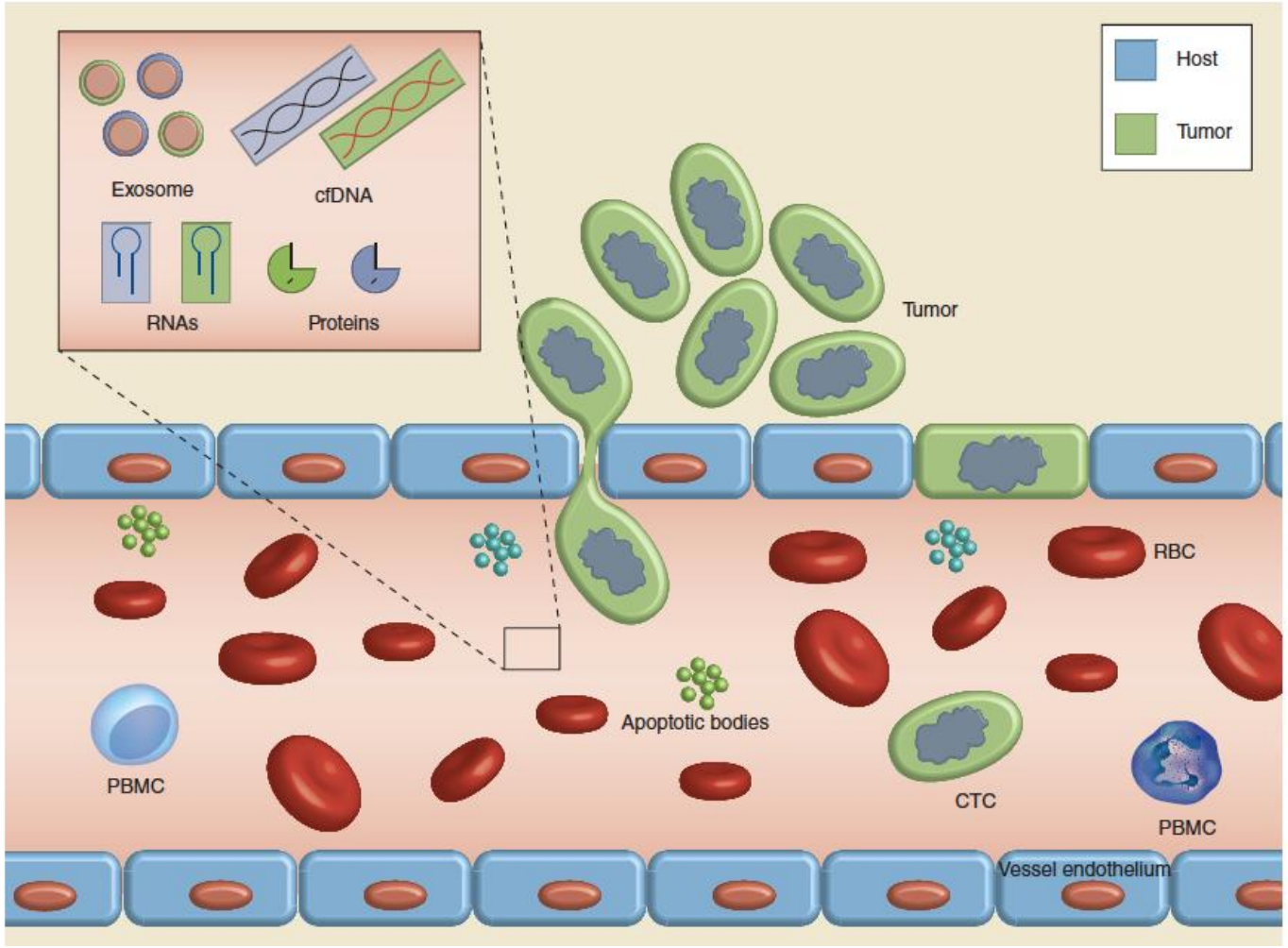
@AlastairGreyst2

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

NHS
North East and Yorkshire
Genomic Medicine Service

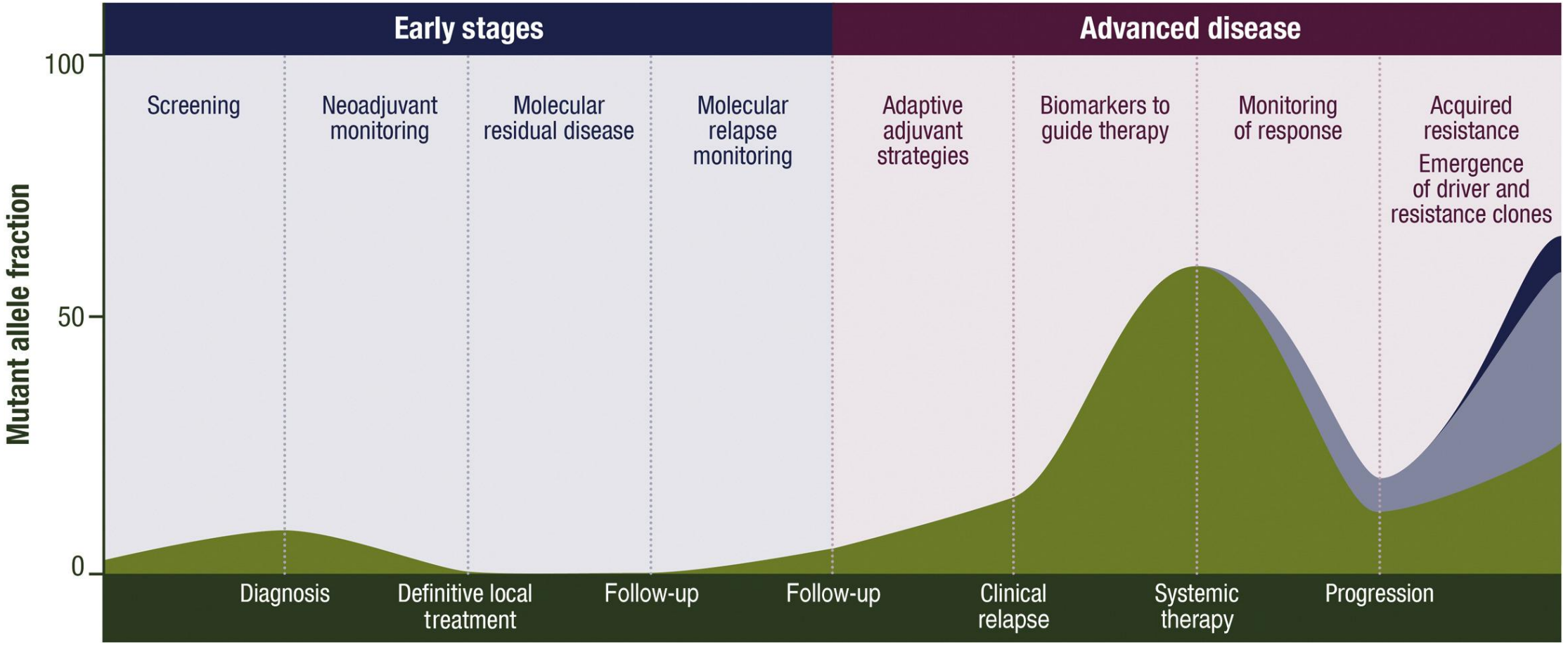
Newcastle University Centre for Cancer

What is cfDNA/ ctDNA



D'Arcangelo and Greystoke Biomarkers in Medicine 2015 ;9(10):1011-23.

Potential roles for ctDNA

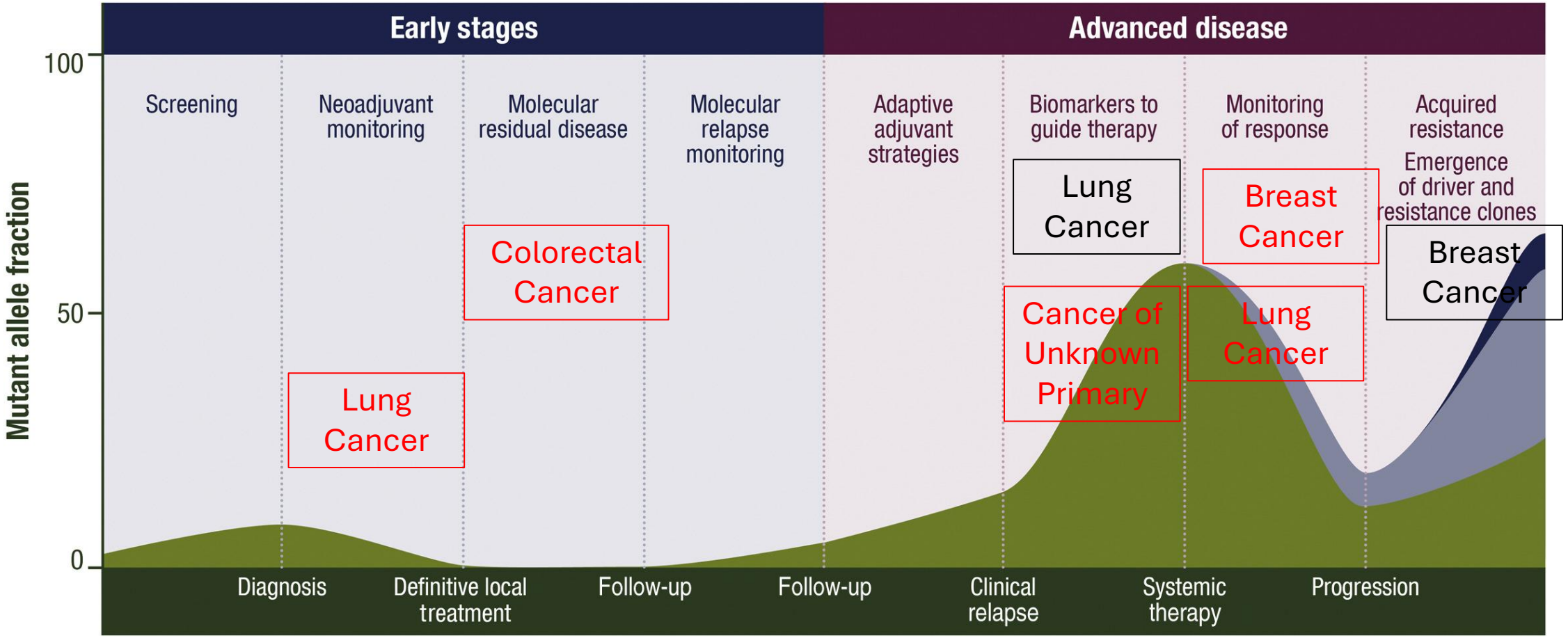


Adapted from Pascual et al. 2022.

ctDNA, circulating tumour DNA.

Pascual J et al. *Ann Oncol* 2022;33:750–768.

Potential roles for ctDNA

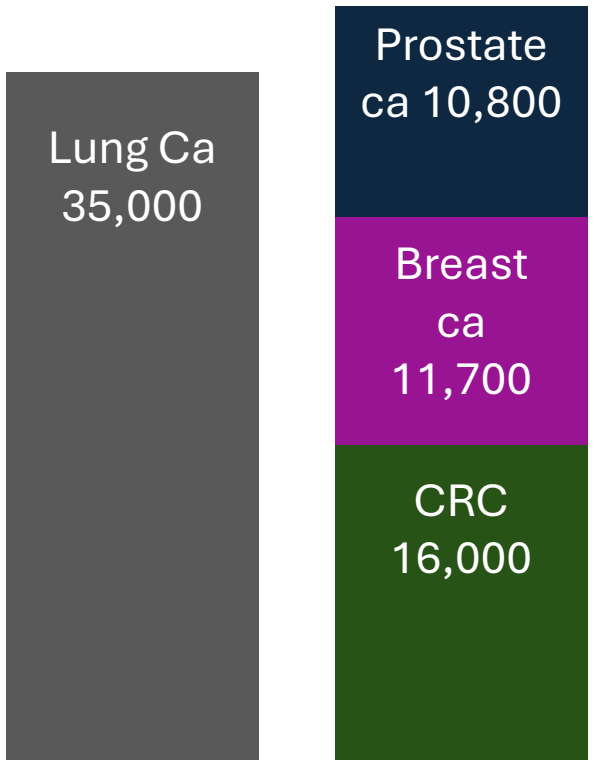


Adapted from Pascual et al. 2022.

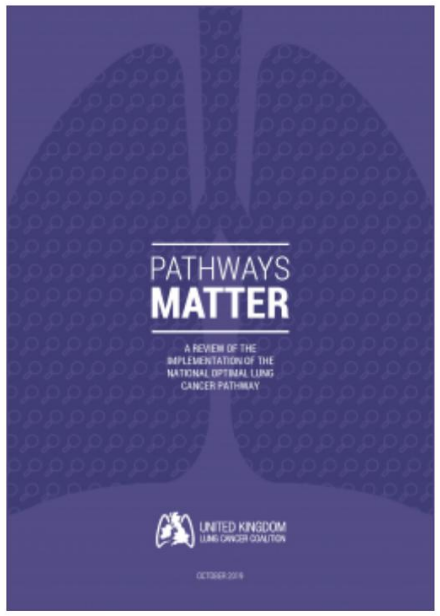
ctDNA, circulating tumour DNA.

Pascual J et al. *Ann Oncol* 2022;33:750–768.

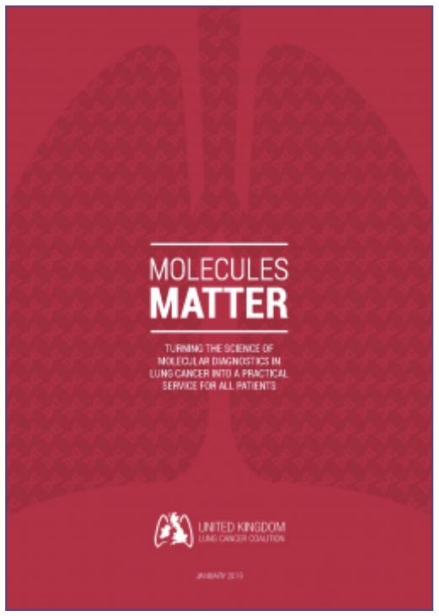
Lung cancer; an unmet medical need



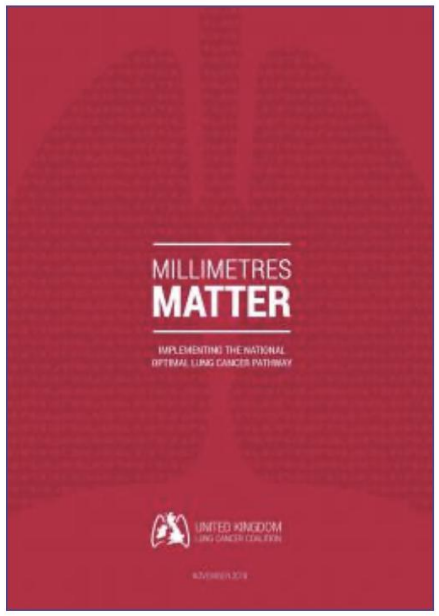
Deaths in the UK per year



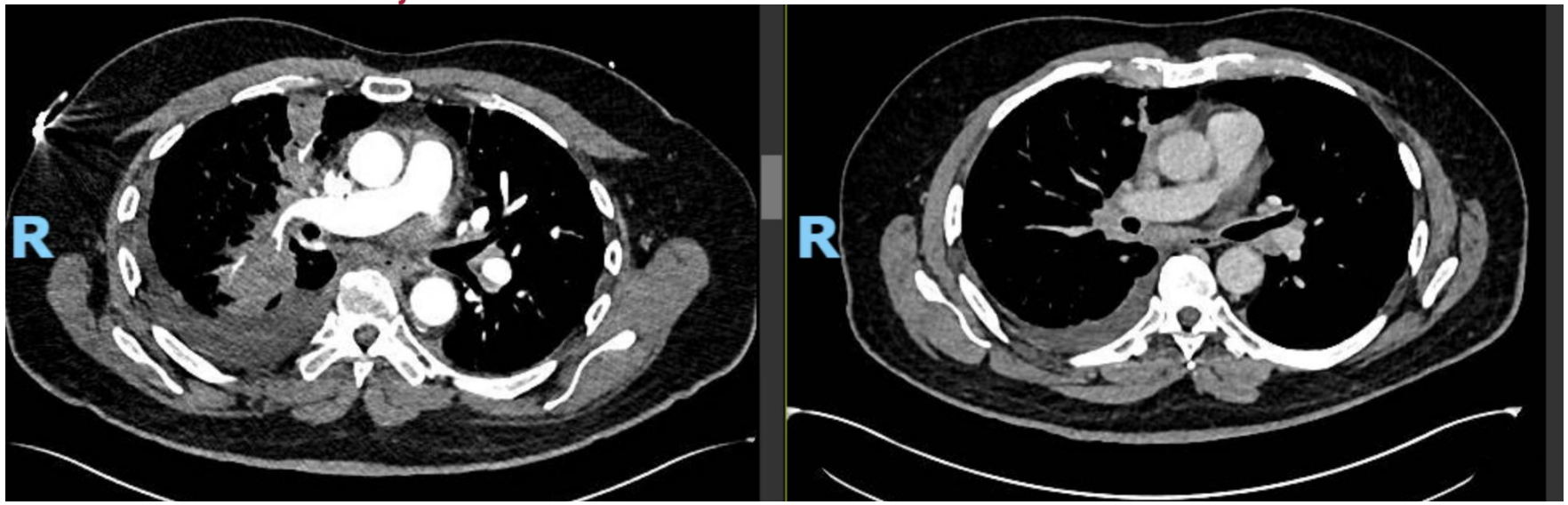
Pathways Matter



Molecules Matter



Millimetres Matter



Cancer Research UK, http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type, accessed 12/11/15

Patients with advanced cancer who may benefit from liquid biopsy

Patients in whom traditional biopsy is inaccessible or impractical

- Anatomically inaccessible/unacceptable risk[1,2]
- Settings where tissue biopsy results may be delayed[1]

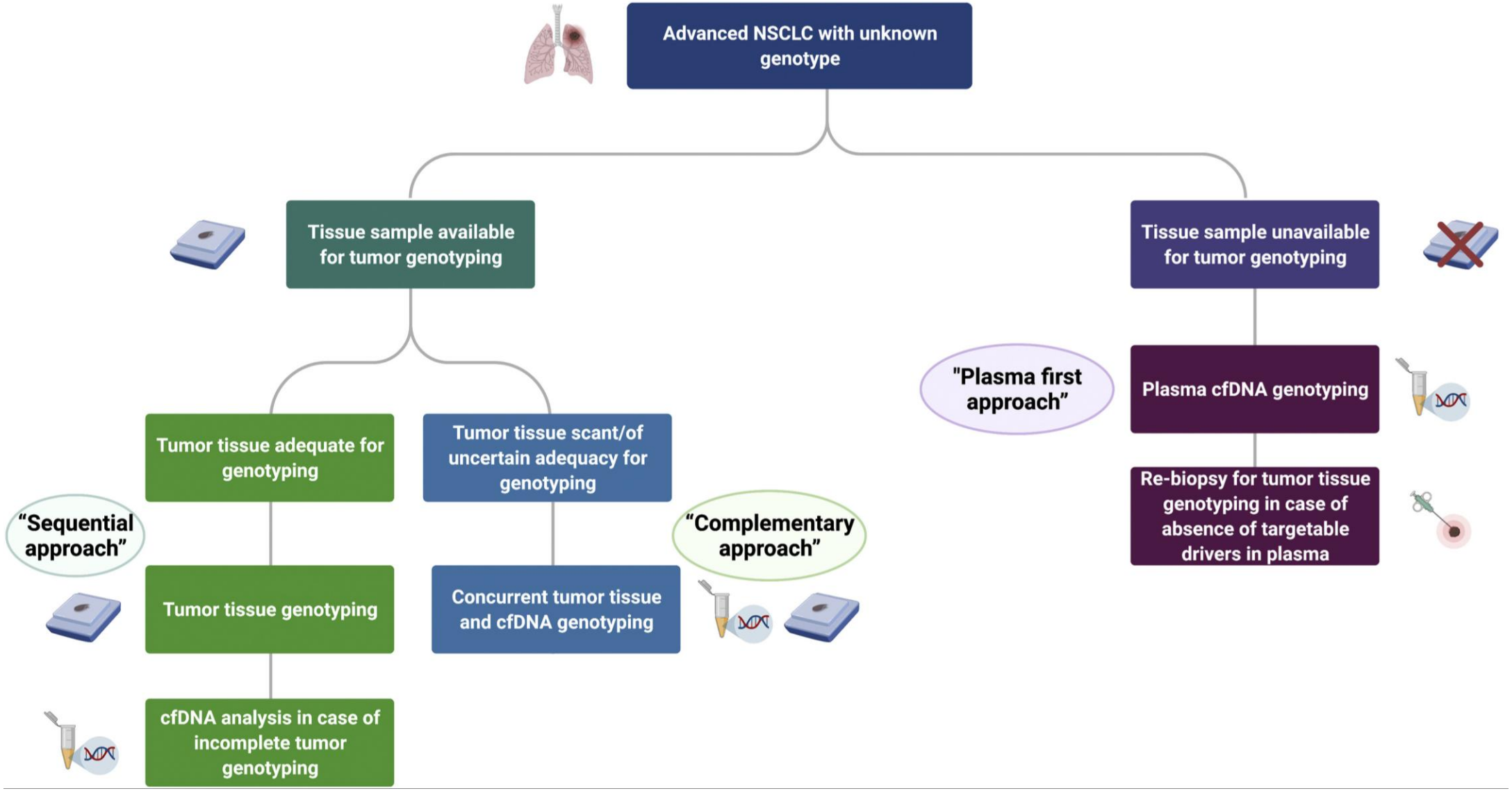
Patients in whom traditional biopsy is insufficient

- Tissue exhausted by other pathology analyses[1]
- Sample inadequate for successful molecular testing (few tumour cells or inflamed, fibrotic and necrotic tissue)[3,4]

Patients who have disease progression or relapse on targeted therapies

- Detection of suspected resistance mutations[1,2]
- Consider new therapy options including clinical trials[1]

1. Rolfo C et al. *J Thorac Oncol* 2018;13:1248–1268; 2. Francis G and Stein S. *Int J Mol Sci* 2015;16:14122–14142; 3. Stevenson M et al. *Cancer Invest* 2014;32:291–298; 4. Al-Kateb H et al. *Mol Oncol* 2015;9:1737–1743.



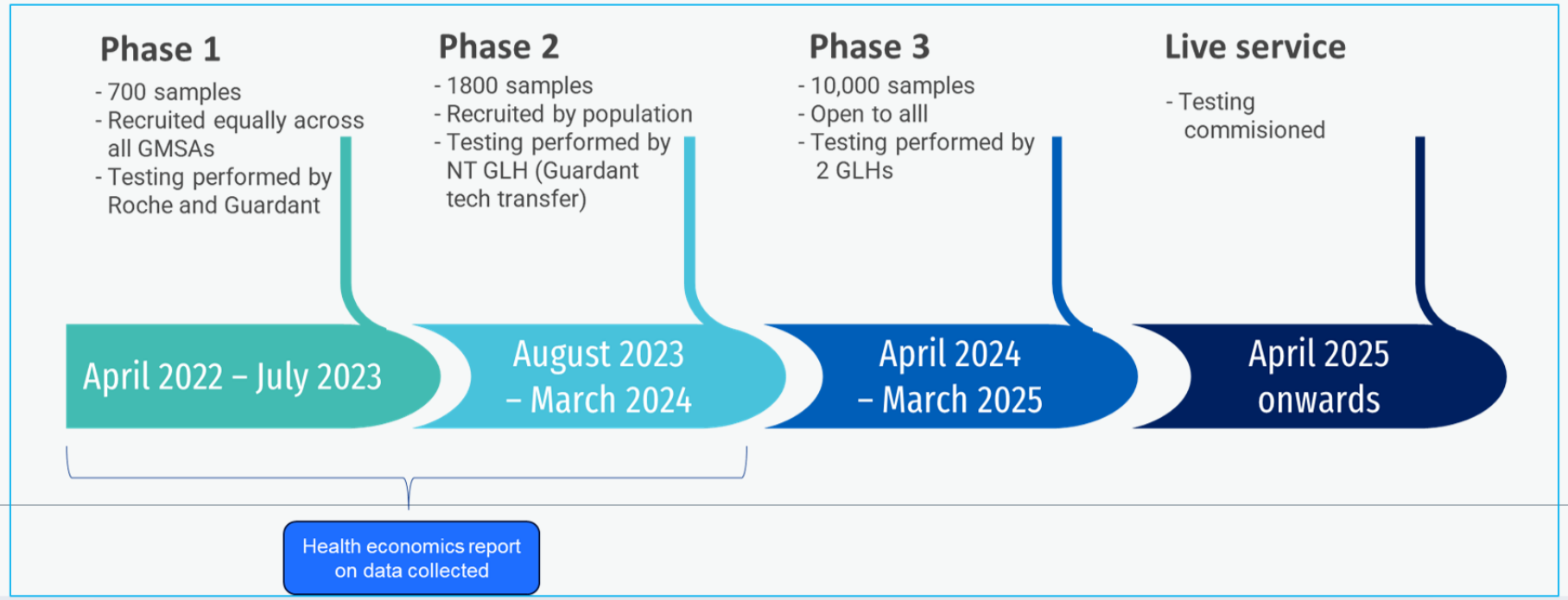
Adapted from Rolfo et al. 2021.

NHSE GMSA transformation ctDNA pilot

Aims to provide evidence:

- For the expansion of ctDNA testing in the NHS to support tumour genotyping from blood
- To allow rapid personalized drug treatment selection and speed up time to treatment for patients with advanced lung cancer
- To support the COVID19 recovery programme
- Through health economics

Patients with CT imaging consistent with suspected advanced (stage 3/4) NSCLC, prior to biopsy



The pilot study in numbers

Phase 1

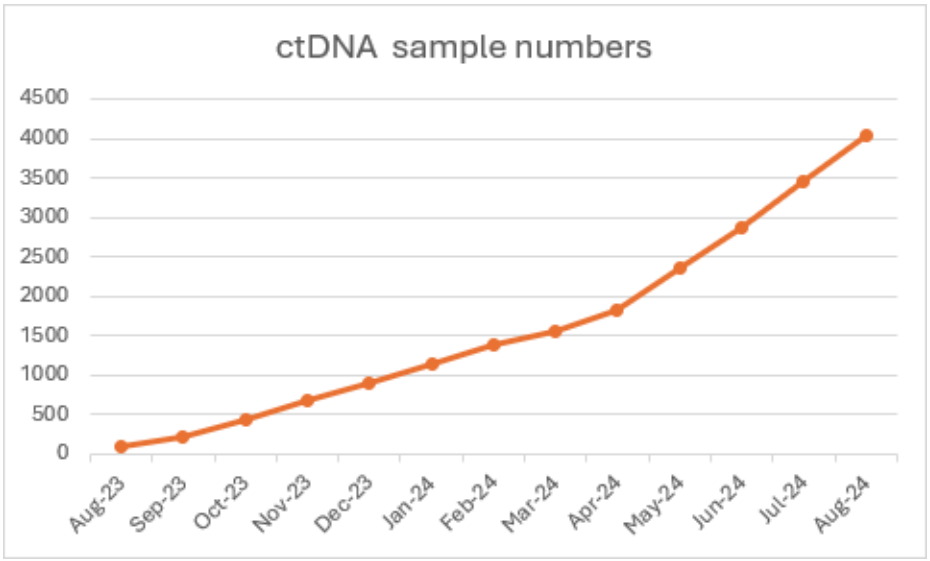
36 Trusts

Phase 3

117 Trusts

Phase 2

81 Trusts



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Change to Funding Criteria

2. I confirm that the patient has histological or cytological evidence of NSCLC that carries a sensitising EGFR mutation based on a validated test **OR** there is documented agreement by the lung MDT that the radiological appearances are in keeping with locally advanced or metastatic NSCLC **AND** there is an informative circulating free DNA test result confirming the presence of a sensitising EGFR mutation. Please mark below on which basis the diagnosis of EGFR mutation positive NSCLC has been made in this patient: ◯ Histological or cytological evidence. ◯ Documented agreement by the lung MDT that the radiological appearances are in keeping with locally advanced or metastatic NSCLC and there is an informative circulating free DNA test result confirming the presence of a sensitising EGFR mutation * Required	◯ Yes ◯ No * Required

NHSE GMSA transformation ctDNA pilot

Integrating ctDNA NGS with the NHS through technology transfer – Phase 3

North Thames GLH Implemented in August 2023

The ROYAL MARSDEN NHS Foundation Trust | GUARDANT

- A high throughput liquid biopsy testing facility established at the Royal Marsden now offering ctDNA NGS testing across England in the second larger phase of the pilot covering 1800 samples.
- Bringing together Guardant Health's innovation with the expertise, know how and service delivery of the NHS Genomic Medicine Service.
- Quality: state-of-the-art technology platform and infrastructure supporting the delivery of a uniform, high standard of care across all hospital settings in England.
  - Marsden360 launched in August 2023, with multiple NHS hospitals already sending aNSCLC patient samples.

Marsden360
Developed in partnership with Guardant Health

North West GLH Implemented in August 2024

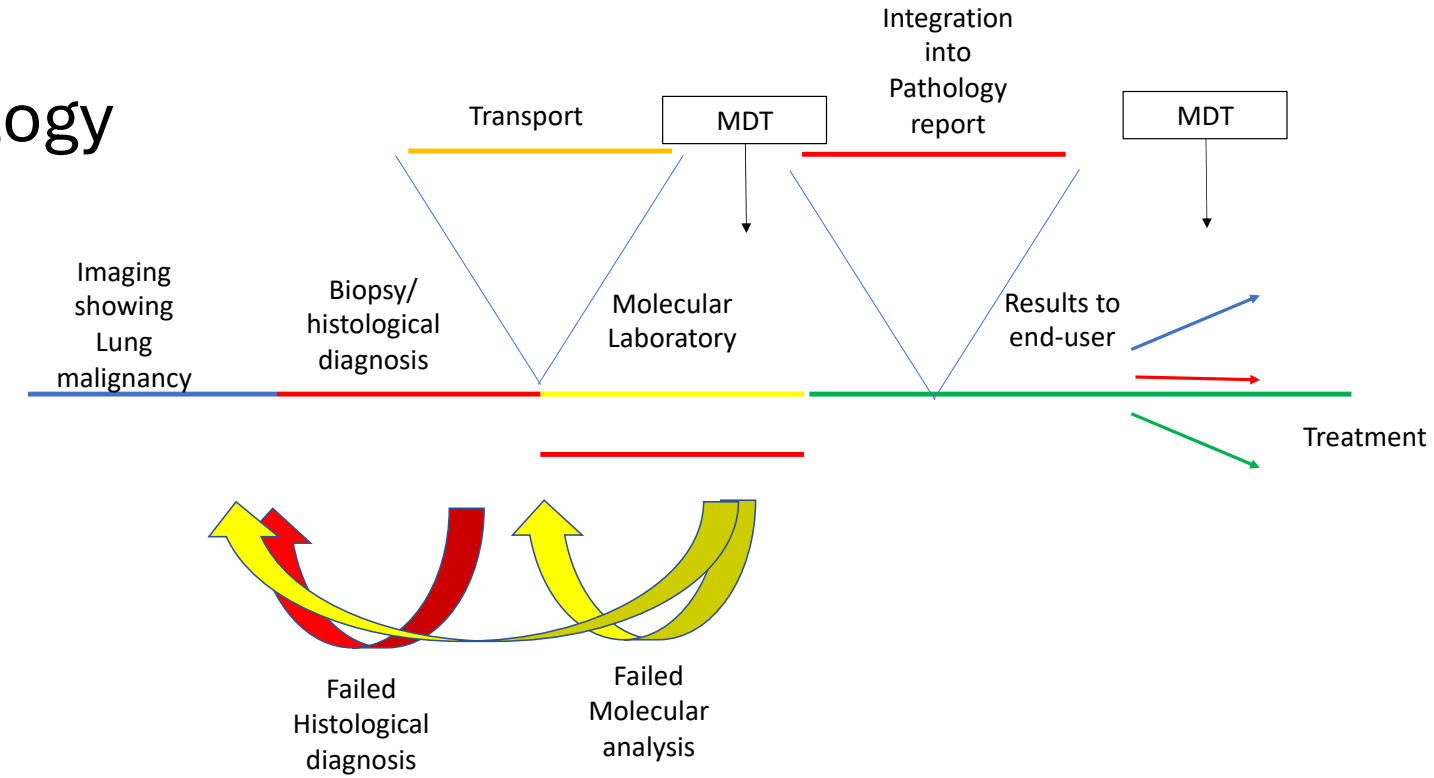
FOUNDATION MEDICINE® | Roche

In partnership with Roche and their subsidiary Foundation Medicine Inc, the North West Genomic Laboratory Hub is providing the FoundationOne®Liquid CDx liquid biopsy test which provides comprehensive solid tumour profiling in advanced cancers, allowing clinicians to personalise treatments more accurately.

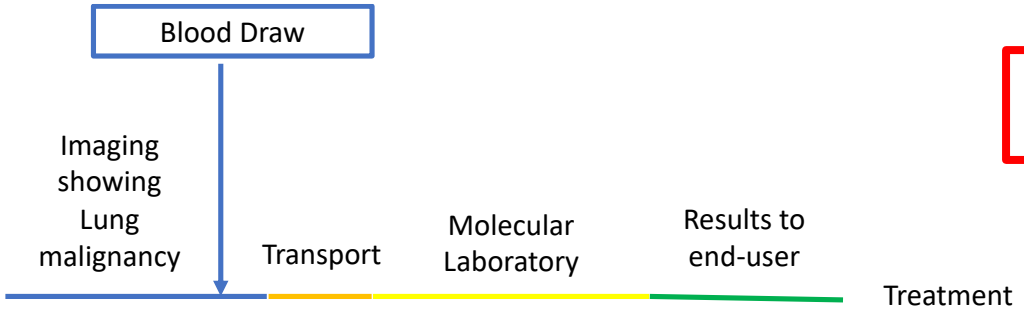
In August 2024 the North West Genomic Laboratory Hub in partnership with Roche and their subsidiary Foundation Medicine Inc, launched a service utilizing this technology for patients with suspected lung cancer to identify treatment option early in the patient pathway.

Impact on turn around times

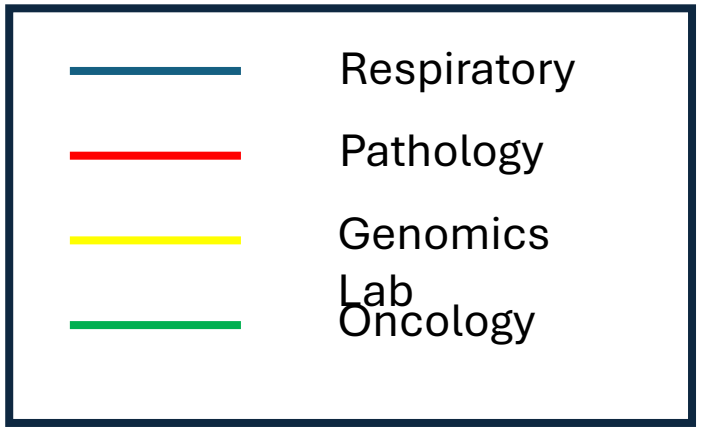
Histology



CfDNA

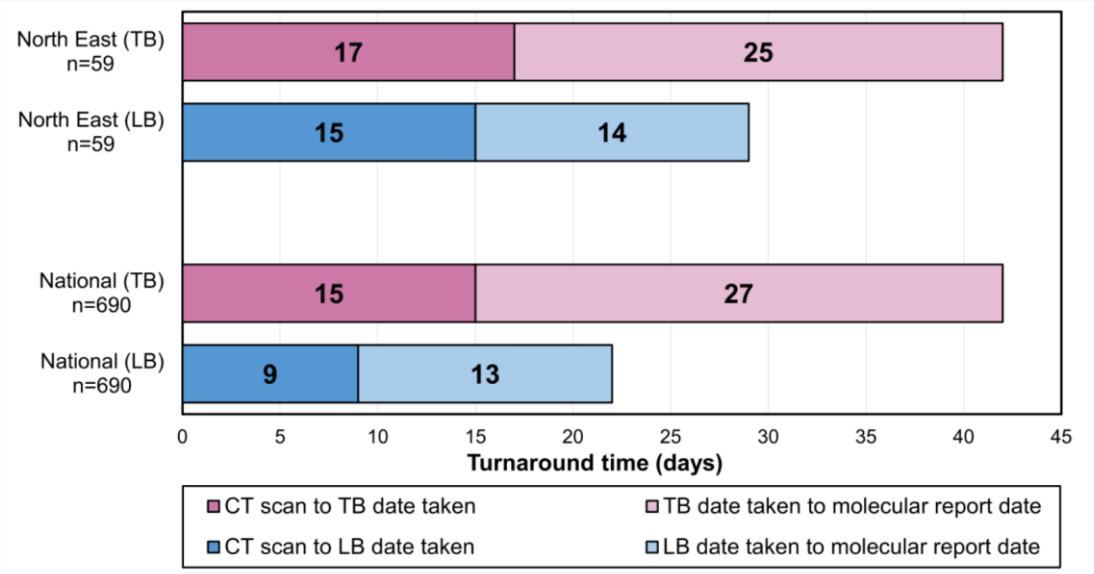


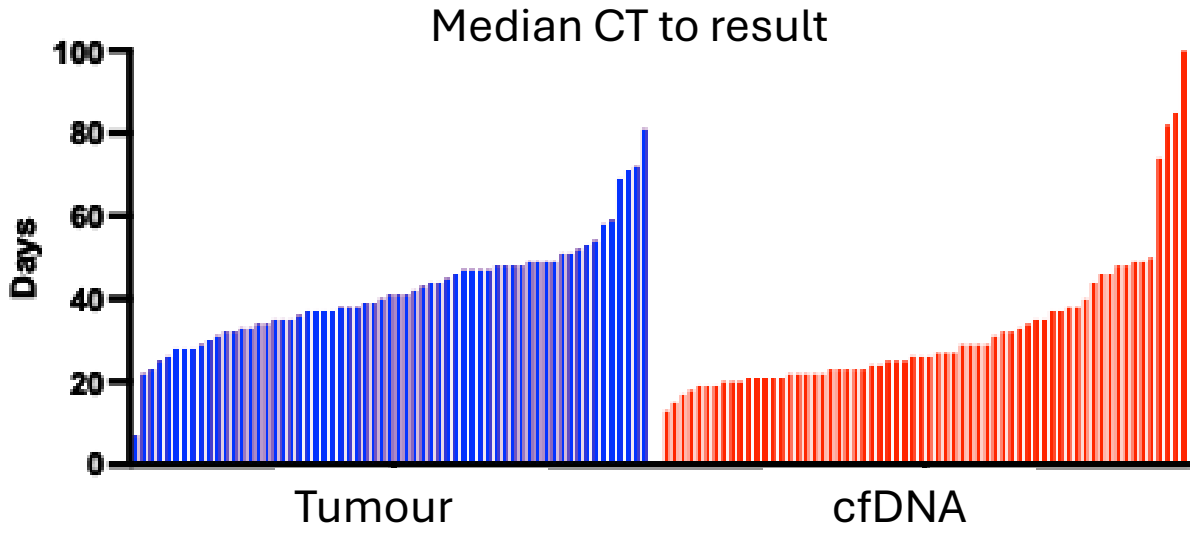
Integrate with Pathology?

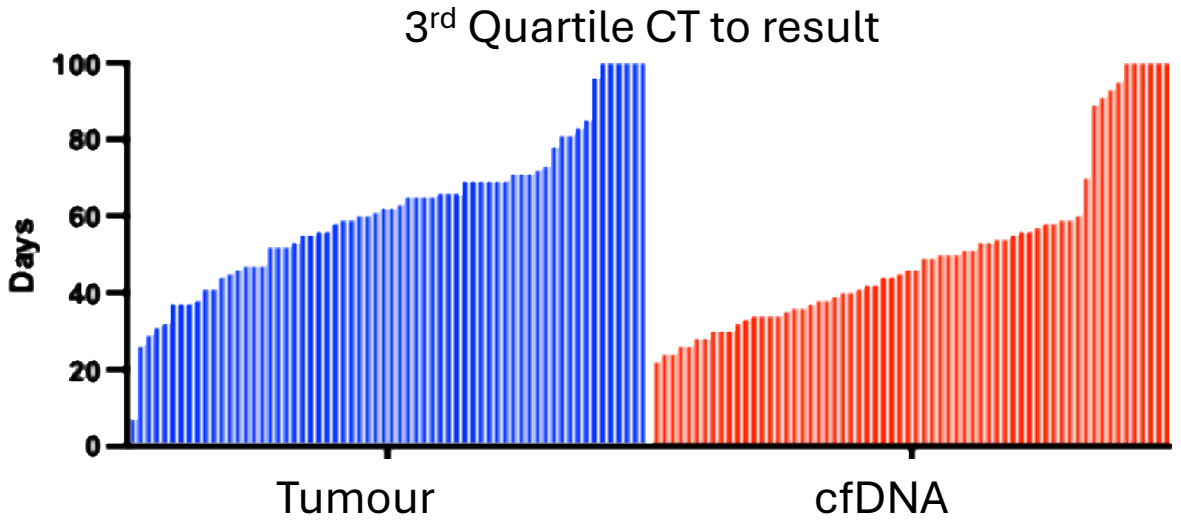


Impact on turn around times

Global reduction in time to results
Reduces “long waiters” in particular
Reduces inequity in TAT between trusts



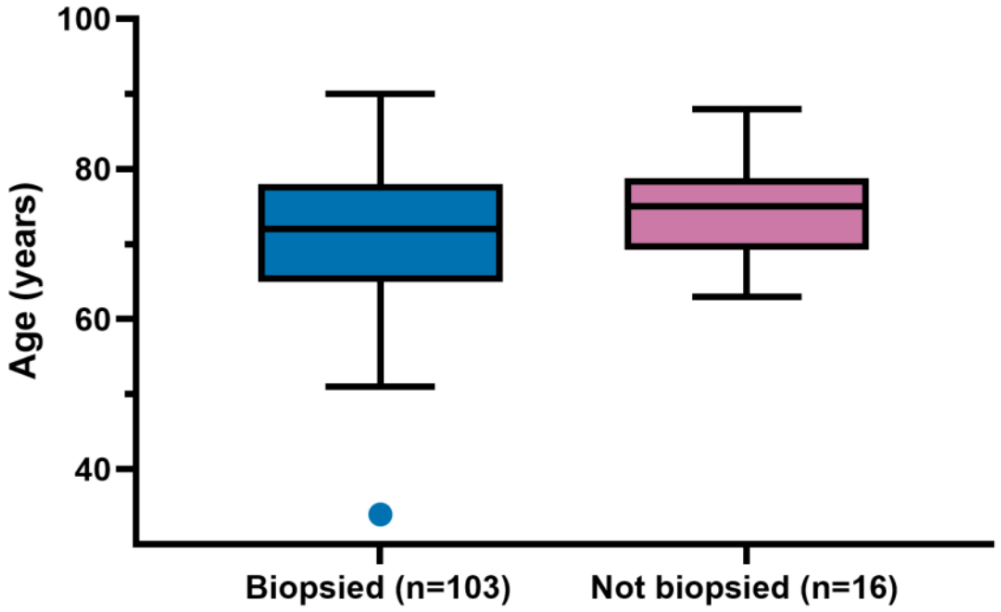


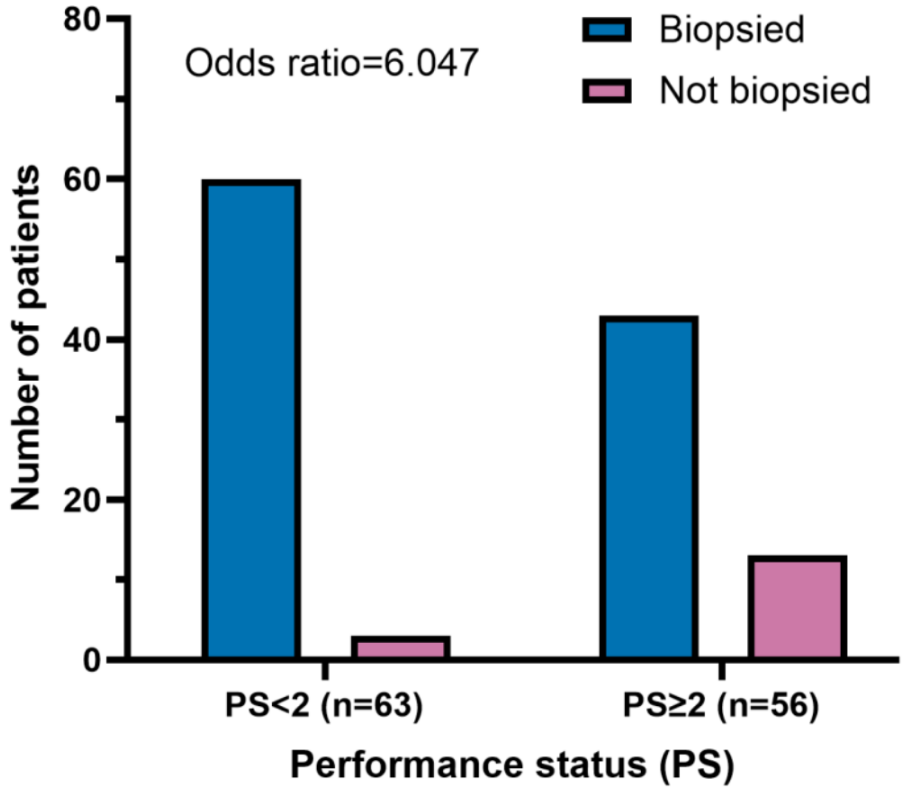


NHS England

NHS North East and Yorkshire Genomic Medicine Service

Reducing inequality





NHS England

NHS North East and Yorkshire
Genomic Medicine Service

Health economics

Net savings to NHS and patient care over 1 year

£ million

Implementation of service

Cost

Benefits

- Impact on patient quality of life
- Reduction in inappropriate treatments and the downstream management of their associated toxicity
- Reduced healthcare time per patient due to shorter diagnostic pathway
- Avoiding repeated biopsies and complications
- Reduction in tumour testing

Extra benefits

- Patients have better access to emerging therapies and clinical trials
- Identification of germline findings (~2% of patients)
- Increased genomic literacy in new staff groups (e.g. respiratory nurses)
- Confidence in difficult calls in tumour analysis

The Liquid Experience:

From Research to Reality

What have we learnt from the lung liquid biopsy pilots in England and Wales?

Stakeholder group chaired by Professor Alastair Greystoke, Professor of Precision Oncology, Newcastle

FOREWORD BY PROFESSOR SANJAY POPAT

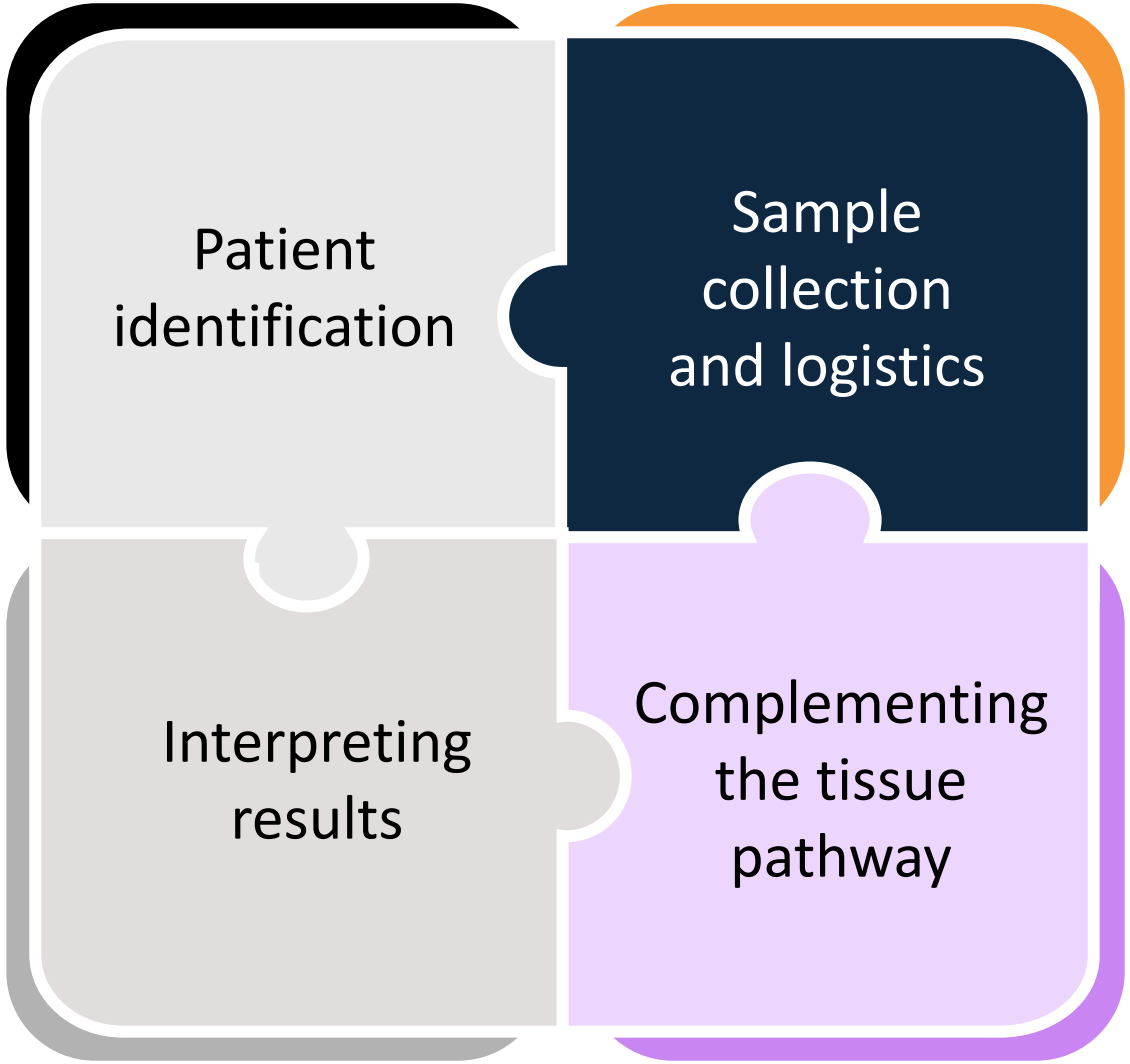
A Health Economics Evaluation of ctDNA testing in NSCLC

31/03/2024

Edge Health

Practical considerations for implementing liquid biopsy

The Liquid Experience report focuses on learnings in four key areas:



Patient and public involvement

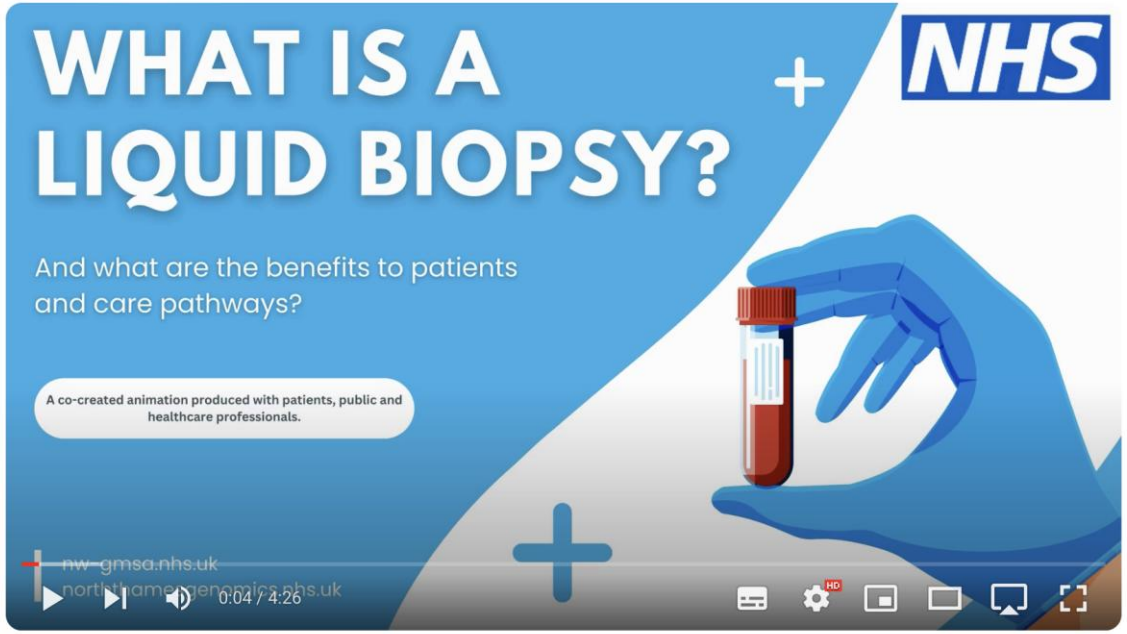
Early Involvement: -

- Input was sought early on from
  a) Lung cancer groups: Ruth Strauss Foundation, ODLC Patient Alliance, Roy Castle Foundation
  b) NHS GMS National People and Communities Forum
- A patient with lived lung cancer experienced participated on the moderation panel for the procurement process with input in designing the specification for the commissioning of the health economic organisation

On-Going Involvement: -

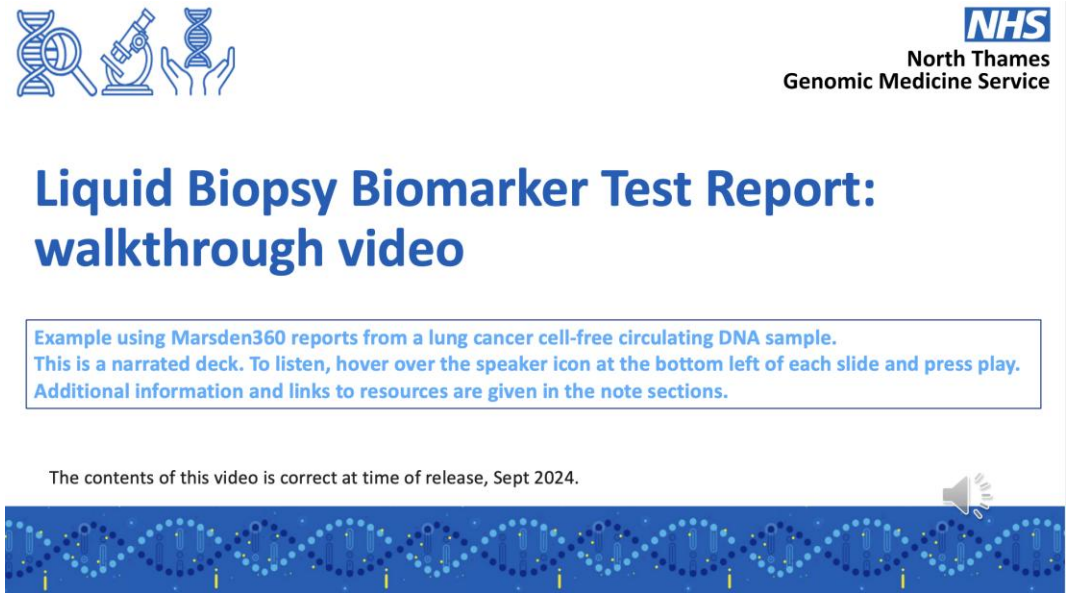
- Review of new patient materials related to ctDNA lung
- Input and co-creation of patient education video explaining liquid biopsy launched in October
- Patient experience blogs from patients who have experience the pilot

Education



ctDNA project explained

Unlisted



Series 5 Episode 3 - Liquid Biopsy Testing Genomics Pilot: A Partnership between the…

5 days ago

Welcome to Genomics Now, a podcast series where you can learn how genomics is developing in England's NHS. This podcast series is recorded in 2024 and is part of the North Thames Genomic Medicine Service's educational toolkit.…

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Series 5 Episode 2 - Transforming Cancer Diagnostics with Liquid Biopsies: Insights fr…

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Series 5 Episode 1 - Revolutionising Lung Cancer Diagnostics: The Promise of Liquid …

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Patient impact

Blood test reveals best lung cancer treatment

22 March

The change to Kat's treatment meant she could spend more time at home with her daughter Paige

By Fergus Walsh
Medical editor

"Those early weeks are a complete blur, my life changed so quickly, and I had to take on so much information. I went from going to the gym multiple times a week to having to wrap my head around the fact that doctors were talking about treatments to try and prolong my life" – Kat

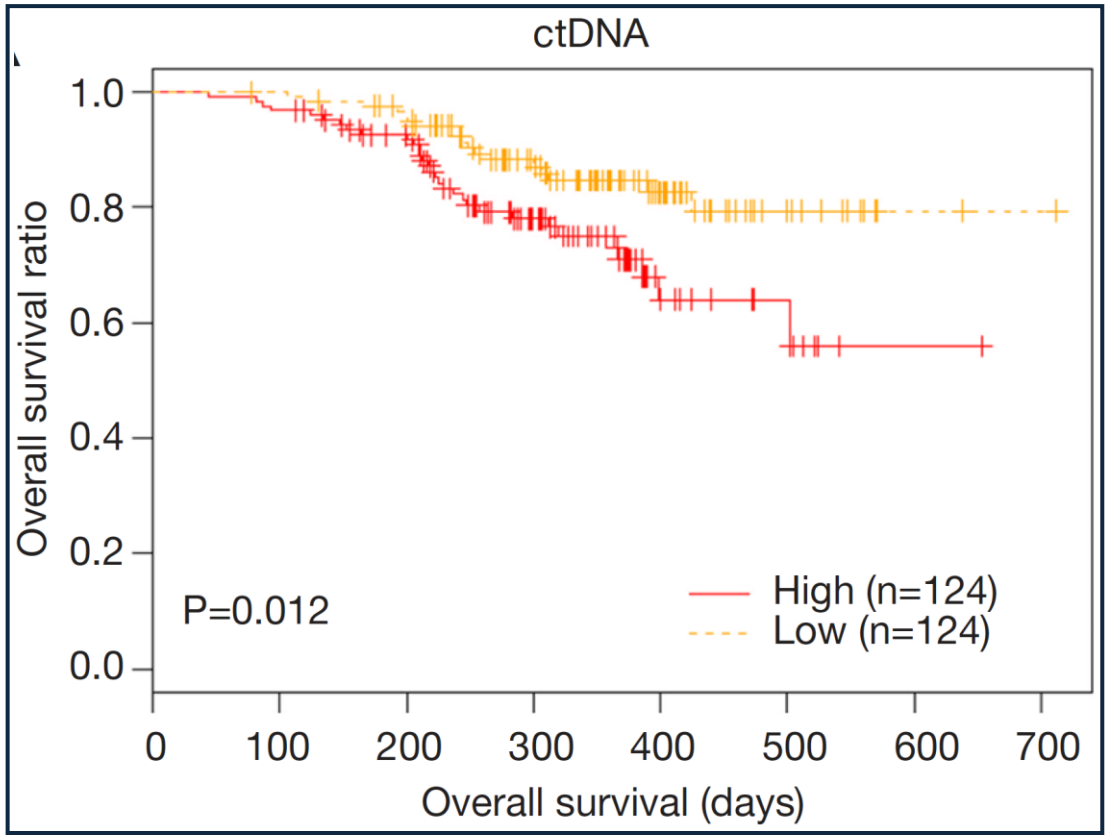
The ctDNA testing meant that within a week, her oncology team were also able to confirm that Kat had two rare mutations, ALK fusion and TP53, that were driving her cancer.

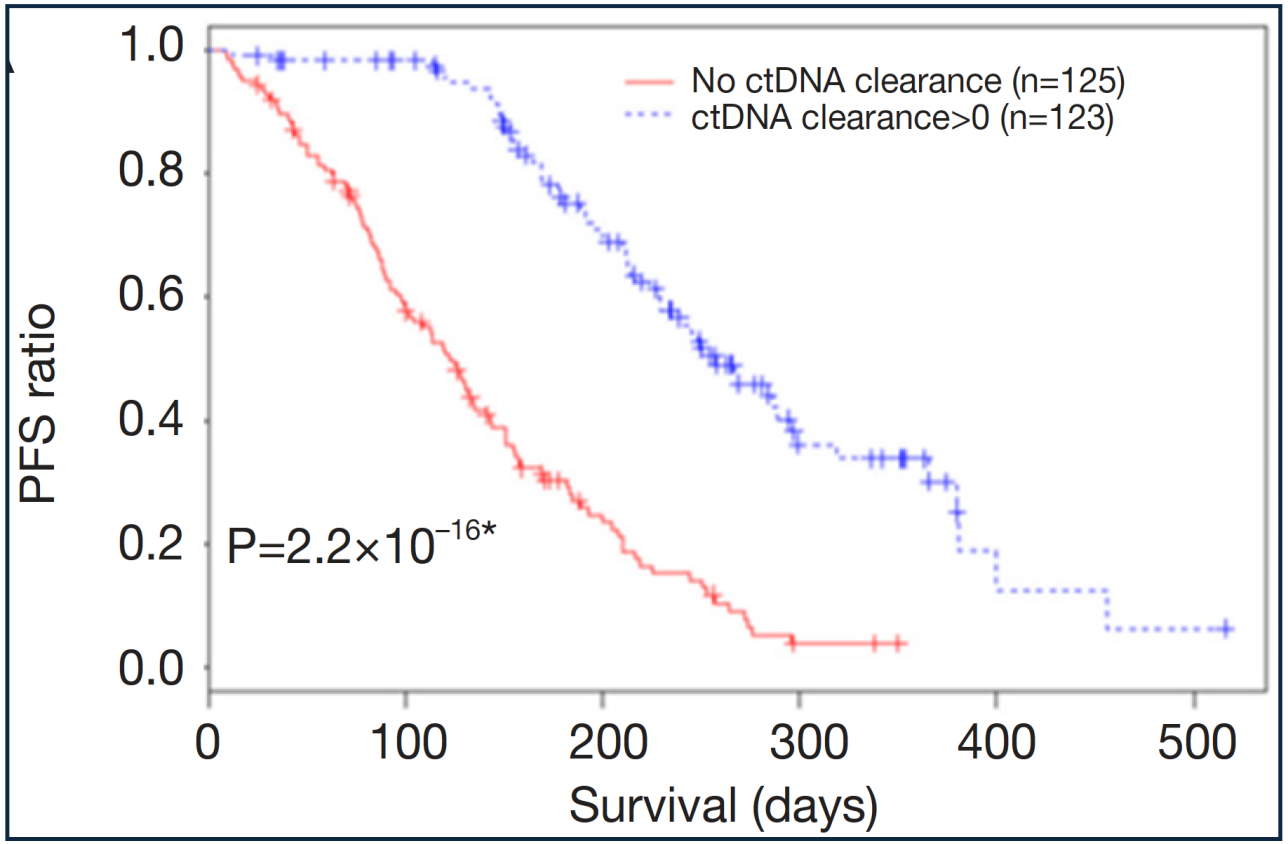
"When I first heard my diagnosis, I spent a lot of time trying to understand if I did it to myself. Having the ctDNA test results back gave me a sense of relief that there was no one to blame, I couldn't be angry about it." – Kat

The results didn't just give Kat some peace of mind, they also meant that her clinical team were able to immediately ensure that she had access to treatments that specifically target the changes in the genome that drive her cancer.

Blood test reveals best lung cancer treatment - BBC News

Future Use Case ctDNA to monitor response

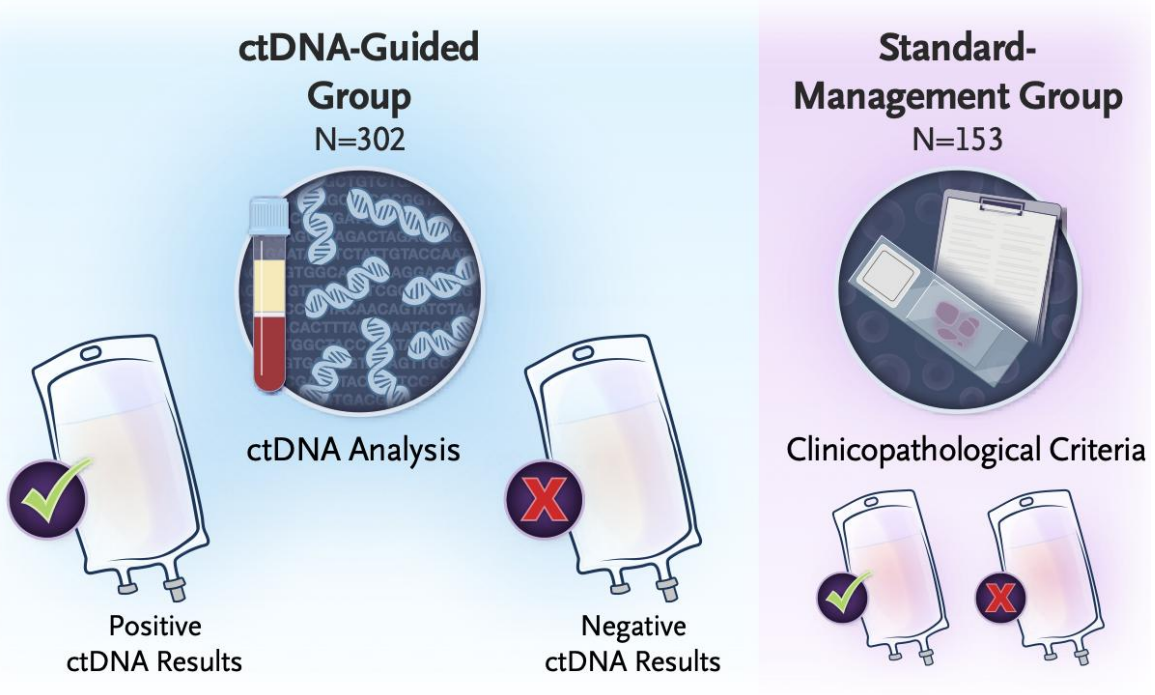


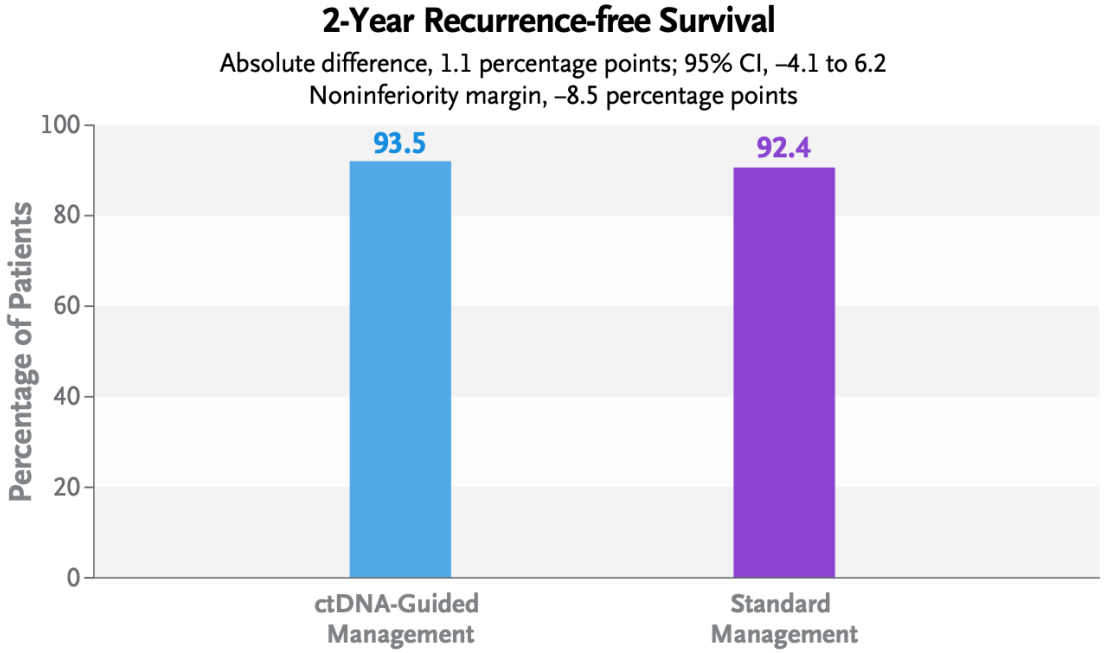


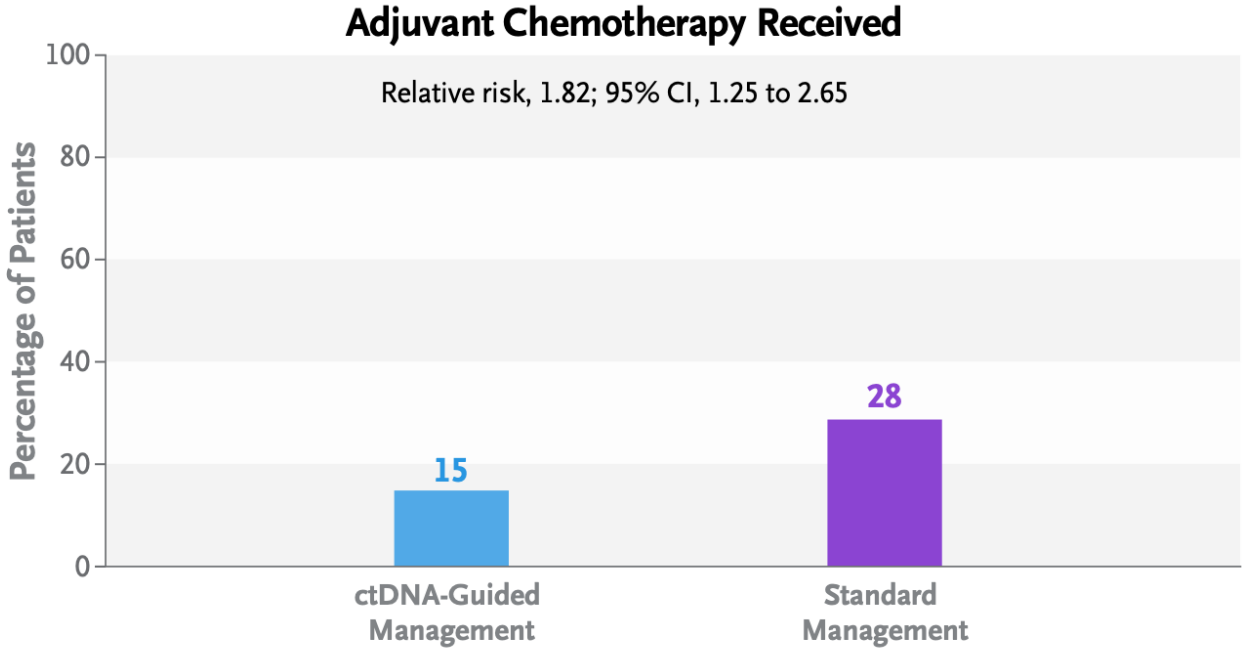
- *Denotes p-value derived from cox regression model.
- ctDNA, circulating tumour DNA; NSCLC, non-small cell lung cancer; PFS, progression-free survival.

- Song Y, et al. *Transl Lung Cancer Res*. 2020;9(2):269–279.

Future Use Case Post-operative cfDNA to guide decisions in stage 2 colorectal cancer

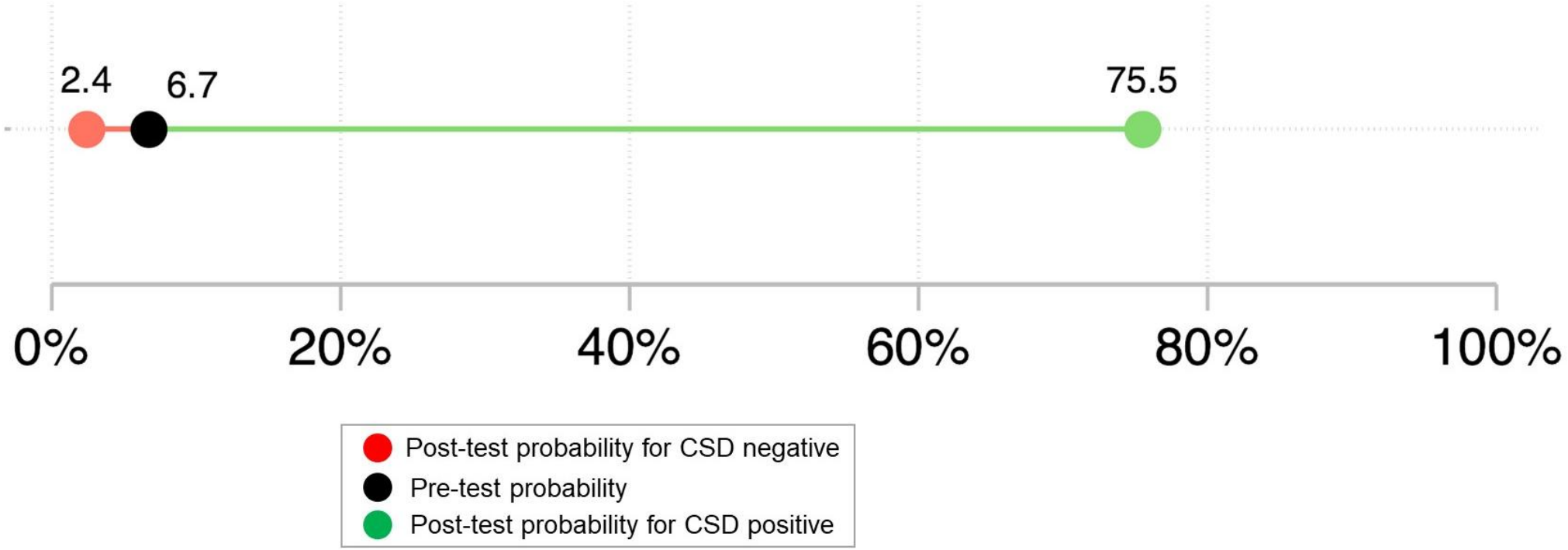






Tie et al N Engl J Med 2022; 386:2261-2272

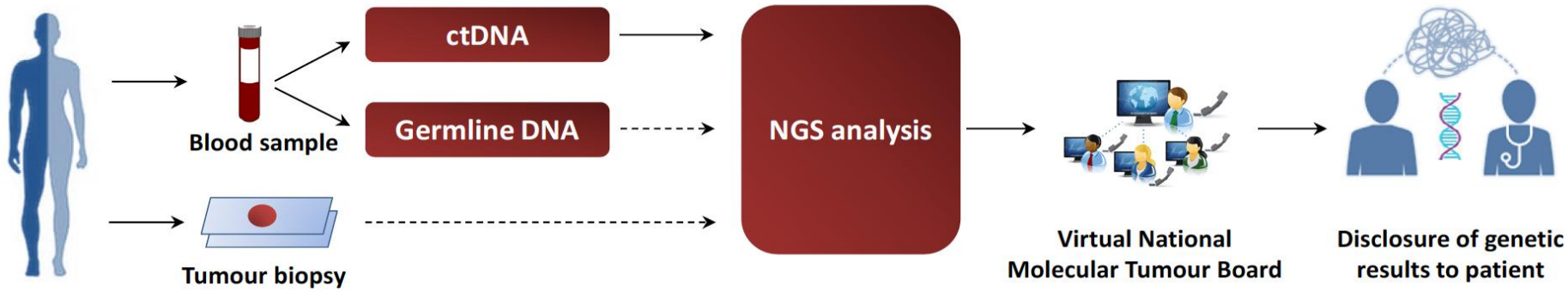
Future Use Case Methylated cfDNA to help in Diagnosis of Cancer in People with symptoms



CSD, cancer signal detected; MCED, multi-cancer early detection test.

cfDNA for Trial Entry?

TARGET NATIONAL



The Christie NHS Foundation Trust

LIVERPOOL CLINICAL TRIALS CENTRE LCTC

ecmc

CANCER RESEARCH UK

MANCHESTER 1824 The University of Manchester

The Christie Charitable Fund

The Sir Bobby Robson Foundation

NIHR | National Institute for Health Research

Summary

- ctDNA a useful new tool in managing patients with cancer
- NHSE Lung Cancer pilot set the structure
  - Delivery of testing
  - Evaluation of cost effectiveness
- Future use cases
  - Other tumour types
  - Monitoring of response
  - Minimal residual disease
  - Mukti Cancer Detection Tests

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Panel Discussion

Oliver Gregory
Programme Lead
NCL Cancer Alliance

Mrs Sue Harrold
Cancer Nurse Consultant
Sciensus Pharma Ltd

Dr Owen Carter
National Clinical Advisor at Macmillan Cancer Support, GPwSI Oncology

Mr John-Paul Crofton Biwer
Founder
Edge of Possible Consultancy

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Dr Sacha Howell FRCP PhD

Senior Lecturer and Honorary Consultant in Medical Oncology

Division of Cancer Sciences, Faculty of Biology, Medicine and Health

The University of Manchester, Oglesby Cancer Research Centre

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Manchester Breast Centre
From Molecular Science to the Clinic

Risk prediction and prevention of Breast Cancer in Pre-Menopausal Women

Dr Sacha Howell

Clinical Senior Lecturer in Medical Oncology

Director Manchester Breast Centre

CANCER RESEARCH UK

ACED
INTERNATIONAL ALLIANCE FOR CANCER EARLY DETECTION

NHS
Greater Manchester
Cancer Alliance

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- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.

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Chair Morning Reflection

Mr Chris Sleight MSc BSc FIBMS
Ex Diagnostics Leader within the NHS

Case Study

BIOCARTIS

Case Study

Professor Matthew Evison
Consultant in Respiratory Medicine
Manchester University NHS Foundation Trust

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Case Study

C the Signs

Case Study

Luke Wyatt
Director of Partnerships
C the Signs

Dr. John Woolley
GP and Clinical Lead
C the Signs

C the Signs

Optimising A Patients Cancer Journey – Better Detection, Faster Flow

Convenzis – Oncology, 7th October 2025

NHS
North East London PCNs

NHS
Norfolk and Waveney
Integrated Care Board

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Liverpool South PCNs

NHS
Bury PCNs

NHS
Dorset

NHS
Staffordshire PCNs

NHS
Somerset
Integrated Care Board

NHS
Somerset
NHS Foundation Trust

Health Innovation
Yorkshire & Humber

Bradford District and Craven
Health and Care Partnership

ACTasONE

C the Signs

Introduction

Cancer in Numbers: Why Interception Matters

Dr John Woolley

Clinical Lead

Luke Wyatt

Director of Partnerships

The Weight Of A Missed Opportunity

For the patient who stays with you

Every clinician has that **one patient** — the one they carry with them, wondering if something more could have been done.

STATISTICS

5-year survival

Early diagnosis

Late diagnosis

STATISTICS

Cancer in the UK

40%

Diagnosed in under 65 yrs

24%

Increase in 25 to 49 yrs in last 25 years

58%

Early diagnosis in England

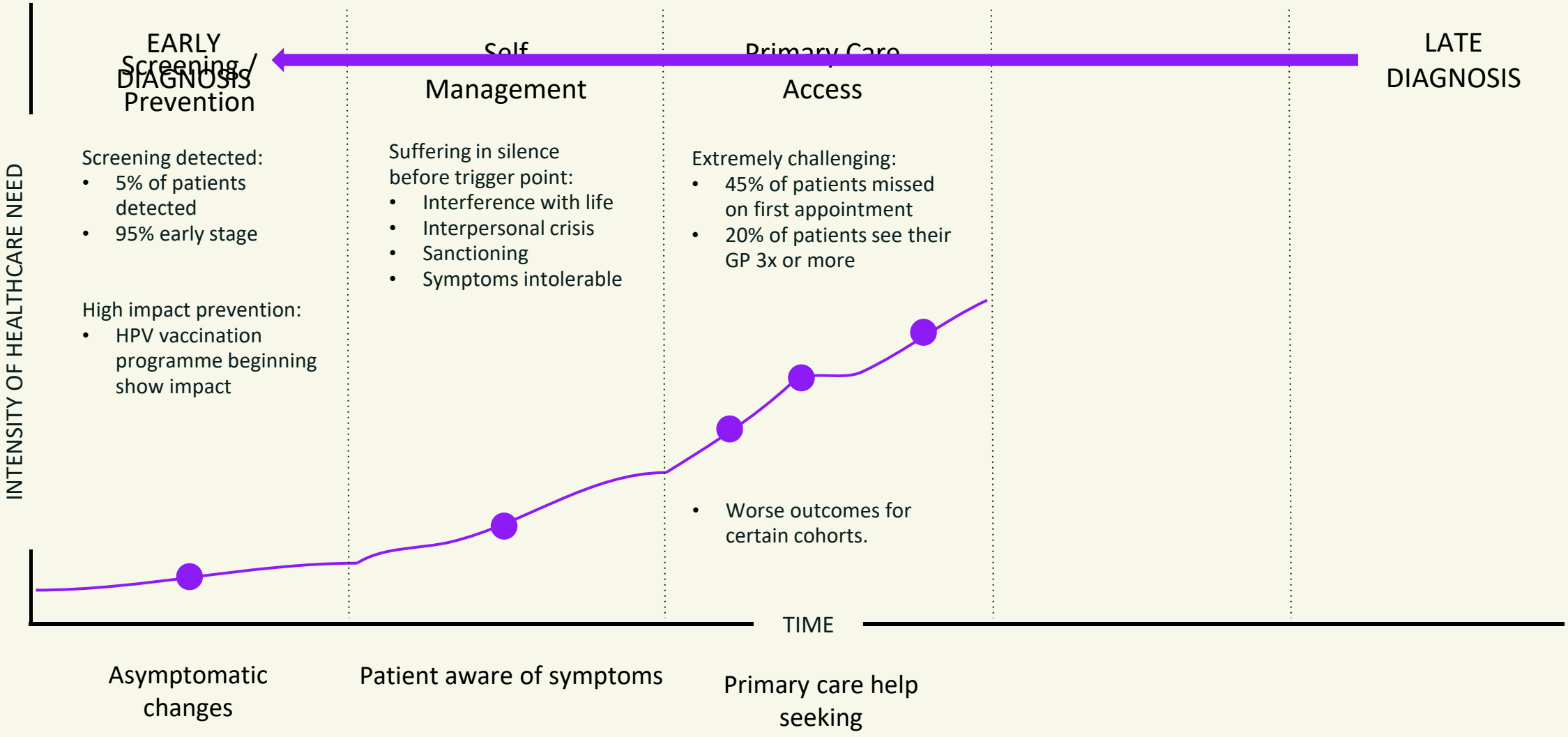
£6,021

More per patient on average to treat a late stage case than early

95%

Symptomatic presentations

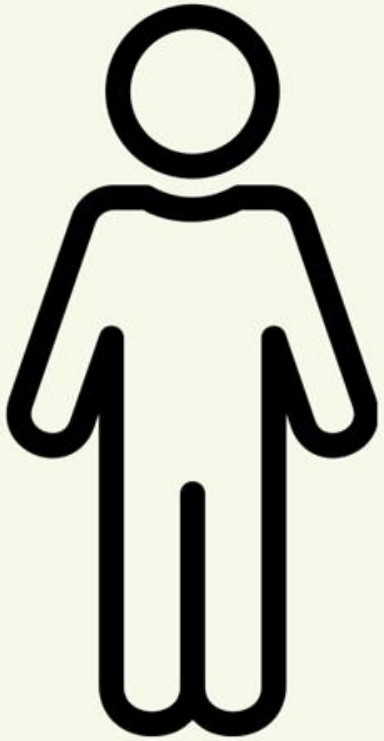
Opportunities Along A Patient Journey



C the Signs

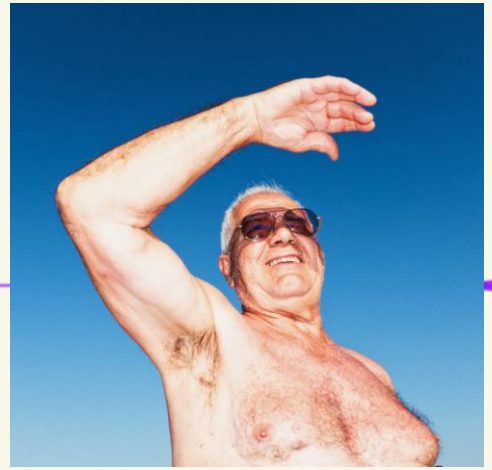
Cancer Doesn’t Fit Boxes — But We’re Trained to Think in Them

Patients present with a broad range of signs and symptoms, it can be difficult now level of seriousness & escalation required



Cancer Pathways Are Built Around Tumours, Not Presentations

At risk of:
Colorectal, Oesophageal, Stomach, Lung, Leukaemia, Pancreatic



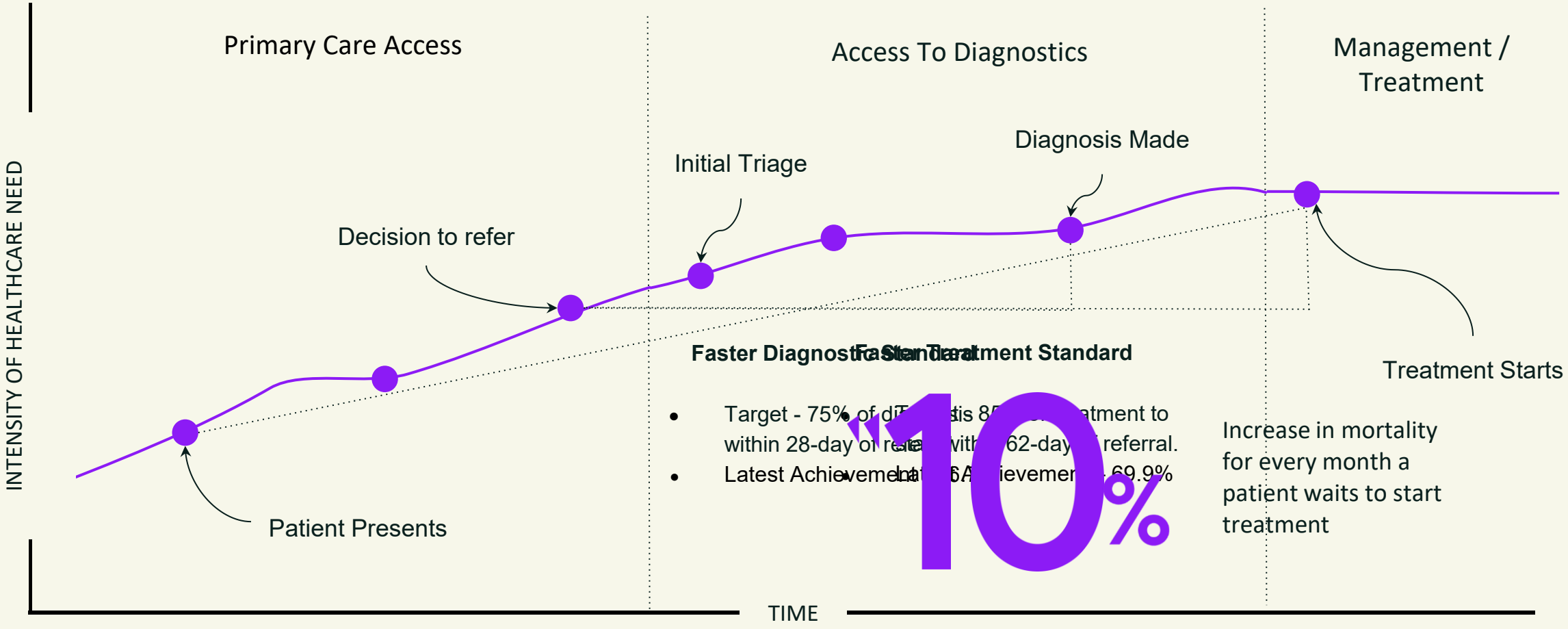
- CT abdomen for pancreatic cancer
- 2WW for colorectal cancer
- Upper GI endoscopy
- CXR for lung cancer or mesothelioma
- FBC for leukaemia

Or demographics

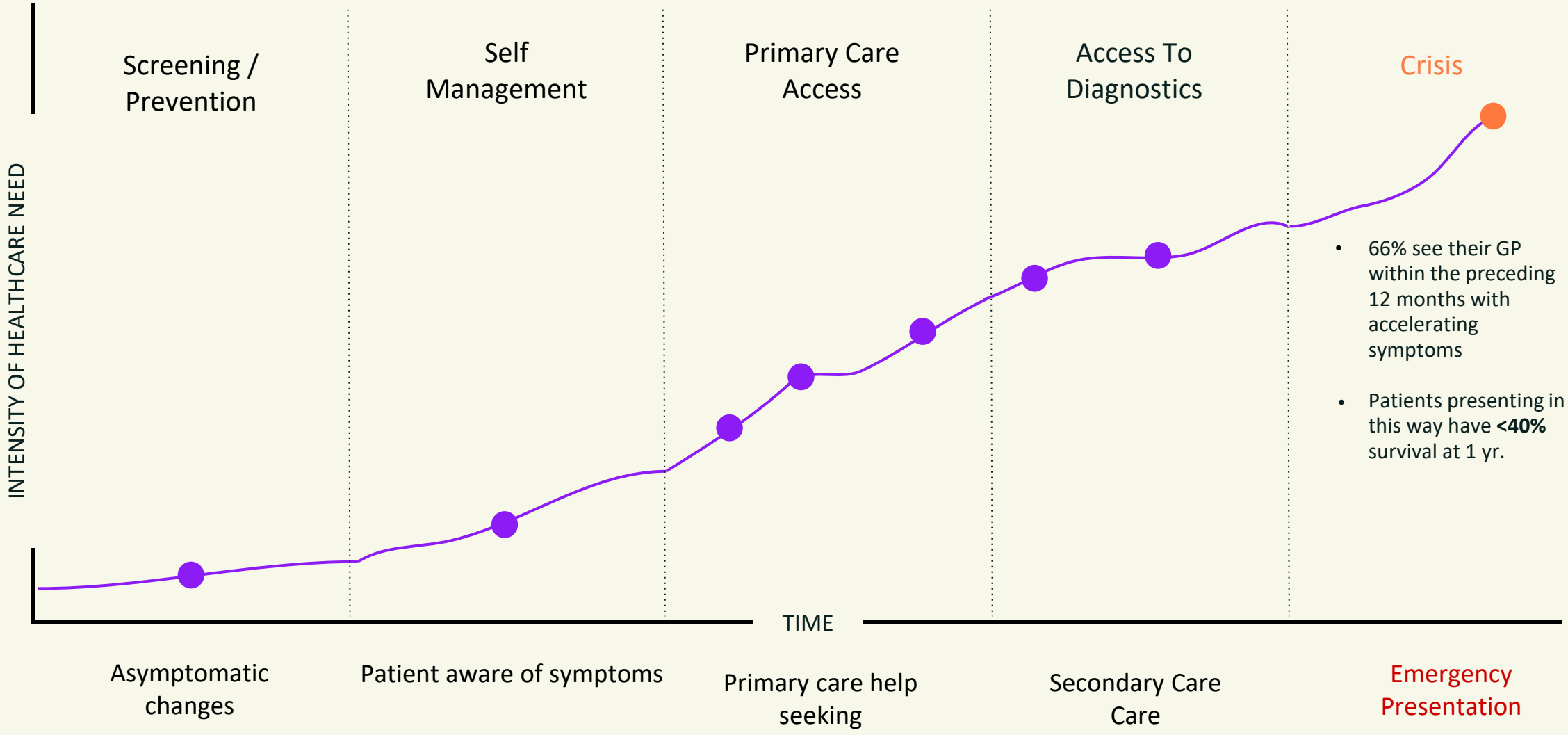
At risk of:
Colorectal, Oesophageal, Stomach, Lung, Leukaemia, Ovarian, Pancreatic

- CT abdomen for pancreatic cancer
- 2WW for colorectal cancer
- Upper GI endoscopy
- Ca125 for Ovarian
- CXR for lung cancer or mesothelioma
- FBC for leukaemia

Opportunities Along A Patient Journey



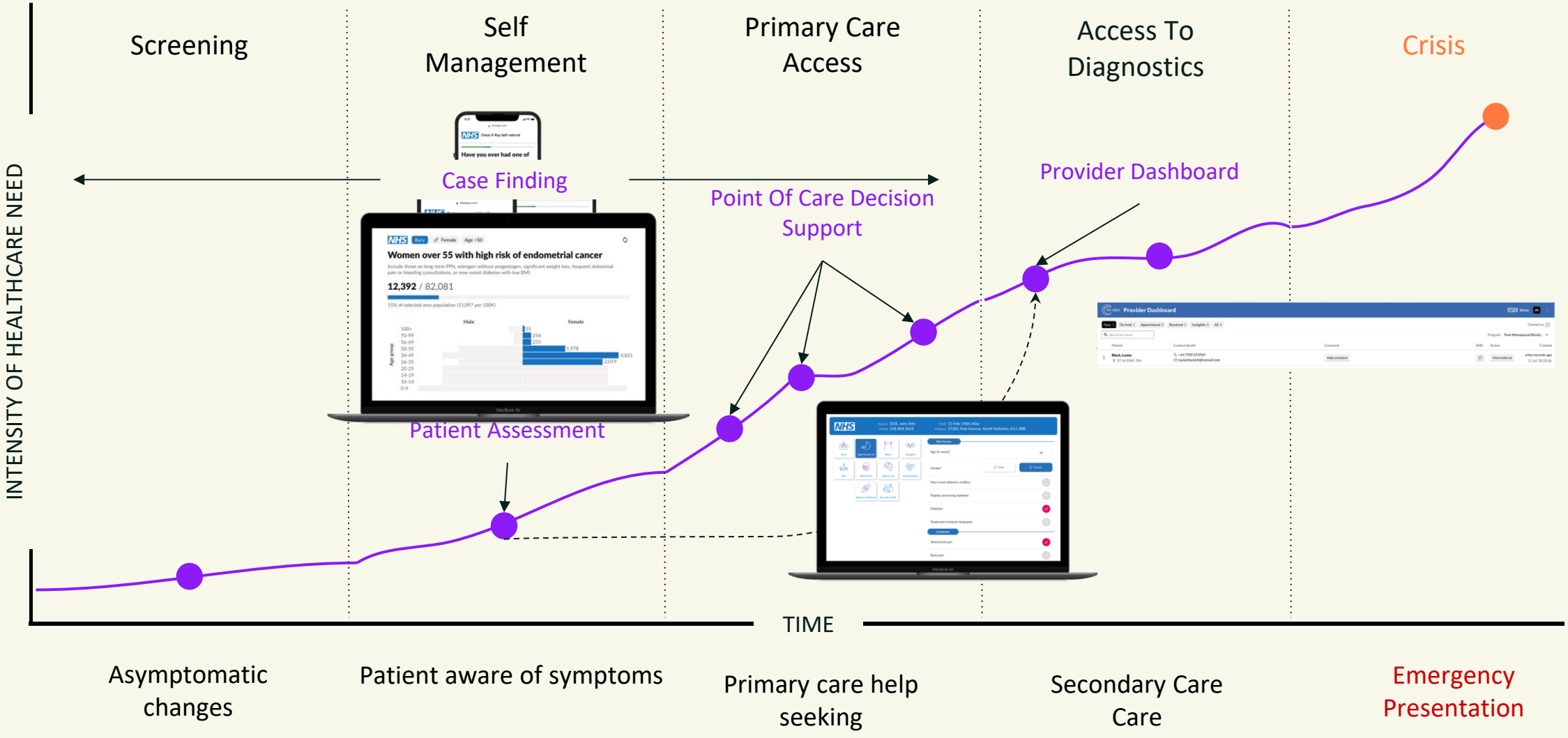
Opportunities Along A Patient Journey



- 66% see their GP within the preceding 12 months with accelerating symptoms
- Patients presenting in this way have **<40%** survival at 1 yr.

C the Signs

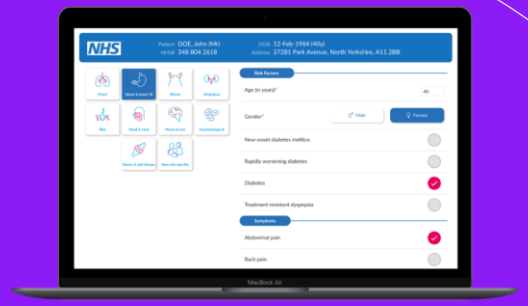
Opportunities For Digital Support



C the Signs

Give everyone the chance to survive their cancer

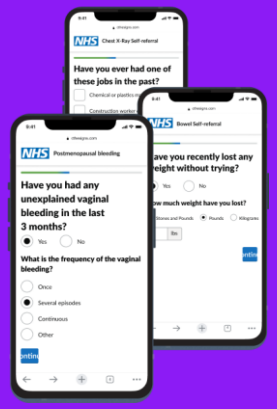
C the Signs
Class I Medical Device
Pan-Cancer AI Driven Detection



01

Point of care decision support

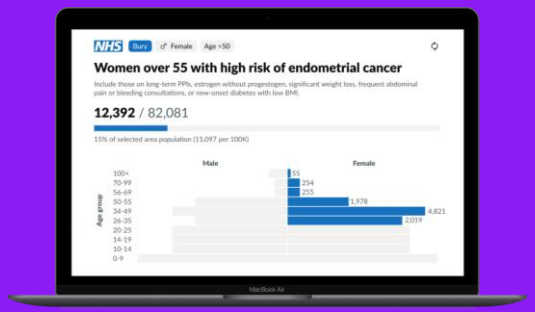
Primary care receives real-time guidance when patients present with symptoms on cancer risk and pathway navigation



02

Patient assessments

On completing a risk assessment, eligible patients are navigated to a diagnostic or a specialist



03

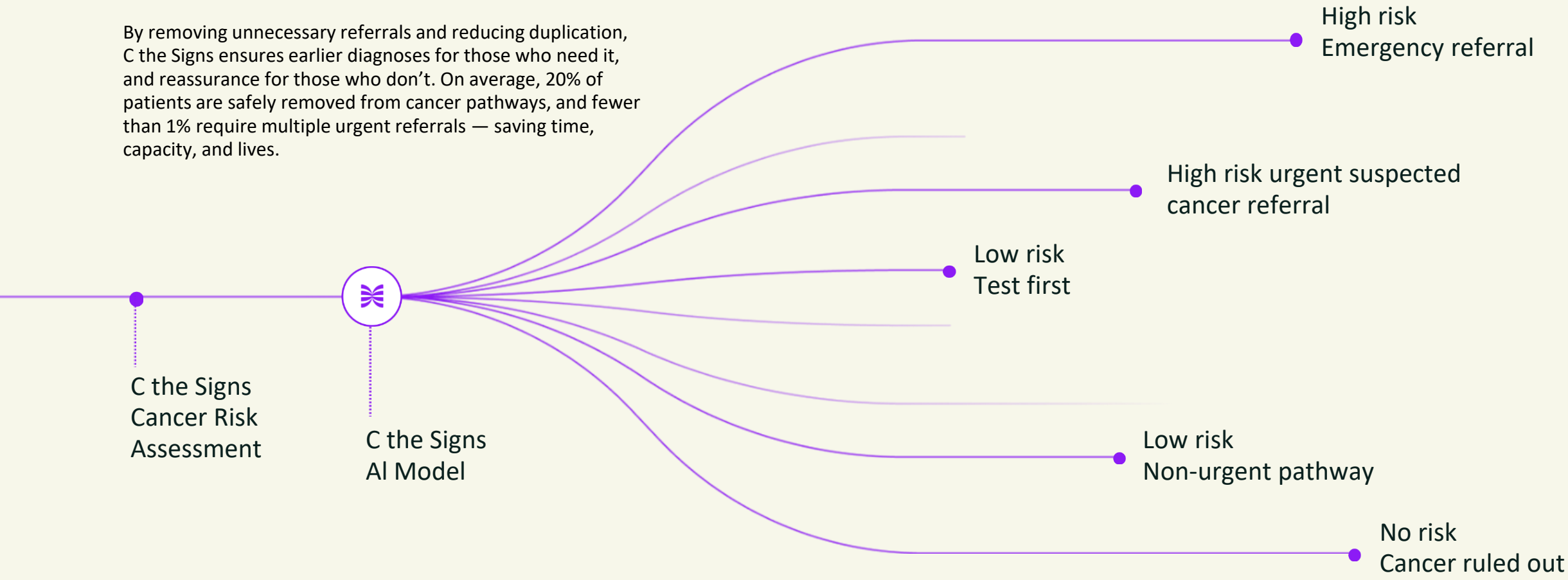
Population case finding

AI scans EMRs to identify high-risk patients, sends a patient assessment for further review, and if eligible, navigates patients to a diagnostic or a specialist

Safer, automated workflows

C the Signs uses AI to triage every patient in primary care — identifying those at risk of cancer, ruling out those who aren't, and guiding each to the most appropriate next step. Whether that's a test, diagnostic investigation, or routine or urgent referral, each decision is driven by individual cancer risk and a 94% accuracy in predicting tumour origin.

By removing unnecessary referrals and reducing duplication, C the Signs ensures earlier diagnoses for those who need it, and reassurance for those who don't. On average, 20% of patients are safely removed from cancer pathways, and fewer than 1% require multiple urgent referrals — saving time, capacity, and lives.



Primary care

REAL-WORLD IMPACT

Point of care decision support in the NHS

Performed equally across demographic groups and in areas of deprivation

94%

Accuracy in predicting tumor origin

8-12%

Increase in primary care detection

20-50%

Improvement in time to diagnosis

Up to 94 yrs

Pan-population risk stratification and cancer detection

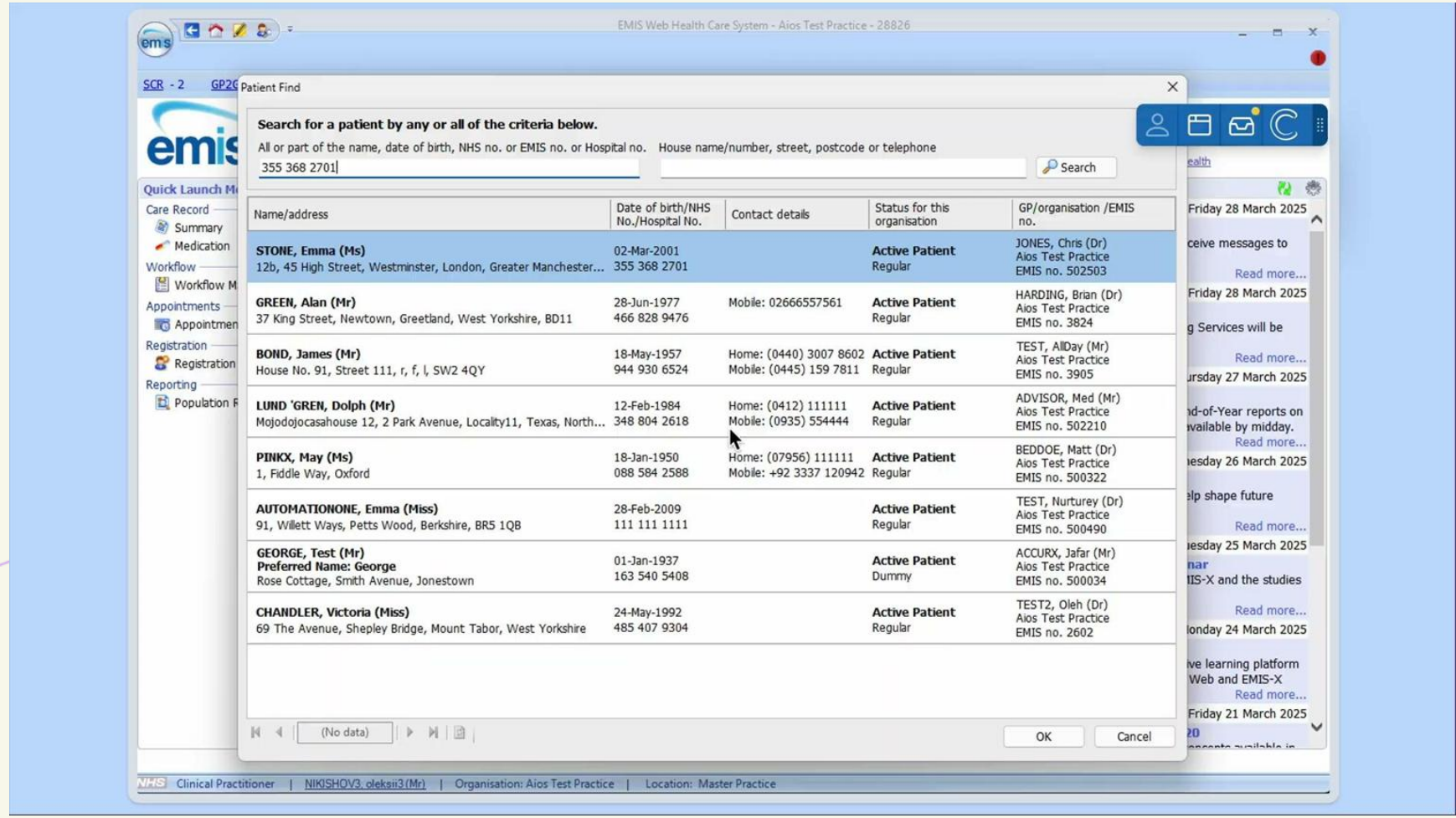
99%

SENSITIVITY FOR CANCER

AUTOMATIC FLAGGING

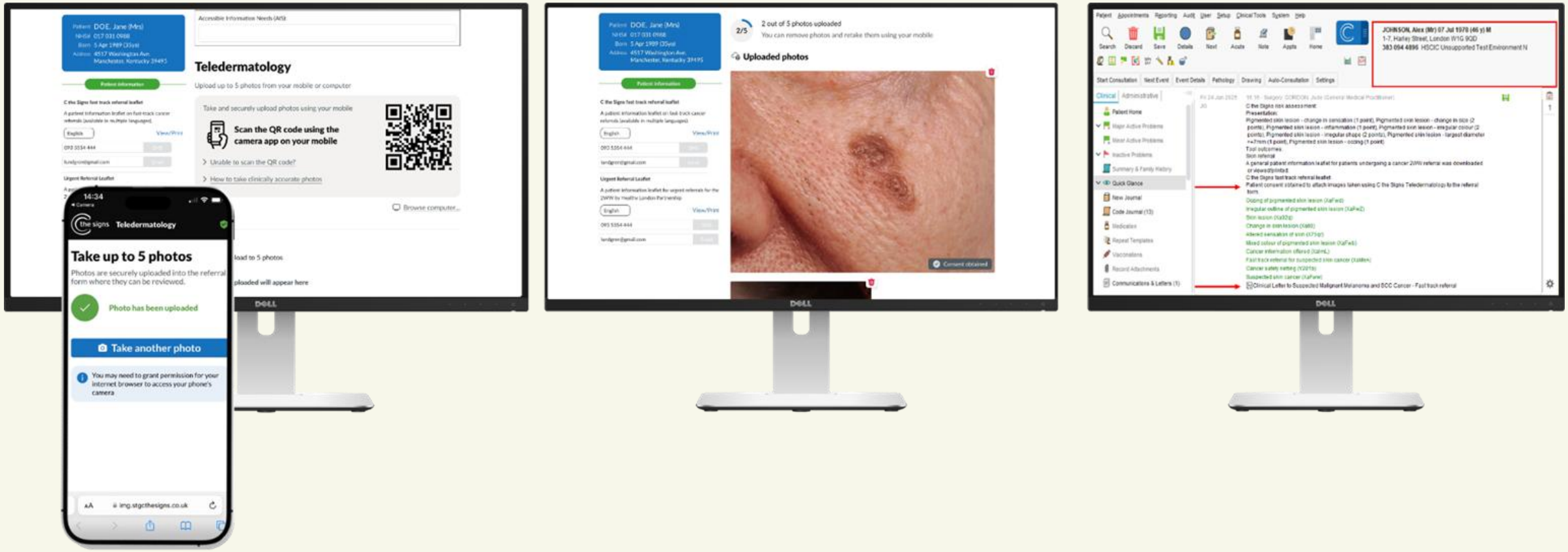
Helping clinicians to think cancer

C the Signs automatically flags patients with high-risk indicators — such as abnormal test results, clinical signs, demographics, and other risk factors — in real time, across pan-cancer or tumour-specific models. These signals are identified from both structured and unstructured data within the medical record. By surfacing what may otherwise be missed, the platform helps clinicians consider cancer earlier — even when it's not yet suspected.



Fast, integrated teledermatology across primary and community care

Healthcare professional anywhere can securely upload dermatoscopic and macroscopic images directly to the urgent suspected skin cancer referral — with no additional software required. It takes less than 30 seconds, automatically codes and saves to the patient record, and compresses the image for optimal quality before sending via eRS.



C the Signs

Population case finding & patient assessment

OUR APPROACH TO SUPPORTING THIS INITIATIVE

Improving Inequalities Through Intelligent Case Finding

IDENTIFY

Identify the right cohort

Automatic identification of hight risk population. Patients who are eligible for symptomatic and asymptomatic pathways, aligned to national and local screening programmes, and targeted tumour specific cancer case finding.

ENGAGE

Personalised communication

Reach patients through personalised, culturally tailored messages across channels such as SMS, email or letter, designed to encourage informed action. Cancer risk assessment to determine eligibility for screening programmes.

ACTIVATE

Move Intention To Action

Enable patients to book in for a test, request a self-sampling kit or referred onto pathway. Track their journey to ensure adherence and appropriate follow-up based on results. Patient information and safety-netting provided throughout pathway.

COORDINATE

Bring the different parts together

Work with system or industry providers to bring together the logistics, delivery of test, access authorised labs and appropriate communication across the pathway. Track time to diagnosis tracked and any bottlenecks identified, and automated referral on to an Urgent Suspected Cancer Pathway for eligible patients.

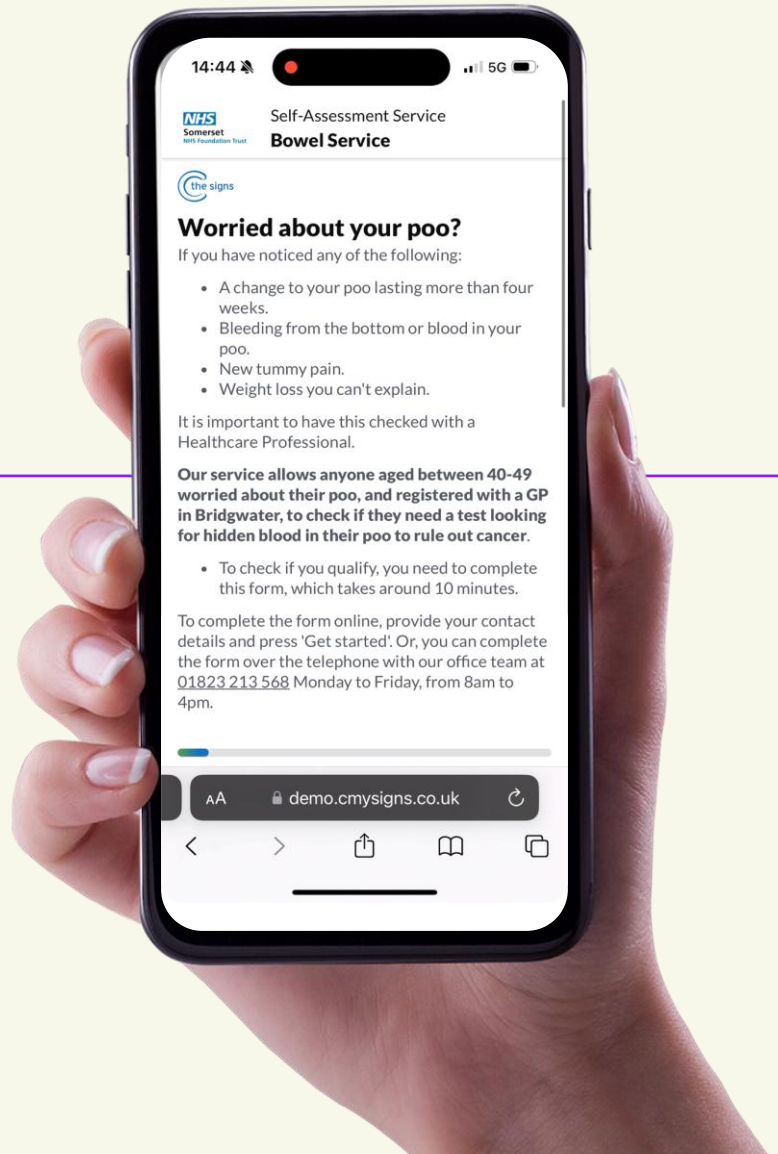
INSIGHTS AT EVERY STAGE

Targeted outreach

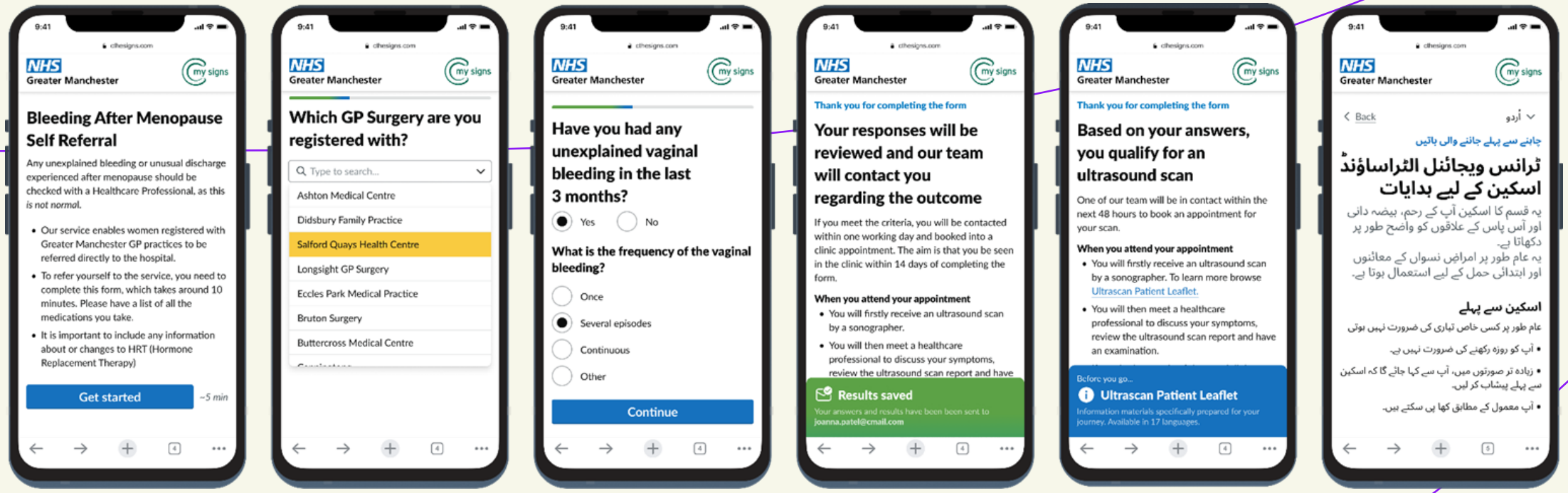
Move patients to action.

Using real-time data from the medical record, patients at risk of tumour-specific cancers or eligible for screening are proactively identified and contacted. Tailored messages guide them to complete a personalised risk assessment, book a screening, or access the right diagnostic service.

Those who meet clinical criteria are seamlessly triaged into cancer pathways, with full tracking and safety-netting. Referrals are automated, with a dedicated dashboard for CDCs and secondary care - supporting fast follow-up, clear communication, and safe discharge back to primary care.



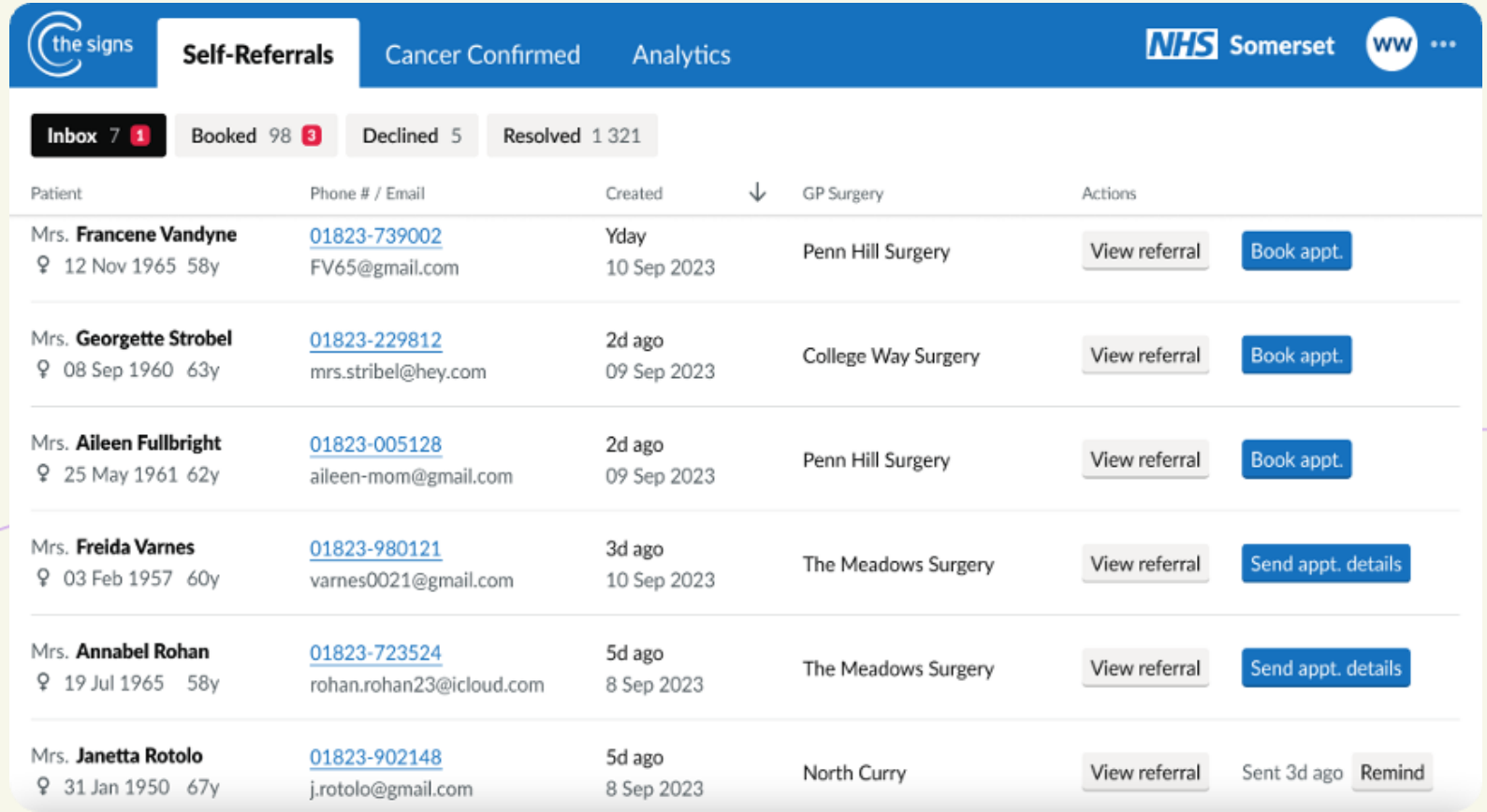
Digital assessment



Live across the NHS for lung, endometrial and bowel cancer, with breast, genetic and pancreatic

Provider dashboard designed for shared care across the NHS

The provider dashboard enables seamless coordination of the entire cancer pathway — from primary care to diagnostics, community services, and secondary care. Using NHS Smartcards, all clinicians involved in the patient's journey can securely access, triage, and manage referrals in real time. With two-way communication and live updates, everyone stays connected, ensuring patients move through the pathway quickly, safely, and without falling through the gaps.



NHS
Somerset
Integrated Care Board

Impact of the post-menopausal bleeding pathway for women over 50, to evaluate for endometrial cancer

600+ patients risk assessed

77% patients eligible

35% had a significant family history

5 days average time to specialist review (down from 60 days)

22 days average time to diagnosis (down from 48 days)

FDS improved from **29-45% pre implementation to 84% post pathway implementation**

32 women diagnosed with early stage cancer, all treated within 62 days

The average age of women completing the assessment was 60

Real-world impact

REAL-WORLD IMPACT

Over 65,000 patients detected in the NHS

- Skin
- Upper GI
- Gynecological
- Brain & CNS
- Urological
- Hematological
- Sarcoma
- Pediatrics
- Breast
- Head and Neck
- Unknown
- Lower GI
- Chest
- Neuroendocrine

Improving early cancer diagnosis with AI-led decision support

	2018-19 (pre-pandemic & pre-C the Signs)	2023-24 (post- C the Signs implementation)	% relative Improvement
Bladder cancer	**91.40%**	**99.00%**	**8.30%**
Breast cancer	**60.00%**	**79.00%**	**31.70%**
Colorectal cancer	**42.10%**	**56.00%**	**33.20%**
Endometrial cancer	**81.60%**	**95.30%**	**16.80%**
Lung cancer	**16.50%**	**38.30%**	**132.20%**
Lymphoma	**40.00%**	**46.60%**	**16.40%**
Oesophagus cancer	**24.30%**	**29.20%**	**19.90%**
Ovarian cancer	**35.00%**	**70.00%**	**100%**
Pancreatic cancer	**18.80%**	**37.50%**	**100%**
Prostate cancer	**80.00%**	**84.20%**	**5.30%**
Renal cancer	**74.40%**	**81.80%**	**10%**
Stomach cancer	**12.50%**	**60.00%**	**380%**

36.8% improvement in early stage diagnosis

Method:

A retrospective study in Somerset ICB looked at cancer staging performance in the pre-pandemic period in comparison to C the Signs after 3 years of implementation.

The largest differences were seen in some of the most deadly cancers: Lung cancer, pancreatic cancer, stomach cancer and colorectal cancer.

Conclusions

- It works!!
- Reduced workload for GPs but not increased the workload for secondary care.
- We have been able to improve the access to health care to those in deprived areas.
- Interception precancerous changes earlier, suggesting prevention.

Slido

Please scan the QR Code on the screen. This will take you through to Slido, where you can interact with us.

SCAN ME

Fireside Interview

Penny Kechagioglou
Consultant Clinical Oncologist and CCIO at University Hospitals Coventry and Warwickshire & Chief Medical Officer at Icon UK

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SCAN ME

Case Study

DATAR CANCER GENETICS

Case Study

Dr Chris Peters

Clinical Reader and Clinical Associate Prof. in Upper GI Surgery
Imperial College and Imperial College Healthcare NHS Trust

IMPERIAL

DATAR CANCER GENETICS

Pancreatic cancer: Early detection and faster diagnosis by liquid biopsy testing with GP based case finding

Christopher Peters

Clinical Associate Professor & Consultant Upper GI Surgeon

7/10/2025

99.9% of academic Biomarker Research is a waste of time

Jade Kabbani, Alice Baggaley

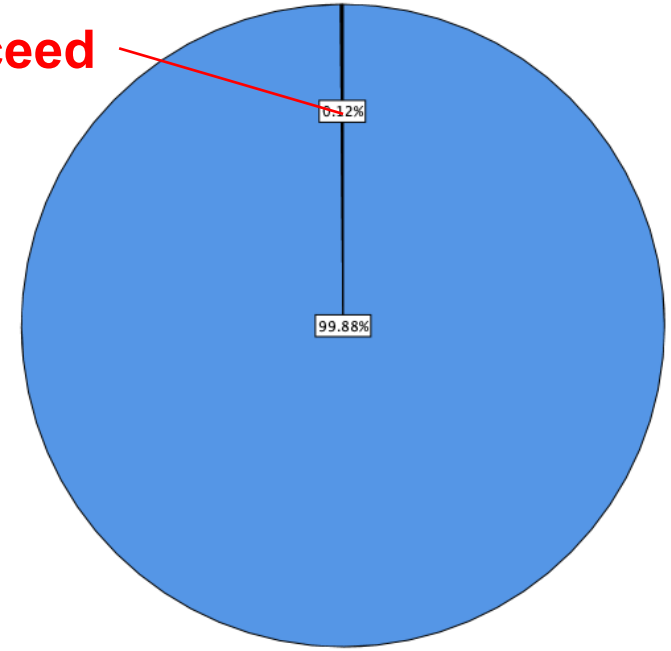
Success rate of Colon Cancer Biomarkers

1977
Relevant publications

2910
Diagnostic BMs Identified

4
Diagnostic BMs used Clinically

0.14% Succeed



99.86% Stalled

0.14% Successful

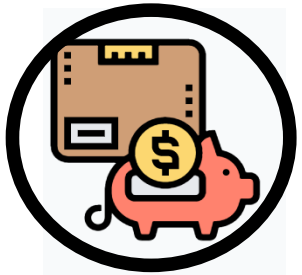
Imperial College London

Successful Biomarkers: A BM which has been suggested by NICE, any national guideline or FDA

The Biomarker Toolkit

- Toolkit that can be applied to
  - Any biomarker
  - Any stage of development
- Then assess it for potential for
  - Academics
  - Industry
  - Research funding bodies
  - NICE / Payers / Assessors

Targeted Biomarker Research



Reduced Costs

Utilise Time More Effectively

Biomarker Toolkit

Group	Impact
Academic/Clinical Researcher	• **Pick the right biomarker to work on** • **Emphasises areas of improvement from an early stage** • **Shapes the biomarker research**
Industry/Funding Bodies	• Pick biomarkers more likely to be clinically useful • Ensures the right studies are being done • Reduce time and cost associated with biomarker development • Rescue stalled biomarkers
Patients	• Improves the chances of biomarkers reaching the patient
Research Community	• Guide to promote uniformity and robustness of study design

Biomarker Toolkit

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Research Community	• **Guide to promote uniformity and robustness of study design**

DATAR
CANCER GENETICS

DATAR CANCER GENETICS

- International IVD onco-genomic organisation
- Unique diagnostics esp. in liquid biopsy
- Fully accredited UK lab facilities
- Close relationships with leading UK oncologists, surgeons and clinicians – for example at Imperial College and The Cromwell Hospital

Office/Lab Locations
UK, India, Germany, USA

Now Marked CE IVD Now Marked

CLIA Accredited Laboratory Reg. No.: 99D2171983

UKAS MEDICAL

Care Quality Commission

ISO 15189

3 FDA ‘Breakthrough Device’ Designations for Early Detection

‘FDA Grants Breakthrough Designation for Early-Stage Breast Cancer Detection Blood Test Developed by Datar Cancer Genetics’

DIAGNOSTIC & RADIOLOGY

US FDA Grants ‘Breakthrough Designation’ for early-stage breast cancer detection blood test developed in India by Datar Cancer Genetics

It is the first blood test able to detect early-stage Breast Cancer wi high accuracy in women above the age of 40 years

‘US FDA Grants the Coveted Breakthrough Designation for Early-Stage Prostate Cancer Detection Blood Test Developed in India by Datar Cancer Genetics’

Health News / Latest Health News / Diagnostics

USFDA grants Breakthrough Designation to Datar Cancer Genetics for blood test detecting prostate cancer

The approved blood test can detect early-stage prostate cancers with more than 99 percent accuracy without any false positives. It has been validated in large clinical studies involving healthy males and prostate cancer patients.

ETHealthWorld • February 15, 2022, 15:34 IST

Mumbai: Datar Cancer Genetics has received 'Breakthrough Designation' for its blood test to detect early-stage prostate cancer from the US Food and Drug Administration (FDA). This follows genetics' breast cancer detection test by Datar Cancer Genetics to receive the Breakthrough Device Designation from the US FDA.

The test available with the name Easycheck in India is the first blood test for men which can detect early-stage prostate cancer with high accuracy. It can detect early-stage prostate cancers with more than 99 percent

‘FDA Grants Datar Breakthrough Designation for Blood Test to Help Diagnose Brain Tumors’

FDA grants breakthrough designation for bloo brain tumours

3 Jan 2023

The US Food and Drug Administration (FDA) has granted 'Breakthrou Device Designation' for 'TriNetra-Glio', a blood test to help in the diagnosis of brain tumours.

Worldwide, brain cancer is the 12th most lethal cancer, and each year, more than 250,000 adults die due to the disease.

Diagnosis of brain tumours is resource-intensive, risk-prone and brain biopsies are impossible to perform in almost 40% of advanced cases.

Presently, no blood test is available for diagnosing brain cancers, and doctors have to rely on complex surgical procedures to obtain tumour tissue for histopathological evaluation.

Datar Portfolio in Comprehensive Cancer Management

Pre-Diagnosis

Cancer Screening

Do I have cancer?

Trucheck™

Detection & Diagnosis

What do I have specifically?

Trublood®

Post-Diagnosis

Treatment Guidance

What therapy will work for me?

celldx™

exacta®

Cancer Monitoring

Is my treatment working?

cancertrack®

cancertrack™-MRD

Early Cancer Detection

chemo-scale™

Organ-Specific Early Detection and Diagnostic Triaging

What do the tests do?

Simple blood tests for when a specific cancer is suspected

TruBlood – Prostate
TruBlood – Breast
TruBlood – Pancreas
TruBlood – Brain
TruBlood – Lung
TruBlood – Colorectal

How is this done?

Immunocytochemistry of CTCs with organ specific/ subtype specific antibodies

Sample requirements

20 mL peripheral blood (+2 degrees C to +8 degrees C)

Turnaround time

Up to 14 working days from sample receipt

Conventional Methods

Often requires a biopsy, an invasive procedure performed under anaesthesia in hospitals - the procedure can be painful and leave scars

Risks

Can be high risk to organs like lung, liver, brain and pancreas

Sensitivity

Tumours are heterogeneous and so might not provide real-time data covering all active sites

Evidenced based approach: Key Circulating Tumour Cells Publications

FDA BREAKTHROUGH DEVICE DESIGNATION

TruBlood Breast, 2022

cancers MDPI

Article

Accurate Screening for Early-Stage Breast Cancer by Detection and Profiling of Circulating Tumor Cells

Timothy Crook [1,*], Robert Leonard [2], Kefah Mokbel [3], Alastair Thompson [4], Michael Michell [5], Raymond Page [6], Ashok Vaid [7], Ravi Mehrotra [8], Anantbhushan Ranade [9], Sewanti Limaye [10], Darshana Patil [11], Dadasaheb Akolkar [11], Vineet Datta [11], Pradip Fulmali [11], Sachin Apurwa [11], Stefan Schuster [12], Ajay Srinivasan [11] and Rajan Datar [11]

Received: 3 August 2023 | Revised: 17 November 2023 | Accepted: 29 November 2023
DOI: 10.1002/ijc.34827

IJC INTERNATIONAL JOURNAL of CANCER

RESEARCH ARTICLE
Tumor Markers and Signatures

TruBlood Brain, 2023

Profiling of circulating glial cells for accurate blood-based diagnosis of glial malignancies

Kevin O'Neill [1] | Nelofer Syed [2] | Timothy Crook [2] | Sudhir Dubey [3] | Mahadev Potharaju [4] | Sewanti Limaye [5] | Anantbhushan Ranade [6] | Giulio Anichini [2] | Darshana Patil [7] | Vineet Datta [7] | Rajan Datar [7]

FDA BREAKTHROUGH DEVICE DESIGNATION

FDA BREAKTHROUGH DEVICE DESIGNATION

TruBlood Prostate, 2023

RESEARCH ARTICLE

Cancer Medicine Open Access WILEY

Accurate prostate cancer detection based on enrichment and characterization of prostate cancer specific circulating tumor cells

Sewanti Limaye [1] | Simon Chowdhury [2] | Nitesh Rohatgi [3] | Anantbhushan Ranade [4] | Nelofer Syed [5] | Johann Riedemann [6] | Darshana Patil [7] | Dadasaheb Akolkar [7] | Vineet Datta [7] | Shoeb Patel [7] | Rohit Chougule [7] | Pradyumna Shejwalkar [7] | Kiran Bendale [7] | Sachin Apurwa [7] | Stefan Schuster [8] | Jinumary John [7] | Ajay Srinivasan [7] | Rajan Datar [7]

cancers MDPI

Article

Liquid Biopsy for Detection of Pancreaticobiliary Cancers by Functional Enrichment and Immunofluorescent Profiling of Circulating Tumor Cells and Their Clusters

Andrew Gaya [1,*], Nitesh Rohatgi [2], Sewanti Limaye [3], Aditya Shreenivas [4], Ramin Ajami [5], Dadasaheb Akolkar [6], Vineet Datta [6], Ajay Srinivasan [6] and Darshana Patil [6]

TruBlood Pancreas, 2024

Full Library of Papers: https://uk.datarpgx.com/cancer-care-publications

Pancreatic cancer in the NHS

An Urgent Need: Improving Pancreatic Cancer Diagnosis

Low Survival Rate:

- The 2025 National Pancreatic Cancer Audit states that the average survival rate 1 year after diagnosis is 23%.
- The 5-year survival rate is only 7%

Late-Stage Diagnosis:

- A significant majority of patients are diagnosed at a late stage.
- Only 25% are diagnosed at Stage I or II, well below the NHS's overall cancer target of 75%.
- 62% of diagnoses are at Stage IV.
- Approximately 80% of patients are diagnosed when curative surgery is no longer possible and only 8% of those diagnosed get an operation

Diagnostic Delays:

- Over 40% of patients with pancreatic cancer visit their GP three or more times before being referred for a diagnosis, highlighting the need for a faster, more effective triage tool in primary care

NHS Pancreatic Cancer Primary Care Case-Finding Pilot

Pancreatic Cancer: The Need for Earlier Case Finding

The Current NHS Pilot: 300+ GP practices across England are proactively searching patient records to identify the highest-risk group:

Target Cohort: Patients over 60 with key early warning signs like new-onset diabetes and unexplained weight loss

Pathway: These patients are referred for urgent blood tests and CT scans to rule out cancer

Goal: To drastically reduce late-stage and emergency diagnoses and improve survival rates

Source: NHS England, June 2025

News

NHS launches drive to catch one of the most lethal cancers

18 June 2025

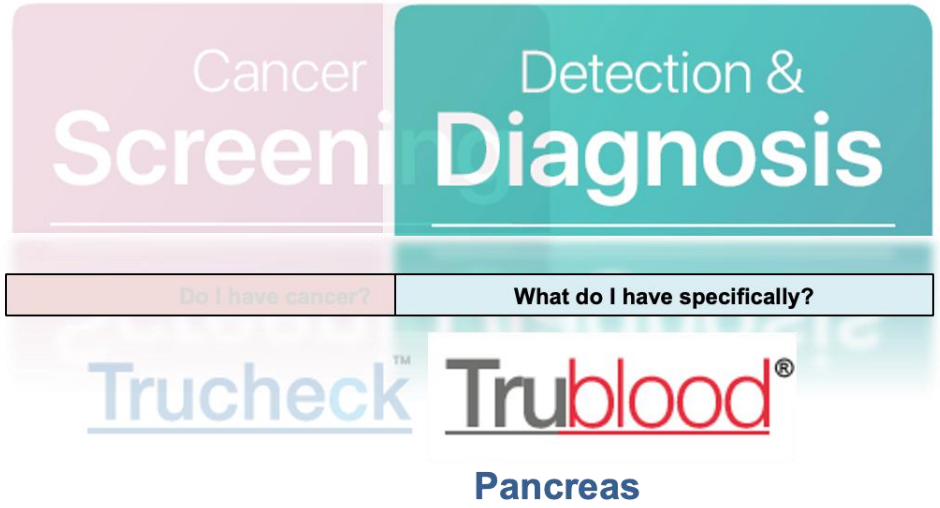
Cancer Primary care

TruBlood Pancreas

Trublood® Pancreas- An innovative blood test

IMPERIAL

Pre-diagnosis



TruBlood Pancreas is a liquid biopsy test, which can help provide a faster, reliable, and minimally-invasive alternative to current diagnostics.

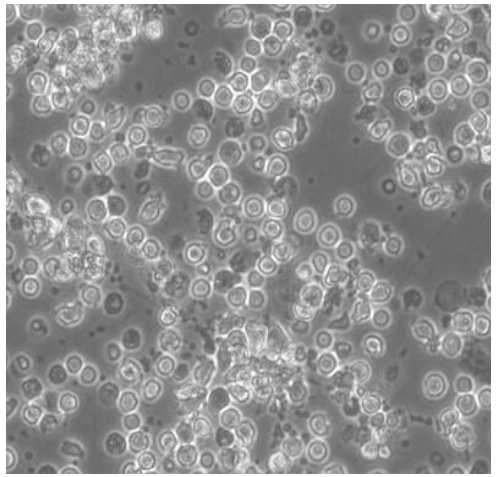
Improved Patient Stratification: The test detects Circulating Tumour Cells (CTCs), which are highly specific to malignancies but undetectable in benign conditions such as pancreatitis. The high specificity allows the test to be used as a "rule-out" or filtering test in primary care for symptomatic patients. This could help GPs more accurately decide who to refer for a CT scan, reducing unnecessary scans.

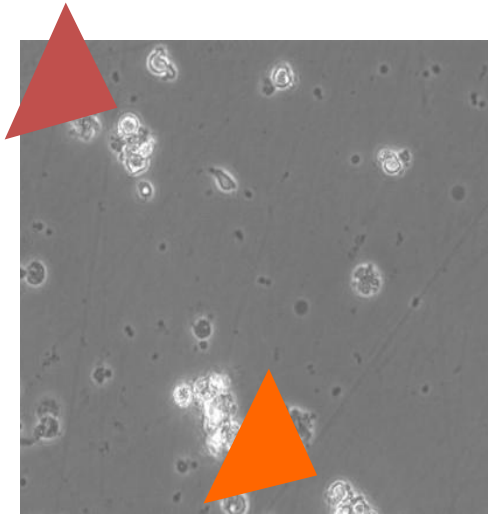
Higher Accuracy and Fewer Invasive Procedures: TruBlood Pancreas's high sensitivity and specificity could reduce the need for repeat diagnostic procedures and provide a clearer diagnosis faster.

Reduced Patient Distress: By providing a rapid, non-invasive diagnostic result, the test can help alleviate the significant psychological distress and anxiety that patients experience during the, often long and uncertain, diagnostic phase.

Trublood® Pancreas- How it works

DATAR CANCER GENETICS



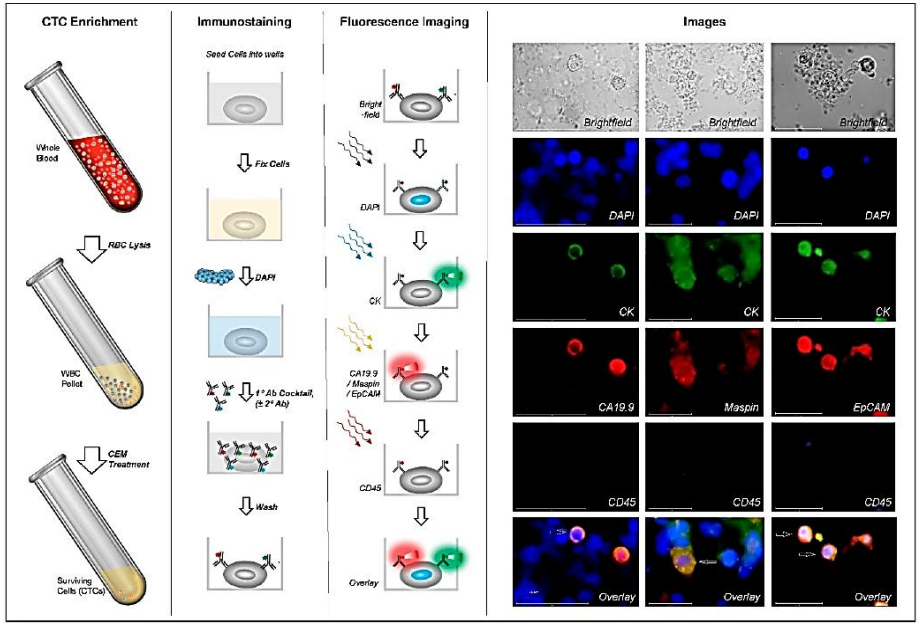


CTC Enrichment:

A proprietary medium is used to selectively enrich circulating tumour cells (CTCs) from peripheral blood, while eliminating non-malignant cells.

Multiplexed Immunocytochemical (ICC) Analysis:

The enriched CTCs are then analysed using morphology and ICC to identify CTCs based on their expression of markers including CA 19-9 and Maspin



Pancreas- Clinical Studies

- The performance of the test was evaluated in two clinical studies
- A case-control study that evaluated blood samples from 188 diagnosed PBC cancer cases and 172 healthy donors:

Sensitivity	Pancreas	Gallbladder	Bile duct	Cumulative (all cancer types)
Stage I	**90.9% (n=11)**	**100% (n=3)**	**100% (n=1)**	**86.7% (n=15)**
Stage II	**100% (n=12)**	**100% (n=3)**	**100% (n=3)**	**100 % (n=18)**
Stage III	**100% (n=6)**	**100% (n=3)**	**100% (n=2)**	**100 % (n=11)**
Stage IV	**100% (n=6)**	**100% (n=4)**	**100% (n=2)**	**100 % (n=12)**
Cumulative (All Stages)	**97.1% (n=35)**	**100% (n=13)**	**100% (n=8)**	**96.4% (n=56)**

Pancreas- Clinical Studies

- The second study evaluated pre-biopsy (blinded) from 82 suspected PBC cancer cases who finally underwent HPE and final diagnosis:

Sensitivity	Pancreas	Gallbladder	Bile duct	Cumulative (all cancer types)
Stage I	**91.7% (n=12)**	**88.9% (n=9)**	**-**	**90.5% (n=21)**
Stage II	**100% (n=2)**	**100% (n=2)**	**100% (n=1)**	**100 % (n=5)**
Stage III	**100% (n=4)**	**100% (n=2)**	**100% (n=4)**	**100 % (n=10)**
Stage IV	**100% (n=5)**	**100% (n=6)**	**100% (n=2)**	**100% (n=13)**
Cumulative (All Stages)	**95.7% (n=23)**	**94.7% (n=19)**	**100% (n=7)**	**95.9% (n=49)**

Pancreas- Clinical Applications and Benefits

- **Simplicity:** Requires only a peripheral blood draw, making it easily integrated into standard diagnostic pathways
- **Accessibility:** Can be performed at any healthcare centre, including primary care – thus also reducing health inequalities
- **Minimises Patient Distress:** Rapid test results reduce psychological distress and uncertainty during the diagnostic phase
- **Boosts Survival with Early Detection:** High sensitivity testing in early-stage disease could drive earlier intervention, increasing the chance of curative treatment and improving poor survival rates
- **Optimised Resource Allocation:** Could enable more accurate decisions on whom to refer for an urgent CT scan, helping to reduce unnecessary scans and relieving pressure on secondary care imaging services
- **Support for the Early Diagnosis Target:** If integrated into primary care, the NHS can better support its critical goal of reducing the significant majority of late-stage and emergency diagnoses

IMPERIAL

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Thank you

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Lunch & Networking

Chair Afternoon Reflection

Mr Chris Sleight MSc BSc FIBMS
Ex Diagnostics Leader within the NHS

Case Study

Claire Marsh RN, ANP BSc (Hons)
NMP IP, Cancer Leadership MSc, Personalised Care Lead (Cancer Care)
University Hospital Southampton NHS Foundation Trust

Patient Stratified/Initiated Follow Up (PSFU/PIFU) for Cancer Patients

UHSdigital

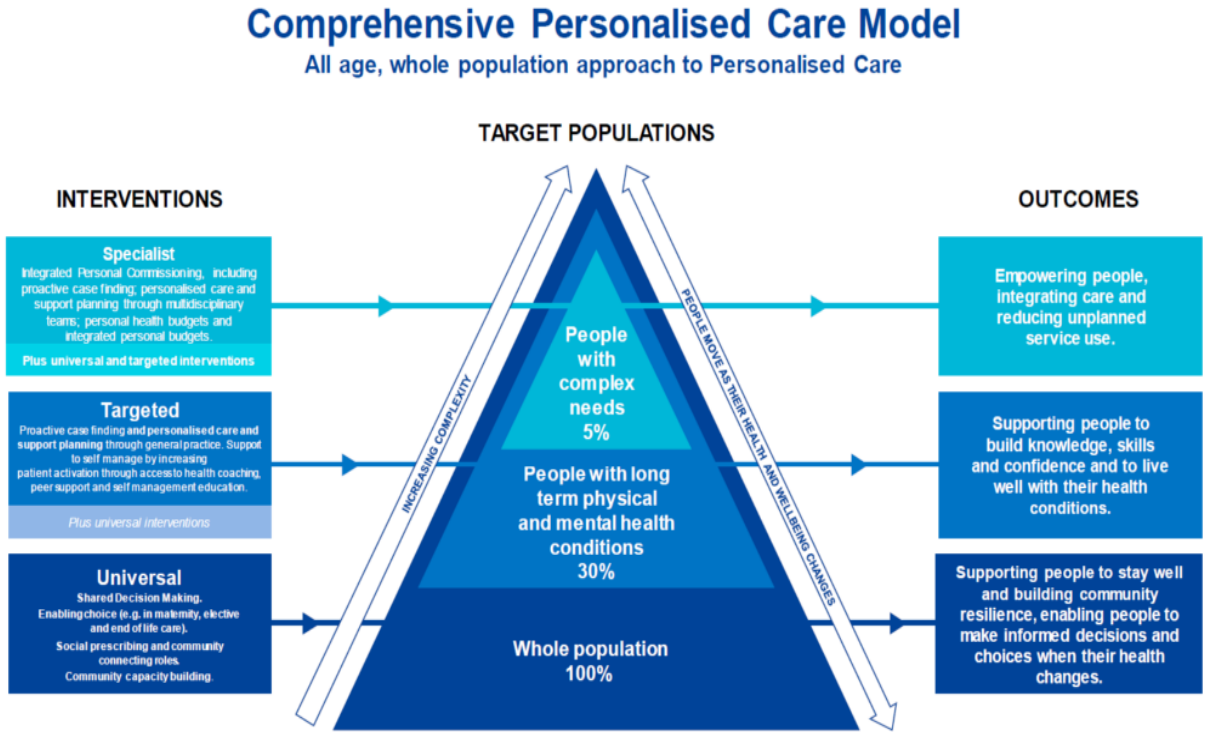
NHS
University Hospital Southampton
NHS Foundation Trust

Claire Marsh

Personalised Care Lead, UHS

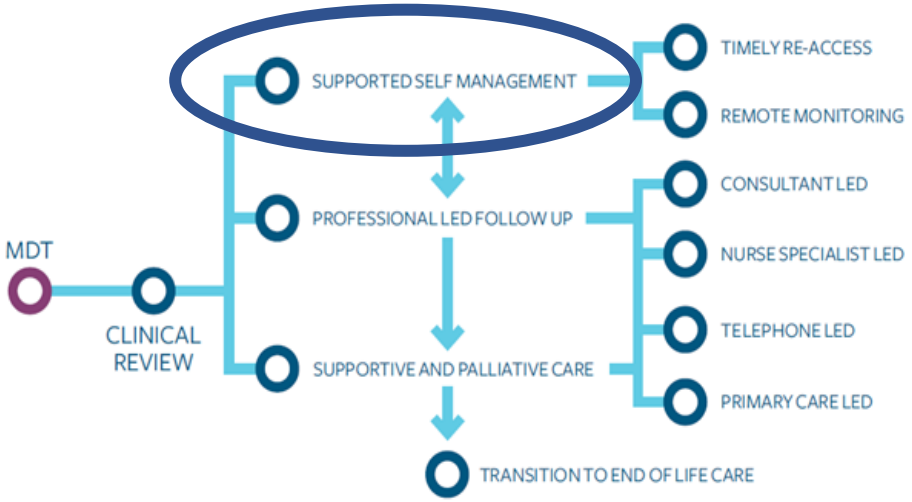
PSFU/PIFU & Supported Self-Management

- Links to the NHS Long Term Plan[1] (Jan 2019) & NHS Health Plan[4] (2025).
- PSFU/PIFU allows patient follow up to be stratified and person centred – Personalised Care[2].
- Removal of follow-up OP appointments for post treatment patients supported by a digital system – MyMedicalRecord (MyMR).
- During PIFU patients:
  - continue cancer surveillance & monitoring
  - are encouraged & enabled to self-manage
  - are only seen in clinic if new symptoms, disease progresses or late effects (based on recall criteria)
- Cancer PIFU established in 2012, currently 9596 pts on a PIFU pathway (Aug 2025).
- 12 Cancer PIFU Pathways Live.
- Prostate PIFU (2014) – part of TrueNth project[3].



TRUENTH
PROSTATE CANCER UK
University of Southampton

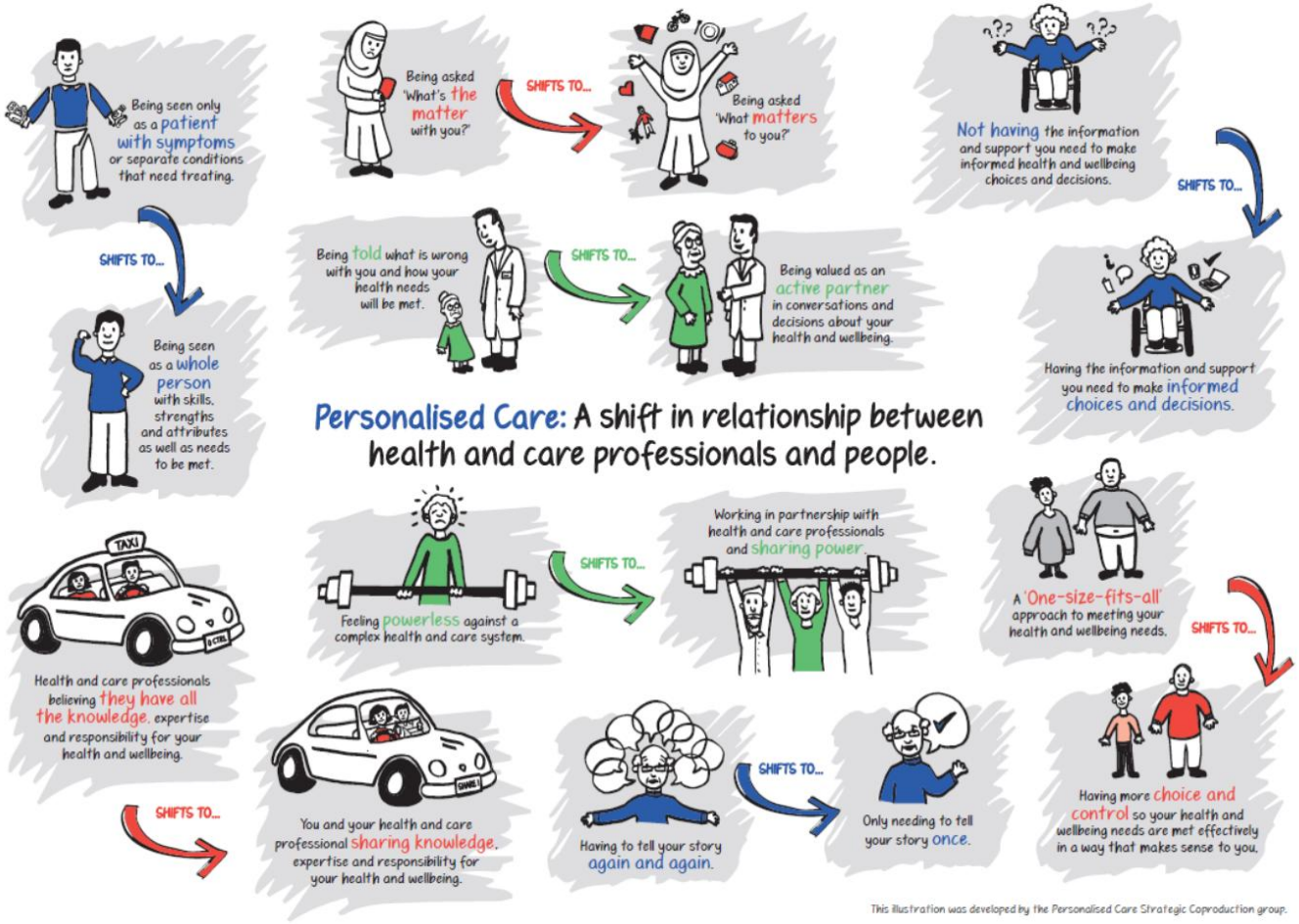
PIFU & Supported Self-Management



Self Management

Shared Decision Making

Enabling Choice



How personalised stratified follow up in cancer (PSFU) aligns with patient initiated follow up (PIFU)

Personalised Stratified Follow Up (PSFU)

- Professional-led follow-up
- Ensures delivery of personalised care within a cancer follow-up pathway
- Allows for some patients to stay on ‘traditional’ follow up (with scheduled consultations with the cancer team) while other patients that are suitable can go onto a self-managed (PIFU) pathway.

Patient initiated follow-up (PIFU)

- Allows a patient or carer to book follow-up appointments as and when they need them, rather than at routine intervals. It is key to delivering a personalised outpatient model and meeting elective recovery ambitions.
- PIFU is one aspect of PSFU - essentially the ‘supported self-managed pathway’ within PSFU
- In PIFU, patients do not receive routine follow-up appointments but instead are empowered to call the oncology team directly

All cancer patients, regardless of pathway type, will have timely access back into their cancer team, ongoing surveillance tests and scans (in line with NICE guidance), and will receive personalised care and appropriate health and wellbeing information and support throughout.

Timeline of Cancer PIFU Development - UHS

Prostate PIFU 2014 → Colorectal PIFU 2015 → Germ Cell PIFU 2018 → Endometrial PIFU 2018

NET PIFU 2019 → Breast PIFU 2020 → Lymphoma PIFU 2021 → BMT PIFU 2022

GI Late Effects – 2023 (info page) → Ocular Melanoma PIFU 2023 → Lymphoid PIFU 2024 → Thyroid PIFU 2024

Thyroid Routine 2025 (info page) → Colorectal Family History PIFU 2025

Upper GI Cancer – on hold, Complex Cancer – on hold, Renal – on hold. Advanced Prostate, HPB, Sarcoma & My Cancer Treatment in development

Lung, Neuro-Oncology showing interest

Governance, Safety & Pathway Redesign

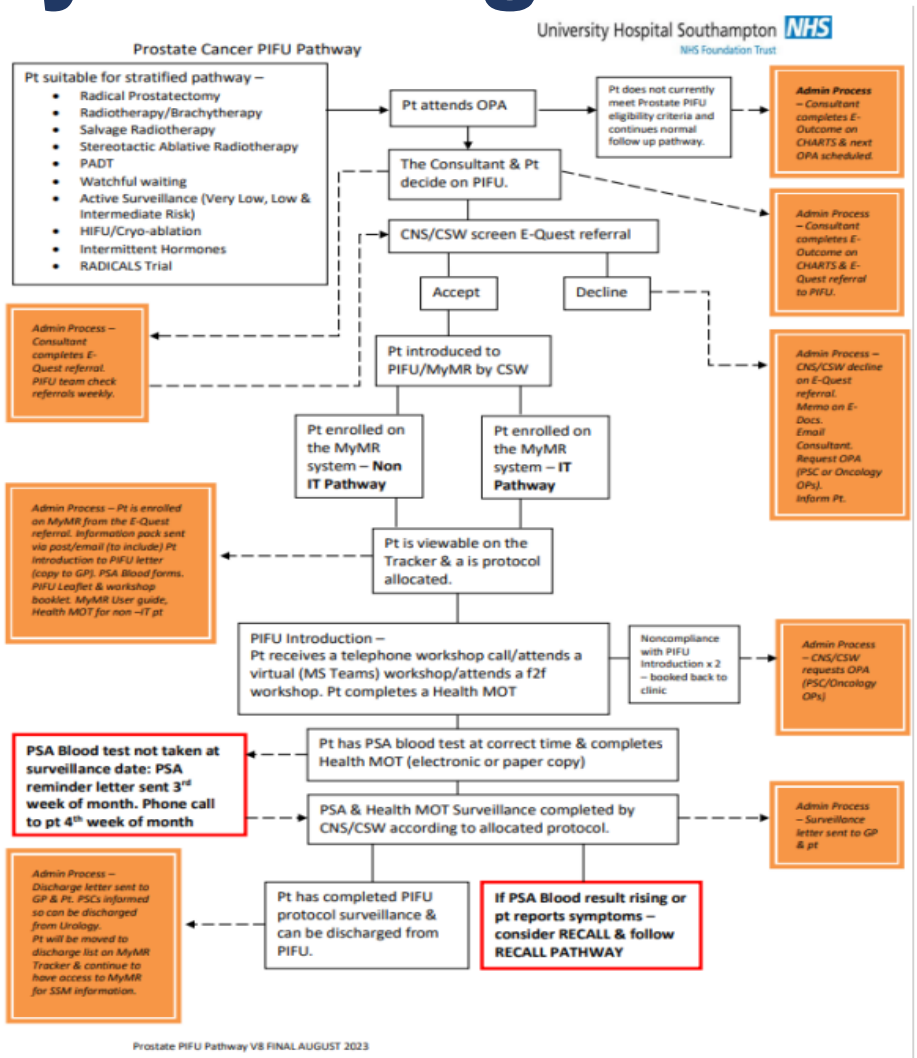
Standard Operating Policy[5]

Clear Process, Pathways and Protocols

STAFFING

Patients enrolled on a cancer PIFU pathway and registered on the My Medical Record Tracker are never lost to follow up. If a patient is recalled to clinic, they are transferred to the recall list on the clinical tracker.

Once further face to face review or treatment is completed, the patient returns to the PIFU pathway and is reinstated on the active clinical tracker list, so that ongoing surveillance continues seamlessly.



Protocols

Prostate Clinical Management Protocol
IT and Non IT patient inclusive

Protocol	Eligibility		Monitoring	Recall
Radical Prostatectomy *From 1st January 2020 discharge to GP at Year 5 if PSA has been undetectable for 5 years. Pts with measurable PSA < 0.05 continue surveillance to year 10.* *(Those patients recruited prior to 1st January 2020 will remain on 10 year follow up)*	Clinical decision by Consultant. Consider from 6 weeks post surgery. PSA ≤0.05 Completion of Holistic Needs Assessment with no ongoing functional or psychological problems requiring secondary care input identified on the HNA. Attendance at SSM workshop Refer to decision aid 2	Exclude patients with non-PSA producing tumours, patients who are unable to self-manage or are required to attend clinic to manage functional or psychological issues.	Protocol will commence from surgery date. • Year 1 – PSA every 3 months • Year 2-5 – PSA every 6 months • Year 6- 10 – PSA annually • Health MOT with every PSA test • PROM every 6 months	Post-Operative Biochemical Failure • Two consecutive rises in PSA and final PSA >0.1ng/ml OR • Three consecutive rises in PSA regardless of whether final PSA > than 0.1 ng/mL • New onset LUTS, visible haematuria, bone pain lasting >6 weeks Follow Recall Pathway

Protocols

Breast Clinical Management Protocol

Breast PTFU – years 1-5 from diagnosis
Breast Surveillance – years 6-10

Protocol	Eligibility		Monitoring/Surveillance	Recall
Breast Conserving Surgery +/- Endocrine Therapy	Completion of - • Surgery • Chemotherapy • Radiotherapy • Anti Her2 Therapy	Exclude patients who are unable to self manage or are required to attend clinic to manage functional or psychological issues. Those patients participating in clinical trials.	**Aged Under 50** **Years 1 – 5:** • Annual surveillance imaging • Year 5 – Pts on Endocrine Therapy: Review original plan. If no plan discuss with Consultant. • Discharged from PTFU **Years 6 – 10:** • Annual surveillance imaging until 50 years of age or 2 yearly if ≥ 50 years of age. • Discharge from surveillance imaging at 10 years. **Aged 50+** **Year 1 - 5:** • Annual surveillance imaging • Year 5 – Pts on Endocrine therapy Review original plan. If no plan discuss with Consultant. • Discharged from PTFU **Year 6 - 10:** • 2 yearly surveillance imaging until year 10.	• Abnormal surveillance imaging result Appointment for further assessment/investigation sent to patient from the Breast Imaging Unit **PTFU (years 1 – 5 post diagnosis)** Direct access back to clinic via CNS or GP Persistent symptoms lasting more than 2 weeks warrant investigation: • New lump in or around the breast, mastectomy or WLE scar, axilla or neck • New swelling of the arm • Unexpected weight loss, or loss of appetite • Shortness of breath or persistent cough • Nausea or abdominal pain • Headache or visual disturbances • Loss of balance • Unexplained bone pain in one or more places Discharged back to care of GP 5 years post diagnosis & re-referral required if new symptoms develop

Protocols

Bone Marrow Transplant Clinical Management Protocol

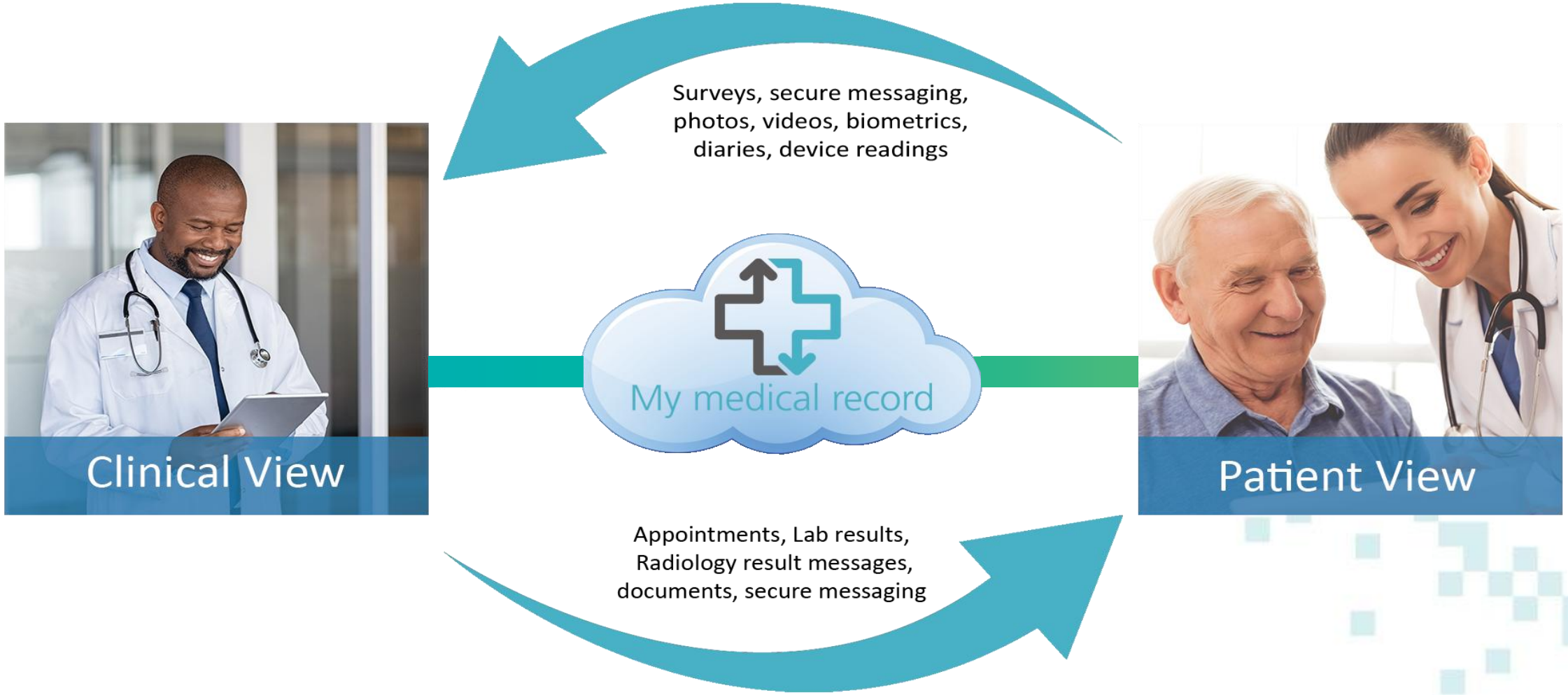
Protocol	Eligibility		Monitoring	Recall
Transplant protocol: All protocols used in Lymphoma **[Diagnosis:** Lymphoma including CLL]	Consultant decision to recruit onto PIFU Disease is in a Complete Remission (CR)/ PET scan negative Has attended PIFU information session Absence of Graft Vs Host Disease (GvHD) Not on active treatment e.g., Tyrosine Kinase Inhibitor/Donor Lymphocyte Infusion From Year 3 post-transplant	Exclude patients who are unable to self-manage or are required to attend clinic to manage functional or psychological issues	**Year 1 & 2 – hospital based follow up** If a patient has low CD4 counts, perform BMT immune reconstitution profile on each blood test **Year 3 –** • **BMT clinic bundle** – FBC, UEC, LFT, Gamma GT, LDH, CRP, Retics, Bone Profile, Phosphate, Magnesium – Month 4, 8 & 12. • **BMT late effects annual screen bundle** – Vit D, HBA1c, Cholesterol, Ferritin, Folate, Glucose, TFT, Vit B12, ESR, Immunoglobulins, Hormone Profile (LH, FSH, Testosterone/Estradiol) – Month 12 • Blood pressure – patient led @ month 12 • Weight – patient led @ month 12 **Year 4 –** • **BMT clinic bundle** – Month 6 & 12 • **BMT late effects annual screen bundle** – Month 12 • Blood pressure – patient led @ month 12 • Weight – patient led @ month 12 **Year 5 –** • **BMT clinic bundle** – Month 12 • **BMT late effects annual screen bundle** – Month 12 • Pneumococcal IgG, Tetanus IgG, and Haemophilus-b for vaccine response assessment • DEXA bone density scan • Pulmonary function test • Echocardiogram (if pre-transplant ECHO abnormal) • Blood pressure – patient led @ month 12 • Weight – patient led @ month 12 **Year 6, Year 7, Year 8 & Year 9 -** • **BMT clinic bundle** – Month 12 • **BMT late effects annual screen bundle** – Month 12 • Blood pressure – patient led @ month 12 • Weight – patient led @ month 12 **Year 10 –** • **BMT clinic bundle** – Month 12 • **BMT late effects annual screen bundle** – Month 12 • Pneumococcal IgG, Tetanus IgG, and Haemophilus-b for vaccine response assessment • DEXA bone density scan • Pulmonary function test • Blood pressure – patient led @ month 12 • Weight – patient led @ month 12	Trend changes/new abnormalities in blood results. Patient reports symptoms lasting more than 2 weeks: • Unexplained bleeding e.g., from mouth, urinary tract, back passage • Skin rash • More than 2 infections in 4 months • Persistent cough for mor than 2 weeks • Jaundice- yellowing of the eyes/skin • Unexplained weight loss or loss of appetite • Pain or unexplained discomfort • Shortness of breath at rest or on exertion • Persistent worsening tiredness/fatigue • Enlarged lymph nodes • Night sweats **OR** A failure for the patient to perform blood tests on 2 separate occasions. [Arrange bloods in preparation for OPA/telephone review: BMT clinic bundle]

Protocols

Endometrial Clinical Management Protocol
PTFU – Year 1-5

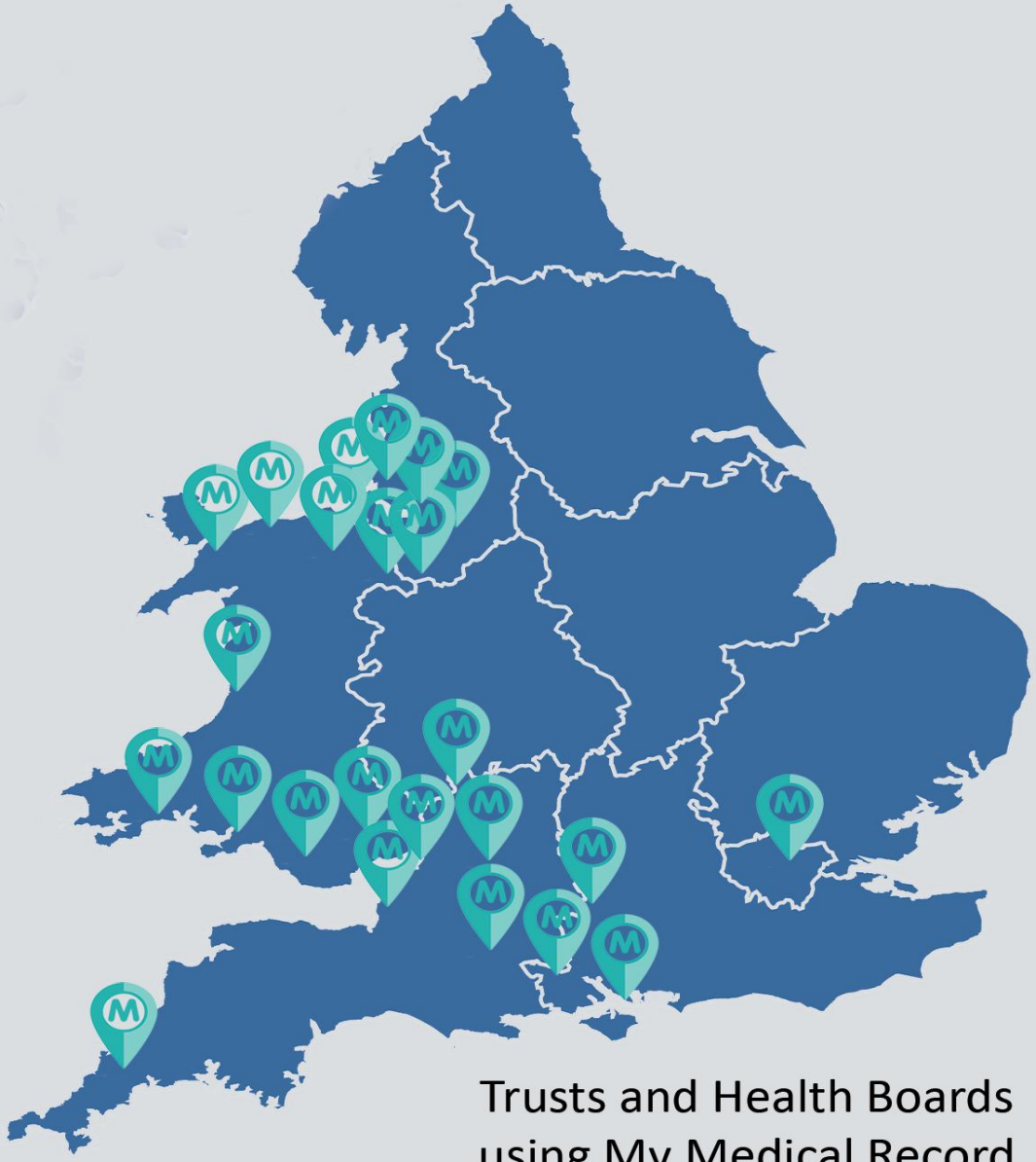
Protocol	Eligibility		Monitoring	Recall
Surgery +/- External Beam Radiotherapy (EBRT) +/- Brachytherapy +/- Adjuvant chemotherapy	Consider at 1st OPA post treatment intervention No ongoing functional or psychological problems requiring secondary care input identified on symptom checklist.	Exclude patients who are unable to self manage or are required to attend clinic to manage functional or psychological issues	Annual Symptom Checklist Surveillance & Care Planning	Patient reports symptoms of - • New onset vaginal bleeding or discharge • Abdominal pain • Unexplained weight loss or loss of appetite • Persistent changes in bowel habit (constipation/diarrhoea) • Persistent problems when passing urine CNS input, discussion with clinical team & ongoing plan made. Book back into OPA for Consultant review. Refer to Endometrial PTFU Recall Pathway

Developing A Digital Relationship With Patients To Manage Their Care



My Medical Record

- UHS started development in 2012
- Live in over 30 hospitals
- Utilised by over 50 different clinical specialties*
- Over 300k registered patients
- 650k documents
- 2 million laboratory results



Trusts and Health Boards using My Medical Record

My medical record

* Cancer Specific in other hospitals - Breast, Colorectal, Prostate, Pre-surveillance (prostate), Haematology, Skin, Upper Gi, Renal, Liver, Dermatology, Gynae, Germ Cell & Lung

UHSdigital

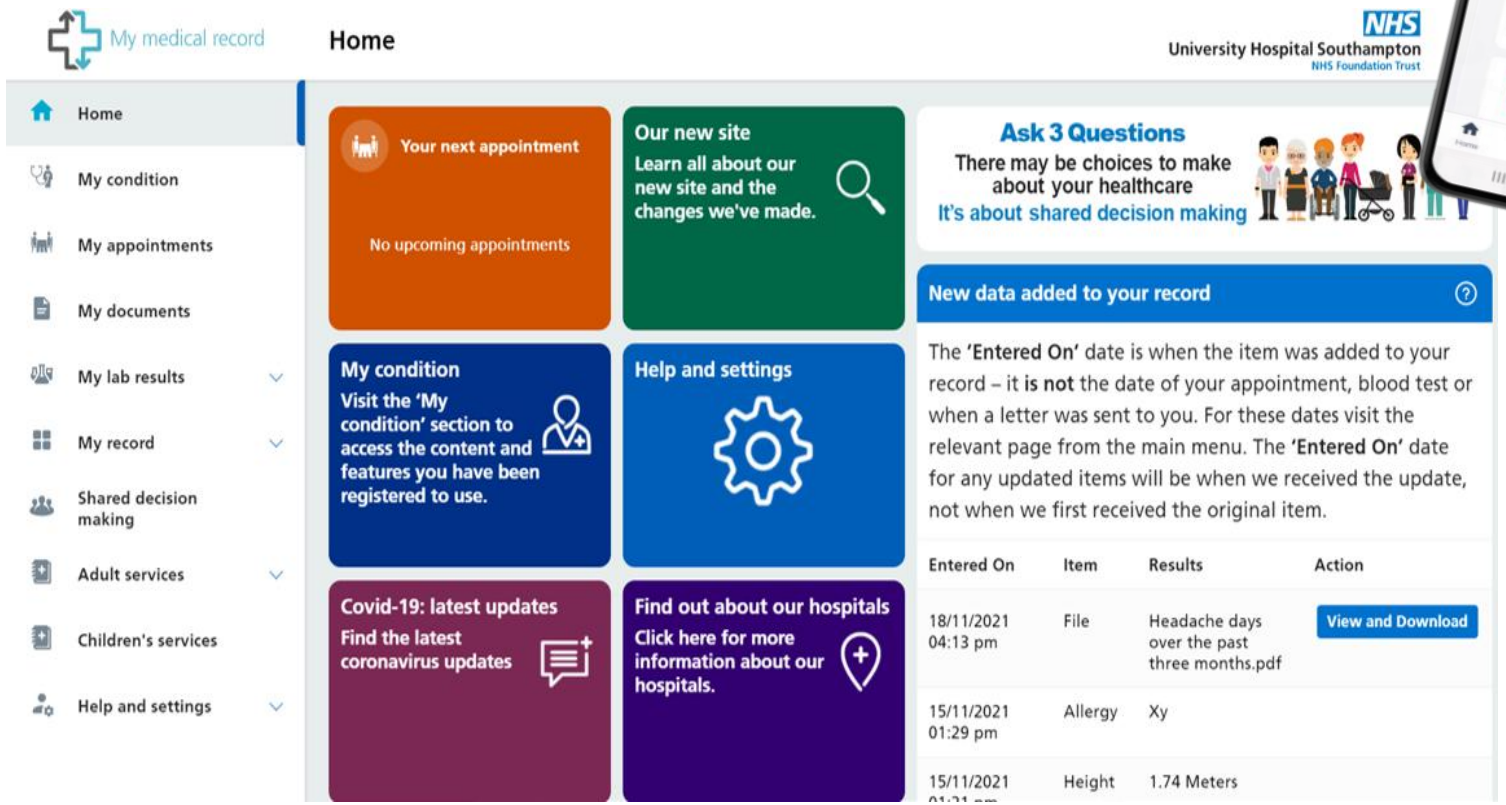
Our Patients

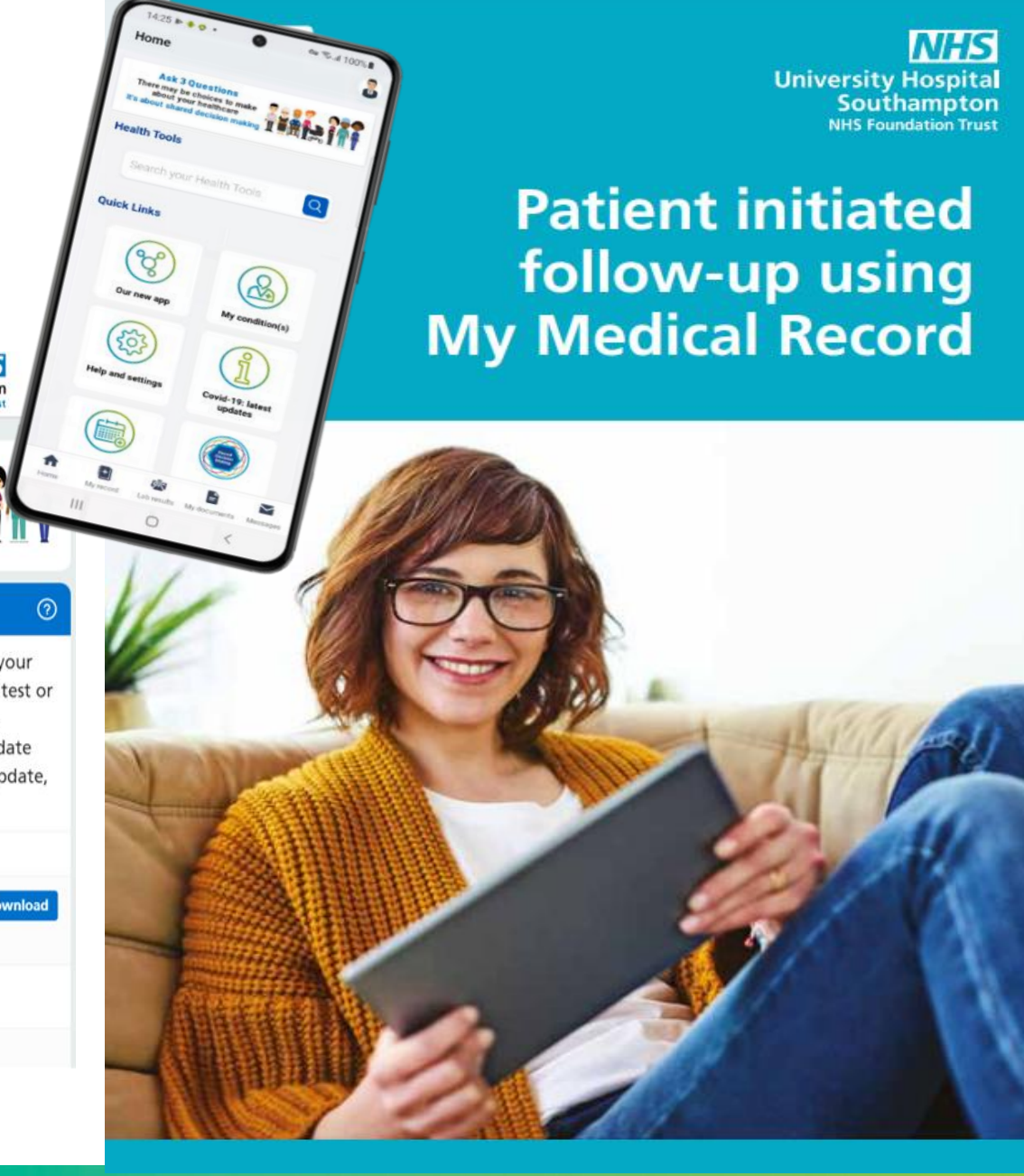
Speciality	Patients Using My Medical Record
Prostate	27,867
Breast	15,733
Colorectal	9,500
Dermatology	4,658
Skin	4,582
Hepatology	4,229
Haematology	2,702
Germ Cell	674
Lymphoma	568
Gynaecology	544
Endometrial	504
Renal	325

Speciality	Patients Using My Medical Record
Liver	313
Lung	284
NET	149
Thyroid	81
Advanced Bowel	52
Prostate Surveillance	11
Bladder	10

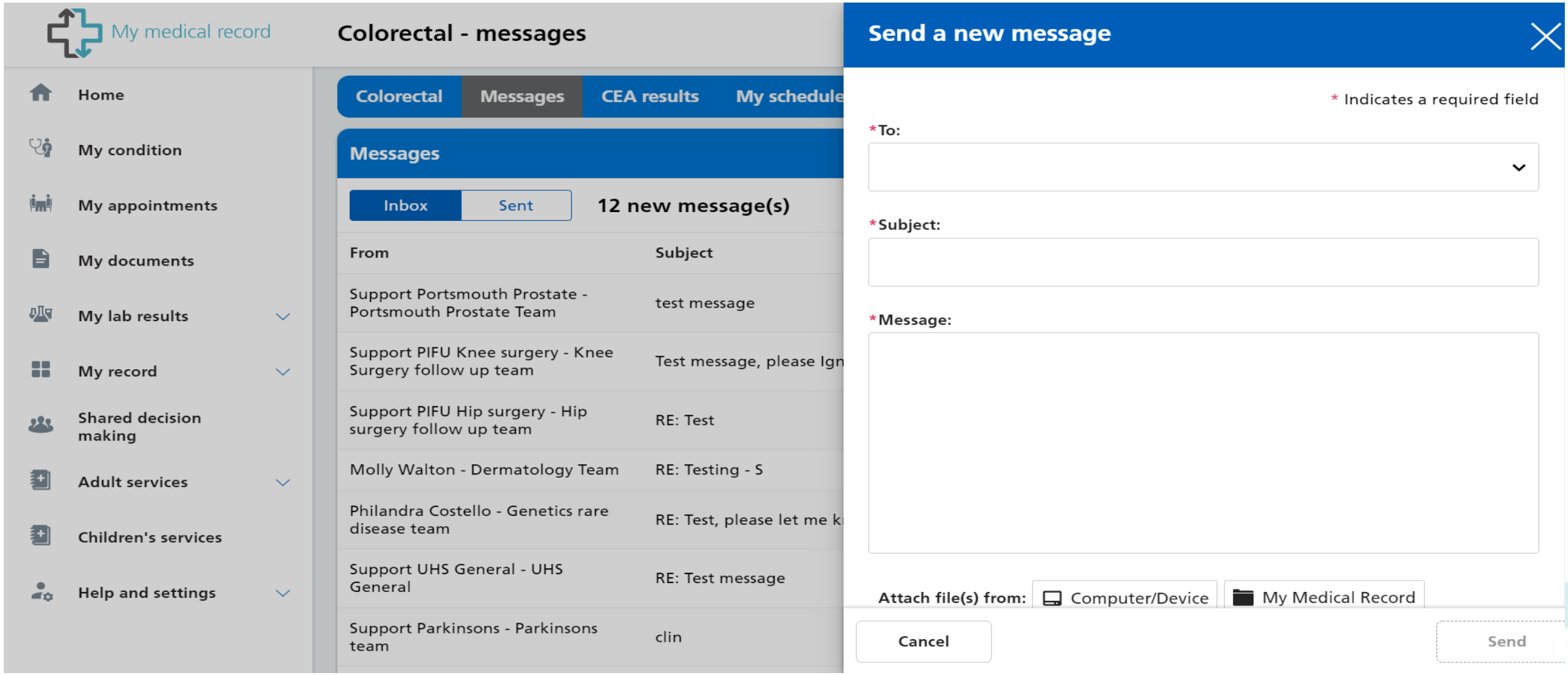
72,786 patients rely on My Medical Record in the UK

My Medical Record - Patient Pages

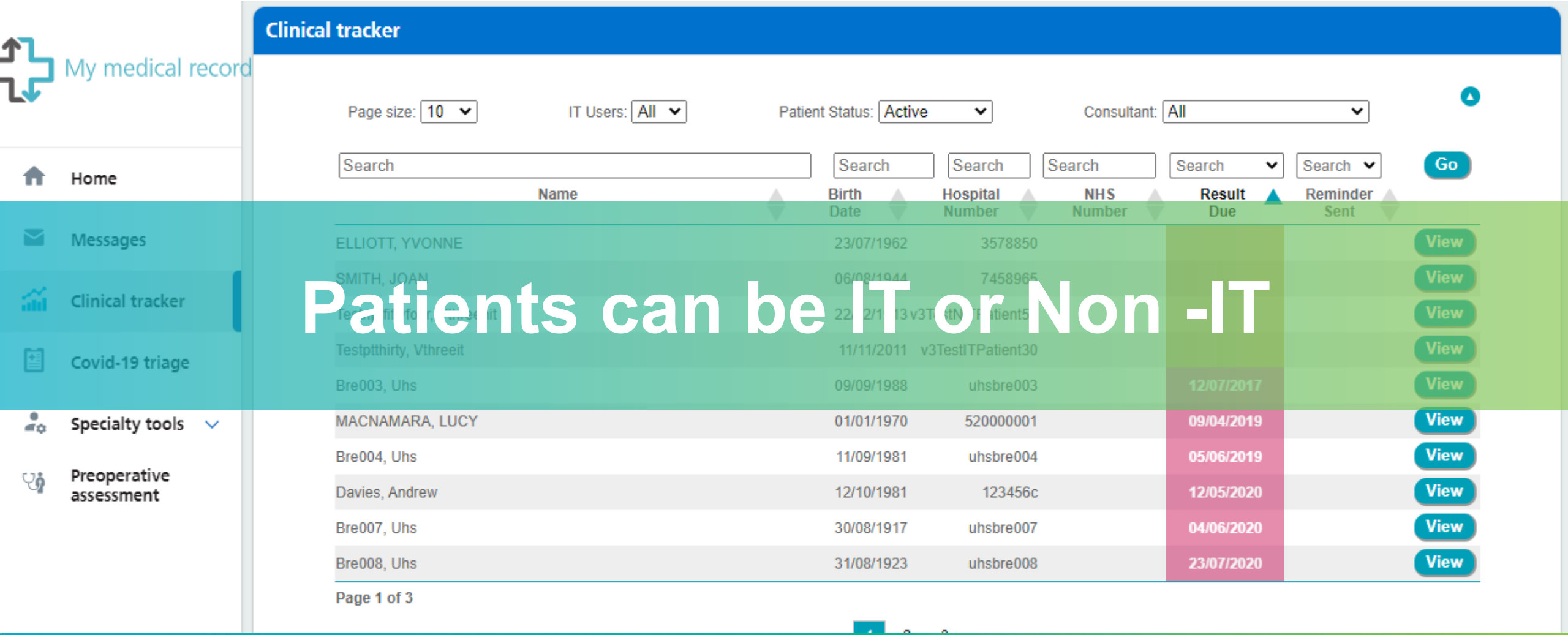




My Medical Record – Messaging

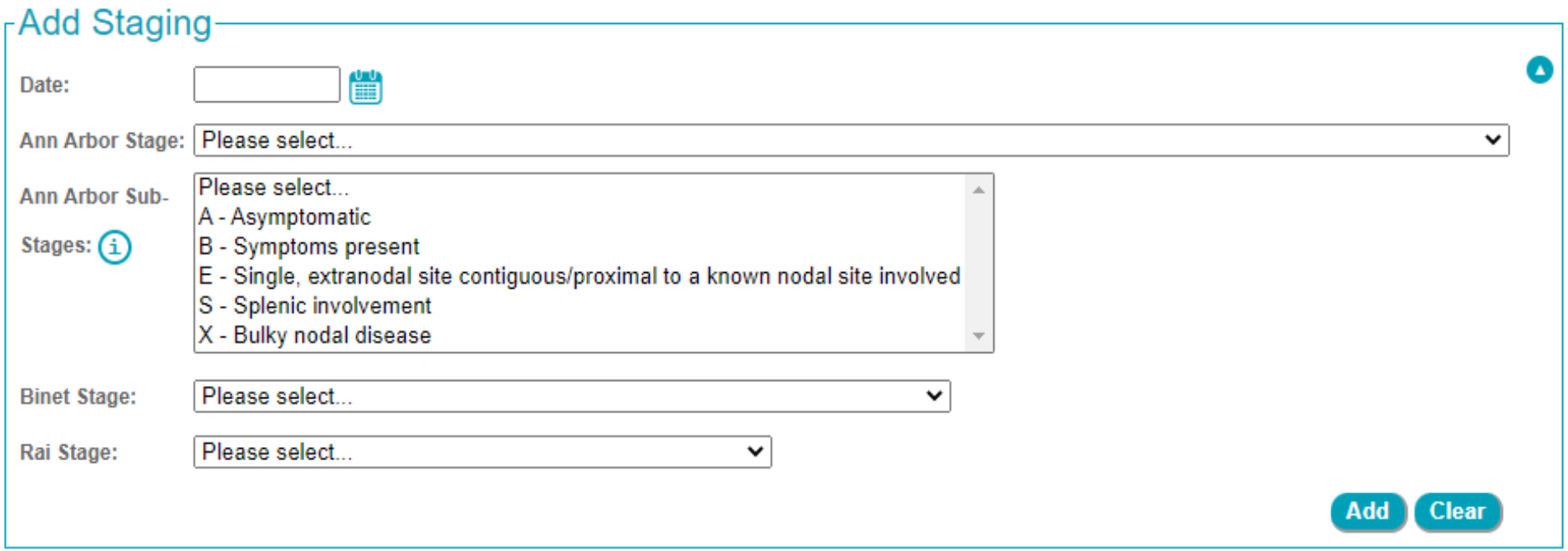


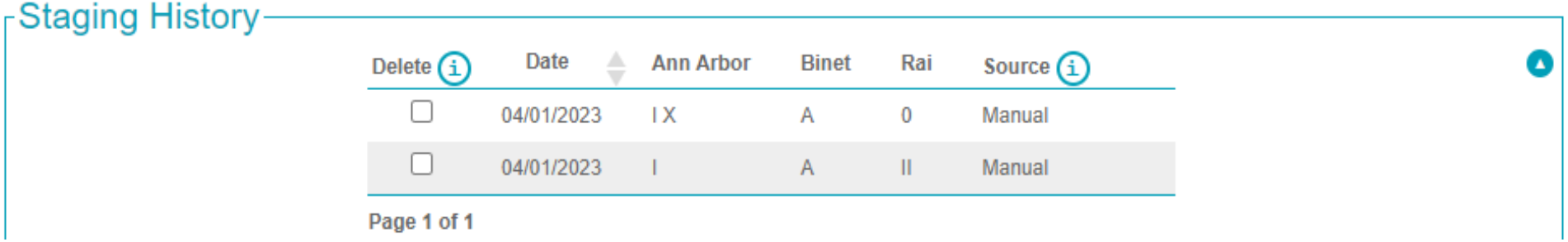
My Medical Record – Clinical Tracker



Patients can be IT or Non -IT

My Medical Record Tracker - Staging





PIFU My Medical Record Tracker - Protocol

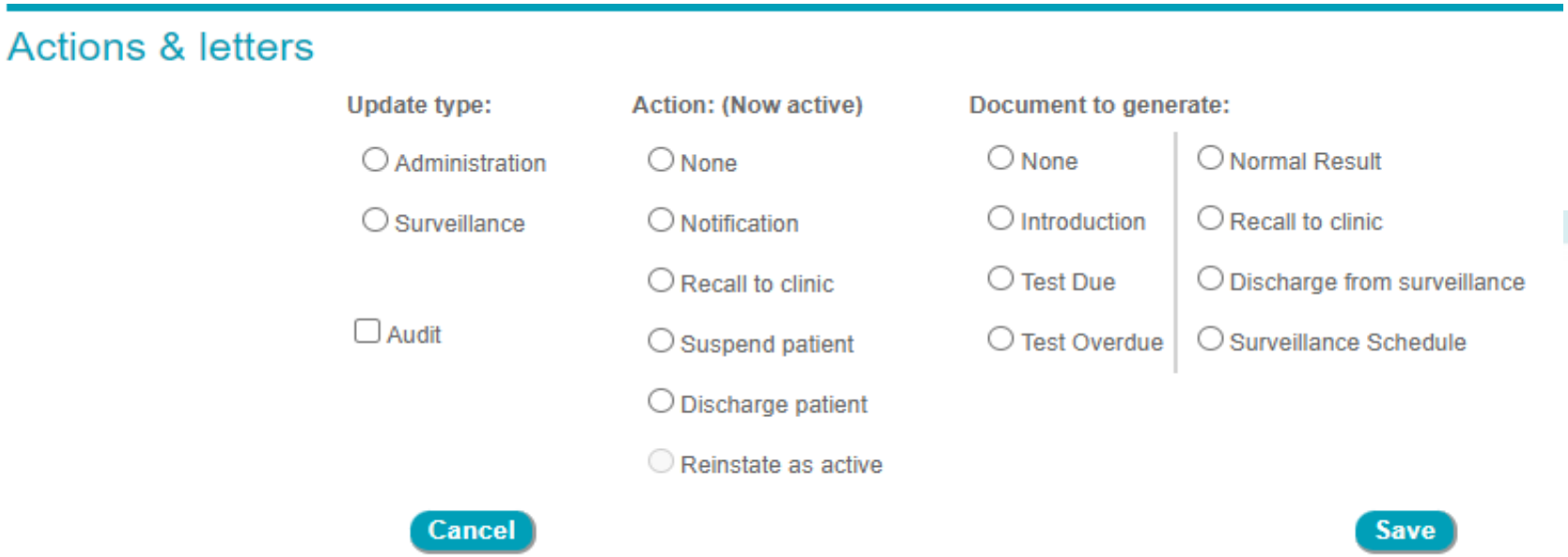
Current Protocol: CLL & SLL started on 04/01/2023

Add Event | Choose Protocol

Protocol	Event	Date ▲	Tasks	
CLL & SLL	6-monthly	04/07/2023	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	Edit Delete
CLL & SLL	Annual	04/01/2024	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	Edit Delete
CLL & SLL	Annual	06/01/2025	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	Edit Delete
CLL & SLL	Annual	05/01/2026	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	Edit Delete
CLL & SLL	Annual	04/01/2027	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	Edit Delete
CLL & SLL	Annual	04/01/2028	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	Edit Delete
CLL & SLL	Annual	04/01/2029	Bone Profile FBC HNA Immunoglobulins LDH LFT UEC	Edit Delete
CLL & SLL	Annual	04/01/2030	Bone Profile FBC HNA Immunoglobulins LDH	Edit Delete

PIFU My Medical Record Tracker - Surveillance

- Monthly surveillance using My Medical Record clinical tracker – CNS/CSW
- Each patient's results are checked against the protocol – bloods, CT, MRI, Colonoscopy etc
- Symptom questionnaire/HNA is checked for any new reported symptoms & action taken
- Surveillance notification sent to patient and G.P. electronically or by post



MyMR – Overall Cancer PIFU Benefits

Between April 2024 – March 2025 there were **10,489 virtual surveillance reviews**

Between April 2024 – March 2025 there were 3**,827 messages** between Patients & PIFU Teams

Virtual reviews saved **3,496 hours of Consultant time = £188k saved**

638 hours of Clinical Nurse Specialist time was saved by using messaging instead of telephone calls

Virtual reviews saved patients **230,000 miles in travel & 61,000 kilos of carbon**

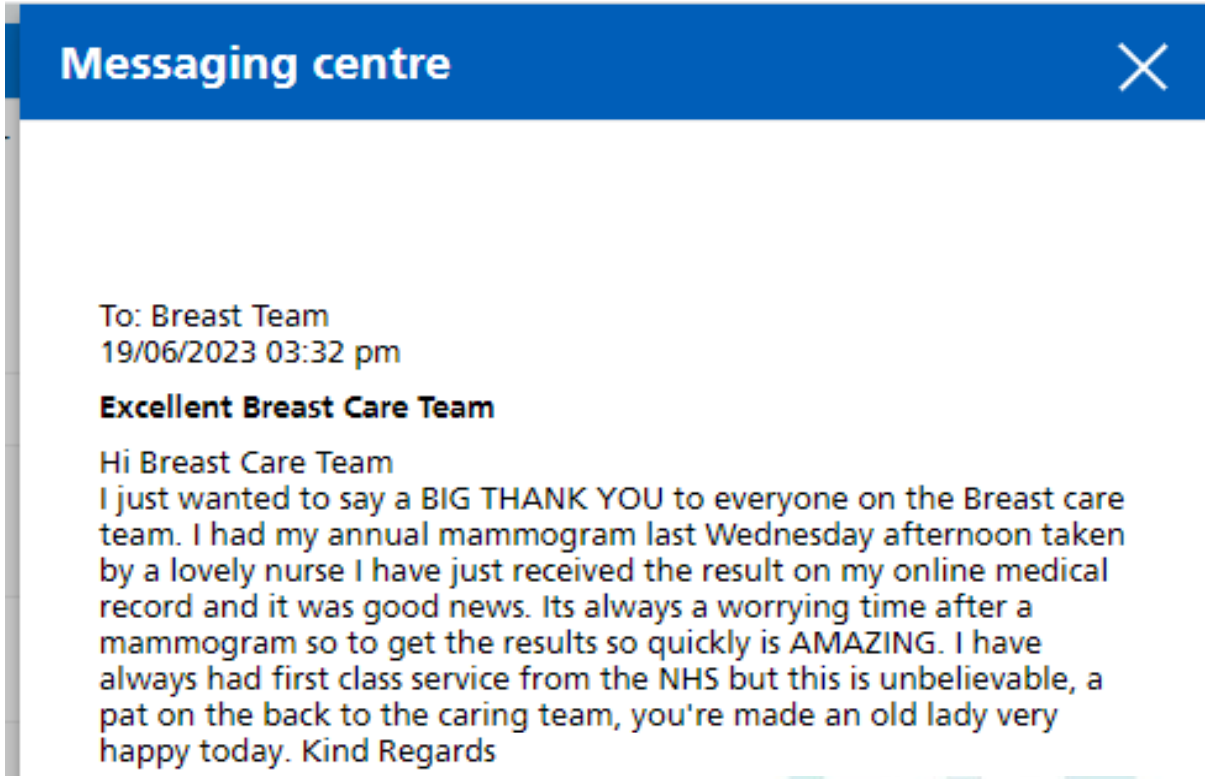
Virtual reviews saved patients **£54k in travel expenses**

UHS Patients Permission for photograph to be used.

Benefits of PIFU

“There is a significant advantage in terms of being able to access both my schedule and results online. I’m safe in the knowledge that if I do have any concerns, I can immediately escalate them”

“Thank you so much for getting back to me so quickly, about 90 minutes by my reckoning. What a fantastic service!”


Messaging centre

To: Breast Team
19/06/2023 03:32 pm

Excellent Breast Care Team

Hi Breast Care Team
I just wanted to say a BIG THANK YOU to everyone on the Breast care team. I had my annual mammogram last Wednesday afternoon taken by a lovely nurse I have just received the result on my online medical record and it was good news. Its always a worrying time after a mammogram so to get the results so quickly is AMAZING. I have always had first class service from the NHS but this is unbelievable, a pat on the back to the caring team, you're made an old lady very happy today. Kind Regards

PIFU Teams – CNS & CSW

Nursing Times Awards 2022
FINALIST

Thank you, any questions?

Email: claire.marsh@uhs.nhs.uk

References

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2.NHS Improvement. Innovation to implementation: Stratified pathways of care for people living with or beyond cancer. A ‘how to guide’ (2013) https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf
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5. https://staffnet.uhs.nhs.uk/TrustDocsMedia/DocsForAllStaff/Clinical/Cancer-Patient-Initiated-Follow-Up-PIFU-Policy/Cancer-PIFU-Policy-1.1.pdf

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Case Study

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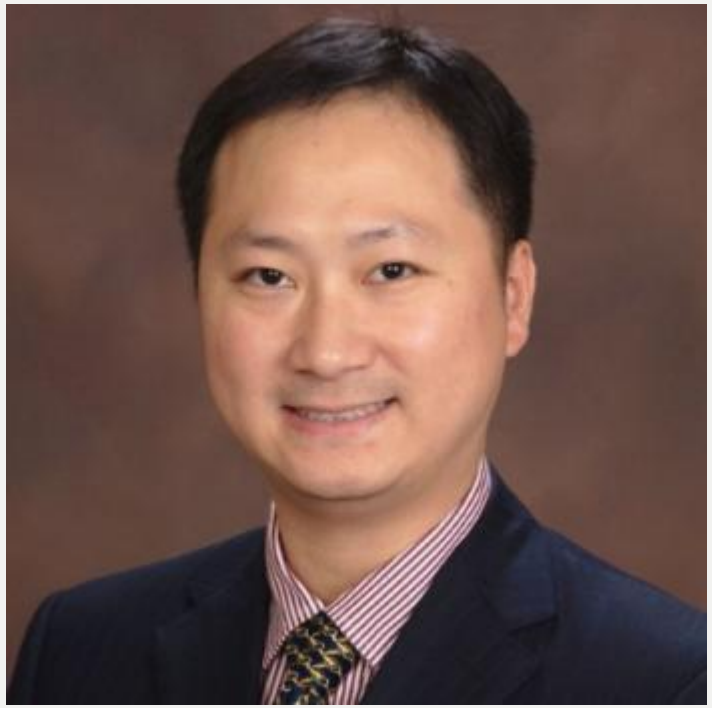
Case Study



Roger (Xiaohua) Zhang
Vice President
Koning Corporation

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Keynote Presentation

Valentin Butnari
Clinical Research Fellow
Department of Surgery, Barking, Havering and Redbridge
University Hospitals NHS Trust

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SCAN ME

Keynote Presentation

Kathy Nelson
Programme Director
BLMK ICB

Improving cancer outcomes

Insights and strategies from the Luton Cancer Outcomes project

Kathy Nelson, Luton Cancer Outcomes Project Lead, BLMK Integrated Care Board (ICB)
Naisha Henry, Cancer Transformation Manager, BLMK Integrated Care Board (ICB)
Sofia Aziz , Public Health Manager – Health Equity, Workplace Health and Communities, Luton Borough Council

Sponsored by BLMK ICS Cancer Board

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

NHS England

Public Health England

Luton

East of England Cancer Alliances

healthwatch

WE ARE MACMILLAN. CANCER SUPPORT

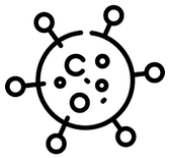
NHS Bedfordshire Hospitals NHS Foundation Trust

What was the problem we identified

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

We know that Luton in particular has:

- Historically low **suspected cancer referral rates**
- Higher than average **emergency presentation** rates
- Lower than average **1 year survival rates** compared to other areas



In 2020 25% of deaths in Luton were caused by cancer.

Urgent GP referrals for breast, colorectal and lung cancer were high in Luton

Lung cancer is the biggest contributor to premature mortality, followed by colorectal cancer and breast cancer.

Awareness of the signs and symptoms of cancer is low in Luton

Specialist provision is outside of the BLMK borders with significant travel times

		Early Stage	Emergency Presentations	Survival Outcomes	
Cancer Alliance	CCG	Early stage	Emergency presentations	One-year survival	Five-year survival, Cancer Alliance-level only
	Period covered:	Calendar Year 2018	Financial Year 2019-Q1	Adults diagnosed 2001 to 2016 and followed up to 2017	Adults diagnosed 2001 to 2013 and followed up to 2017
	Source:	CADEAS on CancerStats 2	CADEAS on CancerStats 2	CADEAS on CancerStats 2	CADEAS on CancerStats 2
East of England South	NHS Bedfordshire CCG	58.4%	17.7%	72.7%	72.9%
	NHS East and North Hertfordshire CCG	60.5%	16.9%	74.2%	
	NHS Herts Valleys CCG	57.0%	19.1%	73.1%	
	NHS Luton CCG	55.2%	21.2%	69.3%	
North Central	NHS Barnet CCG	57.9%	23.4%	78.3%	73.7%
	NHS Camden CCG	54.9%	16.7%	75.3%	
	NHS Enfield CCG	57.3%	20.4%	75.2%	
	NHS Haringey CCG	58.3%	20.2%	73.2%	
	NHS Islington CCG	53.3%	17.9%	73.8%	
Surrey and Sussex	NHS Surrey Heath CCG	54.2%	21.7%	77.1%	75.6%
Thames Valley	NHS Buckinghamshire CCG	55.7%	18.7%	74.8%	
	NHS East Berkshire CCG	56.7%	15.0%	73.8%	74.6%
West London	NHS Brent CCG	51.7%	19.0%	73.8%	74.1%
	NHS Hillingdon CCG	55.7%	22.1%	72.8%	

A review of outcomes in Sept 2020 of the areas served by the Mount Vernon Cancer Centre showed significant health inequalities and poor cancer outcomes in Luton.

The challenge: Setting the scene

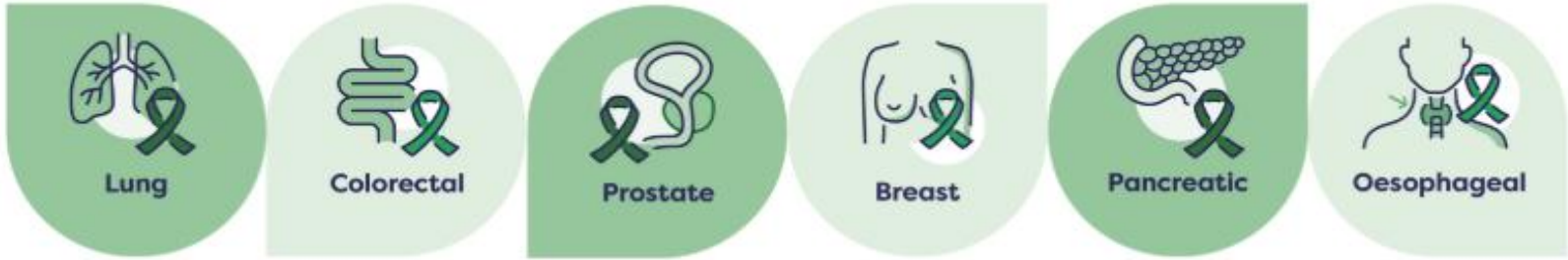
Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

The Luton Cancer Outcomes project aims to identify key factors: medical, behavioral, social, and more that affect cancer outcomes in Luton residents and to recommend and implement improvements for these outcomes.

The project looked at four key **outcome measures:**

1. Stage at diagnosis
2. Emergency presentation
3. One year survival, and
4. Five year survival

The project focused on the six cancers with the highest rates of early deaths in Luton:



The project also aims to identify the sources of health inequalities and implement impactful changes.

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Meet Nam

Nam's story is a powerful illustration of some of the wider determinants that impacts the ability of some residents to access services or make informed decisions about their health or treatment options.

This is Nam.
Nam lives in Luton. She was invited for routine cervical screening last year.

What should happen

Screening is carried out in good time, further tests undertaken and cancer diagnosed early

Nam travels to Mount Vernon for her radiotherapy treatment

The treatment course is complete and Nam's cancer is in remission

What did happen

Nam delayed going for screening because she did not want to see her male GP

Nam does manage to make an appointment with a female nurse, but her cancer is already advanced

As Nam cannot drive and her husband cannot get time off work to take her to her appointments, she is not able to travel to Mount Vernon for treatment

Nam is referred for radiotherapy

Not being able to access treatment, Nam is put onto a palliative care pathway

The challenge: Report Findings

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

- Poor cancer outcomes in Luton are multi-faceted.
- Health inequalities exacerbated during the pandemic affect cancer diagnosis and treatment access.
- Ethnicity and culture influence barriers to screening, while broader issues like transport and work affect treatment access.
- COVID has hindered early prostate cancer diagnosis; new outreach methods are needed.
- Patient experiences are generally positive, but not all community voices are heard.
- Late presentation of cancer symptoms continues to impact survival rates.
- There are opportunities to make small but significant changes to the cancer pathways between the local hospital and Mount Vernon (Cancer treatment centre) that would improve patient experience

Using a QI approach the project group has moved from identification, analytics and review and now moved into testing and implementation phase of change ideas that will benefit Luton residents

The change: Projects overview

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Lung Cancer

Lung Health Check Programme

All cancers

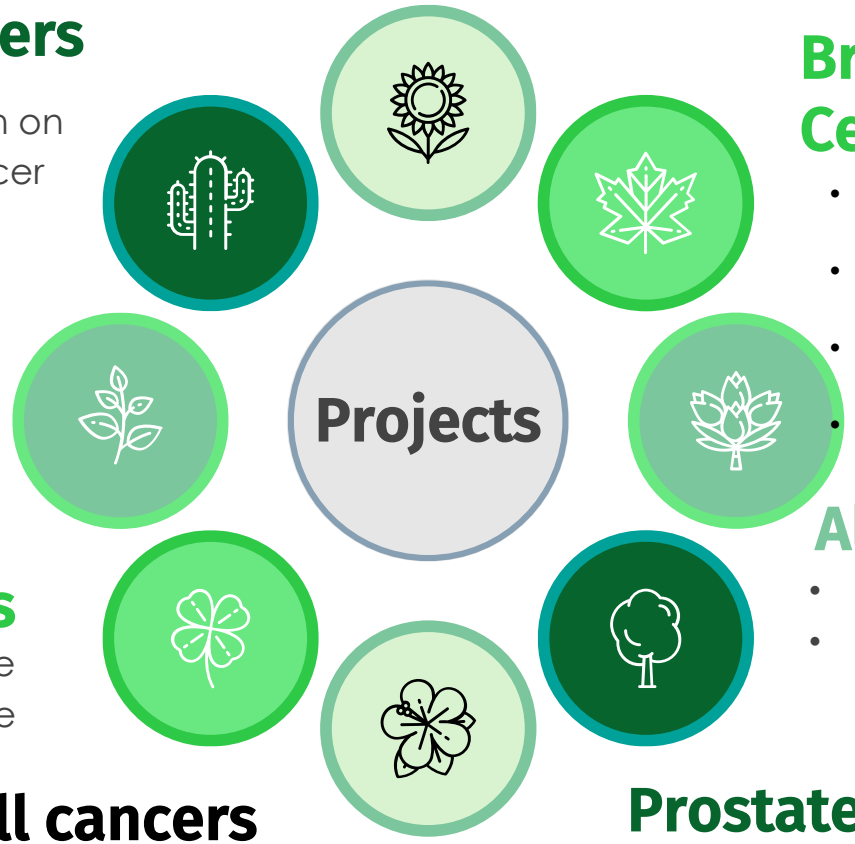
University of Bedfordshire evaluation on community readiness to talk about cancer

All cancers

Improved referral quality and training for GPs and practice staff

All cancers

2 year Community Transport scheme working with local Dial-a Ride



Breast, Colorectal, Cervical Cancer

- Medics PCN breast screening learning disability project
- Phoenix PCN breast screening engagement with South Asian community
- Behavioural change approach to improving cervical screening uptake
- Luton/NHSE Bowel cancer screening text message project

All cancers

- Cancer Community Connectors
- Events to raise awareness of cancer signs and symptoms

All cancers

- Radiotherapy uptake audit
- Redesign cancer pathway for people presenting in A&E
- Care Closer to home (Blood tests and treatments)

Prostate Cancer

- Case finding project
- Barbershop Live community engagement event

The change: Delivering transformation

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

- Reduction of cancer-related deaths from 25% to 19%.
- Increased awareness among GPs and patients about prostate cancer, with 36 cases diagnosed from a targeted pilot.
- The Targeted Lung Health Check program identified 33 cancers, 79% at early stages.
- Hospital staff are more attuned to patient barriers and treatment decision discussions.
- Open dialogues with communities via cancer community connectors and faith leaders.
- Increased referrals for urgent suspected cancer and improved emergency presentation rates (less people are being diagnosed in an emergency setting).
- The Luton Transport Scheme completed 208 trips for cancer patient appointments in 2024 compared to just 1 recorded NHS patient transport journey in 2019.
- Behavioral science resources launched across the system.
- Closer collaboration between practices and the Breast Screening team.
- Strong evidence base and voice for the upcoming radiotherapy consultation.

Demonstrating impact: Prostate Case Finding Project

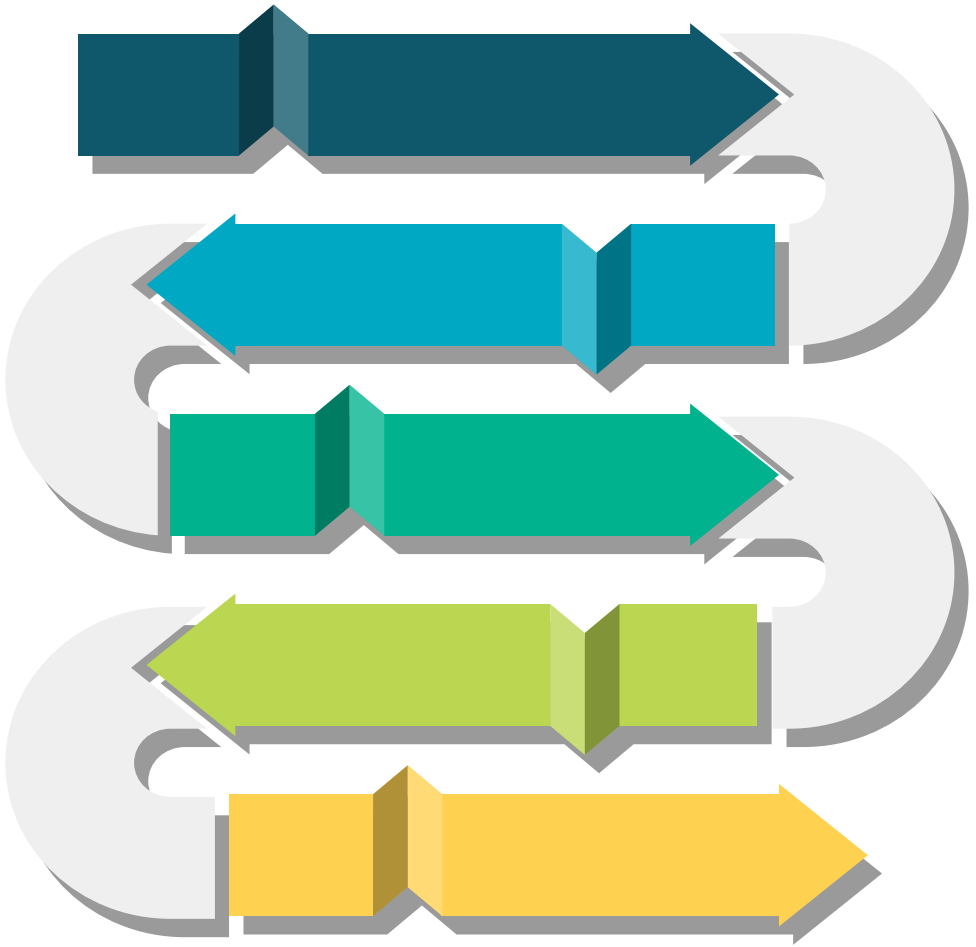
Bedfordshire, Luton and Milton Keynes Health and Care Partnership

What we knew

Low prostate cancer diagnoses during the pandemic/large high-risk population
Prostate cancer risk higher in Black men

Activity

4 Primary Care Networks
736 PSA tests completed
36 cancers diagnoses
'Barbershop' live event



Plan

Implementation of case-finding project.
Link with PCN DES.

Lessons Embedded

- Reviewing of ethnicity codes
- Effective coding of family history of prostate cancer
- Improved coding of PSA tests and recall systems

Karl's story

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Karl went to see his GP in relation to discussing results of his Diabetes management plan. The GP reviewed his notes and determined Karl met the requirements for the Prostate case finding pilot. The GP discussed prostate cancer risk with Karl, as he fell into the high risk category, and offered him a series of tests (PSA and examination). Karl's results came back requiring further review.

A few weeks later Karl had further tests (MRI and biopsy) which confirmed Stage 2 cancer. Stage 2 prostate cancer is treatable with options for surgery or different types of radiotherapy. Karl was able to discuss his treatment and decide on the best option for him.

When asked how he felt he described feeling shocked, concerned and worried about his future but having the support of the medical team helped him understand how catching cancer early improves survival outcomes.

Demonstrating impact: Cancer community connectors

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

The project recruited 4 roles in partnership with Macmillan Cancer, Luton Borough Council and BLMK Integrated Care Board to support the community engagement aspect of the project.

The team engages with Luton residents with a focus on:

- **Eastern European** communities (linked to smoking rates and emergency presentations),
- **Black African and Caribbean** communities (linked to uptake of screening and high incidence of prostate cancer), and
- **South Asian** communities (linked to uptake of screening and liver cancers)

Community Connectors – from recommendation to legacy

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

The problems we started with

- Late-stage diagnosis too common
- Screening rates low in target groups
- Language, trust, cultural barriers
- No tailored model for sustained engagement

What we built

- Connectors who represented their communities
- Multi-stakeholder partnership and steering group
- Engagement with communities to share information, collect insights
- Built on trust between communities, local authority and invested organisations
- Developed community-based approaches by increasing capacity and capability within the community
- Provided a route for co-design / co-production of approaches to service delivery

Community Connectors – from recommendation to legacy

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

What we achieved

- A presence at 124 events
- Over 4,000 contacts made with residents
- New networks built with VCFSE and Faith leaders
- Deep insights into barriers such as language, transport, cancer pathways / systems being overly complex leading to drop-off in engagement

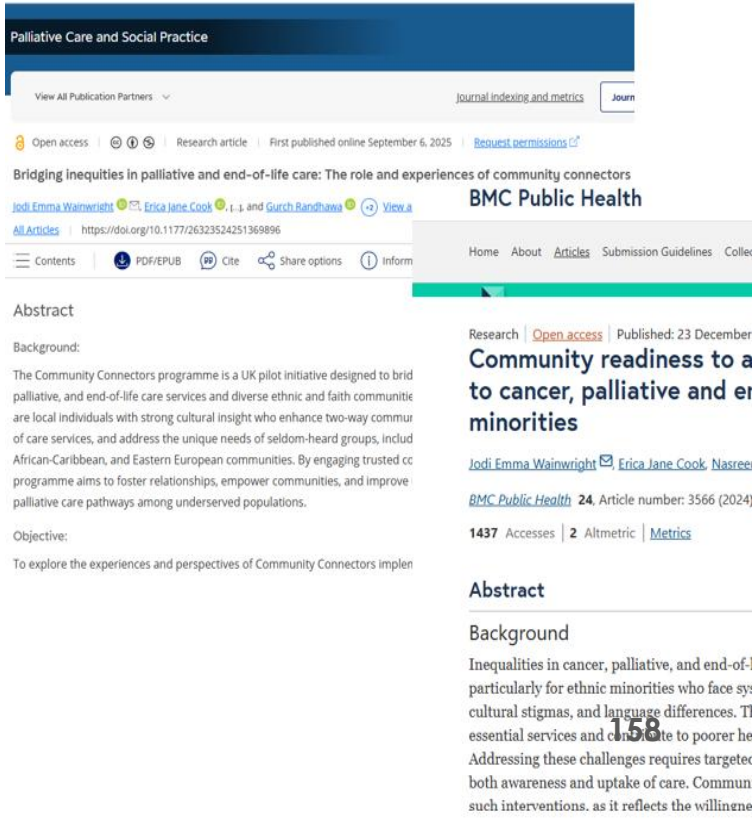
Legacy

- Communities to have an involvement in service design, residents will engage deeply when approached on their terms
- A Black Medical Health Steering group, and a Muslim Health Alliance group
- Understanding it takes time to build trust, especially with newly arrived communities who may not have developed strong community groups
- A chance to align with the NHS 10 Year Plan, Luton Health Equity Town partnership and the BLMK ICB Core20PLUS5 programmes, and widen the scope of connectors, as a model which can be replicated

Conclusion

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

- Used a **QI approach** to make changes – we can see many actions are now embedded as best practice
- The impact on residents – giving people a **voice** and encouraging open conversations about cancer in communities
- The project has **regional and national recognition** ie HSJ inequalities conference, IHI conference, Kings Fund inequalities conference and more
- This is recognised as a priority programme for the ICB/ Local Authority and has **influenced strategic commissioning decisions** around the reprovision of cancer care for Luton residents
- The model of using population health to address a problem can be replicated in other clinical areas
- The work has been **published** in national public health and palliative care journals
- We looked at other solutions and there was nothing that was **whole person** specific we now have a chance to influence **lasting** change for residents recognising the **broader inequalities** not just health.



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Thank You

Any Questions?

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SCAN ME

Panel Discussion

Katey Evans
Personalised Care Navigator
Shrewsbury and Telford Hospitals Trust

Mr John-Paul Crofton Biwer
Founder
Edge of Possible Consultancy

Mr Ravi Chana
Executive Director, Diagnostics
ABHI (Association of British Healthtech Industries)

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SCAN ME

Food, Drinks & Networking