Queen Mary
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Initial approach and invitation

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Considered three main options for initial approach

Whole population in eligible age range

Individuals in eligible age range with **ever smoking** primary care record

Questionnaire to individuals in eligible age range with **absent smoking** primary care record

Approach whole population in eligible age range

- Invite every patient registered with primary care in eligible age range
  - Subsequent assessment of risk/eligibility

- Issues
  - Demand on Lung Health Check service
    - risk assessment, associated interventions
  - Potential unnecessary concern among those not meeting level of risk

Ever smokers in eligible age range identified from primary care record

- Primary care records as a starting point for invitation
  - Ever tobacco smoking history = current or former, excludes never
  - Smoking status incentivised for primary care
  - History rather than most recent record

- Issues
  - Inaccurate or incomplete data capture
  - Missing data ~2%
  - Interrogation needed/ongoing

Questionnaire to individuals in eligible age range with absent smoking primary care record

- Adjunct approach to mitigate some of the risk of inaccurate smoking data
- Requires
  - Active engagement from those approached
  - Resource to receive/update records
- Issues
  - Does not address inaccurate ascription from smoking records
- Surveying entire age-eligible practice population considered problematic

Evidence gaps

- Accuracy of primary care's smoking data capture across regions and UK nations
- Concordance between primary care smoking data and individuals' answers to eligibility assessment during Lung Health Check (and different modes)
- Quality of smoking data key to initial identification
  - Consideration to strengthening ahead of, and concurrently with, national programme
  - Differ by UK nation (e.g., difference in incentivised approach for primary care)

Approaches to supporting participation of unknown effectiveness

- Awareness campaigns: availability, eligibility and effectiveness
  - Opportunity to improve participation, equality of access, data quality
  - Need to be led by behavioural science to reduce inequalities

- Self-referral
  - In place for breast and bowel above upper age threshold
  - Mechanism in place for prompting referral if person visiting GP discloses eligible

- Phone-based triage vs. in-person risk/eligibility assessment
  - Resource implications, public preferences, participation
  - Phone-based feasible in Yorkshire Lung Screening Trial and the SUMMIT Study

Invitation materials and process

- Evidence-based to ensure informed participation and reduced inequality
  - Attendance as simple as possible
  - Need to be led by behavioural science

- Effective approaches in other cancer screening contexts
  - For populations experiencing deprivation for who lung cancer incidence highest
  - Pre-invitation/advanced notification, reminder letters, letter from GP
  - Lung Screen Uptake Trial utilising these (plus scheduled appointments) = 53% uptake

Thank you

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