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23rd September 2026

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SCAN ME

Chair Morning Address



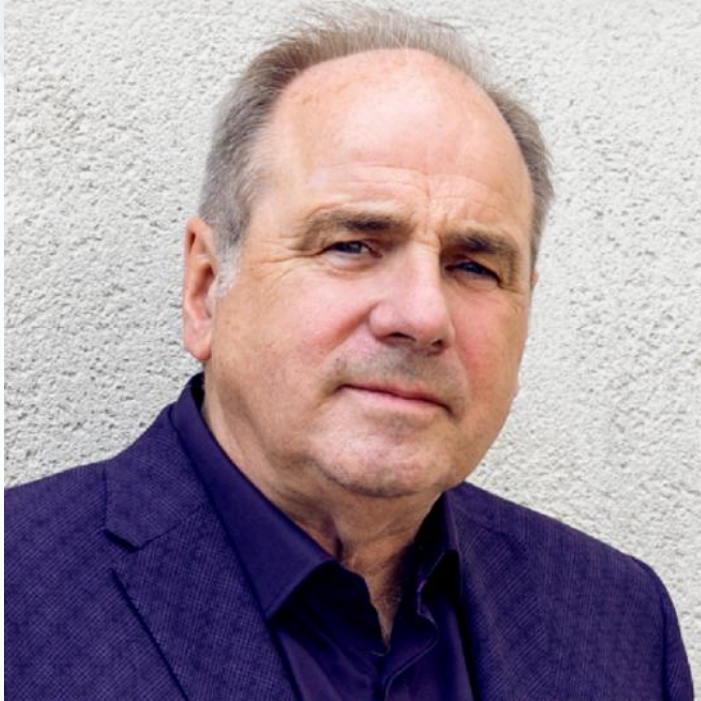
Chris Sleight MSc BSc FIBMS

Chief Executive Officer of Sleight Insights

Formerly Chief Officer of the Greater Manchester Diagnostic
Networks



Keynote Presentation



Kevin Moore

Professor of Hepatology

University College London & Royal Free London
Foundation Trust



Scaling Long-Term Surveillance and Diagnostic Screening Services across the NHS

Kevin Moore

Professor of Hepatology

University College London

& Royal Free London Foundation Trust

Chief Medical Officer & Co-Founder, Salutare Group Ltd

Screening and Surveillance

Decrease morbidity and mortality: Early disease more treatment options $\pm$ cure

Screening

Find disease in healthy

Targeted Screening

Screen an at-risk population

Case finding

Opportunistic testing

Surveillance

Repeatedly test patients at risk

Cervical Screening

Cervical Cancer 3500 cases/year 1000 deaths/year

Pre-2025: Cervical smear every 3 years

- unpleasant, misses 25% cancers
- *In 2018, Capita failed to send 43,220 cervical-screening letters*
- *Historically it was taking several weeks to get results.*

Primary HPV testing is superior to cytology-first screening.

- *Four large European trials - women allocated to HPV-based screening had 40% fewer invasive cervical cancers vs cytology screening*
- *Clinician collected HPV vaginal swab – 93% predictive of CIN2*
- *HPV testing is biologically earlier, more sensitive and more automatable. 5 years*

Lung Cancer Screening

Lung Cancer 33000 deaths/year, 52000 cases/year

Low dose non contrast CT scan

- 800 000 tested, 10 500 cancers detected, with 75% stage 1 or 2 vs 30% pre
- *60% of participants at highest risk account for 88% of the lung-cancer deaths prevented by screening*
- *24% Reduction of lung cancer mortality*
- *NELSON identified nodule volume and growth rate. Only 2.1% were ultimately referred because of a suspicious result. AI is creating further evolution of method*

CT didn't become more accurate — the image analysis became smarter.

Blood Borne Viruses

First 33 months 2022-2024

	HIV	Hepatitis C	Hepatitis B
Tests performed*	1.98m	1.5m	1.19m
New diagnoses†	391	762	1957
New-diagnosis yield	0.018%	0.051%	0.16%
Number needed to test for one new diagnosis	5400	2000	600

Of HBV cases 16.7% had severe fibrosis and 20% needed anti-viral drugs or HBV-DNA >2000 IU/ml

Of HCV, 12.5% had cirrhosis or late-stage liver disease

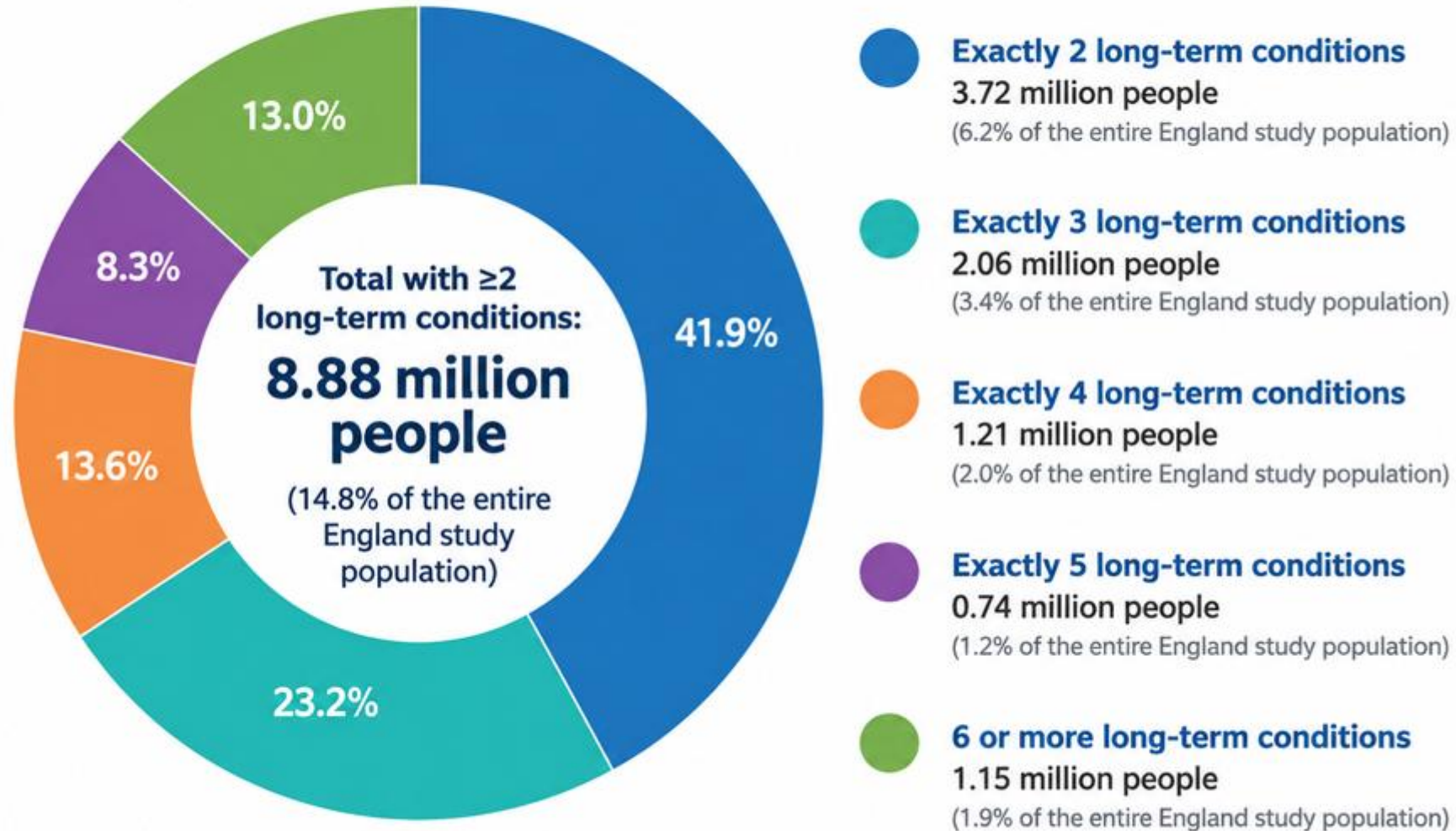
Long-Term Conditions and co-morbidities

26 million have 1 or more long term conditions

- **Chronic medical diseases** and monitoring —diabetes, thyroid, kidney, lung disease, rheumatology, gastroenterology, hepatology and dermatology.
- **Cardiovascular** disease — heart failure, arrhythmia/AF, coronary disease, valve disease and hypertension-related disease.
- **Cancer** and post-cancer surveillance — recurrence surveillance.
- **Ophthalmology** — glaucoma, diabetic eye disease, macular disease etc
- **Musculoskeletal** — arthritis, postoperative review and chronic musculoskeletal disease.

People in England with Two or More Long-Term Conditions

Breakdown by number of long-term conditions



Note: Percentages may not sum to 100% due to rounding. Percentages are of the entire England study population.

Source: England study population (NHS analysis)

How do we currently organise surveillance testing?

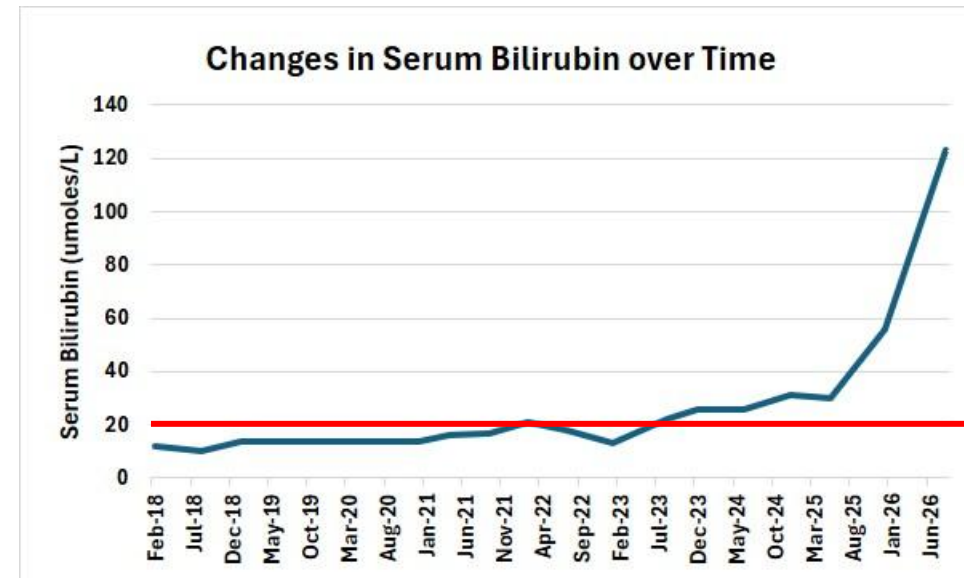
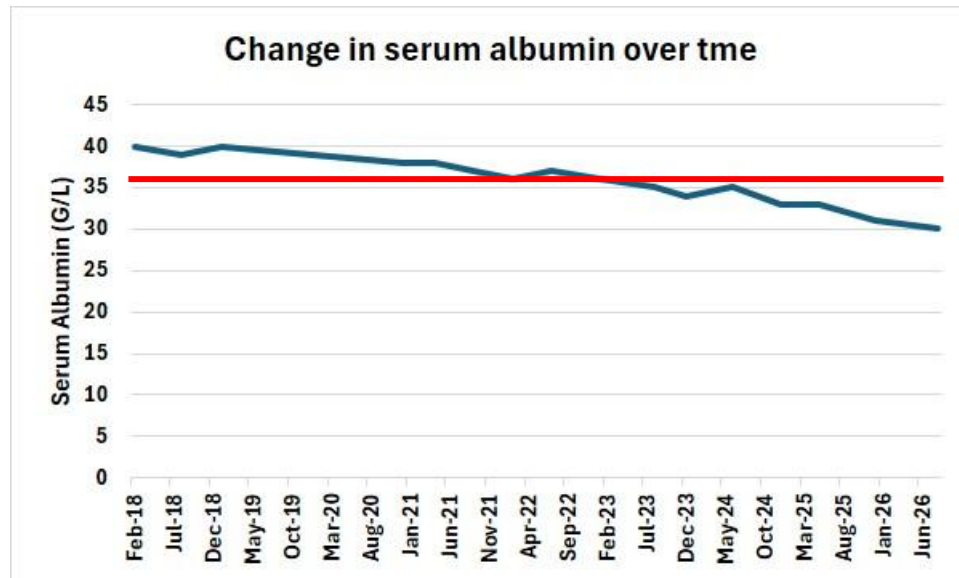
- See patient and make diagnosis e.g. cirrhosis, fatty liver with significant liver fibrosis, chronic hepatitis B. ~100-200 surveillance visits/cancer detected
- Baseline assessment, and identify need for disease specific surveillance
- Request tests every 6 months “Come back to clinic in six months”
- See patient every 6 months, review results, request next batch of tests for 6 months later

We use outpatient appointments
as the NHS's internal reminder system

Long Term monitoring

Pathology is an effective early-warning system, but we often look at results in isolation rather than longitudinal signals

Supervised neglect – *the lady with PBC*



A story of our times

*The man with cirrhosis
and a missed appointment.*

*Seen for years with 6 monthly
Scans.*

Relapse, missed appt - disaster



Outpatients – the facts

The model is broken

- New Referrals
 - 22-24 million/year
- Suspected cancer referrals (2ww)
 - 3.3 million/year
- Total Outpatient appointments
 - 146 million/year (113M attend)
- 7.3 million on waiting list
 - 6.2 million patients
- 54-67% of all attendances
 - Follow ups (2/person)

Streamlining Outpatient Clinics

Automatic monitoring and community blood tests for long-term conditions

Outpatient appointments are used as the NHS's internal reminder system for patients on long term follow up.

Patients with stable, long-term conditions return to hospital time and again to see a clinician who organises repeat tests to monitor disease progression or new complications.

Patients with multiple co-morbidities frequently have tests duplicated across specialties.

Streamlining Outpatient Clinics

Automatic monitoring and community blood tests for long-term conditions

The Problem

Unsafe, expensive, blocks other patients accessing healthcare

When a clinic is cancelled or an appointment is missed, patients have delayed tests or get lost to follow up and come to harm. Covid

Streamlining Outpatient Clinics

Automatic monitoring and community blood tests for long-term conditions

The Solution

All long-term follow-up involves the same tests at regular intervals

Digital solutions automate the requesting of monitored tests, sends a digital blood form to the patient, alerts clinician if missed or critically abnormal, results returned to clinician in the usual way.



Cloud-based paperless phlebotomy - patients can attend anywhere for monitoring blood tests e.g. pharmacies or CDCs.

Patients enter long term monitoring with automated test requests and community phlebotomy and patient-initiated follow up (PIFU). This frees up 50% of outpatient slots.

TESTING WHEREVER SUITS THE PATIENT

GP Practice

Community Diagnostic
Centre

High-Street Pharmacy

Hospital Outpatients

Digital requests · Amalgamated testing across conditions · automatic reminders · rapid escalation · patient-initiated review

HOW THE NEW MODEL WORKS

1 Smart monitoring plans

Evidence-based test schedules for common long-term conditions and medications.

2 Combined testing

One visit covers every due test, avoiding repeat blood draws across conditions.

3 Testing near home

Any approved GP practice, testing centre, or local pharmacy can take the sample.

4 Automatic escalation

Unusual or missing results are flagged at once for a fast clinical review.

5 Patient-reported check-ins

Simple questionnaires for skin and joint conditions tracking how treatment is working.

6 Quick access when needed

New symptoms or critical results get an appointment any time — no waiting for the next visit.

MONITOR WITHOUT EXTRA HOSPITAL VISITS



BENEFITS

Better Patient Experience

- **Fewer trips.** Less travel, less time off work, no hospital parking.
- **Faster action.** Automatic alerts flag problems sooner than routine clinic appointments.
- **Choice and convenience.** Testing near home, appointments when they're needed.

More Capacity For Care

- **Appointments freed up.** For patients who are new, complex, or getting worse.
- **Less duplication.** Bundled tests cut repeat blood draws and lab costs.
- **Staff time refocused.** Clinicians spend time on decisions, not routine paperwork.

Improving Outcomes

- Safer
- Less travel and more convenient for patients
- Amalgamated monitoring means less tests
- Greater access to healthcare
- Enables PIFU to find its place in the clinic
- Creating a research database of outcomes
 - Use data to modify and improving surveillance

Conclusions

Our biggest gains are to be had in long-term surveillance that uses digital solutions to automate monitoring which is better for everyone.

We just need someone bold enough to challenge the existing broken outpatient model.

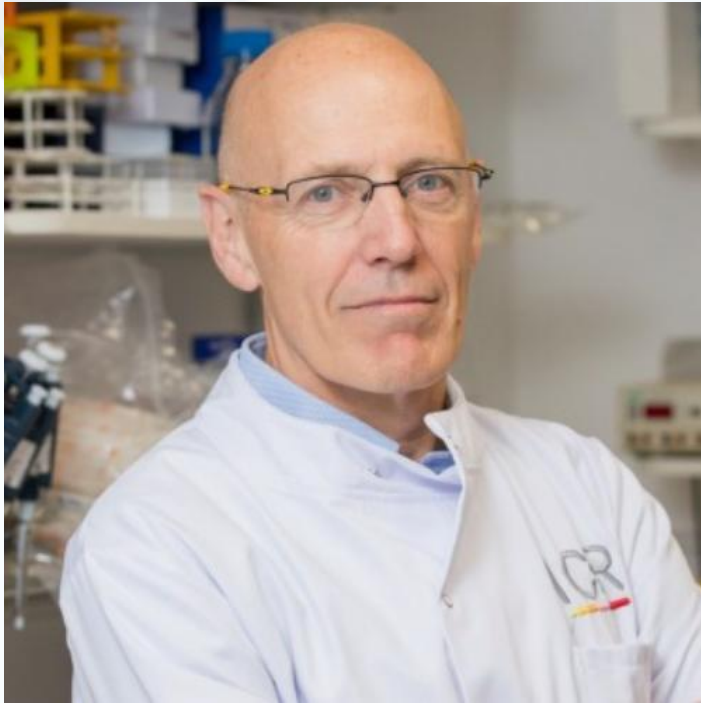
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Conflict of Interest

Co-founder and Chief Medical Officer
Salutare Group Ltd

Salutare:

NHS Deep Dive



Nick James

Professor of Prostate and Bladder Cancer Research
Institute of Cancer Research



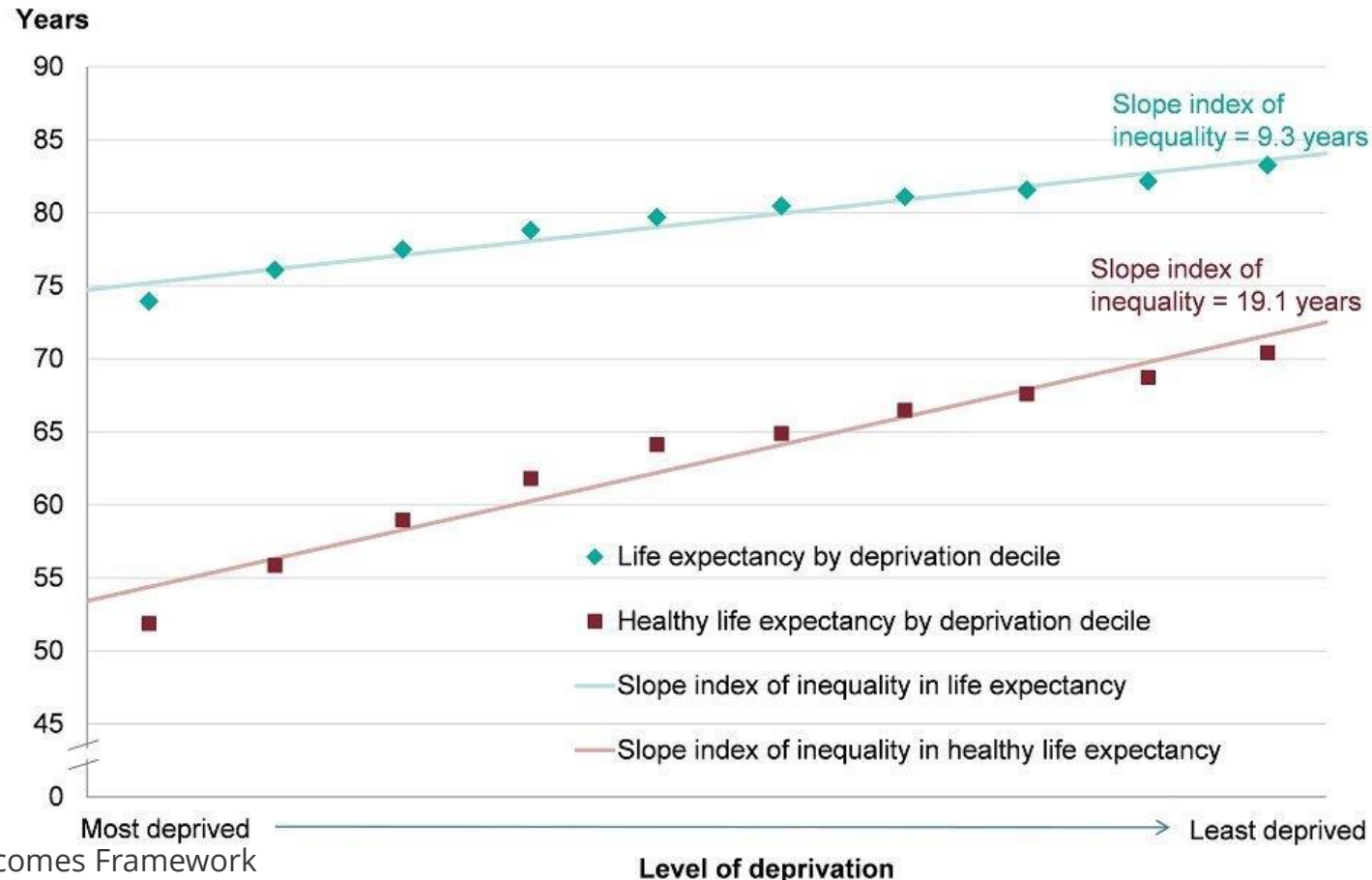
Taking Early Detection into the Community: Lessons from the Man Van



Prof Nicholas James, Professor of Prostate and Bladder Cancer Research, The Royal Marsden and Institute of Cancer Research

Deprivation is a determinant of life expectancy

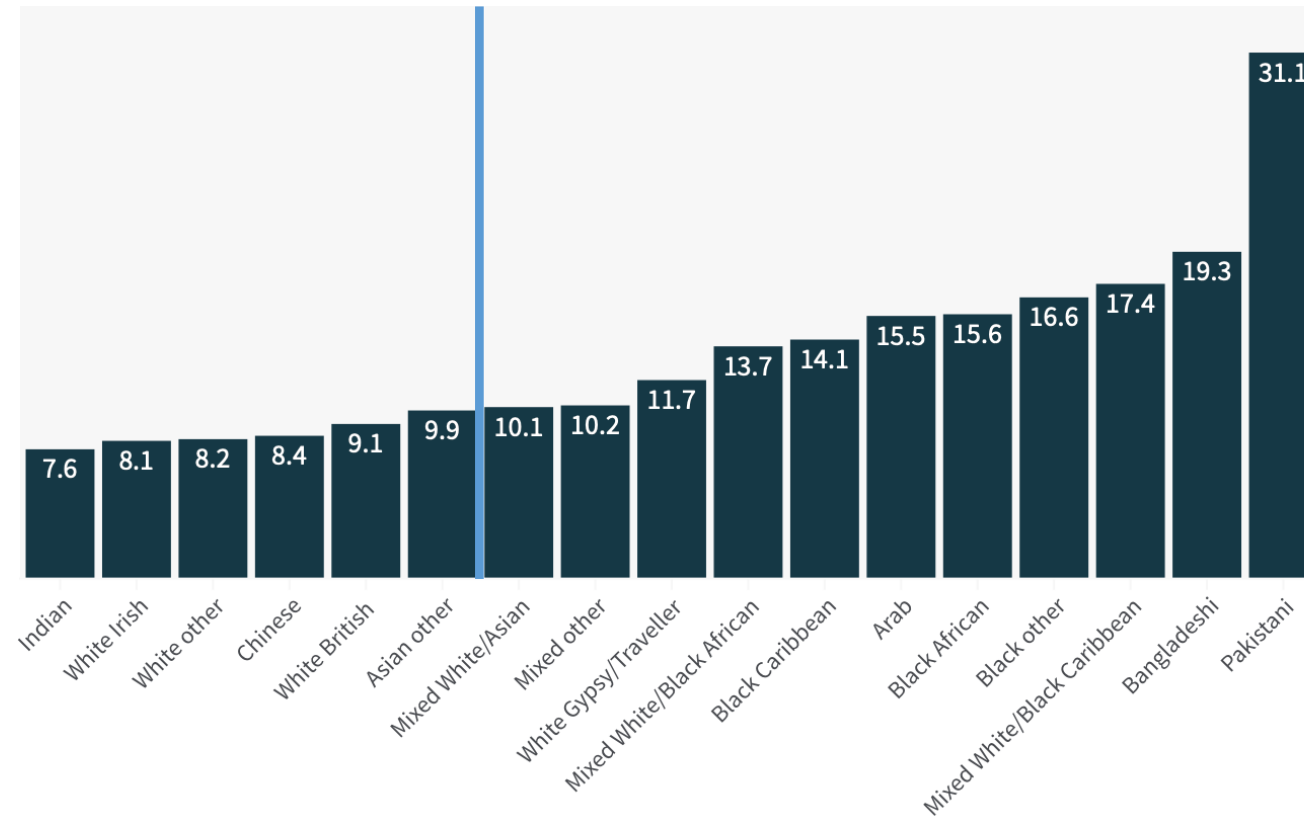
Index of inequality in life expectancy and healthy life expectancy at birth, males, England, 2014 to 2016



Source: Public Health Outcomes Framework

Safe, high quality care **every time**

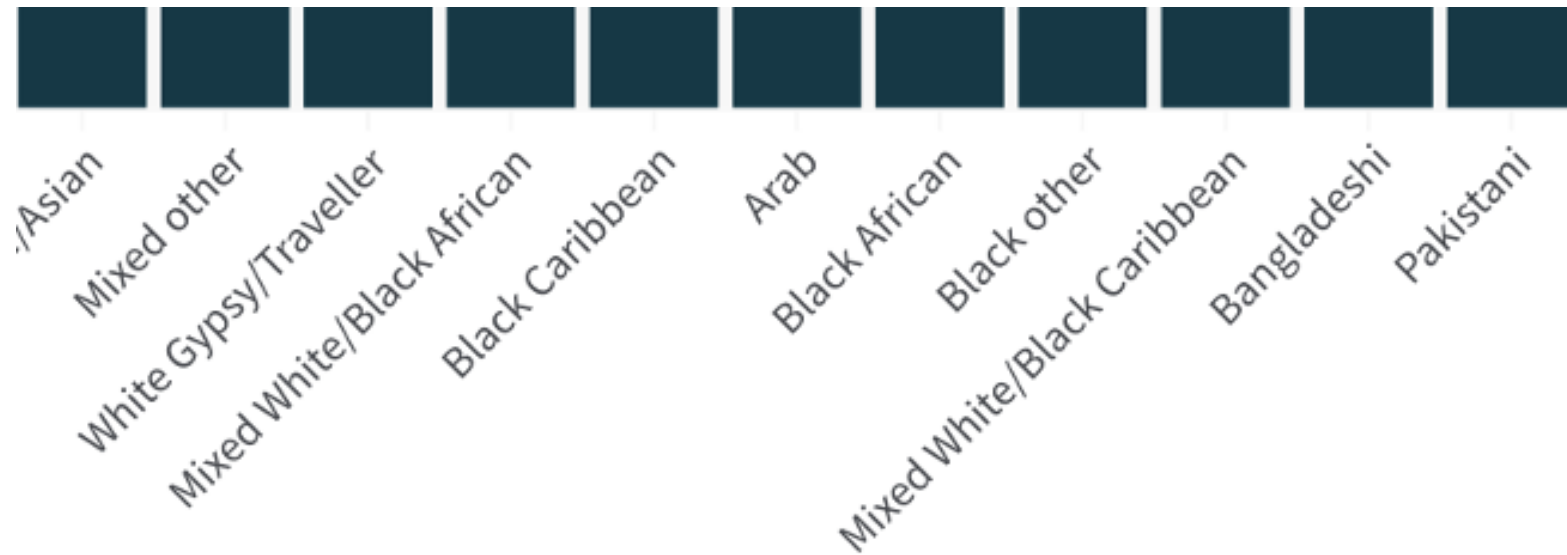
Ethnic minority groups are disproportionately affected by deprivation



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Safe, high quality care **every time**

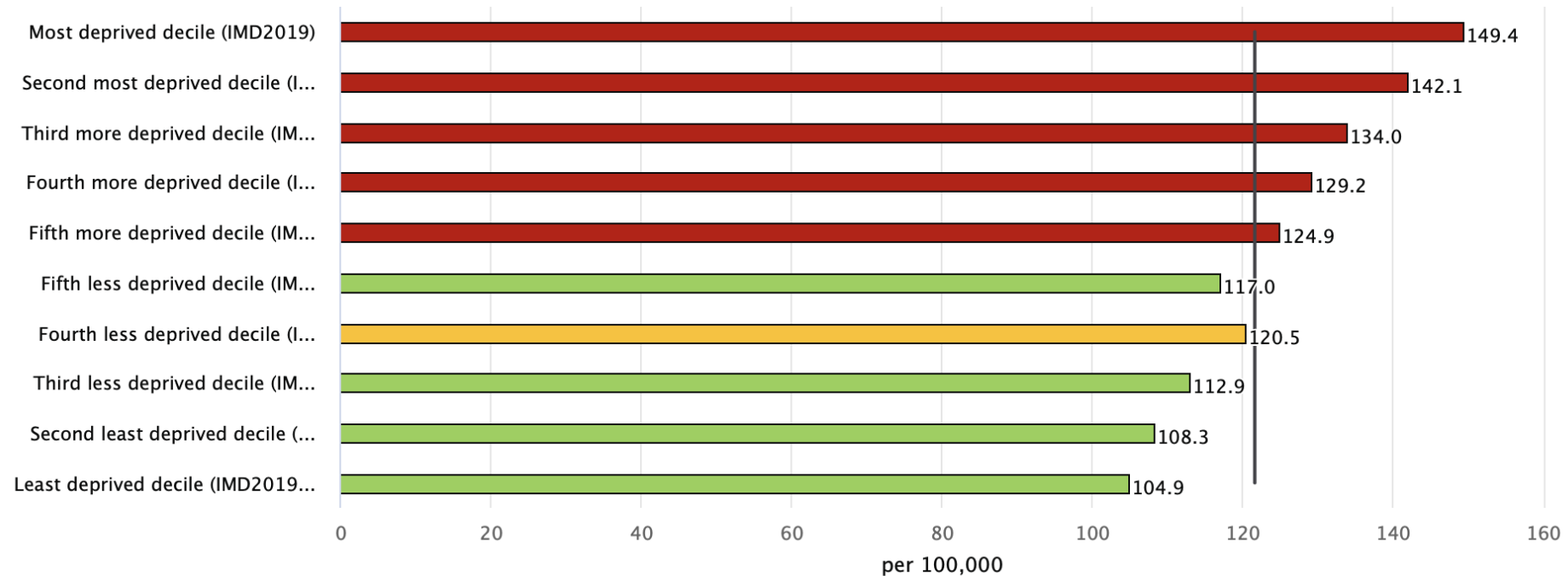
Ethnic minority groups are disproportionately affected by deprivation



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Safe, high quality care **every time**

Cancer mortality rates and deprivation



Source: PHE (2021)

Better 95%

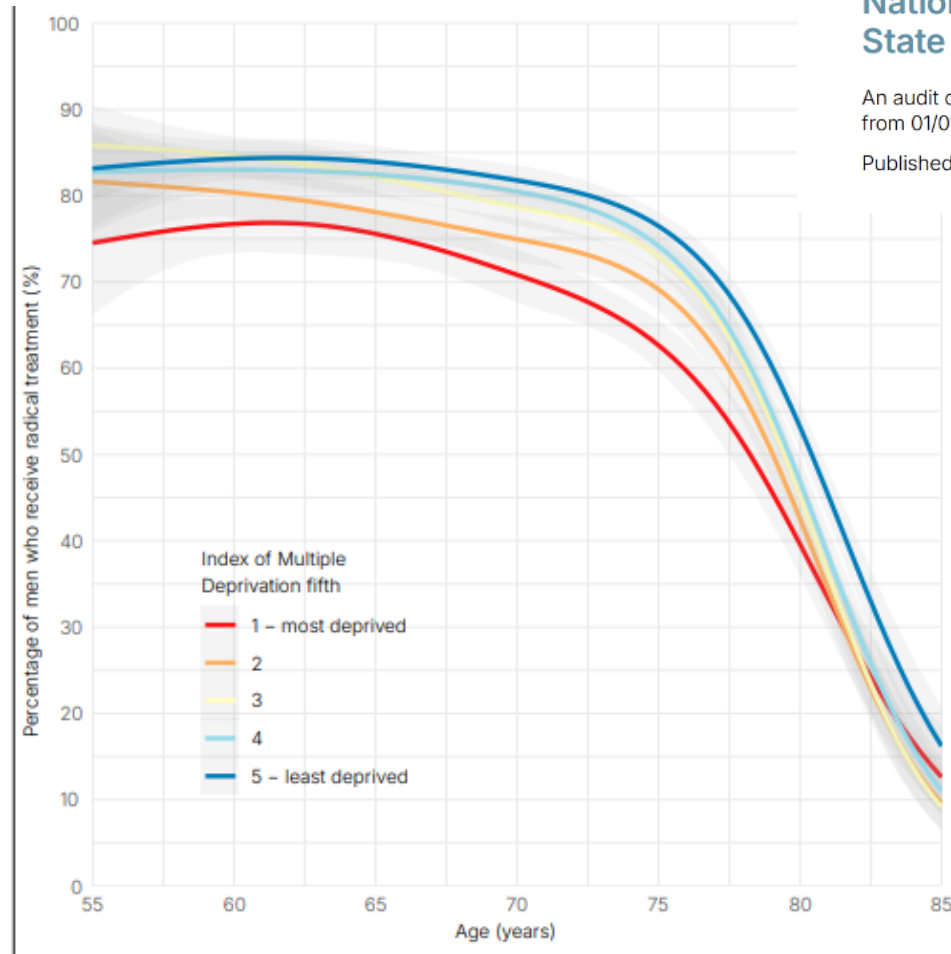
Similar

Worse 95%

Safe, high quality care **every time**

Deprivation is linked to sub-optimal therapy

Proportion
receiving
radical
therapy



National Prostate Cancer Audit State of the Nation Report

An audit of the care received by men diagnosed with prostate cancer in England and Wales from 01/01/2019 to 31/12/2023

Published January 2025

Age

Safe, high quality care **every time**

Health Inequalities in Prostate Cancer

- Most deprived versus least deprived groups:
 - 14% higher mortality rate (Cancer Registration Statistics, England 2020)
 - 29% higher risk of presenting with **metastatic disease** (National prostate cancer audit, England/Wales, 2022)

Man Van Project Aims

- Men often seek help late for a range of medical conditions that are major causes of death and serious illness.
- **Aims:**
- Putting particular focus on prostate cancer, we aim to demonstrate that we can detect clinically significant disease at an earlier stage
- To target at risk groups: black men, and men from more deprived backgrounds who we know have worse health outcomes
- To detect clinically significant evidence of other major health risks as these are amenable either to simple testing or a targeted clinical examination
- Cardiovascular risk factors
- Diabetes
- Liver disease
- Psychological risk factors

Safe, high quality care **every time**

The Problem

- Deprivation linked to poor outcomes with prostate cancer
- Too many men present too late to be offered curative treatment
- The model for cancer diagnosis of
 - Figuring out you have a problem
 - Getting a GP appointment in areas frequently underserved by GPs
 - Getting referred to a specialist centre
- Is loaded against those in lower socio-economic groups, lower literacy, non-English speakers



The Man Van Intervention and Pilot Study

Evaluating the Effectiveness of a Novel Mobile Clinical Unit (the Man Van) in Addressing Health Inequalities in Prostate Cancer



Nicholas James

Masood Moghul FRCS (Urol)

Radiotherapy & Imaging | The Institute of Cancer Research, London

Man Van Supervisory Team

Professor Nick James (Primary Supervisor)

Professor Kevin Harrington (Secondary Supervisor)

Associate Supervisors: Dr Netty Kinsella | Dr Patrick Kierkegaard | Professor Ros Eeles | Mr Declan Cahill

The Man Van Concept



Safe, high quality care **every time**

- Novel mobile clinical unit offering PSA testing and comprehensive health assessments
 - Nurse-led model
 - Information provision
 - Demographic targeting
 - Self booked appointments

The Man Van Model

Geospatial targeting of high-risk populations



Multimodal Comms: GPs, community leaders, church pastors, sports teams etc



Appointments booked



Man Van moves to area for planned 6-8 week period with further awareness raising



Men offered comprehensive health check including: BMI, blood pressure, diabetes and PSA for prostate cancer



Men referred on two-week pathway to secondary care

Results – Phase 1

RECRUITMENT 810 → 610 Invited → Attended	ATTENDANCE RATE 75% Non-attendance: 25%	MEDIAN AGE 56 years Range: 26–88 years	DEPRIVATION 4th Centile IMD rank (lowest)
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Ethnicity Distribution (n=610)

Ethnicity	Number	Percentage	Key Points
Black/Black British	184	30%	vs. 15% background population (2× enrichment)
White	321	53%	Majority ethnic group
Asian/Asian British	75	12%	Significant representation
Other/Mixed	30	5%	Diverse ethnic backgrounds
Non-White Total	289	47%	Successfully targeted high-risk groups

Data from 8 different sites: community centre, construction site, general practice, church, Housing Association, Croydon University Hospital, Royal Marsden Hospital (Sutton)

Cancer Detection Results

PSA UPTAKE (AGE >50) 89.3% High uptake in eligible participants	BLACK MEN (AGE 45-50) 93.9% PSA uptake in high-risk younger cohort	TOTAL PSA TESTS 420 Tests Median PSA: 1 µg/L (range 0.1-45)	REFERRALS GENERATED 56 (13.3%) Elevated age-specific PSA
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Referral Cascade: Pathway Completion and Diagnostic Yield

Pathway Stage	Number (N)	Percentage	Key Points
Men Referred (elevated PSA)	56	13.3% of tested	Age-specific PSA thresholds applied
MRI Scans Completed	48	85.7% of referrals	High pathway adherence
Prostate Biopsies Performed	23	41.1% of referrals	MRI-informed biopsy decisions
Prostate Cancers Diagnosed	13	3.1% detection rate	95% CI: 2.0-5.9%; 67% clinically significant

TOTAL CANCERS 15 (3.6%) 95% CI: 2.0-5.9	CLINICALLY SIG. 10/15 (67%) Gleason ≥3+4	METASTATIC 1/15 (7%) vs. 25% national	STAGE 14/15 T1/2 93% localized
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Significant detection rates of other diseases e.g. 30% hypertension, 5% of HbA1c tests in diabetes/preDM range

Man Van Phase 2 data

Metric	Value	Notes / Additional Detail
Recruitment	3,980 → 3,377	Invited → Attended
Median age	60 years	Range: 40–97 years
Deprivation	6th decile	IMD rank maintained
Black Ethnicity	16.6%	Background 11%

Man Van Cancer Detection Rates

Metric	Value	Notes
Total cancers detected	94 (2.8%) cancers, 88.3% clinically significant	CAP trial: 3.3% 40% clinically significant GÖTEBORG-2: 2.3%, <50% clinically significant
Stage at presentation	72% T1/2	Early-stage detection
Median PSA (at diagnosis)	6 µg/L	Range: 3–167 µg/L

Safe, high quality care **every time**

Man Van cost per diagnosis

Pathway	Cost per participant (£)	Comparison / Saving
Man Van Phase 2	£51.11	Reference cost, also includes assesement for diabetes and hypertension
Primary Care (1 appointment)	£68.44	Saving vs primary care: £17.33 (25.3%)
Primary Care (2 appointments)	£136.88	Saving vs primary care: £85.77 (62.7%)

Safe, high quality care **every time**

Questionnaire – Key Findings

Patient Satisfaction Scores (n=396)



Key Insights



92.2%

Easy/Very Easy Access
(vs. GP Appointment)



72.8%

More Likely to Seek
Healthcare Advice



11.9%

Would be Put Off
by Rectal Exam (DRE)

Interviews

Semi-structured interviews, majority conducted online

Thematic analysis with mapping to RE-AIM

23 men from Man Van

- 5 men of non-white ethnicity

13 Stakeholder interviews

- Man Van staff
- GPs and primary care leads
- Cancer pathway manager
- Local council health delivery leads

Patient Interviews Mapped to RE-AIM

Key Themes and Representative Quotes from Phase 2

Reach

Themes: Trust in NHS/GP branding, convenience of location, and partner encouragement reduced access barriers.

"The fact it was connected to the Royal Marsden made it credible... lack of convenience is a barrier."

Effectiveness

Themes: Perceived as life-saving; provided reassurance and empowerment regarding health status.

"It is lifesaving. I don't think anybody should refuse"

Adoption

Themes: High acceptance of nurse-led model; appreciated ability to bypass GP gatekeeping for PSA tests.

"I was brought up to respect GPs....if they "say no then you don't know what do you do"

Implementation

Themes: Staff friendliness put men at ease; 20-minute appointment length felt appropriate and thorough. Staff professional, but logistical issues noticeable with van

"Very nice, very friendly... they put you at ease very easily."

Maintenance

Themes: Disappointment at service end; strong desire for continuity; support for national roll-out

"Missed opportunity [RE ending the project]... I could even set up a direct debit to help facilitate the process."

Stakeholder Interviews Mapped to RE-AIM

Reach

Barriers: digital exclusion, hard-to-engage groups (e.g., 'macho' culture), location is decisive

Facilitators: local champions/ambassadors, GP linkage, strong van visibility

"It was always to do with location"

Effectiveness

Raised awareness and early detection

Risks: anxiety, privacy in small space, weather discomfort

"Men don't really go to the doctors until it's too late"

Adoption

Leadership and frontline buy-in essential

Constrained by staff/time; ~6-month lead-in useful

Implementation

Logistics: Space, Wi-Fi, electricity, waiting flow, and privacy challenges

Solutions: Strong operations lead, staff rotation to prevent burnout, hub/spoke model

"Definitely have the operational lead at the offset of the project"

Maintenance

Financial sustainability and budget integration essential

Scope to expand to other conditions (multi-morbidity)

Behaviour change likely via fear/anxiety

"The fear, the anxiety it creates often is an intervention"

Discussion

Up-scaling of project from pilot phase with optimisation

Overall detection rates maintained

Improved detection of clinically significant disease

BUT: disparities persist: Black men were significantly more likely to be non-attenders compared to White men

Recruitment via GP practices largest driver: enhanced trust

Integration of Man Van with primary and secondary care resulted in “streamlined” follow-up processes

Limitations

- No long-term data on health impact
- Urban focus of project limits generalisability

Health Economics - Background

Minimal high quality economic data regarding screening

Even less data on health economics of testing high-risk men

Markov modelling challenging due to lack of consensus on disease states

Health economics forms key part of **Maintenance** domain within RE-AIM

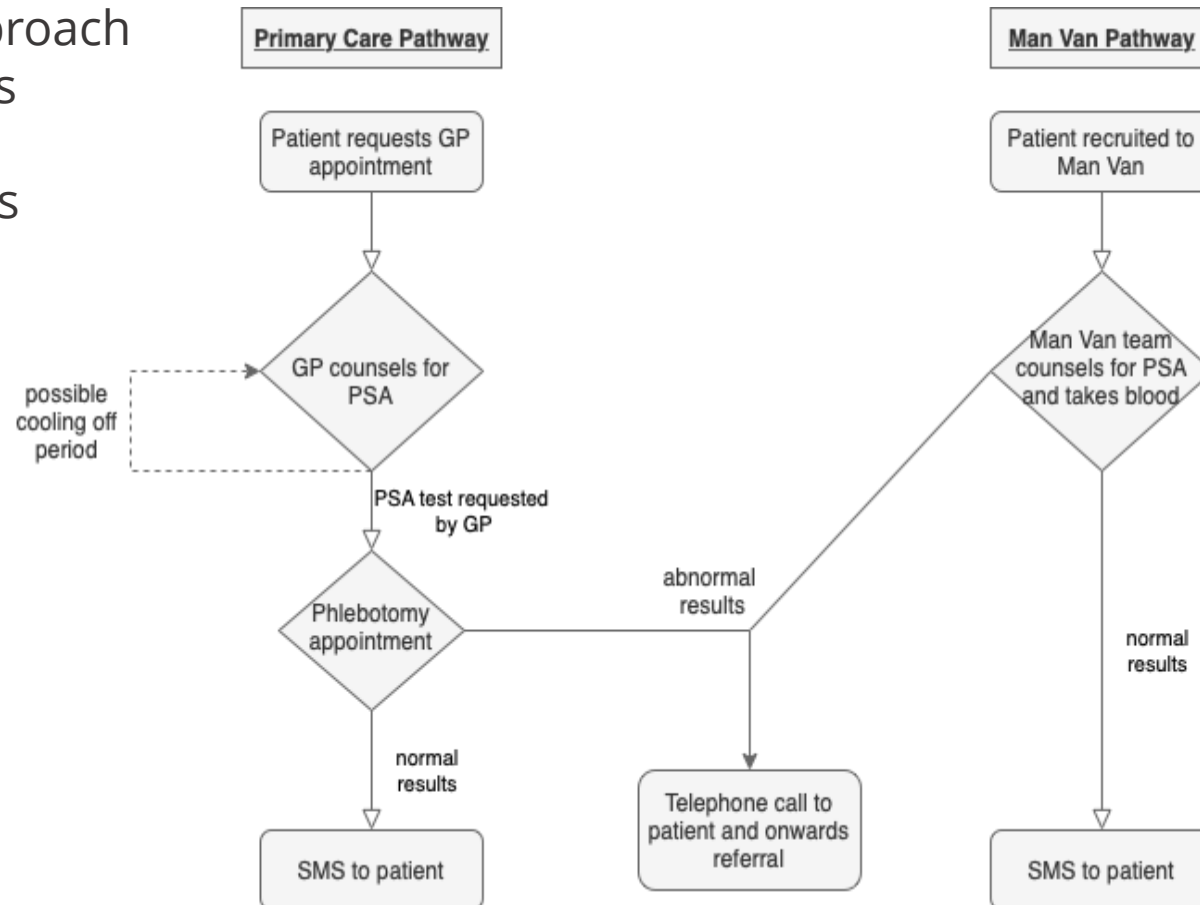
Aim: To determine whether the Man Van model is cost-effective compared with primary care-based PSA testing

Methods

Nurse-led Man Van model vs primary care testing

Multiple economic analyses:

- Micro-costing approach
- Cost per diagnosis
- Cost analysis
- Sensitivity analysis



Results — Micro-Costing & Cost Per Diagnosis

Micro-Costing Analysis of Man Van visit

Component	Pilot Phase	Phase 2
Staffing costs	58% of total	50% of total
Testing (PSA/HbA1c)	28% of total	39% of total
Venue, equipment, other	14% of total	11% of total

PILOT PHASE

£81.1

Cost per patient

PHASE 2

£54.3

Cost per patient

EFFICIENCY GAIN

33.0%

Cost reduction achieved

Key Efficiency Drivers

Throughput optimization: Patient capacity doubled from 9/day (pilot) to 17/day (Phase 2) • Staffing model: Nurse-led approach (Band 7 vs Band 8a) reduced per-patient costs • Economies of scale: Fixed costs distributed across larger patient volume

PILOT PHASE

£5,552

Per cancer diagnosis

PHASE 2

£3,319

Per cancer diagnosis

EFFICIENCY GAIN

40.2%

Cost reduction achieved

Results – Cost Analysis Man Van Phase 2 vs GP

MAN VAN PHASE 2	PRIMARY CARE (1 APPT)	PRIMARY CARE (2 APPTS)
£51.11	£68.44	£136.88
Per participant	Saving: £17.33 (25.3%)	Saving: £85.77 (62.7%)

Cost Component Breakdown by Model

Cost Component	Man Van Phase 2	Primary Care	Notes
Nurse Consultation (Band 7)	Included	—	Nurse-led model reduces costs
GP Consultation	—	Included	Higher unit cost than nurse
PSA Blood Test (Capillary)	Included	—	On-site testing
Phlebotomy (Venous)	—	Included	Separate appointment required
Laboratory Processing	Included	Included	Similar costs both models

One-Way Sensitivity Analysis (±20% variation)

Worst-case scenario: Man Van +£6.59 more expensive per participant than primary care

Best-case scenario: Man Van saves £41.23 per participant vs primary care

Discussion

Optimisation of Man Van from pilot to phase 2 saving costs

Testing for prostate cancer within the Man Van costs 25% less than testing in primary care.

The use of a nurse-led model may free up primary-care physician resource for other medical conditions.

RE-AIM Maintenance domain validated: model demonstrates sustainability through efficient resource utilisation and scalability

Cost-per diagnosis favourable compared with breast cancer (~£5000 per diagnosis)

Diagnosis of other health conditions will add further value



General Discussion, Conclusions and Future Directions

Discussion

Multi-disciplinary research to evaluate the Man Van model in addressing health inequalities using RE-AIM framework

Success at recruitment of high-risk populations

- Addresses historic underrepresentation of Black men in prostate cancer studies
- Demonstrates targeted mobile outreach can disrupt entrenched patterns of exclusion in both research and service delivery

Scalability of model demonstrated → barriers/facilitators

Detection rates of clinically significant prostate cancer higher than previous screening studies

Health economics analysis showing value

Adaptability of model to novel tests demonstrated

Acknowledgements

Category	Group / Organisation	Names / Description
Supervisory Team	Man Van Supervisory Team	Prof Nick James; Prof Kevin Harrington; Dr Netty Kiriakou; Prof Ros Eeles; Mr Declan Cahill
Research Collaborators	Academic & Industry Partners	Convergence Science Centre — Bowen Su; Royal Marsden — Sofia Infirri, Clare Peckitt; Royal Marsden Biochemistry — Berry, Freeda Millet; Royal Marsden Oncogenetics — Hogben, Natalie Taylor; Allelica Inc — Giordano Bot
Operational Staff	Staff Supporting the Man Van	Fionnuala Croft; Kal Kaur; Fiona Mutch; Elisabeth Westaway; Kathryn Bradshaw; Vlad De Souza; Jill Canavan; Lenita Kingston; Frances Endres; Manguexa Vaingoncar; Maria Physicos; Michelle Chen; Likey Rehm; Matthew Withey; Pip Wilkinson; Angela Arora
Partners & Collaborators	Healthcare & Community Partners	RM Partners Cancer Alliance; GP partners; NHS Trusts and community organisations, faith leaders, sports clubs, co
Venues	Venue Partners	IKEA Croydon; Chelsea Football Club; Ealing Town Hall; Leisure Centre; Balham Medical Centre; Hill House Community Square; VEOLIA Factory Lane; Beluah Church; Croydon U
Supporters	Participants & Funders	All participants and communities; NHS England; RM Partners Cancer Charity; Dr John Bolodeoku



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Expert Q&A



Kevin Moore

Professor of Hepatology
University College London & Royal
Free London Foundation Trust



Nick James

Professor of Prostate and Bladder
Cancer Research
Institute of Cancer Research



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The logo for Screening360 AXREM features a stylized orange circular graphic on the left, composed of concentric arcs and arrows. To its right, the text "Screening360" is in dark blue, with "360" in orange, and "AXREM" is in teal below it.

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Chair Morning Reflection



Chris Sleight MSc BSc FIBMS

Chief Executive Officer of Sleight Insights

Formerly Chief Officer of the Greater Manchester Diagnostic
Networks



NHS Deep Dive



Marisa Raquel Durao Portela de Lima
Lead Cancer Nurse
Barts Health NHS Trust



Screening360 2026 NHS Deep Dive

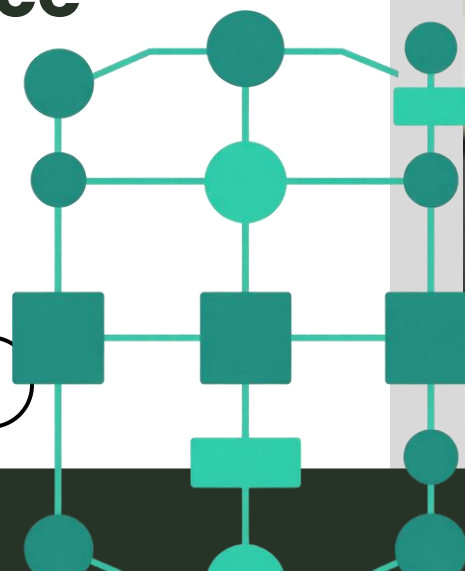
Expanding Screening Capacity Without Expanding Workforce

A practical NHS approach to pathway redesign, advanced practice and intelligent decision support.

Presenter:

**Marisa Raquel
Durão Portela de
Lima**

Lead cancer nurse -Barts health





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Disclosures

Conflict of Interest Statement

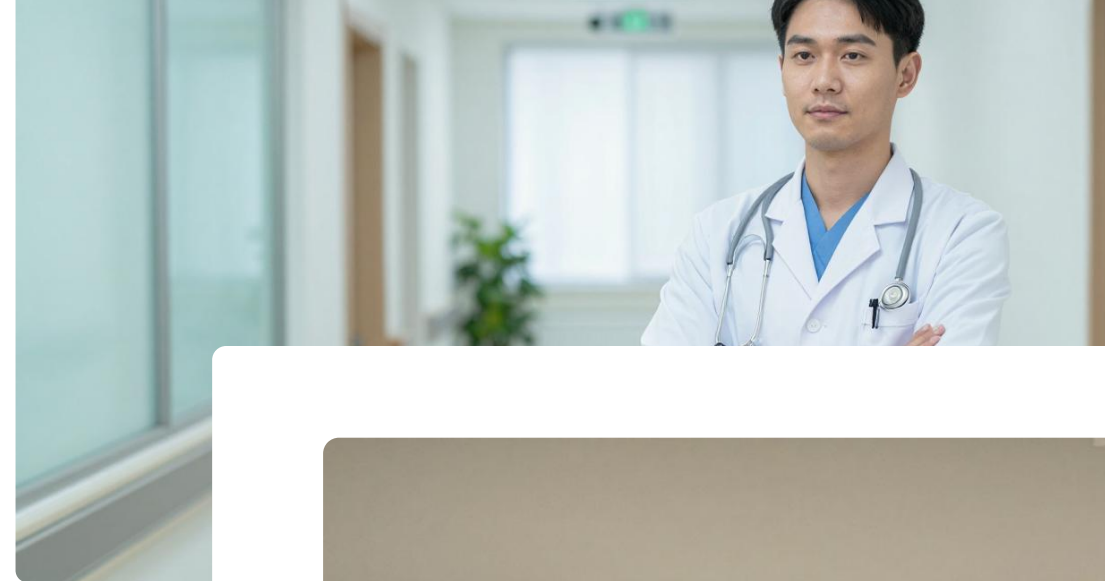
Nil



No relevant disclosures to make. No conflicts of interest or competing interests exist for this presentation.



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Expanding Capacity Without Expanding Workforce



The Instinctive Answer



When screening demand rises, our first instinct is always the same: "We need more staff." But what if we could increase the useful clinical capacity generated by the existing workforce?



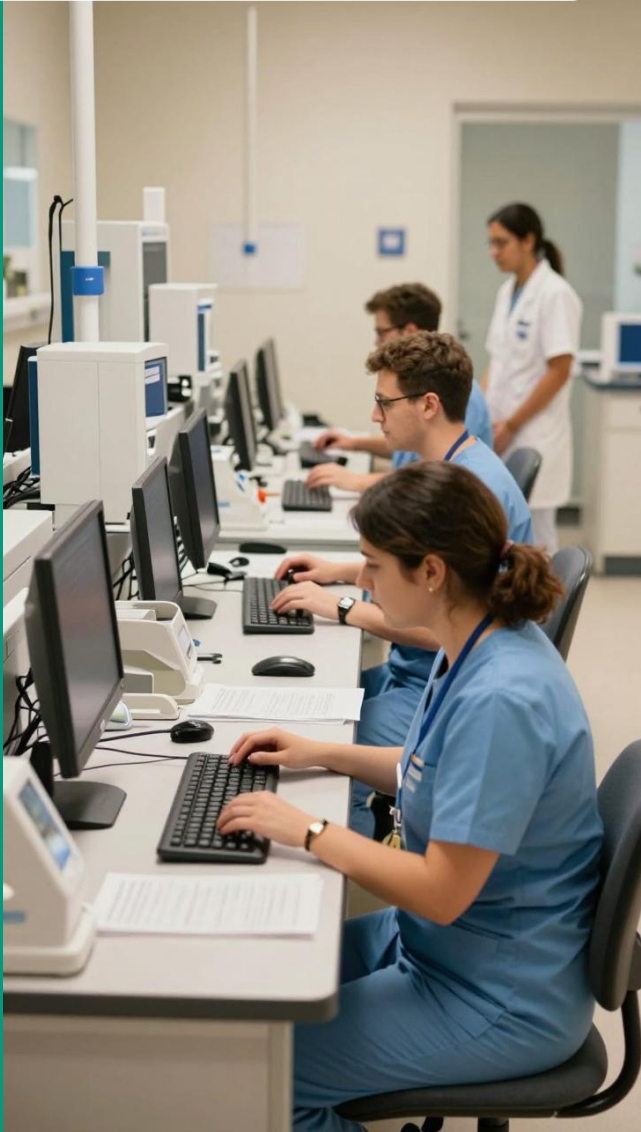
Capacity is not simply a workforce number. It's about creating more clinical value per unit of resource. By redesigning how work flows through pathways, we can stretch our existing talent further and deliver more care without new recruitment.



Rethink Capacity, Not Headcount.



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The Problem is Not Simply Workforce

Complex Demand Drivers

How to redesign work so expertise creates greatest value?

- Increasing screening participation and diagnostic demand
- earlier disease detection increasing pathway entries,
- growing complexity and multimorbidity
- Combined with workforce vacancies, finite diagnostic capacity, and administrative burden consuming clinical time, the system faces unprecedented pressure.





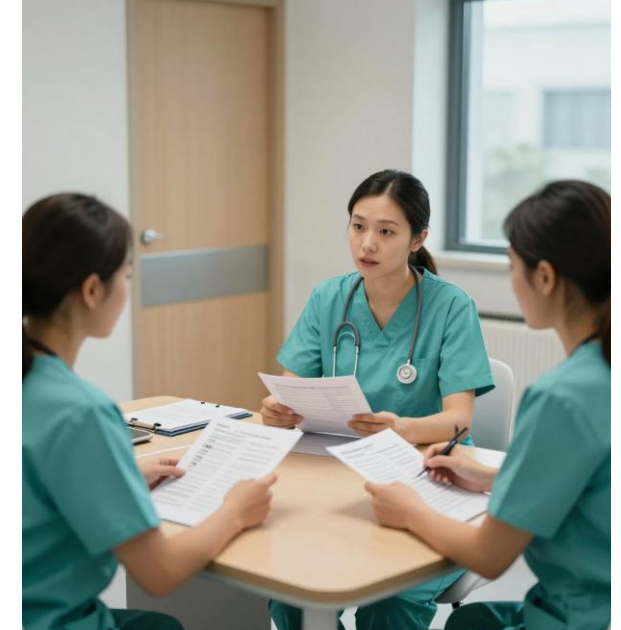
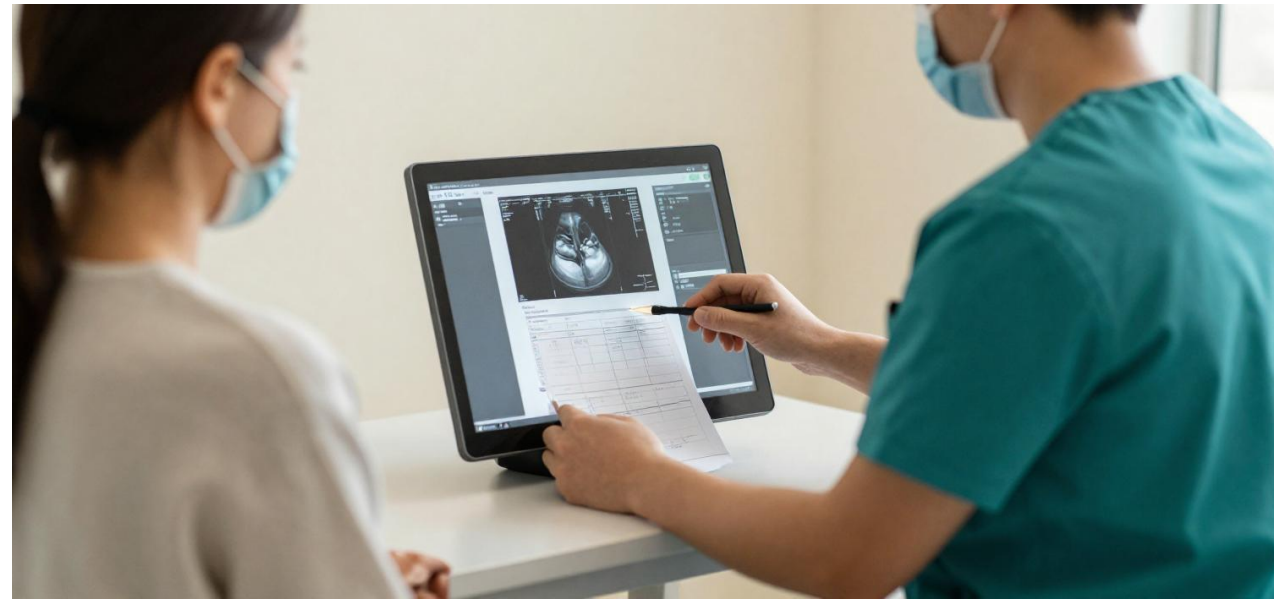
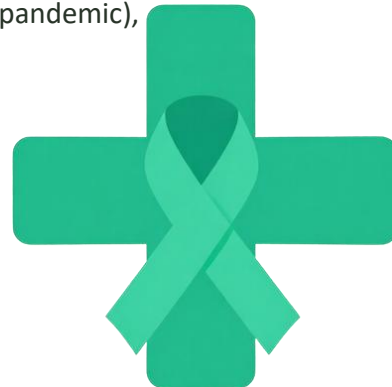
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Why This Matters Particularly in Cancer

Cancer Pathway Pressures Explained

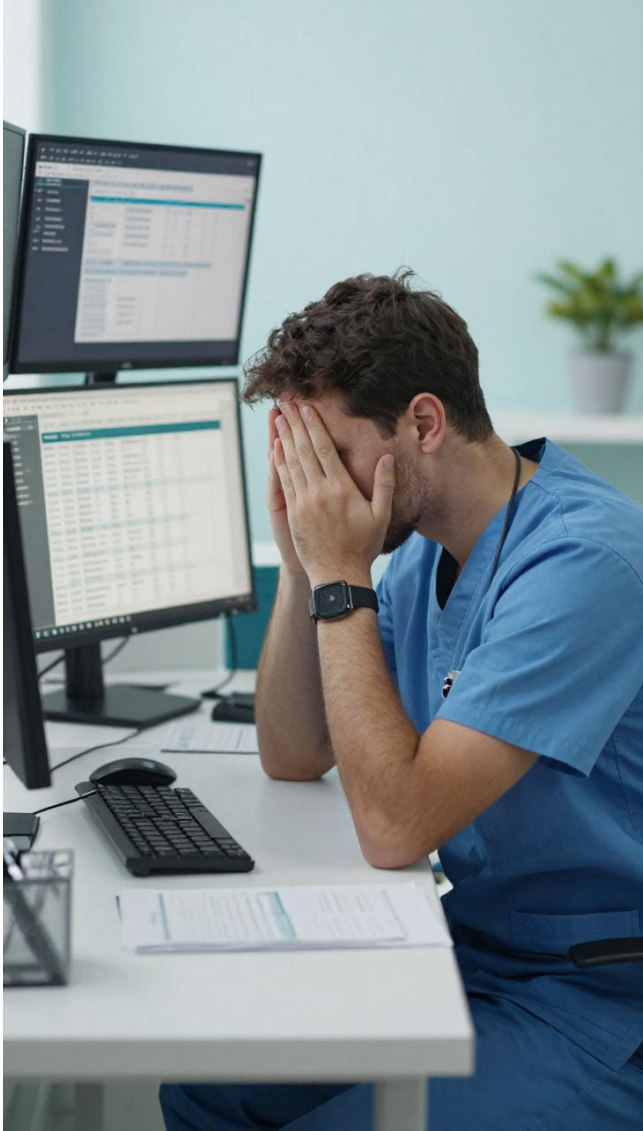
The cancer pathway involves multiple stages:
screening → abnormal result → referral → diagnostics →
pathology/radiology → MDT → diagnosis → treatment.

Current pressures include increasing urgent suspected cancer referrals (~11,598 per working day in January 2025, ~33% above pre-pandemic), earlier disease detection, diagnostic complexity, and limited endoscopy, imaging, and pathology capacity.





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The Capacity Paradox

Moving the Bottleneck

Every screening programme we expand simply transfers the bottleneck to the next step: from screening to referrals, from referrals to diagnostics, from diagnostics to reporting, or from reporting to MDT decisions.

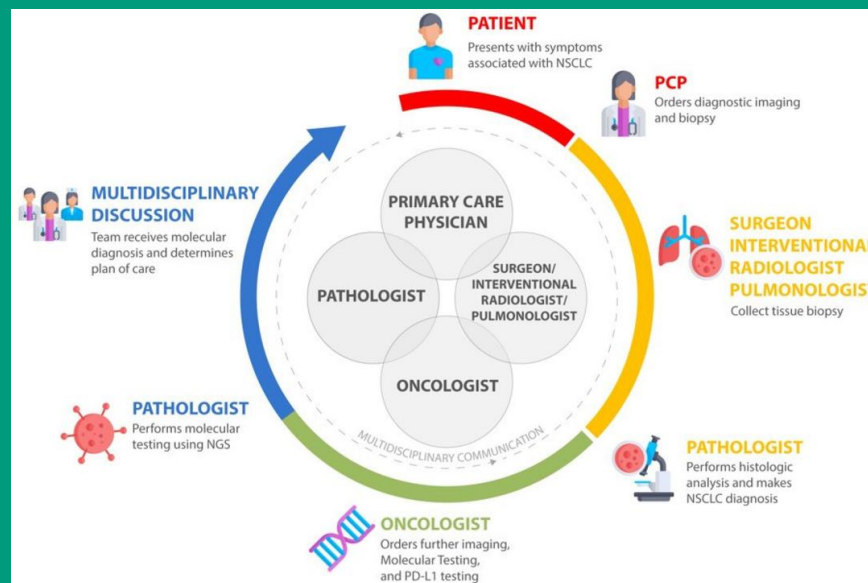
Increasing screening without pathway redesign moves the bottleneck, not solves it. Growth simply shifts pressure downstream.



Traditional vs Sustainable Thinking

Capacity is a Pathway Property

Traditional: more screening → more referrals → more appointments → more workforce. Sustainable: more screening → smarter triage → appropriate investigation → fewer unnecessary steps → faster decisions.

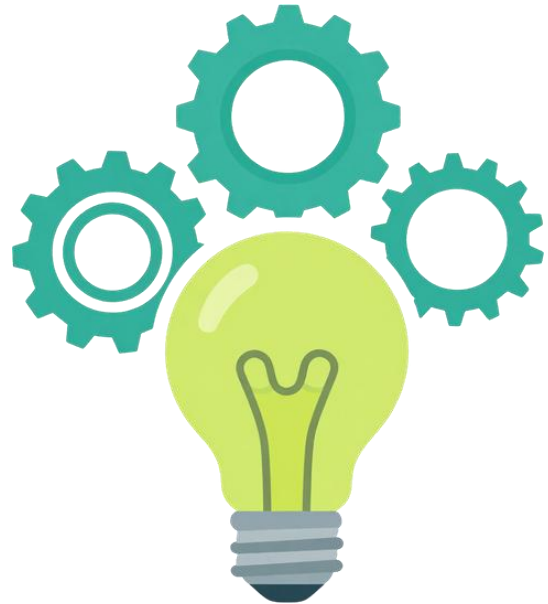




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Five Levers for Sustainable Capacity

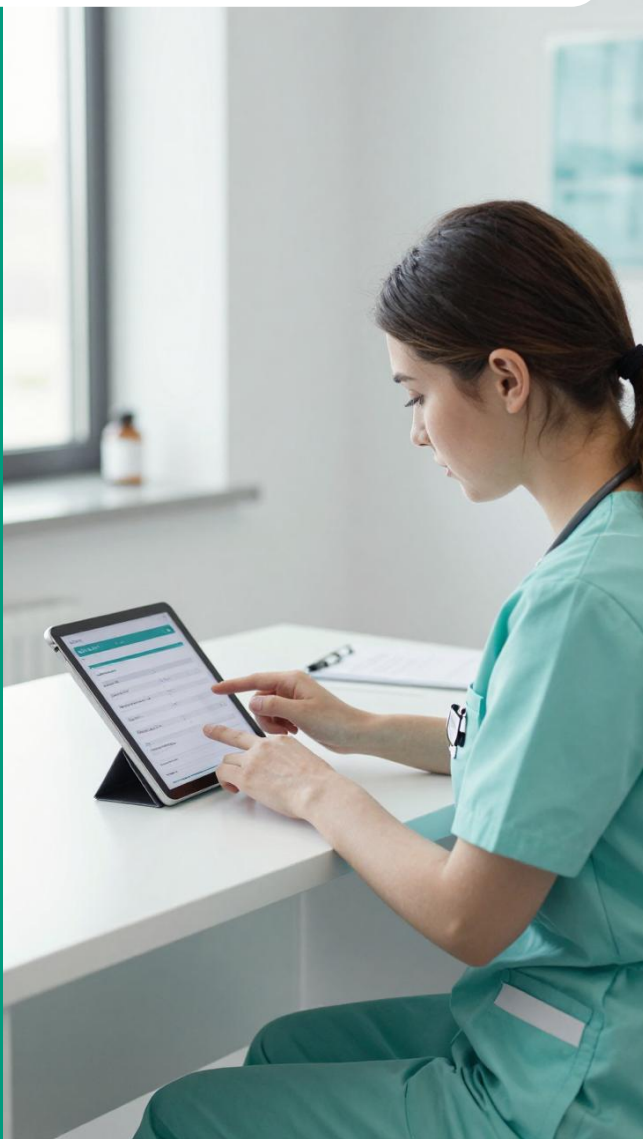


Capacity means creating more clinical value per unit of resource. The five levers: start with the work, not the job title; skill-mix redesign; one-stop and timed pathways; AI and decision support; workforceTransform capacity without transforming workforce numbers.





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Start With the Work, Not the Job Title

Task-Focused Pathway Redesign

Deconstruct every pathway task and evaluate its requirements before assigning to a professional role.

- Clinical assessment
- risk stratification
- investigation requests
- interpretation
- communication
- coordination
- administration
- follow-up, and escalation—each requires different expertise levels.
- Traditional roles aren't the default assignment.
- Ask: Does this task need clinical expertise? Can it be standardised? Delegated? Supported by technology? Combined with another task? Or removed entirely?





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Skill-Mix Redesign

Traditional vs Future Workforce Model

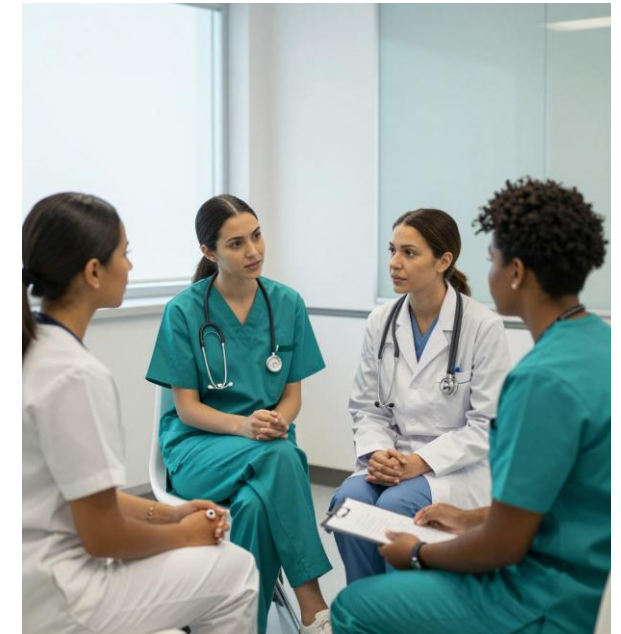
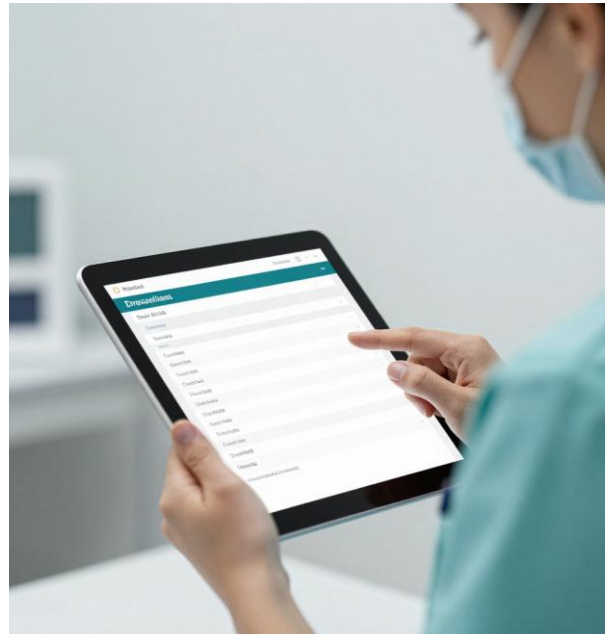
The Traditional Model:

Consultant → Registrar → Nurse → Admin.

The Future Model:

Multidisciplinary skill-mix including advanced practitioners, specialist nurses/CNSs, clinical scientists, radiographers, reporting radiographers, endoscopy practitioners, pathology experts, admin/navigation teams, and digital/AI support.

Key principle: Match complexity to competence, not profession to tradition.





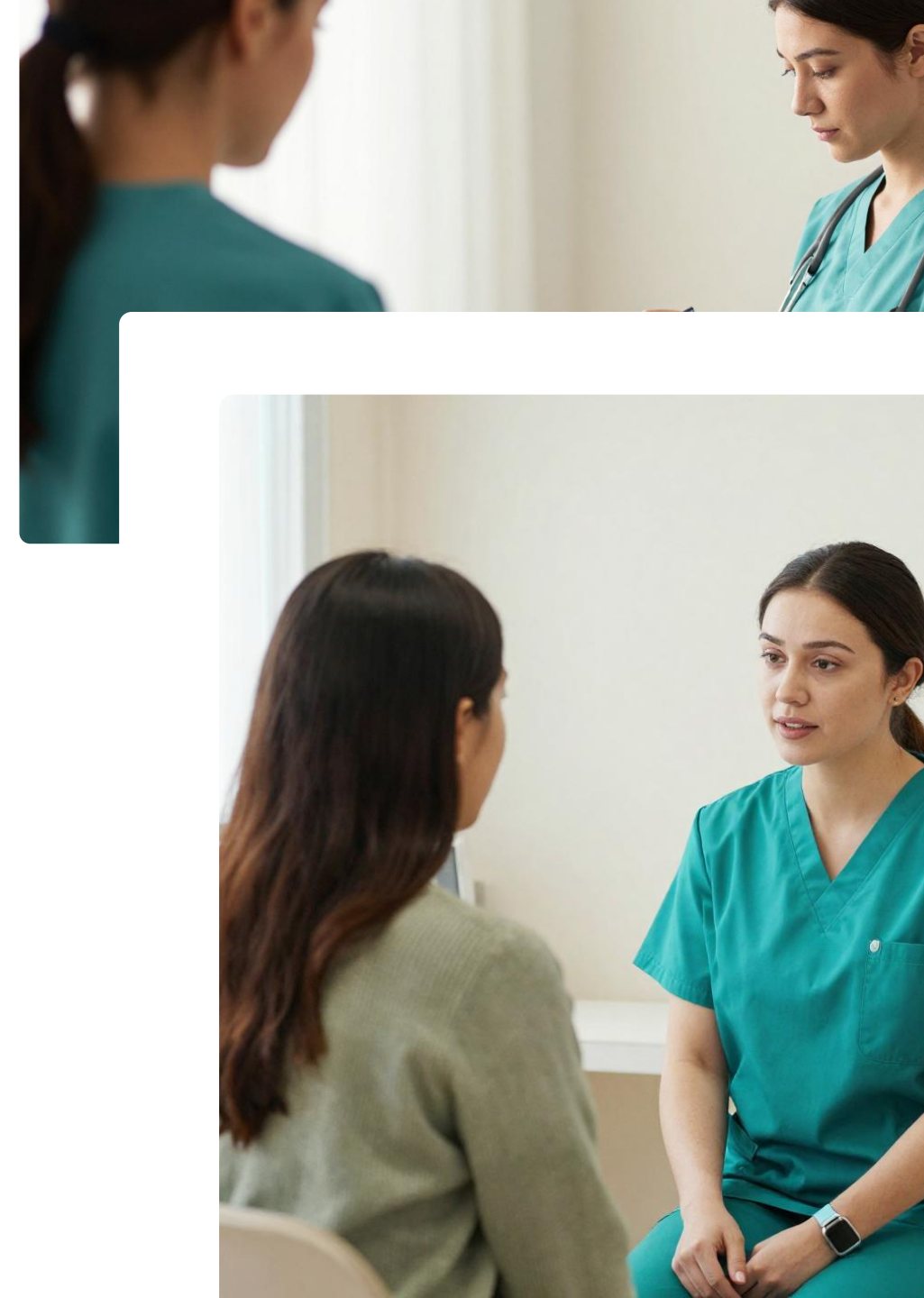
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Advanced Practice as a Capacity Strategy

Expanding Capacity Through Advanced Practice

Three phases of advanced practice involvement.

- ➡ **Before the test:** referral triage, risk assessment, clinical history, red flag identification, investigation planning. Around the test: patient preparation, consent/information, clinical assessment, protocol-driven investigations, results coordination.
- ➡ **Around the test:** Patient preparation, Consent/information, Clinical assessment, Protocol-driven investigations, Results coordination
- ➡ **After the test:** results review, patient communication, safety-netting, follow-up, treatment planning, MDT coordination. Advanced practice requires defined scope, competence, supervision, governance, and outcome measurement.





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Practical Pathway Example

Before vs After Redesign

Before redesign: referral → admin triage → first clinical appointment → investigation request → imaging/endoscopy → separate results appointment → MDT → further appointment.
This fragmented approach creates delays, duplication, and unnecessary patient journeys.

After redesign: referral → risk stratification → appropriate diagnostics → results integration → MDT/clinical decision.
The gains: fewer unnecessary appointments, fewer hand-offs between professionals, reduced duplication, earlier diagnostic decisions, and better consultant time use.





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One-Stop & Timed Pathways

Reducing Delays Through Coordination

Every hand-off is a potential delay. By coordinating assessment, investigation, interpretation, and decision-making in a single coordinated pathway, we reduce travel, minimise administrative contacts, improve physical capacity use, and enhance the patient experience.

Redesign around the patient's journey

Instead of:

Appointment → wait → investigation → wait → review

Ask:

Can we create:

Assessment + investigation + interpretation + decision
within a coordinated pathway?

Benefits

- Reduced patient travel
- Reduced administrative contacts
- Fewer clinical hand-offs
- Better use of physical capacity
- Improved patient experience
- Potential reduction in diagnostic interval



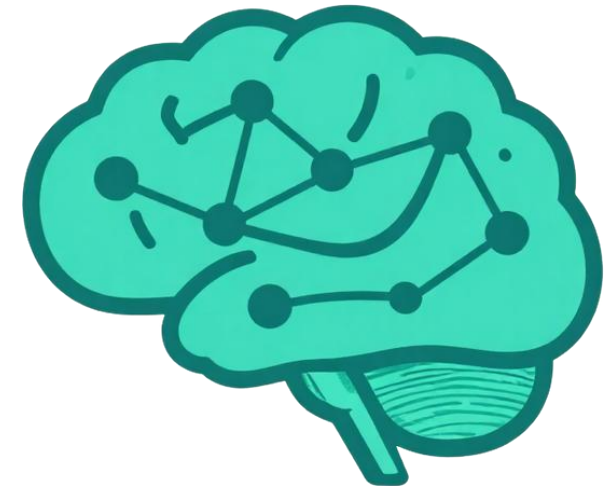
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Lever 4: AI & Decision Support

AI augments clinical capacity—it does not replace accountability. Applications include referral triage, imaging detection and workflow, pathology prioritisation, documentation tasks, and patient navigation.

Can AI safely reduce human
time in the pathway?





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The Human Factors Question

Balancing AI Benefits and Risks

AI augments capacity, not replaces accountability.



Potential Benefit: AI identifies → clinician validates → patient moves faster. **Potential Risk:** AI generates → clinician checks → rechecks → documents → escalates.



Metrics to track: time saved, false positives/negatives, override rates, safety incidents, clinician confidence, patient experience, and inequalities. The goal is genuine capacity building, not simply shifting workload between AI and humans.





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Workforce Wellbeing is a Capacity Issue



Productivity $\neq$ Staff Working Harder



Sustainable productivity requires: less duplication, better workflow design, effective delegation, digital support tools, professional autonomy, psychological safety, and protected development time.



Warning signs to monitor: rising overtime, missed breaks, higher sickness absence, loss of experienced staff, reduced education and supervision, and permanent workarounds becoming standard practice.



Sustainable Care, Not Burnout.



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Balanced Scorecard

Paromc Foua

Patient Outcomes



Safety Indicators



Experience Experience



Emenies



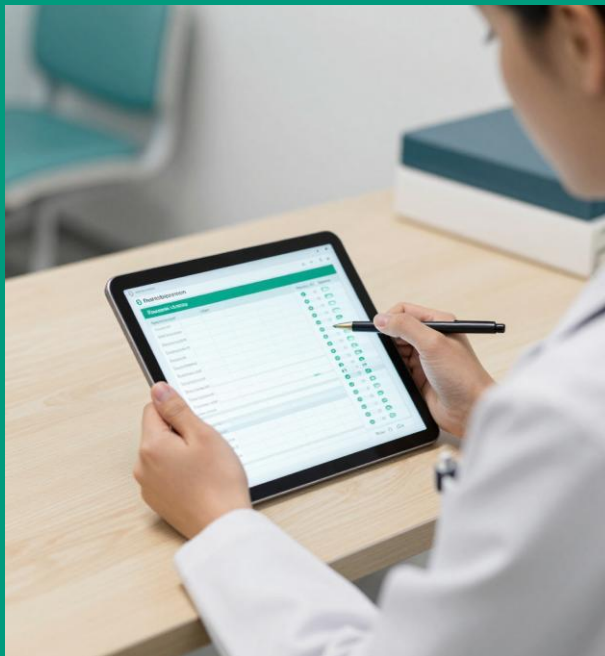
Timues



Timeces



Workforce Welbing



The Productivity Trap

What Should We Measure?

Single metrics create blind spots. Balance is essential for sustainable capacity.

Measuring only volume risks unsafe acceleration. Measuring only waiting time shifts the problem elsewhere. Measuring only staff productivity risks burnout. A balanced scorecard captures patient outcomes, safety, experience, timeliness, variation, workforce wellbeing, and resource use.





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Equity & Access

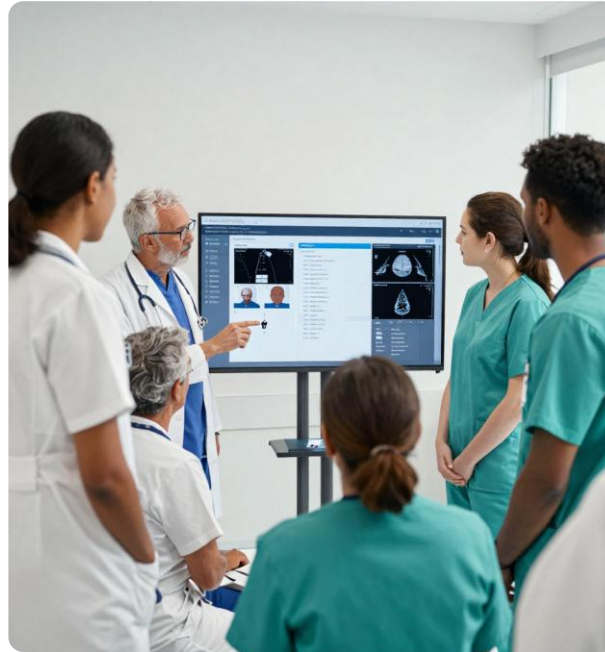
Screening Must Remain Equitable

Capacity expansion must benefit all populations. Digital and technology-enabled screening may widen inequalities unintentionally. Monitor: uptake, non-attendance, digital exclusion, language barriers, disability/accessibility, socioeconomic deprivation, geographic variation, and health literacy.





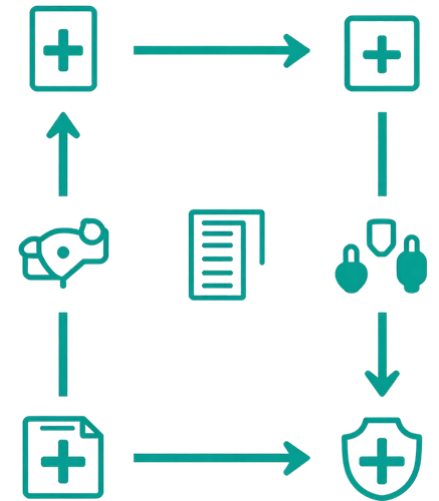
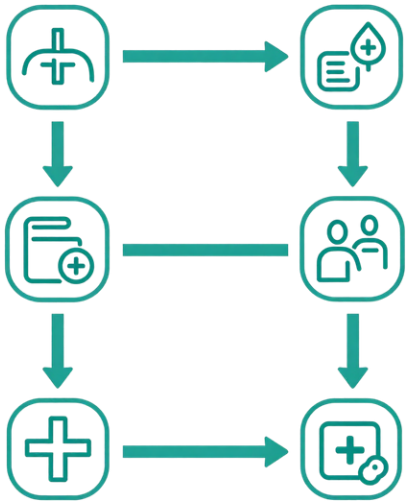
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Future Workforce Model

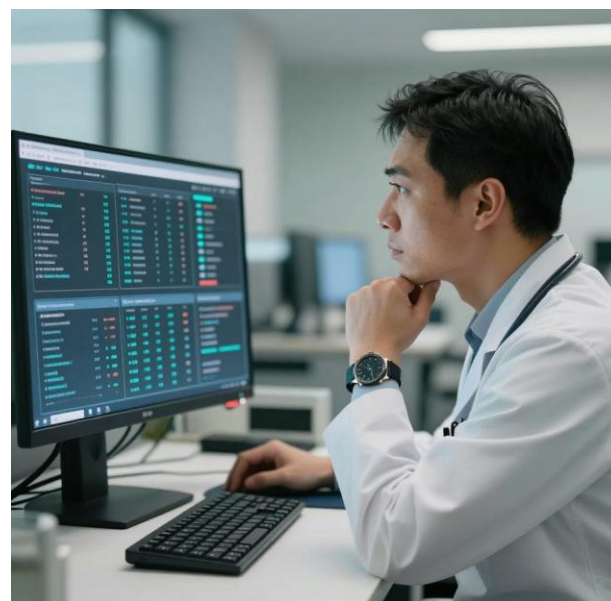
From expansion to transformation: multidisciplinary, digitally enabled, advanced-practice led, data-informed, population-focused, and patient-centred.

Transforming healthcare through smarter pathways.





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Five Risks Not to Ignore

Governance Critical

Innovation without governance is not transformation. Five key risks could undermine pathway redesign efforts and must be actively managed throughout implementation.

1. Role ambiguity: Who is accountable for outcomes?
2. Skill dilution: Is competence matching complexity?
3. Technology bias: Is the algorithm fair?
4. Workload displacement: Where does work go now?
5. Change fatigue: Can staff sustain transformation?



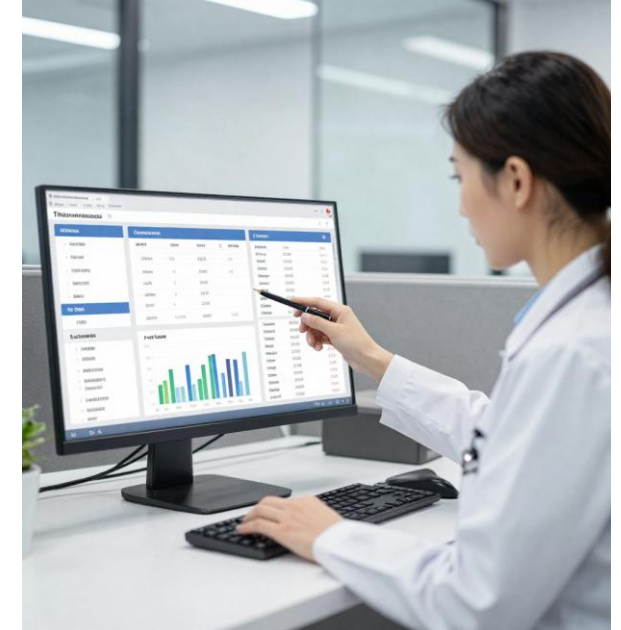


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Practical Implementation Framework

Six Steps to Sustainable Transformation

1. LISTEN: Engage patients and frontline workforce to understand real barriers
2. MAP: Understand the entire diagnostic pathway from referral to diagnosis
3. MEASURE: Assess volume, variation, delays, and workforce burden
4. REDESIGN: Optimize skill mix, pathway structure, and technology
5. PILOT: Test at small scale with clinical governance oversight
6. EMBED: Evaluate → Refine → Standardise → Spread across organisation





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What Does Success Look Like?

Beyond Screening Volume

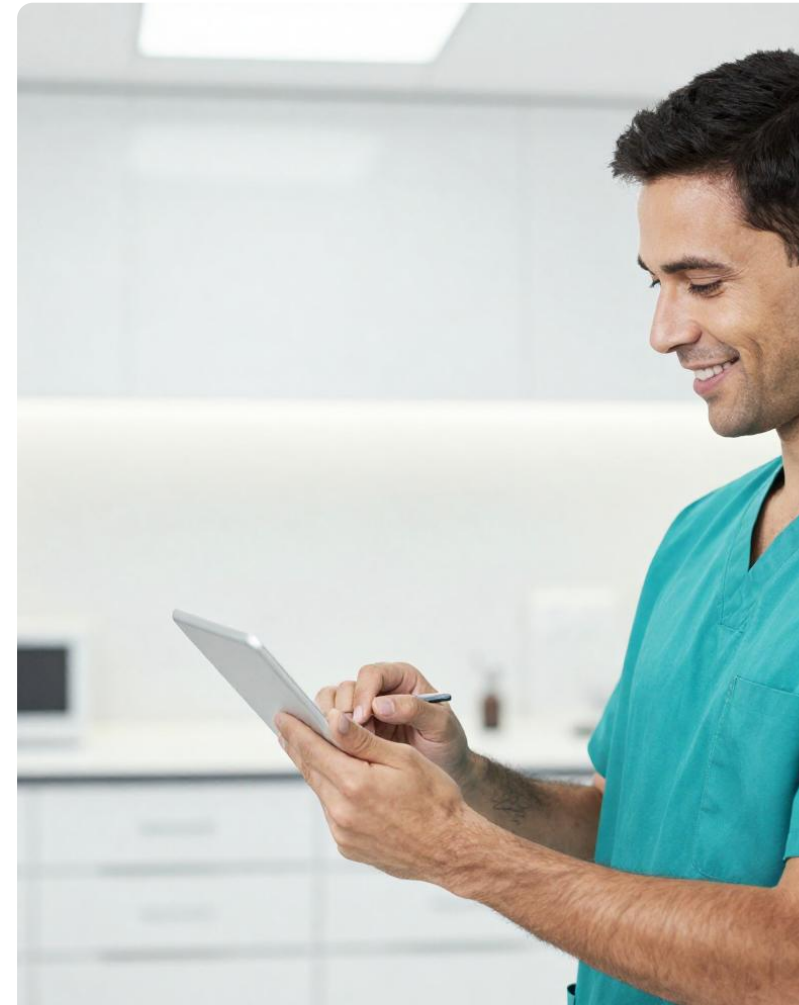
Meaningful improvement across the system.



More appropriate patients screened, faster diagnostic decisions, no safety compromise, better patient experience, and reduced unwarranted variation.



A sustainable workforce that delivers more care without a proportional increase in workforce burden. Success is not simply screening more people—it's delivering higher quality care more efficiently.





Closing Argument

The Future NHS Cannot Recruit Its Way Out of Demand

Capacity is more clinical value from existing people, technology, and resources. The NHS needs better use of every professional's expertise, not more staff.

We must redesign care delivery and pathways. Optimise skill mix, develop advanced practice, use AI intelligently, remove low-value work, and protect the workforce. Measure what matters to patients.





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The Future of NHS Capacity

A Final Thought



"We don't need fewer professionals. We need fewer unnecessary steps, better use of every professional's expertise, and technology that genuinely gives clinical time back."



The NHS transformation journey begins not with recruitment, but with redesign. Every pathway, every task, every decision point offers an opportunity to reclaim valuable clinical time and deliver better patient outcomes.

Capacity = More Clinical Value, Not More Staff.





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References

Evidence Base & Supporting Documents

NHS England 10 Year Health Plan for England: Fit for the Future (2025)

NHS England Planning Framework (2025) | NHS England Productivity Plan Update (Feb 2026) | NHS England AI rollout announcement (July 2026)
NHS England Harnessing Innovation in Cancer Care (2026) | National Cancer Waiting Times Monitoring Dataset Guidance (2025) | Timed HPB Cancer Diagnostic Pathway (2025)

National Cancer Patient Experience Survey (2026) | Multi-professional Framework for Advanced Practice (2025 edition) | Centre for Advancing Practice Minimum Standards for Governance



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Portela de Lima**



NHS Deep Dive



Laura Corbiere, Molecular Technical Manager. NEY Cervical Screening, South of Tyne and Wear Pathology





Lessons Learnt from the Frontline



Ronald Ikpe

Faster Diagnosis Services Project Manager
East Cheshire NHS Trust



Lunch & Networking



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AXREM

Chair Afternoon Address



Chris Sleight MSc BSc FIBMS

Chief Executive Officer of Sleight Insights

Formerly Chief Officer of the Greater Manchester Diagnostic
Networks



NHS Deep Dive



Dr Iskander Chaudhry
Consultant Pathologist
Northampton General Hospital



AI in Screening

The Critical Role of Pathology Services

Artificial intelligence, digital pathology
and the future of diagnostic medicine

Dr Iskander Chaudhry

PathHub | Uralensis Innov8

More than 10% chance AI 'could kill all humans' - as Anthropic reveals another 'cybersecurity' incident

Evan Hubinger said in a post on X that while "the risk from present m



[Warning on AI financial advice as chatbot makes £17,500 error in test | Money](#)

NHS to offer same-day prostate cancer diagnosis - with AI tool used to analyse results

Figures from Prostate Cancer UK suggest about one in eight men will have this disease in

Earlier detection needs diagnostic confirmation



PATHOLOGY PROVIDES THE DIAGNOSTIC FOUNDATION

Disease present?	What type?	What grade?	What stage?	Treatment implications?
------------------	------------	-------------	-------------	-------------------------

Different entry points. A shared diagnostic foundation.

ESTABLISHED CANCER SCREENING PROGRAMMES

Cervical

- 1 HPV primary testing
- 2 Cytology triage
- 3 Colposcopy
- 4 Histological confirmation**

Breast

- 1 Mammography
- 2 Image assessment
- 3 Core biopsy diagnosis
- 4 Multidisciplinary management**

Bowel

- 1 FIT testing
- 2 Colonoscopy
- 3 Polyp assessment
- 4 Histology**

LUNG | TARGETED ROLLOUT

Lung health checks and low-dose CT
Increasing diagnostic workload

PROSTATE | EVOLVING APPROACHES

MRI pathways, biomarkers and targeted biopsy
Not population-wide screening [2]

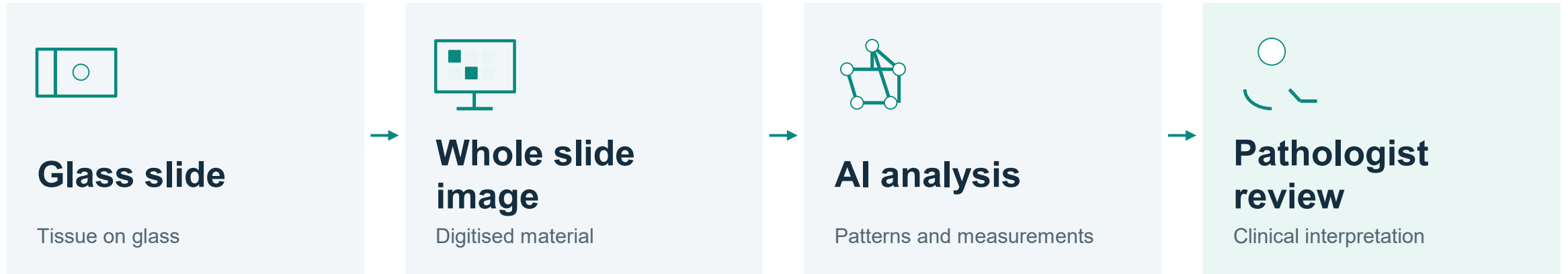
Technology changes where expertise is applied



- 1 Transform the pathway**
Technology can change the diagnostic model.
- 2 Target the automation**
AI can help prioritise abnormal cases.
- 3 Retain expert review**
Complex cases still need clinical expertise.

Technology does not remove expertise. It changes where expertise is applied.

The foundation for image-based AI



DIGITAL PATHOLOGY ENABLES

Remote reporting and image sharing
Standardised workflows and quantitative analysis

PATHOLOGY CONTRIBUTES

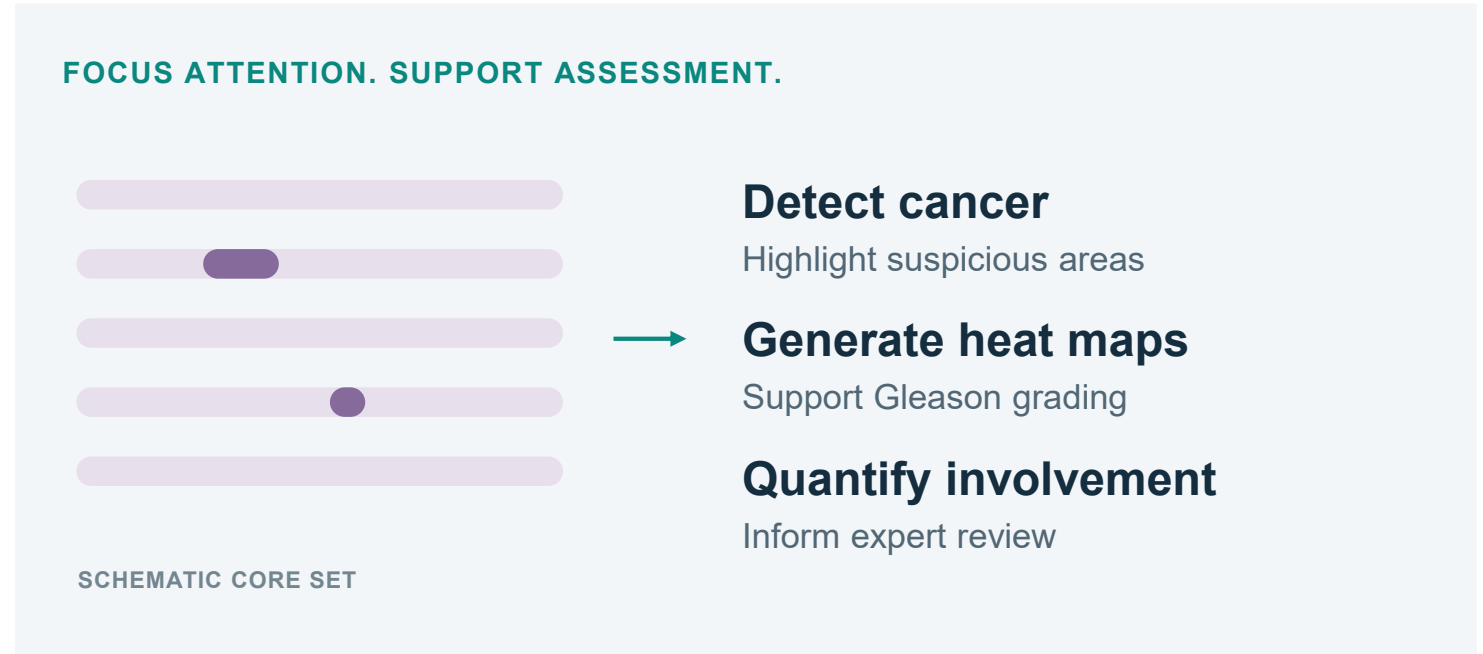
Accurate diagnoses and high-quality datasets
Expert annotation and validation

Digital images enable analysis. Pathology makes the results meaningful.

A leading example of AI in histopathology

THE DIAGNOSTIC CHALLENGE

- Increasing biopsy workload
- Multiple cores per case
- Small tumour foci
- Variation in grading



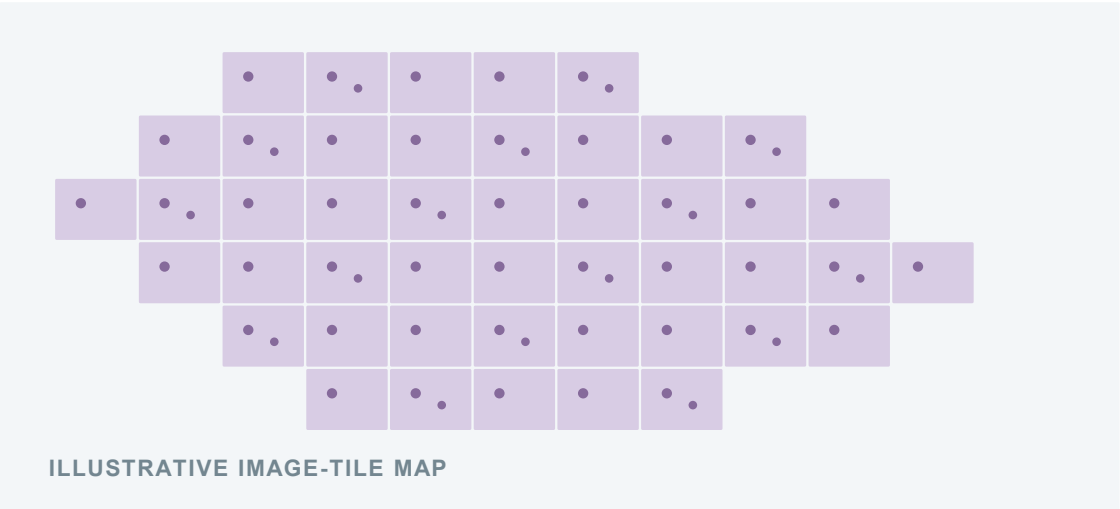
EXAMPLE IN THE SESSION: IBEX MEDICAL ANALYTICS



A visual guide for expert interpretation

Traditional review

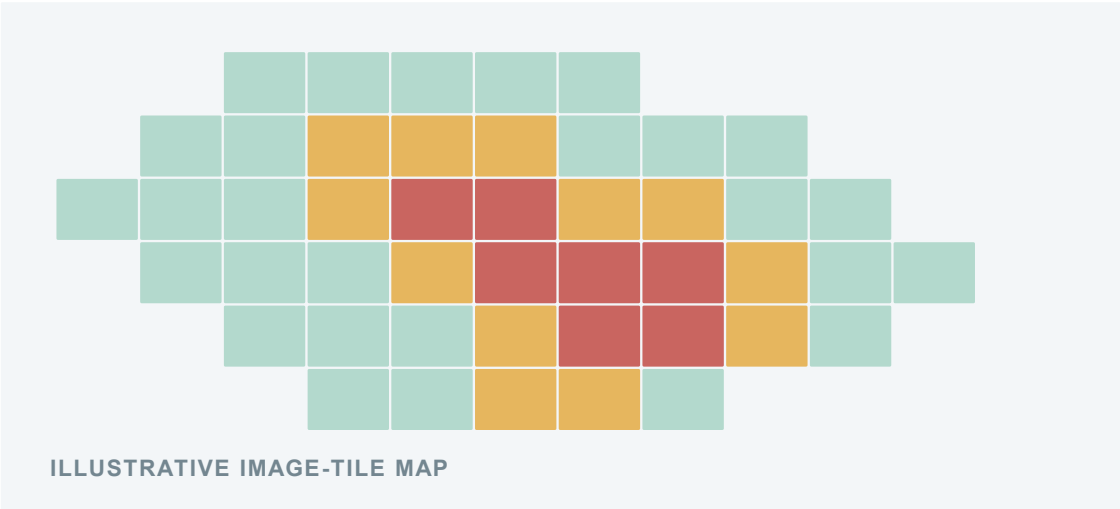
"Find the abnormality"



Lower signal does not rule out disease.

AI-assisted review

"Review the areas of concern"



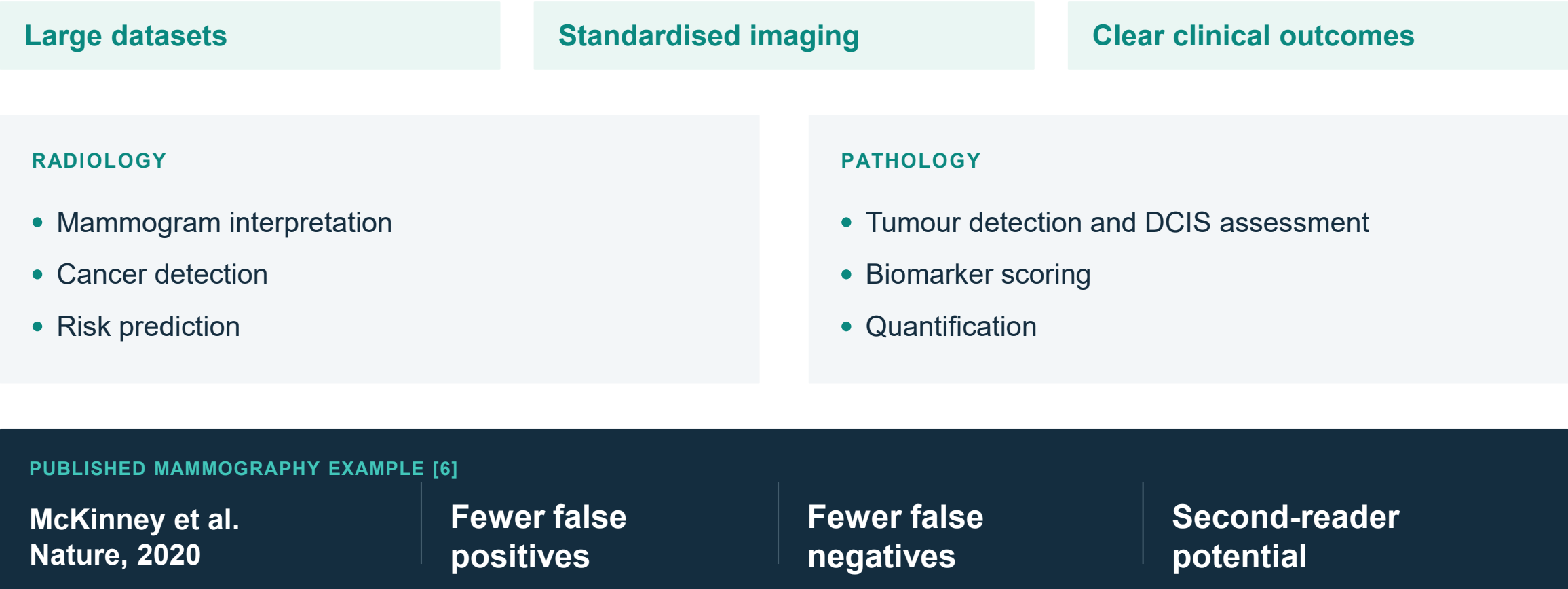
Higher signal Intermediate Lower signal

FUTURE APPLICATIONS

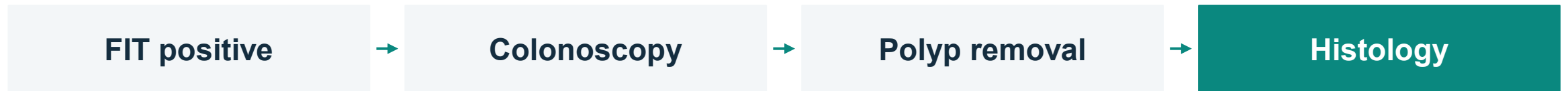
Tumour measurement | Pattern recognition | Immune infiltration | Biomarker prediction

[Published Ibex example](#)

A strong AI evidence base - with clear boundaries



The next major opportunity



THE WORKLOAD: ADENOMAS, SERRATED LESIONS, CANCER RESECTIONS AND SURVEILLANCE

Detection

- Tumour
- Dysplasia
- Serrated areas

Quantification

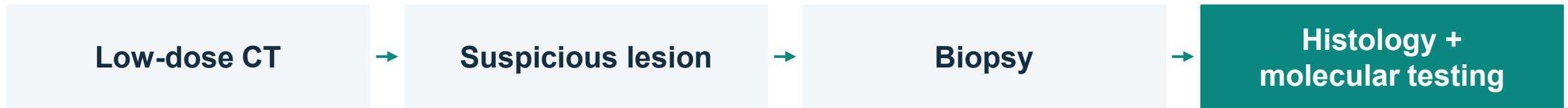
- Tumour percentage
- Tumour budding
- Immune response

Standardisation

- Adenoma classification
- Dysplasia assessment

Promising applications. Clinical readiness depends on the specific task and evidence.

Imaging, pathology and molecular information converge



THE TISSUE CHALLENGE

Small biopsies

Limited tissue

Increasing molecular requirements

RADIOLOGY

- Nodule detection
- Risk prediction

PATHOLOGY

- Tumour classification
- Quantification
- Molecular prediction

The future pathway combines complementary evidence into an integrated diagnosis.

From diagnosis to integrated interpretation

01

Data expert

Create and validate
datasets

02

AI supervisor

Monitor
performance

03

Clinical interpreter

Combine findings
with patient context

Morphology

+

AI output

+

Molecular information

+

Clinical context

Clinical judgement and responsibility remain central.

Validation, bias and governance are clinical requirements

Validation

Does the AI work across...

- Hospitals
- Populations
- Scanners
- Disease types

Bias

Where might it underperform?

- Under-represented groups
- Rare diseases
- Different workflows

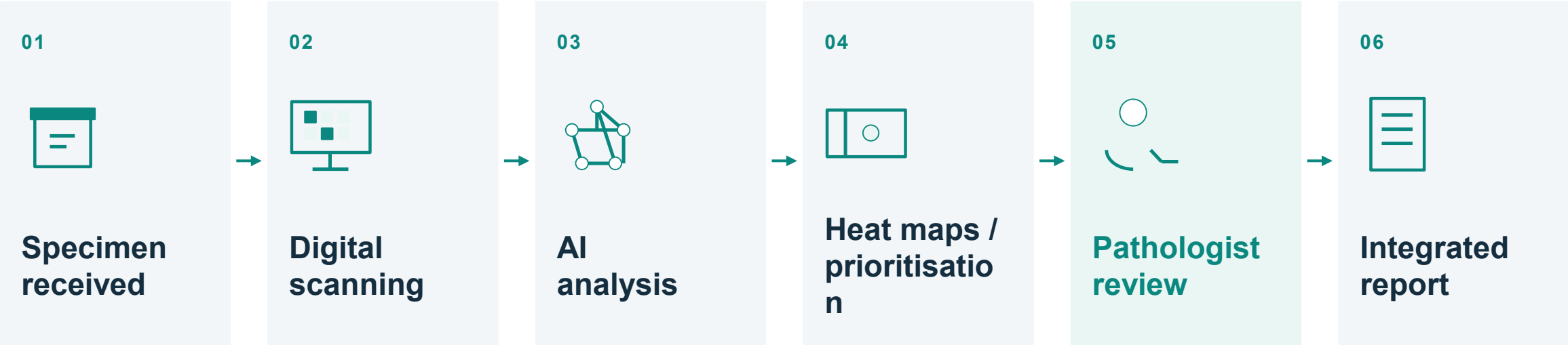
Governance

What must remain in place?

- Appropriate regulation
- Performance monitoring
- Clear accountability

Validate the human-AI team, not only the algorithm. [8]

One connected workflow. Expert review at its centre.



THE WORKFLOW DEPENDS ON



AI will not replace pathology

Pathologist

+

Digital pathology

+

Artificial intelligence

AI SUPPORTS

Speed | Consistency
Quantification | Prioritisation

PATHOLOGISTS PROVIDE

Expertise | Context
Clinical judgement | Responsibility

The greatest impact of AI in screening will come not from replacing pathology, but from enhancing what pathology can deliver for patients.

Source: supplied Screening360 session outline [S], closing message.

Skills Clinic



Josh Soane

Cancer Quality Improvement
Mid and South Essex NHS Foundation Trust

