north west cancer research

Planning for a Cancer-Free Greater Manchester

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

September 2025

nwcr.org

CONTENTS:

03 Introduction

06 Creating the Conversation

08 Solving Systemic Challenges

11 Jobs and Skills in an AI Age

14 Doubling Down on Diagnosis

17 Engaging with Greater Manchester's Communities

22 Key Takeaways

Introduction

Introduction

North West Cancer Research's 2025 roundtable on Greater Manchester's cancer landscape.

Cancer presents a significant burden for Greater Manchester's (GM) population as well as for the clinical, charity, academic, and local government organisations working to improve the region's health and wellbeing rates.

Notably, this disease is placing a disproportionate amount of pressure on the area's people and medical networks when compared to the rest of the country, with prevalence rates for many cancer types being significantly higher than the national average. For example, the prevalence rates for lung, liver, and cervical cancers are respectively 23%, 10%, and 9% above the England benchmark.

Understanding the factors influencing GM's cancer landscape is essential to bringing the rates into line with the national picture – and ultimately putting the region on a path to achieving a cancer-free future. These factors are undeniably complex, multifaceted and interconnected, and need to account for the region's high levels of inequality and deprivation, lifestyle behaviours, healthcare access issues, and a large geographical area.

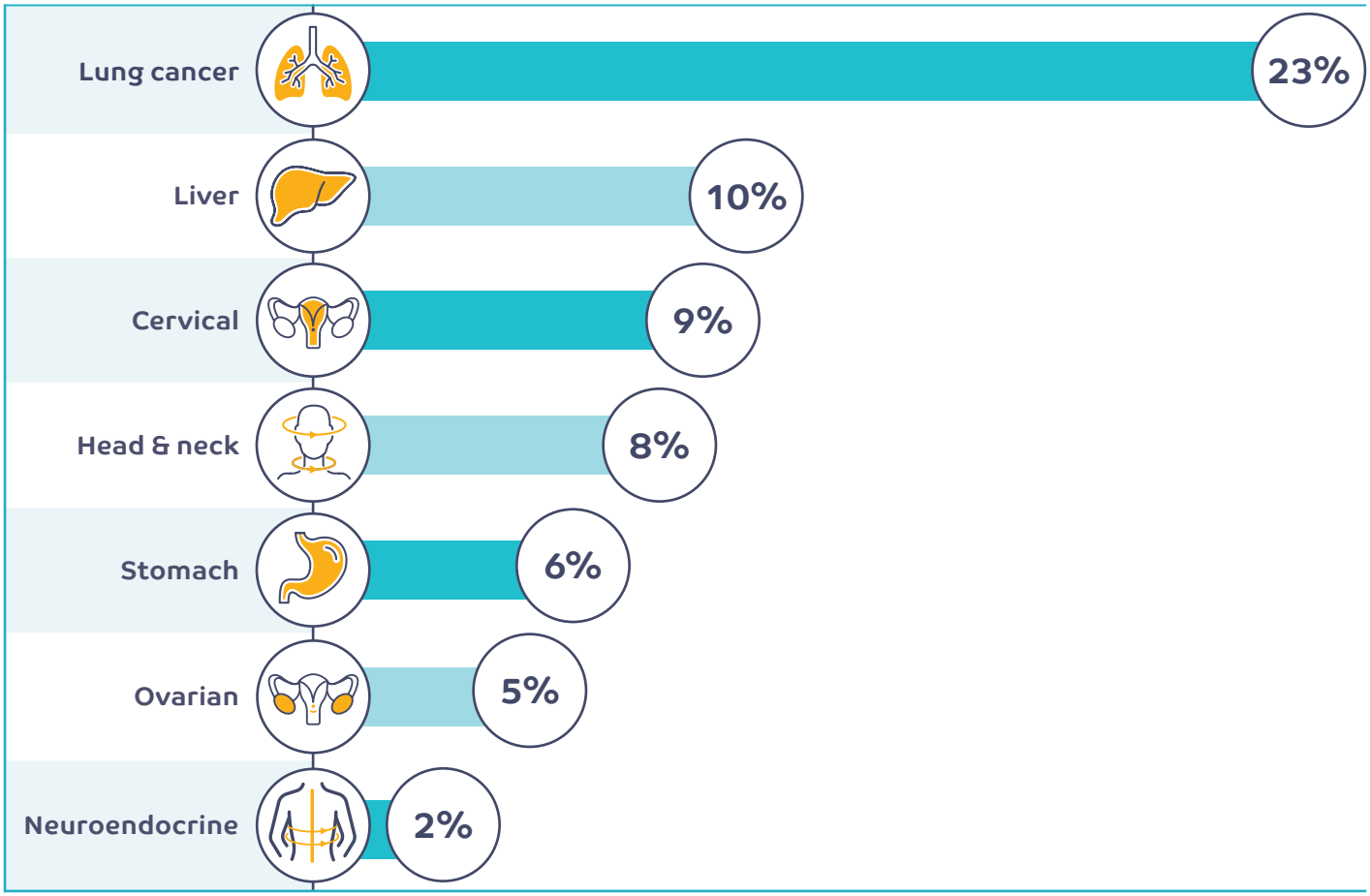
The unique nature of the region's political and healthcare networks also need to be considered, with significantly devolved systems that exhibit a high level of autonomy and interconnectivity. Yet these organisations face a range of workforce and funding issues while being impacted by national frameworks and challenges.

Right now is a particularly critical time to discuss these issues, as the government's 10-year health plan has been sitting on desks for several months and the 10-year cancer plan is due to be published.

To discuss how GM's cancer and healthcare landscape can be improved, as well as how these healthcare blueprints can best be made to work for the region's communities, we convened a roundtable of local clinical experts with researchers, charity, community, and political leaders. The attendees discussed the realities of GM's cancer rates, major healthcare hurdles, how to maximise progress, and the urgent need to turn strategies into tangible outcomes.

This provided a valuable opportunity for many of the region's stakeholders to reflect on local healthcare priorities, and the sort of policy asks that need to be built into the pending 10-year cancer plan if it is to make a significant impact on GM's cancer rates.

Greater Manchester top seven over-indexed cancers by prevalence



Our latest regional report highlighted that a number of cancer types are significantly more prevalent in Greater Manchester than across England as a whole.

The graph above shows the seven cancers that were most out of line with the national average for prevalence. Notably, many of these diseases are lifestyle related and are present at disproportionately high levels even despite Greater Manchester's younger than average population.

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.

Cllr 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.

Oliver Butterworth
Senior Programme Manager, GM Cancer Alliance Primary Care & Early Diagnosis team

Oliver Butterworth oversees multiple programmes of work, including targeted lung health checks and screening, with a focus on improving earlier diagnosis of cancer in Greater Manchester. He also supports early diagnosis initiatives regarding novel case finding and works with comms and engagement teams to encourage presentation.

Recently, Oliver worked on a project to bring an NHS mobile clinic to Radcliffe and Bury. Oliver has previously worked at the Northern Care Alliance NHS Group, where among other roles he was the bowel cancer screening programme lead.

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 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.

Dr Rebecca Leon
GP Lead, GatewayC

Dr. Rebecca Leon is a GP partner at the Middlewood Partnership in East Cheshire, covering Disley, Poynton, and Bollington. She is GP lead educator at The Christie Institute for Cancer Education and GatewayC, a specialist doctor at Francis House Children's Hospice, and has a special interest in primary care oncology, palliative care, and women's health.

Rebecca does a lot of work to improve diagnosis and prevention rates as well as minimising healthcare barriers in GM's communities. She co-hosts the podcast GPs Talk Cancer, which discusses symptoms, patient case studies, and expert advice with leading clinicians.

Chris Dabbs
CEO, Unlimited Potential

Chris Dabbs is Chief Executive of Unlimited Potential, a social enterprise that specialises in social and economic innovation for happiness. Unlimited Potential has run innovative projects and services for over 15 years to address challenging social and economic issues.

Chris is a Fellow of the School for Social Entrepreneurs and a Fellow of the Royal Society of Arts. He is also an Assembly Member at the Greater Manchester Chamber of Commerce, and a member of the Greater Manchester VCSE Leadership Group, the Salford Health and Wellbeing Board, Salford Social Enterprise City, and Salford Social Value Alliance.

Dr Sarah Taylor
Associate Medical Director for Primary Care and GP Lead, GatewayC

Dr Sarah Taylor has been a GP in Manchester since 2003 and currently works at the Bodley Medical Centre in Fallowfield. She is also the primary care / early diagnosis lead for Greater Manchester Cancer Alliance, a GP lead for GatewayC and has recently been a Cancer Research UK GP.

Sarah co-hosts the podcast GPs Talk Cancer, which discusses symptoms, patient case studies, and expert advice with leading clinicians and her special interests include early cancer diagnosis, student health, and medical student education.

Dr Kelechi Njoku
NIHR Academic Clinical Lecturer, University of Manchester

Dr Kelchi Njoku is an NIHR Academic Clinical Lecturer in Cancer Diagnostics and Machine Learning at the University of Manchester and an Academic Futures Scholar in Evidence-Based Health Care at the University of Oxford. He is also an Eve Appeal / North West Cancer Research Fellow and an honorary Clinical Oncology Specialist Registrar at The Christie NHS Foundation Trust. His research has been published in journals including The Lancet, Lancet Neurology, JAMA, British Journal of Cancer, and EBioMedicine.

Dr Njoku has won multiple awards for his work. This includes for his recently completed PhD in Cancer Sciences at the University of Manchester, for which he was awarded the Edgar Gentilli Prize by the Royal College of Obstetricians and Gynaecologists of the United Kingdom for the best piece of original work on the cause, nature, recognition and treatment of any form of cancer of the female genital tract. He has been awarded a three-year Fellowship by The Eve Appeal, together with North West Cancer Research, to develop a simpler and kinder test for detecting womb cancer.

Solving Systemic Challenges

Solving Systemic Challenges

The roundtable covered a wide range of key issues relating to the region's healthcare and cancer challenges.

A key topic discussed at the roundtable was the type of reforms required to overcome the challenges within GM's NHS and care systems that are affecting their capacity to more effectively tackle vital healthcare issues.

Cllr Thomas Robinson believes "there is still disconnect in GM's cancer system". He added that: "In Manchester, our breast cancer screening rate in March 2024 was 59.2%, the GM average is 68.8% and the England average is 70.4%. For bowel cancer screening, Manchester had 60.9%, GM at 68.6%, and England at 71.8%.

"These figures become more complicated and disheartening when you start to break it down for ethnicity and sex. For cervical cancer screenings, the 25-49 cohort in Manchester has a rate of 57.4%, GM is 66.2%, England, 67.1%. For the 50-64 cohort, Manchester is at 68.4%, GM is 73.3%, and England is 74.7%.

Cllr Robinson acknowledged there was "a lot of amazing work by the Cancer Alliance, Cancer Delivery Group and by great institutions like The Christie and the Manchester University NHS Foundation Trust (MFT)". Despite this "Manchester is almost categorically at the bottom of the league table in GM, in every single one of these, and is below the national average on all of these".

Dr Sarah Taylor, Associate Medical Director for Primary Care and GP Lead at GatewayC, said: "If we can fix bits of the cancer system, some of the rest of the system will get much better. This is because there are so many people who are put into the cancer system, because there's no other way to get them seen in a relatively timely manner."

She added: "We need to look at how we work better with other disease groups, as we've seen cancer as separate for too long. For example, we should be working with frailty, dementia and mental health, because the outcomes for people with severe, enduring mental health illness are really bad. COPD (Chronic Obstructive Pulmonary Disease) patients have got the same risk factors. So why does a COPD check not include a discussion about having been for a lung health check? Why do mental health checks not go through all the cancer screening?"

Dr Neil Bayman, Medical Director at The Christie, concurred: "People with other physical and mental health conditions often have lifestyle factors that increase their risk of cancer. If we can manage the whole cancer diagnosis system, that would have a massive impact on everything else, because it's all interlinked."

On this point, Dr Rebecca Leon, GP Lead at GatewayC, said: “We’re just seeing cancer as a single entity, and in primary care, patients are getting more complex because they’re coming in with lots of different things. You’ve got 10 minutes to see one patient, and they could have frailty, dementia, potential cancer diagnosis, and a chronic lung condition, and we’re supposed to deal with one thing. We need to look at the whole picture.”

On the broader scope of the national NHS context, Alastair Richards, CEO of North West Cancer Research, said: “We’ve got a health secretary that’s saying to the NHS ‘go and do things differently’. And sometimes the NHS can be brilliant at adapting, but I think there’s a real message here about the NHS needing to turn to communities, to community organisations, to the VCSE sector, and say ‘there are people that we don’t reach, or people that are easy to overlook’. And what we need to see is a real partnership between the NHS, between the system and community organisations, so that the NHS reaches people that it hasn’t reached before.”

Cllr Thomas Robinson remarked that better systemic communication is a regular talking point within government. He said: “Wes Streeting would ask me, ‘how are things going in Manchester?’, and what he means is, ‘how is the system talking to each other?’ GM has been at the forefront of health devolution since 2014 but now it feels like we’ve had a step back due to the devolution white paper. The white paper forced us all to have locality boards and work in a uniform way. But it also meant we stopped speaking as frankly to each other as we used to in the GM Social Care Partnership. Since the abolishment of NHS England (NHSE) - and I welcome that it was done but not how it’s been done - the pressures put on ICBs have left brilliant specialists and long term health workers worrying for their jobs and not able to do what they need to do, because it relies on having systems that will speak to each other properly.”

Even with these challenges, Cllr Robinson recognises that: “In Manchester, we’re still very good at talking to each other, and the trust that the council has with MFT is absolutely essential to the Oxford Road corridor as well as to bringing in mental health, the VCSE sector, and primary care. I’m going to chair the Manchester partnership shortly, where we speak frankly to each other.”

Alastair Richards added: “And this collaboration is one of those things that Manchester has done well, and other parts of the North West haven’t done at all.”

Cllr Robinson did point out that: “We’re hindered in what we can do on specific issues, because we’re so busy firefighting and building up what we need for government. I find that quite irritating, because the whole spirit of the white paper was to make sure local conversations could happen. But the conversations we should have been having on cancer, haven’t been happening since April.

“The only way we can start to nail down the asks and the access question is if we keep having frank conversations. I go back to people like Gill Heaton [MFT’s Chief Nurse], and Mike Deegan [former Chief Executive of Central Manchester University Hospitals NHS Foundation Trust] because they expanded their heads just 10% outside of targets and said ‘if we just open the door for one day a week with the council, public health, and universities, maybe we can achieve better things’. If we can keep that spirit going, which I know Mark Cubbon [MFT Chief Executive] and a lot of GP boards are, maybe it might be a little better in two years’ time.”

Oliver Butterworth, Senior Programme Manager for the GM Cancer Alliance Primary Care & Early Diagnosis team, said: “The reflections around NHS reform and the endless conversation on what’s going to happen is creating a distraction that’s preventing people from focusing on the priorities. As a team at the Cancer Alliance, we’ve cracked on and we’re delivering what we said we were going to do. We’ve had to change the odd bit, but overall I think it’s really important that we don’t get caught in stasis and not be able to improve outcomes.”

Jobs and Skills in an AI Age

Jobs and Skills in an AI Age

The roundtable discusses how to improve Greater Manchester's cancer rates.

Dr Neil Bayman said: "One of the acute crises affecting the North West, and the country generally, is the fragility of some cancer services because of a lack of workforce. Over the last three months, I've had distress calls from major cancer centres to the east and the west of here, asking for support with certain services because they don't have the workforce to run them. These are coming from smaller cancer centres a long way from here, which suggests they've already asked closer centres for support. It's a very acute issue right now and the cancer plan needs to pay attention to it."

He added: "We're a tertiary Cancer Centre at The Christie. That brings with it a reputation that means we're still able to recruit competitively. But if you do that at a cancer centre somewhere else in the country, you won't get anybody applying. At national meetings, people are saying they can't get anyone to apply, because there's not people in the pipeline. And it's not just medical, it's across the multi-disciplinary, multi professional teams that are involved in cancer care delivery. As an oncologist, I'm aware that in two years' time, one in five oncology posts across the country will be vacant. It's worse in radiology, which has a direct knock-on impact on early diagnosis rates, as radiologists are vital for reporting on screening tests.

"The situation is particularly bad for rarer cancers, where there's very few oncologists. Also, for whatever reason, breast cancer hasn't been seen in the last decade as a desirable specialty to go into in oncology. That's changed now, but the pipeline means we haven't got people coming through."

Dr Rebecca Leon built on this point, saying: "The problem in general practice is there are not enough jobs for GPs at the moment. Because money in general practice is drying out, we're hiring other health professionals who are cheaper. We've had two GP partners leave and we're not taking on any more GPs, but paramedics are doing house visits, and we're taking on nurses to bridge the gap.

"Many GPs who can't get jobs are going into middle grade work such as A&E or out-of-hours jobs in hospitals. There are more-and-more doctors being churned out in training, but there's no jobs for them to go to or the jobs are in the wrong place. So, patients can't get appointments for GPs - but then we can't give GPs jobs because we're not getting money."

Dr Neil Bayman agreed, adding: "We need an intermediate and long-term workforce plan that's able to forecast the future. We need to be able to inform our medical students what the workforce is going to look like when they finish their training to nudge trainees into the right places.

"We also need to diversify our workforce and skill mix. We've adopted having GPs in the oncology clinic and advanced nurse practitioners supporting our inpatient activity at The Christie. We're able to train and delegate certain responsibilities to non-medical staff now, and we've got specialist radiographers who do some of that work as well. And we're employing technology. In our radiotherapy pathway we use AI to do a lot of our planning, which means we're able to accommodate an expansion in our patients."

On the use of AI, Dr Rebecca Leon said: "We're starting to use AI as a PA to help with consultations. There's talk about using Heidi Health and Lexicon AI in consultations to amalgamate all our notes. I'm starting to think there's a lot of jobs in medicine that can be done by AI, and yes, computers don't care, but they can be taught to care."

Dr Neil Bayman said: "More people are being diagnosed with cancer and living longer. So, there's more to do but we've got a workforce crisis. That means we've got to absorb that capacity without the same level of growth that we've enjoyed over the last 20 years. One way we're able to accommodate more people is because computers can do a lot of the stuff we were doing.

The ambient technology, which sits in a consultation with you and listens, can produce the summary and write a letter to send to the patient. AI can order the test you mentioned in the consultation, so all you've got to do at the end is checking, which across an organisation can save a significant amount of time."

Doubling Down on Diagnosis

Doubling Down on Diagnosis

Chris Dabbs, CEO at Unlimited Potential, talks through key issues affecting the health of Greater Manchester's population.

A central focus for the attendees was boosting early diagnosis rates with targeted screening programmes and exploring how to help people live healthier lives and so prevent cancer diagnoses in the first place.

Oliver Butterworth said: "It'd be interesting to see if there's a shift towards a reduction in late-stage disease, coupled with an increased proportion of early-stage cancers. I know we can go out there and find cancers at an earlier stage, but we're also recording a lot of late-stage presentation."

Dr Sarah Taylor added that: "The screening figures are really interesting and very depressing, and they've been like that for a very long time. If we look at the early diagnosis figures, they will show similar things. I think we miss a trick if we concentrate just on screening or early diagnosis, we need to look at the whole thing together."

Dr Rebecca Leon picked up on this point, saying: "Screening is a big part of diagnosing cancer before the symptoms appear, which is the way that we're going to have better cancer outcomes. Sarah and I teach a way of working we call 'opportunistic medicine'. Somebody comes to us for a mental health review, and then I'll notice they've not presented for their cervical screening and ask why, and they'll say 'I've had the same partner for 25 years. I don't need to attend screening', or there's a taboo around it for them and we need to break down stigmas. In certain pockets, the idea of being diagnosed with cervical cancer means they've been promiscuous, but the fact is that 85% of women who have been sexually active in their lifetime will have had HPV, and their immune system will get rid of it. By us educating the patient, they realise this could potentially save their life by being diagnosed."

Dr Neil Bayman explained that: "My worry with any cancer plan is that it goes off looking at some other area of innovation, when actually the most effective plan for detecting cancers at an earlier stage is to just properly do what we already know works. We know that our national screening programs work, we know when people engage with them we can detect cancers earlier which then translates to improved outcomes. Let's just have a laser focus on that."

He added: "In addition to early diagnosis and screening, there's also the timeliness of getting treatment. This underlines the importance of access, so that whatever part of the country you're from you're getting the best treatment. And then looking at what your life is like during and after a cancer diagnosis."

Dr Kelechi Njoku said: "There was a James Lind Alliance consensus meeting where experts, patients, and carers met together, and they felt that early detection is the most important priority when it comes to cancer. We need to find a simple, safe, and accurate test that can detect cancer early, because this is the kind of test that will be easily acceptable to all patients, including from ethnically diverse populations."

The roundtable concurred that a simpler, less invasive test will help target communities where further medical engagement is required. Dr Kelechi Njoku explained the work he is currently doing in this space: "The hypothesis of my fellowship with North West Cancer Research, is that the anatomical continuity of the genital tract means that womb cancers can secrete biomolecules, whether it's proteins or cells, and they can go down through the cervix into the female genital path, where they can be collected.

"Our pilot shows proof of principle that we can collect the proteins and pick up cancer with over 95% accuracy in the vaginal fluid of women. We've got funding now from North West Cancer Research to test this in a larger population of 500 women with, or at risk of, womb cancer. We are in the validation phase, and we're trying to see whether we can develop a much simpler test, like a pregnancy test, that can be done by the women themselves or by practice nurses. This will make it easier for women experiencing bleeding after the menopause to be investigated for cancer and so will help improve early detection of womb cancer."

While being aware of the region's concerning cancer statistics, the intense pressures the medical system faces and the vital work that needs to be done, the attendees also recognised the importance of highlighting the recent advances and successes that have been made.

Dr Sarah Taylor said: "Greater Manchester is now the second Cancer Alliance for lung cancer survival nationally and we are still second in terms of proportion of early stage diagnosis. This is amazing considering the population."

Dr Neil Bayman also emphasised how today's medical landscape is very different. He explained that: "For all the negative discussions, it is still the case that there are millions more people living much longer who have either been treated, or are being treated, for cancer. In my specialty, lung cancer, 20 years ago I didn't have patients in my follow up clinic, because they didn't live long enough.

"Earlier diagnosis and detection is how we're going to shift outcomes. Those outcomes are shifting currently, but let's not take our eye off the treatment and the living with cancer aspects. We need to find a way to support the lives of the millions more people who have had cancer and are living after cancer now."

Oliver Butterworth said: "In 2023, only seven percent of cancers were diagnosed via screening and 65% came via a primary care route. And those screenings were effective at diagnosing cancers, with 80% of them being at an early stage. Primary Care is also effective at 60%. Patient advocacy, access, and education are all vital here, so that people know how to recognise when something's incorrect and what language to use that will take it further."

On the need to inform GM's communities, Alastair Richards said: "Education, education, education. I started off thinking about screening and new screening programs, and we've got Dr Kelechi working on new screening systems which is great, but I think there will always be a question about the capacity of the NHS to deliver. There's a huge fall off rate between what is being created in academic labs and what reaches the patient. So, this is about education, because if you want to even out those screening figures, education is where you start."

Dr Kelechi Njoku added: "We've talked a lot on screening and early detection and how that's important to improving outcomes. But what's really going to drive down the incidence of cancer is prevention. This is critical, especially when we think about deprivation, which we know is a big problem in GM. Socio-economic lifestyle factors like smoking, alcohol, and obesity influence the risk of developing cancer and the outcomes following treatment. There should be targeted interventions to address those lifestyle factors and the deprivation that underpins them to bring down the incidence of some of these cancers."

Alastair Richards added: "Most agree that what is required lines up with Wes Streeting's strategy of focusing on moving healthcare delivery into communities, doubling down on prevention and early diagnosis, and tackling the causes of ill health. But there remains the question of how the cancer plan is going to take these ideas and ensure they match the scale and complexity of the challenges that cancer creates.

"As cancer is the point at which medicine meets society, it's imperative that the dedicated plan clearly addresses not just clinical research and therapeutic treatments, but also how we deal with entrenched social factors such as poverty, unhealthy diets and lifestyles, healthcare accessibility, and education gaps."

Engaging with Greater Manchester's Communities

Engaging with Greater Manchester's Communities

Chris Maguire, Executive Editor of BusinessCloud, chairs the conversation during the roundtable.

A through-line in much of the roundtable's discussion was that any plans to prevent cancers or boost early diagnosis rates rely on effective engagement and communication across GM's many communities.

Cllr Robinson underlined the issue, saying: "We still cannot seem to create that element of trust that's needed within our communities. I can speak to some extent for the white working-class communities, where there's a fear of cancer and where they don't want to give up power over their bodies. This leads them to say no, but when they realise they need those screenings and support, it can be too late."

On specific communities that require further engagement Cllr Robinson said: "You've got Hulme and the City South where cervical cancer screening rates are 39.2%, but then you've got Gorton at 11% and Hulme on 61.6%. I would advocate that the median income between those two Primary Care Partnerships (PCNs) is quite similar. If you break down the ethnicities, this is where that discrepancy comes in. And for all the top line figures I've given you, there's a breakdown in engagement when you go into certain ethnic minorities. For example, intergenerational households in Asian communities, where you can find that the child often has much better English than the grandparent. And so, you have children trying to explain and create access to essential services such as cancer screening, which just can't work.

"The issue of access keeps me awake at night. I don't walk down the street afraid, but so many of these communities do, and where their health's concerned, trying to create that bond of trust and trying to get into those communities, is a constant evolving battle."

Dr Rebecca Leon explained that: "We have to work alongside local champions and not make presumptions with groups of what they want to know. This is something we're looking at as part of my work at The Christie, where we're working alongside members of the community, such as the Hasidic Jewish community and the traveling community. We're finding out what the taboos and stigmas are, and what their reasons for not presenting early are, then we can really get to the core of it."

Oliver Butterworth described a project to bring a mobile screening clinic into GM's communities. He said: "The team at Wythenshawe hospital, who lead on a lung cancer screening programme, started a pilot in 2016-17. People who were 55-74 and a current or former smoker were invited for a free lung health check. As part of the check, they would go through a questionnaire with them, which informed two clinically validated Risk Calculators. One called the PLCO (prostate, lung, colorectal and ovarian) risk, and one for the Liverpool lung project, the LLP, and if they scored above a certain threshold the patient was offered a CT scan the same day."

"This all happens face to face. We have four mobile units, and the patients come along, sit with the nurse for 10-15 minutes to go through those questions and then have a discussion around entering the lung cancer screening programme and having a CT scan.

"We sent over 250,000 invites to the eligible population and we see around 1,900 people a week for a lung health check across GM. In terms of cancers diagnosed, we were the first ICB in the country to reach 1,000 cancers diagnosed through this programme.

"The mobile and real time nature of this is borne out in the data, with a shift in people from more deprived areas being diagnosed at an earlier stage through screening because these vans are targeting those areas. We invite people based on the primary care network footprint and have started expanding outside the initial geographies. We've gone from Wythenshawe and are going to end up in Hale, so we'll see very different types of patients.

"We're on the fourth iteration of our van now which has clear messaging on there around cancer signs and symptoms. We have brand ambassadors, and they talk to people on the street. It's not about offering people a clinical test on the day, it's just to get people talking about cancer. We know that intervention won't lead to an increase in our charts within the next few months, it's a really long-term impact.

"These projects are vital, as the problem remains that lung cancer is very difficult to diagnose at an early stage. In a world without screening, it used to be around 25-30% of people were diagnosed at stage one or stage two. In this program, we see 80% of people diagnosed at stage one or stage two, and over the last 12 months around 50-52% of people in GM were diagnosed at an early stage. So, the shift seen in the early detection of lung cancer is significant, and that now informs the national programme we are rolling out over the next few years, ahead of the government target of 2029-30 for a lung cancer screening programme."

On screening programs, Dr Sarah Taylor said:

"There's quite a lot of research to show that people like CT scans, but they don't want a cervical smear, they don't want to dip their poo, and they don't want a mammogram. Part of the advantage of this is that it provides an opportunity, if someone comes for a CT scan to do a lung health check we can ask if they're also eligible for bowel screening? When did you last have your smear? Have you had your mammogram? Do you want some advice on early symptoms and awareness?"

Dr Rebecca Leon added: "CT scans are not only non-invasive but they're one of the most effective tests. As GPs, we can get access to chest X rays easily and we often ask for more of them as it's a cheap investigation to do. But then we're told the scary statistic that 25% of chest X rays will come back as normal but there might be a lung cancer sitting there that isn't being reported."

Dr Neil Bayman said: "Lung cancer screening piloted in GM nearly 10 years ago, but we're still not able to offer it for the entire population of GM. Nationally, some areas of the country have appallingly low access to lung cancer screening, but we know it works. The national cancer plan needs to focus on this so that in the next 18 months we can get it out everywhere."

Dr Sarah Taylor added: "I think the other thing that we need to look at is what we can do as health professionals to try and increase trust and improve communication, and what needs to be done more out in communities, to encourage people and give them information."

On increasing engagement among people with mental health issues in particular Dr Sarah Taylor added: "There's two bits to it. One is simply because of their lifestyle risk factors they have a lower uptake of screening. They have lower recognition of symptoms and a lower ability to get into the system. Some of the work we've been doing is trying to give people the right words to get into appointments."

On how to better reach out to GM's communities, Chris Dabbs commented: "There's no such thing as a hard to reach person. It doesn't exist. But the

Dr Kelechi Njoku provides insights from his research and experience during the roundtable.

issue is that they can be easy to ignore. For those parts of the population that we aren't reaching with screening, we should consider what public health learned through Covid vaccinations. What they found across GM was there were certain populations that weren't taking up vaccinations. The only way they could change this was to go to those communities.

"Sometimes people are scared. Sometimes lives are too complex. Some people experience multiple disadvantages. For some of them, if you say, 'well, if you don't do this, you might die', that might be an attractive option. There's a risk that we assume everybody is motivated the way that I'm motivated. You must understand their motivations, whether that's because of faith, culture, belief system, or whatever it is, it has to be done on their terms."

He added: "Who has the conversation is important. In Salford, the NHS gave us a load of data that said people are not turning up to their GP, and they'd tried all the standard approaches with health education but it hadn't worked. So, for our approach, we employed people from within those communities who have the same accents, live in the tower blocks, who can say, 'yes, I know what this is like'. It's not like me turning up and saying this stuff.

"Two things that we learned from that. One was that what they effectively said was 'please do not come and talk to us about this stuff. My life is bad enough without you talking to me about cancer and heart disease and dying. But if you come and you make it fun, and we can have a bit of a laugh that'd be better'. So, we created giant games that we took to all sorts of places, and they were run by local people. And we narrowed the messaging down to one very simple message, which was if you had symptoms, go and see a doctor."

Dr Sarah Taylor picked up on this point about messaging around symptoms, she said: "We can't rely entirely on screening and need to work out how we get out messages about concerning symptoms. On my podcast [GPs Talk Cancer], we talk about persistent, progressive symptoms, and what I really want to do is give people a simple message and the confidence and ability to take that message into a GP appointment. We do loads of education with our GPs. We do loads of education with the public. But we don't necessarily link the two things to make sure that people have those words.

"We can do as much on raising awareness as we want, but if they can't then get the appointment, they're not going to do it. It can be quite difficult to navigate the health service, so we need to make it easier to get that GP appointment. 60% of patients are diagnosed via a GP appointment and probably a lot of the ones who go to A&E have probably gone because they couldn't get a GP appointment."

Oliver Butterworth said: "When we do lung cancer screening in certain areas of Oldham we know there are certain health behaviours like shisha use which would qualify somebody for a lung

health check. So, we've had assets translated and messages read out at Friday prayers and we've had feedback to not put people on posters but just put a picture of the van. Tobacco use could be taboo in certain cultures so some people might not disclose to their GP that they've smoked. So, we need to think about how messages can be delivered authentically and by somebody who's trusted."

Chris Dabbs added: "Inequality is increasing in GM. We have various people and organisations who know how to engage those people, given the right capacity and degrees of resource, and it's not enormously expensive compared to what the NHS costs around that. This was demonstrated during Covid, when the system learned how to reach many of those communities. How do we focus both on the access issues and on the prevention side, and use everything that we know - this is where Live Well kicks in."

Cllr Thomas Robinson said: "The thing that still worries me is access, and if we in Manchester can't understand our population and how we meet them halfway with an ask to government - then that's our problem as much as it's DHSE's. The Live Well agenda, was an idea which Andy Burnham had no statutory powers on. He wasn't Chair of the ICP at the time, and it was something that started to join up a lot of the work that we were already doing in communities as localities."

Alastair Richards commented: "The history of GM tells us that people are very creative and overcome problems. You can hear lots of things about problems, but you come away from a day like today having met a room full of people who are quite inspirational, people that are dedicated to their job and will overcome problems."

Key Takeaways

Left to right: Chris Dabbs, Dr Kelechi Njoku, Dr Neil Bayman, Dr Sarah Taylor, Oliver Butterworth, Dr Rebecca Leon, Chris Maguire, Alastair Richards, Cllr Thomas Robinson

Key Takeaways

1

Solving Systemic Challenges

GM's healthcare system can be made to work harder and smarter to improve the region's cancer rates. Tangible examples of this include breaking down silos so that cancer is not isolated from other conditions, as patients often present with multiple complex needs during brief consultations. Developing a stronger alignment between NHS bodies, community organisations and charities will also help clinicians and medical educators reach more communities.

While GM has a notably collaborative spirit between councils, NHS trusts, and primary care, recent restructuring and reforms have created communication barriers and workforce concerns. Bureaucratic firefighting risks distracting the region's stakeholders from critical issues like cancer, but crucially there are many teams who continue to deliver healthcare improvements and who shine a light on a route forward.

2

Jobs and Skills in an AI Age

Like the rest of the country, GM faces a cancer workforce shortage. This issue is particularly acute when it comes to oncology and radiology posts due to the limited pipeline of skilled clinicians. General practice is facing a paradoxical situation, with insufficient GP jobs due to funding cuts forcing practices to hire lower cost clinical professionals, while newly trained GPs seek hospital roles instead. This results in patients facing higher levels of appointment shortages than might otherwise be the case.

Solutions include long-term workforce forecasting, diversifying the skill mix with advanced practitioners, and embracing AI technology. AI now assists with radiotherapy planning, consultation notes, and administrative tasks, enabling teams to manage increasing cancer diagnoses and workload demands despite workforce constraints.

3

Doubling Down on Diagnosis

The attendees agreed that screening is central to improving early cancer diagnosis, however while GM has achieved notable successes in this area, screening uptake rates remain low. To improve the situation, the roundtable discussed "opportunistic medicine", which uses routine appointments to address missed screenings and dispel stigmas, and the need for a concerted focus on implementing proven screening programs. The development of simpler, less invasive tests would also help increase accessibility across diverse populations.

In tandem with earlier diagnosis, helping GM's population with preventative measures was also highlighted as crucial for reducing regional incidence rates. To achieve this, the prevention support needs to address socioeconomic factors like smoking, obesity, and deprivation while providing additional education and ensuring that all communities can easily access high quality healthcare.

4

Engaging with Greater Manchester's Communities

Effective community engagement is crucial for improving cancer prevention and early diagnosis rates. Getting this right requires gaining the trust of GM's diverse populations. Effective examples of this include mobile lung health check vans, which achieved successful community outreach using a combination of tactics, including targeted invites, Facebook advertising, brand ambassadors, and culturally sensitive messaging.

Working with local champions who understand community-specific taboos and motivations is also important to gaining trust and spreading impactful healthcare messages. Covid vaccination strategies proved that reaching "easy to ignore" populations requires employing trusted community members who share residents' backgrounds and who can deliver health messages on their terms.

north west
cancer research

Get in touch

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

nwcr.org

Registered Charity No. 519 357