north west
cancer research

Uncovering Manchester's cancer contradictions

A North West Cancer Research roundtable exploring Greater Manchester's healthcare and cancer landscape

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Introduction

Introduction

Alleviating the cancer burden in our communities is a highly complex issue and one which presents today's healthcare ecosystem with a multifaceted array of challenges. The importance of overcoming these hurdles in order to better detect, prevent and treat cancer is underlined by the fact that residents in the North West are 25% more likely to be diagnosed with cancer than in the rest of the UK.

To improve these statistics, it is vital we understand the factors affecting these numbers.

In our annual regional reports, we analyse the North West's cancer data at a granular level and repeatedly find that the area exhibits rates significantly higher than the national average across a broad range of metrics and cancer types.

This was the case in our latest research, which found that the North West over-indexes for mortality on 13 of the 18 key cancers surveyed compared to the average in England and that many areas are experiencing mortality rates ranging from 8% up to 33% higher than the national benchmark.

While there are many commonalities across the five North West regions that need to be taken into account, such as deprivation, lifestyles, and a shared industrial heritage, each area also has its own geography, history and idiosyncrasies which play a role in the cancer picture.

Greater Manchester in particular is a region exemplified by contradictions. We can see this in its economy, having the second highest GDP per capita for any UK city and some of the country's most deprived areas; and also some of its culture, which gave birth to Take That and Oasis within a year; and its geography, which ranges from the hilly Pennines to the Cheshire plains.

There are also many contradictions and complexities found in Greater Manchester's cancer statistics. A significant discrepancy is that, on the face of it, the area's cancer incidence rates are better than the national average. However, this is masked by Greater Manchester's youthful population, with 66% of adult residents aged under 54.

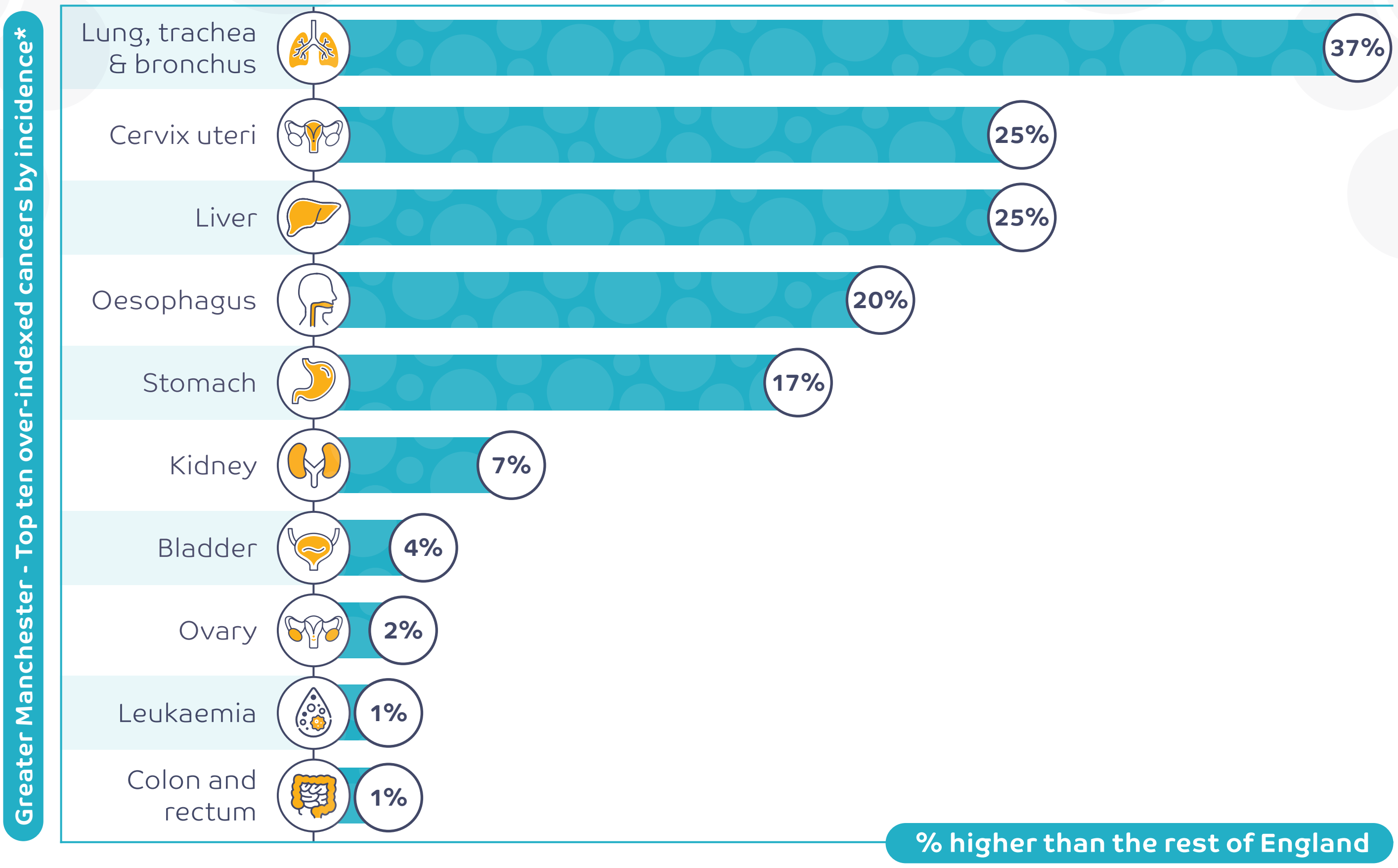
When the data is age standardised, Greater Manchester has one of the highest cancer incidence rates in the North West and a total death rate from cancer 10% above the national average. The county is particularly impacted by lifestyle related cancers, with lung, trachea and bronchus cancers being annually diagnosed at a 37% above average rate, while incidence rates for liver, oesophageal, and stomach cancers are respectively 25%, 20% and 17% higher than the rest of the country.

When considering Greater Manchester's health landscape, there are other crucial opposites that must be balanced. This includes recognising the differences between the medical experience of the city's centre and affluent suburbs with those of outlying areas such as Oldham, Salford, and Rochdale. Deprivation is a central factor here, as was underlined by a [Manchester Health and Wellbeing Board Report](), which found that 75% of lung cancer patients and 60% of breast cancer patients are from the most deprived quintile. Nationally, these figures are substantially lower at 27% and 15%.

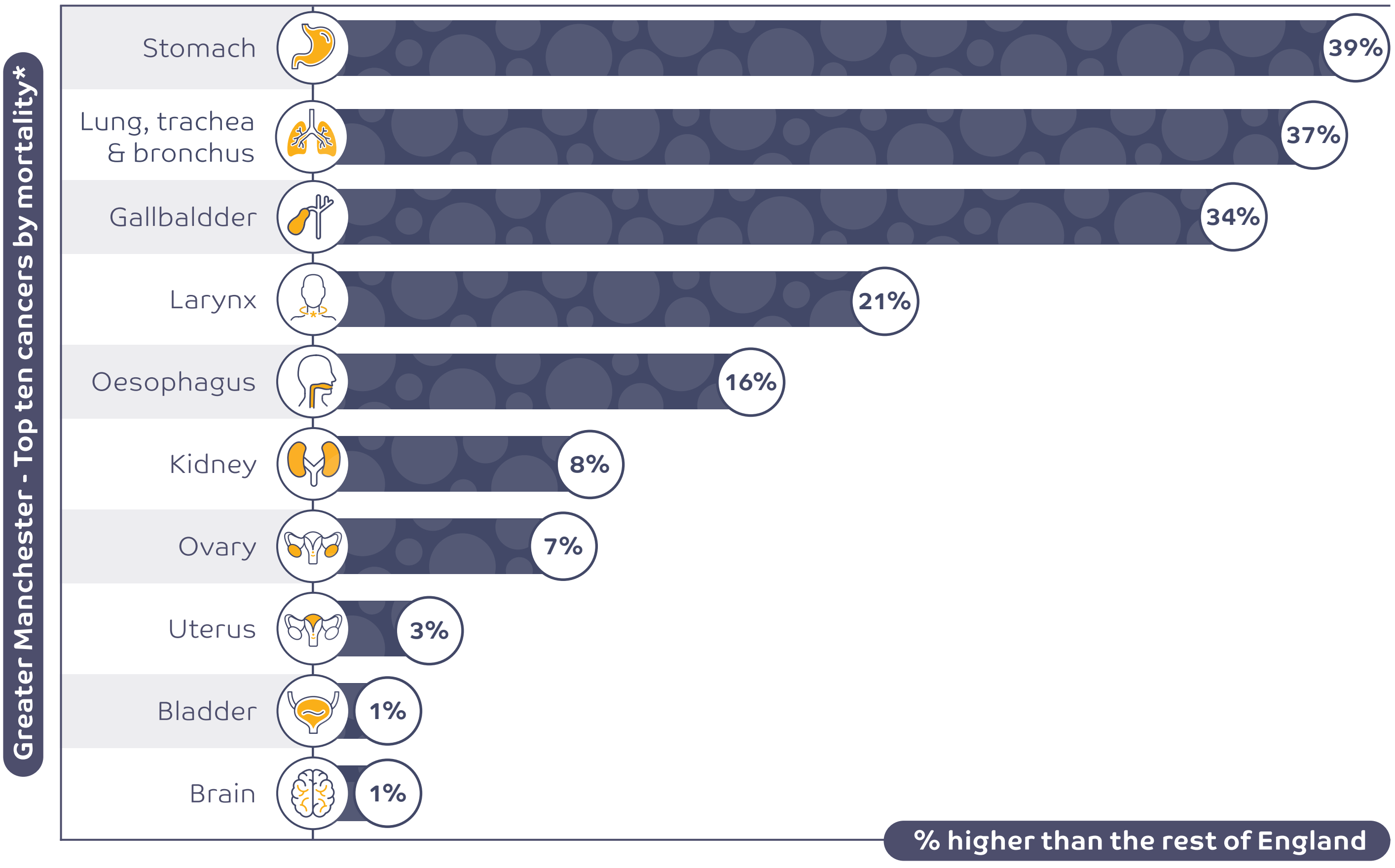
To shine a spotlight on the issues at hand, we brought together a panel of Greater Manchester's healthcare experts with charity, community and political leaders. The roundtable explored a wide variety of topics, ranging from the connectivity of different cancer-focused organisations to the importance of data, messaging, and community engagement, as well as the effect of devolution, the steps the region needs to take moving forward, and more.

The aim of the discussion was to better understand the priority areas that need to be worked on if we are to achieve meaningful change in the county's cancer rates, and ultimately how we can collectively develop the regional approach to cancer to improve outcomes and achieve a cancer-free future for all.

> **"Greater Manchester has one of the highest cancer incidence rates in the North West and a total death rate from cancer 10% above the national average."**



* Graph is based on age standardised total cancer deaths for which data was available.



* Graph is based on age standardised total cancer deaths for which data was available.

Creating the conversation
Attendees

The roundtable was chaired by award-winning journalist Chris Maguire, who is the executive editor of BusinessCloud and TechBlast.

Alastair Richards
CEO of North West Cancer Research

North West Cancer Research is an independent charity dedicated to putting the region's cancer needs first. Alastair qualified as an accountant before working in a number of charity roles in regulated organisations providing health and social care. He joined North West Cancer Research as CEO in 2017.

Councillor Thomas Robinson
Clayton and Openshaw, and Executive Member for Healthy Manchester and Adult Social Care

Councillor Thomas Robinson represents Clayton & Openshaw and became Manchester City Council's Executive Cabinet Member for Healthy Manchester and Adult Social Care in May 2022. In his cabinet role, Cllr Robinson's responsibilities include public health, tackling health inequalities, health and care integration, as well as early intervention and prevention. He previously served as a Parliamentary Assistant, local government officer, and fundraiser for Comic Relief and The Royal British Legion.

Alison Jones
Director of Cancer Commissioning and Early Diagnosis, Greater Manchester Cancer Alliance

Alison has held roles in Primary Care Groups, Primary Care Trusts and recently the Clinical Commissioning Group in Tameside & Glossop where she was Deputy Director of Commissioning. She has been in her current role with the Cancer Alliance since January 2019, which has a focus on key areas including stakeholder engagement, primary care, innovation, patient outcomes and strategic development.

Alison works with colleagues across Greater Manchester to design and deliver a strategy to achieve the Long Term Plan ambition of 75% early-stage cancer diagnosis by 2028.

Dr Neil Bayman
Executive Medical Director, The Christie NHS Foundation Trust

Neil was appointed as Executive Medical Director in November 2021 having been interim Medical Director since April 2021, and the Trust's Associate Medical Director (Quality) since June 2017. Neil holds strategic positions both regionally and nationally and has a proven track record of influencing cancer policy. He has significant expertise in fostering clinical engagement, delivering transformation and safeguarding quality and patient safety through robust clinical governance.

Since joining The Christie in 2009 as a consultant clinical oncologist focused on lung cancer, Neil has retained an active clinical practice. He previously served as the Clinical Director for Lung Cancer at Greater Manchester Cancer Alliance from 2014 to 2017, where he improved lung cancer pathways and reduced waiting times for patients. Neil has led impactful research in lung cancer and mesothelioma and held various national roles, including Specialist Advisor for Oncology at the Care Quality Commission and membership in several NHS and Royal College committees.

Edna Boampong

Programme Director for Diverse and Inclusive Communications, NHS Confederation

Edna chairs the Taskforce for Diversity in NHS Communications in partnership with the NHS Confederation and NHS Providers. The Taskforce brings together leaders from NHS communications, social mobility advocates, and a diverse group of ethnic minority communicators.

With over 20 years of experience, Edna is a multi-award-winning communications, engagement, and marketing director. She has a strong track record in strategic planning and has successfully led projects that support organisational rebrands, policy changes, and service transformations. Edna is dedicated to ensuring equitable access to services and advancing equality, diversity, and inclusion in healthcare.

Hannah Stirzaker

Strategic Lead, 10GM

In her role at 10GM, a joint venture to support the VCFSE sector in Greater Manchester, Hannah works with the Greater Manchester Cancer Alliance to achieve a permanent reduction in inequalities within cancer incidence rates and outcomes and improve equity in access and experience of cancer care for all people affected by cancer within Greater Manchester.

Hannah is passionate about people and addressing the inequalities experienced in healthcare, especially within the cancer system, and is determined to ensure that the VCFSE sector furthers its role in addressing these inequalities.

Graham Morgan

Commissioner, Salford Poverty Truth Commission

Graham is a member of the Salford Poverty Truth Commission (PTC) and uses his experience and insights from being diagnosed with prostate cancer while living on only £74 a week to help others.

The PTC was launched in 2016, originally comprising 15 individuals with personal experiences of poverty and 15 people from business or public life whose positions could help facilitate change. It has made significant progress by listening to the voices and evidence of those with firsthand experience of poverty, working closely with the council to inform the Tackling Poverty Strategy, and changing the way the council engages with residents.

Susannah Penney

Consultant Head, Neck and Thyroid Surgeon and Medical Director at Greater Manchester Cancer Alliance and Manchester University NHS Foundation Trust

Susannah has worked as a consultant head, neck, and thyroid surgeon at Manchester University NHS Foundation Trust since 2012. She has also been the Associate Medical Director for the Greater Manchester Cancer Alliance since 2018, after serving as the clinical lead for the head and neck cancer pathway for three years.

A graduate of The University of Manchester Medical School, Susannah completed her basic surgical training at the Royal Bolton Hospital before specialising in Otolaryngology. She focused on head and neck cancer during an 18-month placement at the Christie Hospital and completed her general training in the North-West deanery.

Danielle Ruane

Network Chief Coordinating Officer for Healthwatch Greater Manchester

As Chief Coordinating Officer for Healthwatch across Greater Manchester, Danielle works at all levels of the Integrated Care System to represent the Network and ensure the voices of Greater Manchester's communities are heard and acted upon.

Danielle's role is focused on coordinating efforts across the ten Healthwatch localities, driving collaboration, and ensuring that lived experiences are central to decision-making and service improvement.

Lorraine Cliff

Director of Elective & Cancer Care, Manchester University NHS Foundation Trust

Lorraine is currently the Director of Elective & Cancer Care at Manchester University NHS Foundation Trust and was previously the Trust's Director of Performance. She recently worked on the Manchester University NHS Foundation Trust's Winter Plan to support the management of demand increases and the associated challenges of winter across the Trust's hospitals.

Mapping out the county

Mapping out the county

Alastair Richards and Graham Morgan

Greater Manchester's (GM) physical and political geography creates a layered map that has a direct impact on the organisation and provision of cancer care for the county's communities. Prominent landmarks across this map include clinical sites such as The Christie, the largest single cancer centre in Europe and home to the Greater Manchester Cancer Alliance, and the Manchester University NHS Hospital Trust's (MFT) multiple sites, as well as local authority bases including Manchester Town Hall and the seats of the region's 10 borough councils.

The roundtable's participants agreed that the close, collaborative relationship that has been built up between these organisations is quite a feat when compared to other parts of the country. However, it was important to interrogate exactly how these points on the map interact, what works well and what needs to be developed moving forward.

Councillor Thomas Robinson, Clayton and Openshaw, and Executive Member for Healthy Manchester and Adult Social Care, outlined the positives and areas for improvement from his perspective: "Greater Manchester has two massive cancer related organisations and that affects the pathway and means funding here is different. This is where I believe the council is essential in helping to bring those pathways together."

An example of this collaboration is the Manchester Local Care Organisation, which is part NHS and part local authority and therefore able to operate across traditional organisational boundaries to provide community health and adult social care services. One of the valuable benefits of this is that it empowers data sharing. However, Cllr Robinson believes that this could be even better optimised if organisational friction was further smoothed out, a development he envisions being facilitated via the Director of Public Health.

Dr Neil Bayman, Executive Medical Director at The Christie NHS Foundation Trust, emphasised that cancer care is a collaborative effort, requiring strong partnerships between organisations. He explained: "Over the past decade, Greater Manchester has made significant progress in improving cancer care through collaboration, especially with the establishment of a mature Cancer Alliance. Historically, there was intense competition between hospital boards and clinical teams over cancer services in Greater Manchester.

An example of this was that: "For years, lung cancer care in Greater Manchester was divided between surgical services at MFT and non-surgical treatments at the Christie, leading to fragmented patient care. However, through collaboration between MFT and the Christie, a unified service has been established and now patients visit a single clinic where they are seen by a multidisciplinary team, including surgeons, oncologists, anaesthetists, research nurses, and other specialists. This integrated approach ensures comprehensive, coordinated care for lung cancer patients."

A significant aspect of this development in cancer care has been the Cancer Alliance, which Dr Bayman said has "brought together healthcare professionals from various disciplines - beyond just doctors - to align on best practices, strategic planning, and innovation. Thanks to this, the Alliance fosters a collaborative approach to cancer care across the region, with input from both clinical experts and the public, ensuring high-quality service delivery. While challenges remain, the shift towards collaboration is a positive development and our Cancer Alliance is recognised nationally as the exemplar Alliance. So, I think we've got a lot to be proud of."

Dr Bayman concluded by saying that it's these innovations and collaborations that we need to learn from as "we can't carry on trying to deliver cancer care the way we've been delivering it over the last 10-20 years, cancer care in 2035 has to look very different to what it looks like now."

Susannah Penney, Consultant Head, Neck and Thyroid Surgeon and Medical Director at Greater Manchester Cancer Alliance and Manchester University NHS Foundation Trust, explained how the Cancer Alliance is organised and why this enables it to be so effective. She said: "The Cancer Alliance is clinically led. We've got 14 pathway boards, one for each tumour type and all led by a senior clinician, Allied Health Professional (AHP) or nurse, and they look after the remit for their sites across the whole of Greater Manchester. They meet four times a year, hold education events and have all got patients on the board. The Alliance is the vehicle for all that and we have a seat at just about every table."

Susannah explained how this collaboration was illustrated by "a trial that was rolled out over the last three years, where people turned up to a van in a supermarket car park in each locality in Greater Manchester and had a blood test looking for tumour DNA. All that was delivered by the Cancer Alliance because we have the reach to be able to access all the organisations and pull them together."

Alison Jones, Director of Cancer Commissioning and Early Diagnosis at the Greater Manchester Cancer Alliance, commented that the locality structure and coordination between local leaders is a pivotal and highly beneficial factor in GM's healthcare network.

Alison said: "In Greater Manchester, each of the 10 council areas has an identifiable and named cancer lead. I still have regular conversations and formal meetings every month with those 10 individuals and with the 10 GP leads in those places. Having 10 identifiable places with 10 identifiable GPs and 10 identifiable people who are the advocates for cancer care is really positive."

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>
> Dr Neil Bayman, Executive Medical Director
> at The Christie NHS Foundation Trust

Dr Bayman added that Greater Manchester's organisations are also affected by wider national organisations. He said: "It's important to recognise that one in four of our patients comes to The Christie from outside Greater Manchester, and one in 10 are from outside the North West. So we've got a big footprint to look at and we need to consider the workforce risk, as at The Christie we're receiving distress calls from other cancer centres around the country, to see whether we can support them because they cannot recruit the staff they need to keep up with demand."

Lorraine Cliff, Director of Elective & Cancer Care at Manchester University NHS Foundation Trust, likewise illustrated the scale of the challenge. She said: "We're the second largest acute provider of cancer services in the country and have 400 referrals just for breast cancer alone. There's approximately 1,500 referrals a week coming through our doors on a two week pathway, and we do 500 treatments a month. They're big numbers, and that's going to continue to grow, so we've got to look at how we do things differently."

Lorraine suggested that what would help the system is "directing more funding to prevention and public health, but we can't take that away from acute care". She added: "We're going to have to change the model for cancer care in the future because the demand that we are seeing through the acute sector is going up year on year, and we do not have the capacity to continue to deal with the numbers. So, we've got to really think about the models of delivering cancer care."

Dr Bayman underlined the need to change the model for cancer care. He said: "The reason why we need to do things differently are threefold. One, we haven't cracked cancer, particularly the inequalities question. Two, there's no money. And three, there aren't many people to do the work that we need."

Edna Boampong, Programme Director for Diverse and Inclusive Communications at the NHS Confederation, said: "We need to keep up the passion and commitment fuelling the partnerships and collaborations, because that doesn't happen everywhere and that's something that's very unique to Greater Manchester."

Alastair Richards, CEO of North West Cancer Research, summed up the sentiment at the table, saying "what we've seen here that's different to other regions is the passion around joining stuff together. That's been a theme that's come out from this room that, yes we are doing things together, but that we can do better. We can do more. We want to communicate more. And we want to deliver more."

Councillor Thomas Robinson, Councillor for Clayton and Openshaw and Executive Member for Healthy Manchester and Adult Social Care

"We need to keep up the passion and commitment fuelling the partnerships and collaborations, because that doesn't happen everywhere and that's something that's very unique to Greater Manchester."

Edna Boampong,
Programme Director for Diverse and Inclusive
Communications at the NHS Confederation

Devolution and decisions

Susannah Penney, Consultant Head, Neck and Thyroid Surgeon and Medical Director at Greater Manchester Cancer Alliance and Manchester University NHS Foundation Trust

One of the underlying reasons for GM's unique healthcare landscape is the devolution agreement, which gave the county additional powers and decision-making capabilities in 2014.

For Cllr Robinson, one of the main benefits of devolution has been enabling GM to better align its healthcare organisations. This has recently been illustrated by the creation of the Manchester Cancer Delivery Group, which brings multiple stakeholders together to have conversations which could otherwise be difficult.

However, he notes that since the Levelling Up white paper was introduced two years ago, the conversation around devolution in Greater Manchester "has become more focused on finance". This development risks "overshadowing years of progress in integrated care, as the emphasis on cost-cutting has affected preventative care and strained various sectors, especially councils and acute trusts, which face co-funding challenges". Despite these financial pressures, Cllr Robinson is optimistic that "collaboration between healthcare providers has improved, though tensions remain due to differing funding mechanisms" but remarked that it is vital that financial priorities don't supersede patient-centred care and the breaking down of silos.

Graham Morgan, Commissioner at the Salford Poverty Truth Commission, echoed this sentiment, saying: "Sadly, it's always the case that finances are thrown into the equation, but it shouldn't be because it's people's lives we're talking about."

Edna Boampong made the point that Greater Manchester was ahead of the national curve, and recent national developments could risk undermining the already effective integration. She said: "When I started, there was the Association of Greater Manchester Authorities, and then there was the Greater Manchester public organisations and the NHS, who used to work very closely together. There was a mature relationship in Greater Manchester and there was a lot of integration happening. And then a couple of years ago, when the white paper that introduced ICBs was published, it undid a lot of the work because some of the new structures didn't match what we had. While it was supposed to be bringing organisations closer together, Greater Manchester was already doing that, but in its own way."

Reflecting on how devolution has affected the Cancer Alliance, Susannah Penney said: "I think the Alliance is very privileged because we're funded centrally from NHS England and not via Greater Manchester. So, the devolution agreement, although it affected us a little bit in 2016 when some of the original funding was sent out, we're not funded via the ICB. All 21 alliances in the country are funded directly and proportionally according to the work you do and what the planning guidance says we have to deliver on behalf of the ICB. Also, we can apply for extra funding."

Data powered strategies

Hannah Stirzaker, Strategic Lead at 10GM

The interconnectedness of GM's organisations means that the region is better able to measure important healthcare metrics and use this information to improve planning, treatment, and strategies.

Cllr Robinson flagged an example of this, saying: "The leadership between the council and other organisations means we've got a Local Care Organisation that can monitor data and access vital information on different types of cancer."

Susannah Penney pointed to how one statistic highlighted an urgent issue, this being that 16% of cancer diagnoses in GM are made in emergency settings, indicating gaps in primary care access or awareness. She said this showed that "some individuals either fail to visit primary care or don't understand how to engage with it, while others are unaware of available screening programs".

Dr Bayman explained why GM has data advantages and how they were working at The Christie to make sure the data is as representative and insightful as possible. He said: "We know that in traditional research there's a tremendous inequality in patient access which can mean that the research doesn't accurately reflect the population.

"One of the advantages of The Christie being one of the biggest cancer providers in Europe is that we have access to a vast amount of data from a vast population. And one of the things we've done differently is that we're running a clinical lung cancer trial where instead of asking patients if they would like to consent, which inherently introduces all sorts of bias, every patient is recruited unless they opt out - and I can count on two hands the number of patients who've opted out. So, we've entered thousands of people, and this means it's translatable to our entire population that comes through the Christie for non-surgical lung cancer treatment. While it is still selective based on who accesses cancer services, it's much less selective than these sorts of trials usually are.

"And we get real-time feedback from the data that we're collecting on treatment, outcomes and toxic side effects from radiotherapy. This allows us to adjust how we deliver that radiotherapy, so it's a continuous improvement of treatment based on a feedback loop from the data that we're getting. There's never been a clinical trial like this, and the advantages of being able to change practice in real time is having a direct improvement on care for patients as the trial goes on."

Lorraine Cliff added that leveraging data is important for understanding GM and its communities as well as informing "where and when do we put screening, where do we put mobile units, etc. These decisions are really important to reaching out, especially to harder to reach places."

Underscoring early diagnosis

Underscoring early diagnosis

The roundtable discussed in depth how one of the main ways to reduce cancer rates and improve outcomes in GM is to substantially boost the level of early diagnosis. Alastair emphasised that it's vital to "prevent where you can. But also get people through the door and talking to their GP at the very earliest stage and then into the treatment pathway at the earliest point".

Alison Jones added to this point, saying: "The sooner you can get people to come forward, the better, however that is dependent on a significant number of different things. At targeted lung health checks, 80% of those diagnosed are at stage one or two, but if you wait for a symptomatic presentation of lung cancer, it's likely to be a significantly later diagnosis.

"To help get people checked earlier, we're identifying risk factors in the age group of people who are most likely to contract those cancers. And then we're going into the areas of high deprivation, high lung cancer incidence, high lung cancer mortality, to encourage people in those areas to get checked. We're literally driving an enormous truck into the middle of the places where we're most likely to find those cancers. But it's not one-size-fits-all, and it's about finding multiple different ways of engaging and raising awareness and taking things out to people, rather than waiting till someone goes to their GP."

Susannah Penney outlined the number of people entering the cancer care pathway at different points. She said: "Nearly a fifth of all the cancers we diagnose will have come from someone just turning up at an emergency ward. That's a huge number of people and represents where the problem is. Why are people coming through my door at MRI with lung metastases, lung cancers, obstruction from bowel cancer? A lot of them will have had symptoms, and a lot of them would have been invited for screening programs.

"If you look at the demographic of people that get cancer, yes, some would be too young, yes, some might not have symptoms. There will always be exceptions, but there's a lot of patients who still walk through the doors of the hospital as an emergency who we've clearly failed to reach. They may have either attempted to access primary care, or they don't realise they can access primary care, or they're in the middle of a pathway, but things have accelerated, and they've decompensated and had to come to A&E."

Alison Jones added that: "We spend a ridiculous amount of time making sure our GPs know the signs and symptoms as well as how and when to refer, and we make sure all the referral forms are on the GP systems so they know exactly where to go. I think the primary care education bit is massive, and it is something we're constantly working on - as is the message that primary care is open. We've recently picked up with the outcomes and engagement team on a piece of work about this, to tell people that if you've got signs or symptoms, go and see your GP."

Danielle Ruane, Network Chief Coordinating Officer for Healthwatch Greater Manchester

Edna Boampong, Programme Director for Diverse and Inclusive Communications at the NHS Confederation

When it comes to screening, Danielle Ruane, Network Chief Coordinating Officer for Healthwatch Greater Manchester explained that: “The rates of cervical cancer screening have dropped significantly lower than the national average in some seldom heard communities. At Healthwatch, we’re doing work with community leaders to get to the bottom of why that’s happening. This includes linking in your primary care and asking a lot of questions, such as is it appointment availability? Is it certain days and times that are a problem with childcare? Are certain holidays in communities affecting take-up? And we’re bringing these factors together and working out the jigsaw.”

Susannah Penney elaborated on her point about the large number of diagnoses being made at A&E and screening issues. She said: “Language barriers, especially among non-English speakers, contribute to challenges in communication, such as difficulties with screening letters when certain medical terms, like “cervix,” don’t exist in some languages.

“In addition, breast cancer diagnoses often occur outside the recommended screening age range, but data shows that many of these cases are unlikely to be fatal. This highlights a complex issue: while some cancers may be detected early through screening, they might not pose a significant risk to the patient, leading to potentially unnecessary treatments like chemotherapy or surgery. There is a need for better communication about the nature of some cancers and their risks.”

Cllr Robinson remarked that GM is “nowhere near where we need to be” for breast cancer screenings. For him, this came back to asking “What more can the public health team do to help support cancer care organisations?” to make sure that they’ve got the right teams and assets in the right places.

Dr Bayman added that alongside making sure cancers are diagnosed earlier, that patients are “getting to treatment much more quickly, in a way that is person-specific and personalised to the individual”.

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> Susannah Penney, Consultant Head, Neck and Thyroid Surgeon and Medical Director at Greater Manchester Cancer Alliance and Manchester University NHS Foundation Trust

Engaging with our communities

Engaging with our communities

A common factor that has touched on all these areas is the need to ensure clear, consistent and effective engagement with GM's communities. This requires having a robust understanding of each community, recognising the cancer challenges being faced and how best to enter into a conversation with local people to effect behaviour changes that will minimise their risk of contracting cancer as well as improve early diagnosis rates.

Edna Boampong remarked that getting this right is central to achieving better levels of prevention, as she noted that "moving from acute to community and treatment to prevention has been talked about for a long time, and we still haven't quite managed it. We need to really recognise that if we are going to fix this then prevention methods and approaches need to be tailored to each community."

She added that certain high-risk communities are less likely to engage in screening and are being diagnosed at later stages, leading to higher mortality rates. Edna shared an insight from one project she worked on regarding South Asian communities, in which for some of them "there isn't even a word for cancer, because they don't talk about it - because if you say it, you're going to get it. So, we had to find different ways of engaging with that community because the normal mainstream campaigns that we were doing in Greater Manchester weren't going to work."

Edna also advocated for increasing diversity in healthcare communication teams, pointing out that "70% of communication teams in NHS trusts do not reflect the communities they serve". This gap means that health messages may not reach or resonate with ethnic minority groups, who often face the most significant health disparities.

She added: "We really need to understand our communities and then engage with them in the right way, but that starts with recognising that we don't quite have it right within the structures of our health and care system."

Alastair explained how a lot of the work North West Cancer Research undertakes is aimed at empowering local care systems with tailored measures that reflect the lived realities of their communities. He said that central to this is "generating targeted education and outreach programmes that provide people with the support they need to live healthy lives while simultaneously minimising their risk of being diagnosed with cancer".

He said: "This has seen us engage in a wide range of activities, including school outreach to provide pupils with healthy lifestyle skills. We've also rolled out region-wide awareness campaigns focused on some of the most problematic cancer types. For this, we've developed creative messaging, shared vital information with local media and implemented in-person outreach across Greater Manchester to disseminate information first-hand.

> **"We've got to educate people to achieve the prevention result, that is absolutely critical."**
>
> Alastair Richards, CEO of North West Cancer Research

North West Cancer Research's 2025 Manchester roundtable

"An important aspect of these campaigns has been taking the time to understand why people in our area are not taking measures that would help prevent cancer or facilitate early diagnosis, such as wearing sunscreen or completing bowel cancer screening kits. These insights were used to design engaging messages that spoke to these perceptions, encouraging changes in behaviour while giving us a wider understanding of the cancers that are impacting our communities."

Alison Jones also shared an insight into tailoring messaging to the right audience in order to increase prevention and diagnosis levels. She said: "We've done a not insignificant amount of work over the last 18 months into risk factors for prostate cancer and getting the message out there that if you are black, 50 or have a family history of prostate cancer, that those are massive risk factors for developing it yourself. Public and patient facing messages come through a number of different routes and it's essential to go out into the places where those people live, rather than just thinking they've seen a social media post or been to a GP."

Alison added that in a similar way the lung health check campaign has been very effective, with having "now hit over 700 lung cancers diagnosed in Greater Manchester through the lung health check program".

Danielle Ruane said: "It has to be a bottom up approach to make sure that you're getting into those communities and those groups. You have to start by making a concerted effort to reach out and listen to what they're telling you they need."

Lorraine remarked that part of this equation is that: "People do not know or understand how to navigate the system, and that's one of the biggest challenges we've got. We also need to look at how we communicate with patients, as we've got a reading age of seven across Greater Manchester. Ensuring people have access digitally is also absolutely essential. There's lots of things out there that we need to get ahead of the curve."

Susannah Penney explained how the Cancer Alliance works to "get a diverse range of patients involved" , which, while a challenge, is vital as "we listen to our patients, and they help drive changes in the cancer care delivered in Greater Manchester".

Cllr Robinson shared a personal example of someone he knew who had suffered due to a lack of information and access. He said: "I knew a person, she was a working class cleaner, who found she had an inverted nipple. She was absolutely terrified about treatment and the one thing she could do about that was refuse it, and she ended up dying quite an awful death. And I often think about that and the isolated feeling that the 'C word' can have when it hits you and how it can block you off from the rest of the world.

"The question is, how do you get to that person? How do you pull them in after the diagnosis? A lot of this comes down to commissioning and that's where the council can come in, as place-based leaders. That is where our public health team and the Manchester Cancer Care Delivery Group is really important."

Hannah Stirzaker, Strategic Lead at 10GM, discussed community engagement in relation to breast cancer screening, saying: "Efforts to improve breast cancer prevention and screening are advancing, with research exploring lowering the screening age and addressing factors like breast density that affect detection. Current screening targets the broader population's health, but identifying specific risk factors could refine approaches. While breast cancer can affect anyone, community engagement is critical in raising awareness and promoting early detection.

"The cancer screening engagement programme in Greater Manchester (Answer Cancer), running for over six years, exemplifies this. It focuses on connecting with diverse communities, using familiar languages, and training cancer champions who support local residents. These champions help normalise conversations about breast health, ensuring individuals recognise potential issues early. Their persistent and trusted voices encourage action, fostering a proactive approach to cancer prevention."

Hannah added: "The VCFSE sector is really important at providing a way of disseminating information and linking up organisations to support community screening. "For example, spreading awareness of cancer signs and symptoms through grants funding which helps to train up individuals in community groups in a hyper local setting." Initiatives like this are essential, as many people in communities feel like it's a battle to get a diagnosis, and that's not how it should be."

Edna said: "We have done lots of research where you get people, particularly from certain backgrounds, who'll go to the doctor when there's a problem, but they'll be too embarrassed to talk about what's going on. They'll go in to have a conversation about what's going on, and with most GPs you've got eight to 10 minutes, and they'll talk about things like 'I've got rash' or 'I've got kids', and then maybe give you a slight insight into something that's serious, but the GP doesn't always pick it up because they're under pressure."

This is why Edna thinks that "there are different ways that we need to think about how our primary care engage with patients to understand and to see when there's a problem, so that they can be treated early, which makes all the difference."

Alison Jones said: "What's come out a lot in this conversation is understanding the population, and we need to keep understanding it and not making assumptions. One of the eye-openers for me is tiny, but we make the assumption that it's areas of high deprivation where we've got the greatest challenge and where we need to reach. However, from an ovarian cancer perspective, the highest level of late-stage diagnosis is in our most affluent parts of Greater Manchester. So you shouldn't assume, but keep looking at the data, and especially the data that we've got around inequalities."

Hannah commented that: "I think the key to all of this is listening to people - don't assume, listen. Sometimes, I think we assume that, because there are extended out-of-hours GPs, that people can get smears, and other appointments etc. But do they know this? Not always. So, a woman getting a smear letter may not choose to call in because she assumes that there are no appointments other than nine to five, which won't work for her. It's about communication both ways and listening."

Alastair Richards remarked that "The real secret to this is, if we want to drive down numbers, then we've got to provide people with information. We've got to educate people to achieve the prevention result, that is absolutely critical."

> **"We listen to our patients, and they help drive changes in the cancer care delivered in Greater Manchester."**
>
> Susannah Penney

> “The real secret to this is, if we want to drive down numbers, then we’ve got to provide people with information. **We’ve got to educate people to achieve the prevention result, that is absolutely critical.”**

Alastair Richards,
CEO of North West Cancer Research

Linking to lifestyle

Linking to lifestyles

Alastair raised the issue of lifestyle and deprivation factors affecting Greater Manchester's cancer statistics, which was evident in the fact that the region records a number of acutely above-average mortality and incidence rates for cancer types related to issues such as drinking, smoking and obesity. This includes lung, trachea and bronchus cancer, which has a total death rate 21% above the national average and an incidence rate 17% higher than the norm. Liver cancer is also a concern for GM communities, with a non-age standardised mortality rate that is 13% above average.

GM's deprivation levels also illustrate demographic complexities. Overall, the county has very high inequality levels, being 38% more deprived than the national average. The city centre is one of the country's poorest areas, with deprivation levels 54% higher than the English norm.

Susannah Penney said these are issues she considers when looking at referral numbers. She explained: "We get 450 referrals a week for suspected breast cancer admitted. A lot of those patients will not have cancer, but they may go on to develop it later in life. What do we do about that? Especially when they have risk factors, but have just been told 'you don't have cancer, see you later'. What do we do about reducing their obesity risk? What do we do about reducing their smoking or vaping risk? What do we do about making sure that they know about nutrition and exercise and all the other things that we know help reduce the risk of cancer?

"Over a third of cancers are preventable. They are down to lifestyle choices made by people – or possibly not made by people, as it's just the way that they were brought up and what was normal for them. What do we do about that? We're so busy saying 'if you've not got cancer, you're absolutely fine' and we're also pressed for time because we're seeing all these patients. But where's the function that says, 'we've told you you've not got cancer, but your BMI is 32 and we know that if you reduce your BMI to 26 then your risk of cancer will reduce by this much'.

To facilitate this preventative support, Susannah added that "We have predictive data that will give us the answer of percentage reduction if a lifestyle change is made. It's about education, but we don't use it often enough, and as healthcare professionals, we often don't have the time to do that. But it doesn't need to be us. It needs to be the people that go out and know their local communities and can communicate on the same level. The cancer team is well placed to get out into their local communities and drive that educational change."

Greater Manchester has very high inequality levels, being 38% more deprived than the national average.

Chris Maguire, executive editor of BusinessCloud and TechBlast, chairing the roundtable

As someone with lived experience of going through a cancer diagnosis and treatment while living on only £74 a week to spend on essentials such as food, bills, and housing, Graham Morgan was able to explain how this affected him, the sort of challenges that people facing deprivation have to manage and how this has an impact on their ability to live healthy lives and access treatment.

Graham explained that during his radiotherapy treatments, "you survive somehow", but he often had to choose between eating and staying warm. Recognising the difficulties he faced in accessing food due to his limited finances and concerns around COVID-19 (his diagnosis came during the height of the pandemic), he relied on a café in Salford which had government funding to deliver home-cooked meals, and which was then funded by local businesses. This was "a lifeline" for Graham as it meant he could afford to have the heating up, which just further underlines the importance of funding hyper-localised initiatives within communities.

To boost early diagnosis, Graham said that there needs to be local and national awareness programs and that financial support needs to be made available to anyone who needs it at the point of a cancer diagnosis because "as soon as you get the diagnosis, it screws with your mindset. You go into shock and that makes it even harder to navigate complicated systems such as applying for Personal Independence Payments".

Lorraine thanked Graham for sharing his story, especially because "there are too many people across Greater Manchester in this position. We've done a lot of work at the MFT through our public health consultant to understand our population and know that some families have just 30 pounds a month. So they're faced with questions like 'do they feed their families, or do they get travel to the hospital?' Which affects what they're prioritising and able to manage. Our job is to reach out to those communities. And actually, do we need to consider delivering more cancer care in the communities rather than in a hospital? If so, how can we do more of that in the future?"

Key takeaways

Key takeaways

1

Organisational collaboration is key

Greater Manchester's geography and governance have shaped a collaborative approach to cancer care, featuring key institutions like The Christie, Manchester University NHS Foundation Trust (MFT), and local councils. Over the past decade, Greater Manchester has fostered partnerships to unify care pathways, with the Cancer Alliance playing a key role in driving this progress.

Greater Manchester's model was recognised as being a national leader and collaborative efforts like localised cancer leads, data sharing, and accessible trials illustrate the region's commitment to improving outcomes. However significant challenges lie ahead, including rising demand, workforce shortages, and funding constraints, requiring innovative models for prevention and care delivery.

As Alison Jones summed it up: "We need to harness the 'sum-of-the-parts' style approach, because we can't do this in isolation and none of the organisations around this table can do it alone".

2

Devolution's impact and future

Greater Manchester's healthcare landscape benefited from the 2014 devolution agreement, which enabled greater alignment among organisations. This is exemplified by the Manchester Cancer Delivery Group, which fosters and supports collaboration across multiple stakeholders. However, the roundtable was concerned that the focus has shifted toward finance since the Levelling Up white paper, risking progress in integrated care as cost-cutting pressures strain services and a national structure risks jarring with the local one. Despite challenges, collaboration between providers remains robust and, in many areas, has improved, though financial tensions remain.

3

Harnessing Greater Manchester's data advantages

Greater Manchester's interconnected healthcare organisations enable effective data gathering and sharing to enhance planning, treatment, and strategies. Examples including the Local Care Organisation and The Christie's lung cancer trial highlight how this data can be leveraged in innovative and impactful ways. This level of monitoring has also flagged areas for concern, such as the fact that 16% of cancer diagnoses are made in emergency settings, revealing gaps in primary care access and awareness.

4

Breaking down early diagnosis barriers

Engaging patients early and guiding them promptly into treatment pathways was agreed to be essential to improving Greater Manchester's cancer rates. Targeted initiatives, like lung health checks in high-risk areas have proven successful at detecting cancers earlier. However, too many patients are still being diagnosed at later stages and this needs to be addressed. Community outreach, education programmes, personalised care, and tailored strategies like mobile screening units can all play a part in overcoming barriers such as language challenges, misconceptions about screening, and structural issues like appointment availability.

5

Engaging with Greater Manchester’s communities

One of the most important aspects of tackling GM’s cancer challenges was agreed to be clear and targeted engagement with communities. Effective communication must account for diverse cultural, linguistic, and socioeconomic factors, as generic campaigns often fail to resonate.

Tailored strategies, such as involving trusted local leaders and cancer champions, help normalise conversations about cancer and encourage screening. Participants emphasised the importance of listening to people in order to address practical challenges in local areas, as well as diversifying healthcare communication teams to better reflect the populations they serve.

6

Lifestyle and deprivation

Cancer rates in GM are significantly influenced by lifestyle and deprivation factors, with cancers linked to smoking, drinking, and obesity far exceeding national averages and high inequality levels compound these issues. The roundtable emphasised the need for education initiatives to drive behaviour changes within communities as well as structural changes such as post-referral support to address risk factors. The challenges of navigating cancer treatment while living in poverty was discussed, which highlights the importance of local initiatives and financial support at the grassroots level.

Left to right: Danielle Ruane, Hannah Stirzaker, Thomas Robinson, Alison Jones, Susannah Penney, Lorraine Cliff, Chris Maguire, Graham Morgan, Edna Boampong, Neil Bayman, Alastair Richards

Get in touch

E: info@nwcr.org
T: 0151 709 2919

nwcr.org

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