north west cancer research

# The future of Lancashire and South Cumbria's cancer landscape

A North West Cancer Research roundtable exploring Lancashire and South Cumbria's healthcare and cancer landscape.

June 2025

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# Introduction

# Introduction

**Understanding the cancer picture across Lancashire and South Cumbria raises many complex questions and requires factoring in everything from the region's unique geography to healthcare access, available technology, demographics, and lifestyles within each community.**

However, it is imperative that the area's cancer rates can be understood and addressed. This was highlighted in our latest regional report, which revealed a number of stark disparities between cancer rates in Lancashire and South Cumbria when compared to the rest of the country.

As residents in the North West are 25% more likely to be diagnosed with cancer than in the rest of the UK, we analyse cancer data each year at a local level to determine which diseases are having an outsized impact on the people who live and work in the region.

This information has enabled us to create an annual benchmark and assess if the cancer situation is improving or worsening. Unfortunately, Lancashire and South Cumbria has remained starkly at odds with the rest of the country when it comes to key cancer metrics.

In Cumbria, we found that the cancer mortality rate is 33% above the national average and 25% above the regional average. Lancashire likewise records a number of challenging cancer statistics, such as a mortality rate for oesophageal cancer that is 40% higher than the national benchmark.

To discuss Lancashire and South Cumbria's cancer statistics, what needs to change moving forward, and how the 10-Year Health Plan can best work for local communities, we gathered together a panel of regional healthcare experts, along with charity, community and political leaders.

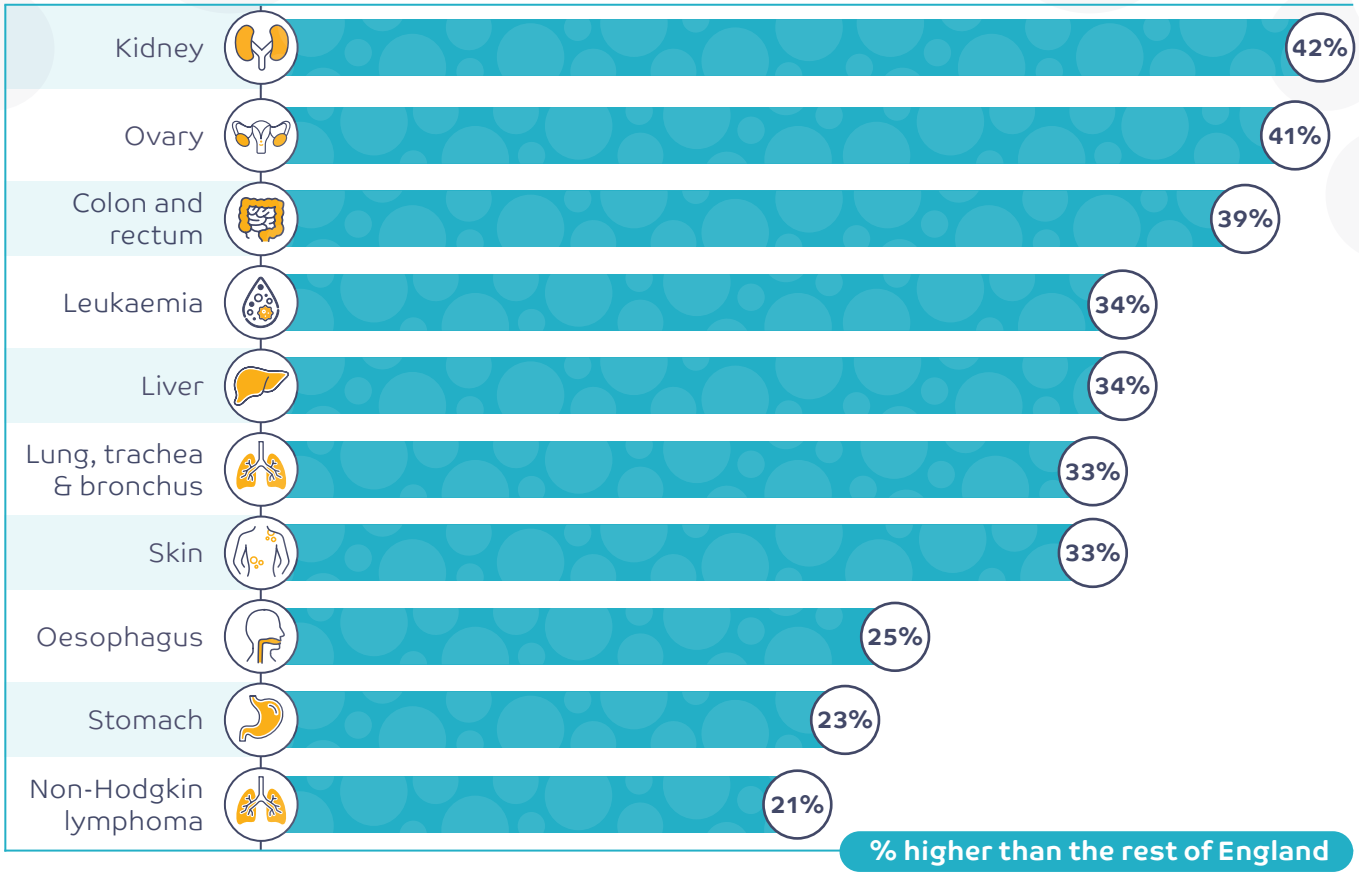
With the government's 10-Year Health Plan focusing on big shifts in healthcare, including moving services from the hospital to the community, switching the NHS from an analogue to a digital approach and promoting preventative measures, this is the ideal time to ask how it can best be implemented to make the most difference on the ground in Lancashire and South Cumbria.

The aim of the discussion was to better understand the priority areas that need to be tackled and how they should be reflected in local and national strategies, to achieve meaningful change in the region's cancer rates.

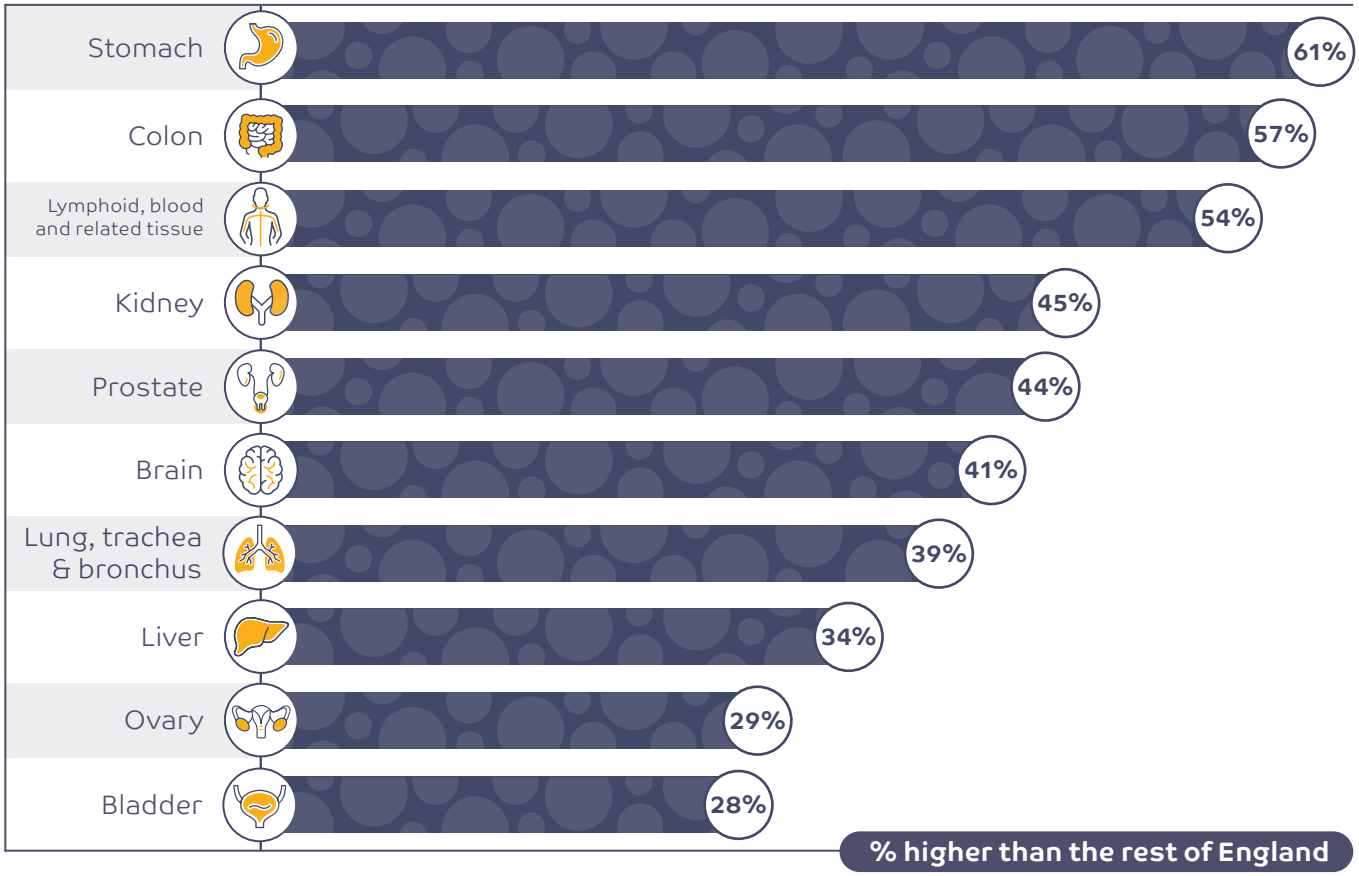
The roundtable provided a valuable opportunity to confer on a wide variety of topics, ranging from developments in the local and national healthcare environment, the problem of entrenched inequalities, and the importance of community-level initiatives, education and intervention to making a real, long-term difference.

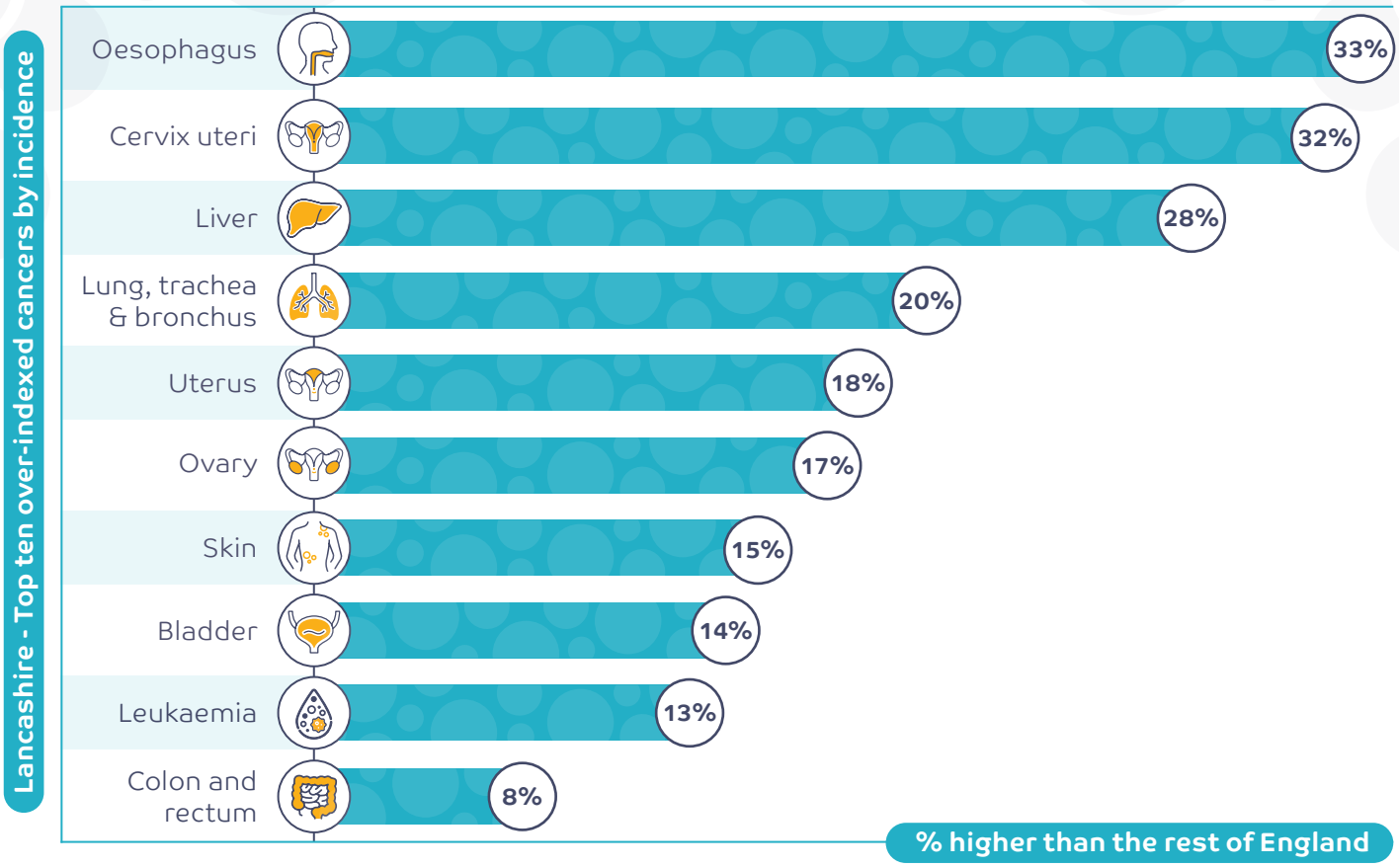
"The cancer mortality rate in Cumbria is **33% above** the national average."

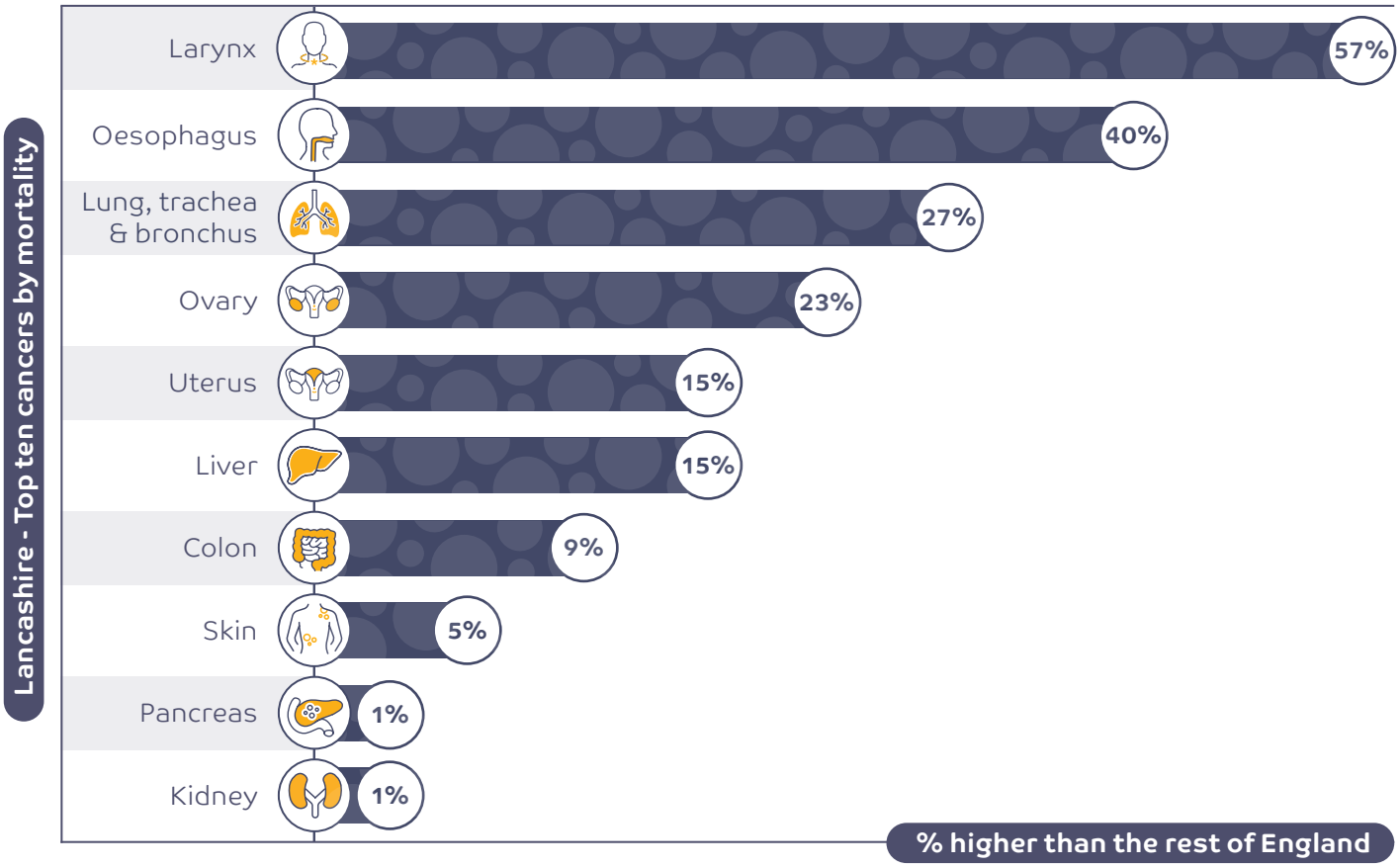
## Cumbria - Top ten over-indexed cancers by incidence




## Cumbria - Top ten cancers by mortality




Lancashire - Top ten over-indexed cancers by incidence
Oesophagus
33%
Cervix uteri
32%
Liver
28%
Lung, trachea & bronchus
20%
Uterus
18%
Ovary
17%
Skin
15%
Bladder
14%
Leukaemia
13%
Colon and rectum
8%
% higher than the rest of England


Lancashire - Top ten cancers by mortality
Larynx
57%
Oesophagus
40%
Lung, trachea & bronchus
27%
Ovary
23%
Uterus
15%
Liver
15%
Colon
9%
Skin
5%
Pancreas
1%
Kidney
1%
% higher than the rest of England

# 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.

### Sakthi Karunanithi
**Director of Public Health at Lancashire County Council**

Dr Sakthi Karunanithi is an experienced Public Health Director who has worked across the NHS, local government, and industry. He Led the public health response to the COVID-19 pandemic across Lancashire as well as the accelerator programme for population health management.

### Daren Subar
**General Surgeon at Blackburn Hospital**

Daren Subar's practice includes advanced laparoscopic surgery of the liver, pancreas and biliary tree both for cancer and benign diseases. He is also the surgical lead for Research and Development at East Lancashire Hospitals NHS Trust.

### Lizzi Collinge
**MP for Morecambe and Lunesdale**

Lizzi Collinge is a Labour politician who has served as MP for Morecambe and Lunesdale since 2024. Born in Lancashire, Lizzi moved to rural Cumbria as a child and now lives in Heysham. She was a long-term county councillor and improving cancer survival rates is one of her key policies.

### Andrew Giles
**CEO at the Morecambe Bay GP Federation**

The Morecambe Bay GP Federation covers North Lancashire and South Cumbria, which has over 30 GP practices with around 300 GPs working for a registered population of over 350,000 people. Andrew has been the federation's CEO since August 2019 and he is also a Non-Executive Director of the Castle and Coasts Housing Association.

### Ailsa Brotherton
**Executive Director of Improvement, Research and Innovation at Lancashire Teaching Hospitals NHS Foundation Trust**

Ailsa Brotherton is the Executive Director of Improvement, Research and Innovation at Lancashire Teaching Hospitals NHS Foundation Trust and an Honorary Professor at the University of Central Lancashire. Before joining the trust, Ailsa was Director of Transformation for the Single Hospital Programme at Manchester Foundation Trust.

Ailsa has experience delivering quality improvement and large-scale change programmes at national, regional and local levels. She has an interest in system level improvement, working across organisational boundaries, and is working with the improvement directors and clinical leads across Lancashire and South Cumbria in collaboration with the University of Cambridge to test the Engineering Better Care framework across the ICS.

## Professor Ihtesham ur Rehman

**Head of Translational Research at the University of Lancashire**

Ihtesham is a leading expert in biomaterials and regenerative medicine, and clinical spectroscopy research and teaching. He has written many publications on spectroscopy of biological tissues, cancer research, multiple sclerosis, synthesis and characterisation of biomaterials, human bone, and dental materials.

## Sarah Drake

**Founder and Managing Director of Elephant in the Room Training**

Sarah Drake has lived experience of cancer and is the founder of Elephant In the Room Training, which provides an interactive training programme designed to help employers, managers, and team leaders to positively address the way cancer is navigated in the workplace.

## Mick Fleming

**Lead Pastor at Church on the Street Ministries**

Pastor Mick Fleming is the lead pastor and founder of Church on the Street (COTS), a faith-based charity serving the community in Burnley, Lancashire. Born in Burnley, Mick experienced childhood trauma which led him into drug dealing and addiction as a young man.

Mick went on to study theology and in 2013 he began COTS, starting with a simple setup outside McDonald's in Burnley with sandwiches, coffee, and clothes for those in need. COTS is committed to helping society's most vulnerable and has gained national recognition as well as support from Prince William and Kate Middleton.

## Lee Threlfall

**Associate Director of Performance and Planning at Lancashire and South Cumbria Integrated Care Board**

Lee Threlfall has held a number of performance-related posts in local government, commissioning organisations and secondary care providers. During his career, Lee has built up extensive public sector experience, including working with Local Government, the NHS, and Universities.

In his current role as Associate Director of Performance and Planning, Lee is responsible for supporting transformation, pathway redesign, planning and performance improvement across the Lancashire and South Cumbria Integrated Care Board.

## Dr Luigi Sedda

**Senior Lecturer in Spatial Epidemiology at Lancaster University**

Luigi Sedda is a biostatistician and academic at Lancaster University who often works with local NHS Trusts on statistical projects about health inequalities. He has also advised on lung cancer screening programmes in Italy designed for hard-to-reach communities. Recently, Luigi has been working on a project analysing cancer cases in the Morecambe Bay area. This has involved mapping cancer cases in the region, exploring significant clusters and societal factors such as deprivation.

# Geography, demographics and deprivation

# Geography, demographics and deprivation

Alastair Richards, CEO of North West Cancer Research, opens the roundtable.

**The roundtable began by assessing the healthcare landscape and how the conversation surrounding cancer issues has evolved over the past year. Alastair Richards, CEO of North West Cancer Research, started the discussion.**

He said: “A lot has happened in the last year, a change of government amongst many other things and a different mood music within the NHS. Still lots of problems, lots of issues, but a noticeably different zeitgeist.

“And one of the main things that’s been announced is that the government is working on a cancer plan for the NHS. It’s been attempted before, but if the government is committed to making this work then it’s imperative that we examine what is required at a national and a local level to ensure it succeeds.”

Setting this scene, Alastair asked the attendees to think about: “If you were Wes Streeting and you were writing the cancer plan, what would you put in there? What do you think is important. And what would you want to see for Lancashire and South Cumbria? This is an incredibly wide and diverse area, with many different populations and challenges. How do we account for this in the plan.

“We’re sitting here surrounded by green fields in rural North Lancashire. But this is a very different place to the middle of Preston or the front of Morecambe or the Four Bs as they’re referred to within the ICB area - Blackburn, Burnley, Blackpool, Barrow. There are city areas with strong elements of deprivation, and some very different challenges to what you would think about if you were writing a cancer plan for Lancaster.”

Lizzi Collinge, MP for Morecambe and Lunesdale, commented: “A lot of the things we need to do to prevent cancer are also the things that prevent all sorts of morbidity and mortality. The challenge in a constituency like mine is variable. You have Morecambe, where the services are relatively close, but you have huge levels of deprivation. The west end of Morecambe is in the top 10% most deprived wards in England. You have low health literacy and higher levels of smoking, alcohol use, and obesity.

“And then you’ve got rural areas where access to healthcare is an issue, particularly now that healthcare is increasingly specialising and people have to travel further for treatment. But that’s a huge challenge if you’re up in Sedbergh or Dent or Cowgill, which is currently cut off by a land slip. I know a constituent with a toddler who’s got serious multiple disabilities, and who has to take a 40 minute detour because of the land slip causing a road closure, and it looks like the road will be closed for another 18 months.”

Dr Luigi Sedda, Senior Lecturer in Spatial Epidemiology at Lancaster University, said: "It's true that rural areas suffer less from cancer, but actually when you look at all the cancers these areas can exhibit a higher risk for the major cancers. This is interesting for the Lancashire and South Cumbria region, as we always think of areas like Barrow and Morecambe as being similar, but the cancer situation in Barrow is much worse than Morecambe."

He added: "We should also stop thinking about cancers as in their own silos. In some geographic areas, upper GI, colorectal, and urology, are strongly associated - which means that they are concentrated in some areas and among specific demographics. So, in targeting one cancer there are benefits for other cancers, however without using geographic-level data, how can we design targeted interventions?"

Ailsa Brotherton, Executive Director of Improvement, Research and Innovation at Lancashire Teaching Hospitals NHS Foundation Trust, said: "I've always wondered why we have the same approach for everybody, when our risks are different. We invite everybody for screening at the same time, but we know that in populations with health inequalities, many people die 15 or 20 years younger than in other areas, so how do we ensure they access their screening sooner?"

Lee Threlfall, Associate Director of Performance and Planning at Lancashire and South Cumbria Integrated Care Board, agreed. He said: "If you're running a business and you know where the problem is, you direct your resources to that problem. But from a healthcare point of view, that's very hard to sell. Because one person won't be getting the same attention as someone else. This is a really difficult problem to solve.

"With screening, what you find with individuals who don't engage isn't that they're actively choosing not to, but they prioritise their children's health, or they'll live somewhere where it's difficult to access healthcare, or they don't have time to go to their GP even if they've got a significant health issue. The areas where screening is lower is where we need to target, because there are populations who might have a higher prevalence of a particular cancer, or areas with greater health inequalities and poorer health outcomes, where they won't access screening because they won't access any form of health care.

"But how do you target populations with health advice that will provide them and their communities with an understanding of how, why and where they should go? That isn't best coming from someone that says they're a health expert, but when it comes from people in their community. This is a more sustainable way to help local communities really understand how they access health, what their barriers are, and how the NHS can help them."

Andrew Giles, CEO at the Morecambe Bay GP Federation, said: "I spoke to a GP practice in one of our more deprived areas, in Morecambe, and their perspective is that there needs to be research into late presenters and how to support general practice to detect those individuals at a point of opportunistic consultation. The consultation might not be about a lump or something similar, but there could be an opportunity to look at the markers that make up disease progression and try and draw those individuals out. There will be challenges with that, but it feels like the right thing to do in the imperfect environment we're in."

Mick Fleming, Lead Pastor at Church on the Street Ministries, said: "I see thousands of people every month, all from deprived backgrounds, and 100% of the ones who develop cancer die because poverty means a lack of access. There's a growing number of people who are homeless, they're addicted, they don't have technology, and they have a different type of need. When they do get to the hospital, they're treated differently, because if someone is a drug addict and needs pain relief, the clinicians can't prescribe it because they don't know what they're on. So that person must leave the hospital, take heroin and then go back, which is highly dangerous.

"For the first time we're having breakthroughs, and I've had the first person that's survived cancer. It's taken me five years to get to this place. But the problem with the peer group I'm working with is that they're growing, and also, they're not sexy and they don't vote. So, they're a lot easier to ignore. But the voice is getting louder."

Dr Sakthi Karunanithi, Director of Public Health at Lancashire County Council, summarised the conversation, saying: "We need to keep putting people and their living conditions at the centre. If that isn't committed to, then we can talk about cancers but we're unlikely to improve any outcomes in the short term. We improve living conditions. We improve cancer rates."

# Pushing for a left shift

# Pushing for a left shift

Lizzi Collinge, MP for Morecambe and Lunesdale

Lizzi Collinge, said: “The government and I are very committed to the left shift, so trying to prevent and diagnose earlier. But the pressures we have as a country means there’s not just one challenge here. We’re coming in with a poly crisis in every area of the country.

“The challenge when you’re working with limited resources is that you can’t do everything at once. But we need to get people treated faster. We are focusing hard on waiting lists, and they are coming down, but I’m passionate about getting that real left shift and getting far more resources into prevention.”

On this topic, Andrew Giles remarked: “There’s an opportunity for left shift delivery, especially if you think about technology and what can be used in community settings. That’s certainly something that should be a facet of a 10-year plan. But there’s also opportunity for left shift in research. I would love to see an increase in opportunities for smaller scale research about implementation of treatments or detection, particularly in primary care.

He added: “Another risk group is patients with learning disabilities. These are individuals who often face barriers to care, and cancer often has an incredible effect on them, because the opportunities to spot cancer may not be as well taken. If you imagine a needle phobic disability patient, the idea of having a blood test to take cancer markers is terrifying to them. It can involve up to three people literally restraining them, so you can imagine the scale of that and the questions it raises? You must be very sure you want to put them through that.

“But there’s new technologies around needleless blood taking, and incredible tools that have been applied for patients who maybe have cancer. However, there’s no in place to be able to have cancer markers, which are well recognised in full vials of blood, validated for micro samples. I think there’s opportunities like that, where smaller scale research can sit on the implementation end of the pathway and really help people.”

Daren Subar, General Surgeon at Blackburn Hospital, said: “I think Wes Streeting is right that we have to do something different. What we’re doing isn’t working. I agree with the shift-left as we have to look at prevention and early diagnosis. That is the only way to decrease the pressures on the NHS. And it’s a lot cheaper to go down that road, but we don’t understand that. Why? Because we made a business out of the NHS.”

Lee Threlfall said: “When we talk about things like social prescribing and left shift, the problem is that they’re not backed up by investment and policy. To illustrate the problem, if in primary care we did a test and found 31 additional cancers we would have missed, then that could be half a million pounds saved because those patients wouldn’t end up presenting at A&E with stage four cancer. The

problem is, you can't shift left because there's no money available to use for that initial investment in the preventative or early diagnosis initiative in the first place. In essence, what's being said is that all of the money's gone but still shift left."

Alastair Richards commented: "Freeing up resources and making sure they're allocated as effectively as possible is crucial to achieving a left-shift in our health system. As part of this, while supporting the necessary clinical infrastructure, skills, and personnel, it's vital that targeted research and community-level education initiatives are sufficiently resourced. Without investing in life-long learning and tailored technologies, approaches and therapies, we're not going to see the prevention and early diagnosis improvements necessary to resolve the region's entrenched cancer-related issues."

Ailsa Brotherton said that it's important for the local area to "refocus as a leadership team on what matters. I think we've been overwhelmed since our system began facing financial challenges. We've had a really heavy focus on finances, and we've lost focus on the service redesign work. We need to regroup as leaders working with partners and really look at how we address the health inequalities challenge."

Lizzi Collinge, added: "When we're thinking about the left shift, we need to be brave enough to say less stuff will happen. That's politically extremely difficult, because people care about hospitals, A&E, and ambulances. People don't care about social care until they have to use it. People don't care about screening until it saves their lives and that is a very difficult position."

Daren Subar explained the need to change the system of care. He said: "There's a famous saying that 'some people fear the rain and others get wet'. And it's only when we feel that rain and it impacts us that some of us will do something about it. The NHS is broken. We have to accept that. When you see patients in the corridors of hospitals and having beds put in between beds, you have to accept we're no longer running a First World service. We also have to accept that there's a financial issue within the NHS and we must work with what we have.

"Three days ago, there was a patient I was called to see. Two days postpartum. Metastatic pancreatic cancer. This lady will be dead within six months. She had two other kids at home. This was absolutely disastrous. What are we going to do about it? What are we going to do about the inequalities within the inequalities?"

Andrew Giles said: "It's important to talk about the access challenges in primary care. There are huge backlogs in the NHS and those patients who can't move on to the other places where they'd normally receive care are going back to their GPs. However, the GPs are beyond their realms of competence and scope, and so they're really struggling to look after those people. This means it takes more time, and those individuals are taking up capacity. Some of those patients will have cancer. So, we must recognise we are in an imperfect world, and we have to try and figure out solutions to operate in that space.

He added: "GPs are under a lot of pressure, and they've got eight minutes to see a patient and to make a decision that could affect their life. It's a huge responsibility, and it's not just a responsibility to the patient that's in front of them. It's responsibility to patients that can't access the therapies, treatments, diagnostics that those individuals may take up if they're given an inappropriate referral into further care. There's a real challenge there in terms of making sure you know when you're in a different diagnosis stage of a care pathway, and that you have your most senior decision makers making decisions about where to direct an individual which values that experience and continuity of care.

"The whole purpose of general practice is to act as a gatekeeper, and the unfortunate reality of being a gatekeeper is sometimes that means the gate is closed. And I don't think we can shy away from that, because if we didn't, the NHS would be overwhelmed. There are risks that come with it, and it's very challenging."

# Leveraging technology and data

# Leveraging technology and data


Sakthi Karunanithi, Director of Public Health at Lancashire County Council

Sakthi Karunanithi, said: “We need to embrace emerging technology and understand the benefits of it while being aware of potential issues. Tech in its broadest sense is the manifestation of how our knowledge has evolved as a society. So, we shouldn’t be afraid of embracing it.”

Professor Ihtesham ur Rehman, Head of Translational Research at the University of Lancashire, said: “The real challenge is detection and diagnosis. I strongly believe that we need a technology which can be taken to the patients, rather than always bringing patients to the hospital. There’s an initiative in West Yorkshire with a chemotherapy bus which stops at Colne and does the treatment there. Initiatives like this are providing care where patients can easily access it.

“Similarly, we require a new technology which can test patients where they are. I’ve been working for many years on the biopsies of tissues, which is an invasive procedure that we cannot carry out all the time. So, can we do liquid biopsies? Groups are working on biofluid testing to find biomarkers in urine, saliva, and blood samples. This is an emerging technology, and with the combination of AI and machine learning, it’s really pushing the boundaries. And the translation pathway, which could have been five to 10 years can now be minimised to two or three years.

“This all supports detection and diagnosis for better prevention and long-term prognosis. This technology is not only able to look at cancer, but we can also target other diseases as well. And we can take this technology to the people to more easily pick up cancer early and then monitor regularly.”

Sakthi Karunanithi added: “We could look at connecting the information we have about individuals, such as NHS records, and put that alongside other information to create a complete picture of the cancer risk in a certain population cohort – but right now this information connectivity is not nuanced enough when it comes to cancer screening. But it could potentially be over time and a key subject area for research should be putting all that information together in a personalised manner at a population level to help target people.

“We know people with learning disabilities are less likely to come forward, and we also know certain ethnic populations have a higher risk of developing cancer or other diseases. We have begun to see with cardiovascular disease how scoring someone’s risk of developing a heart attack varies depending on not just age, but also from community groups. I think cancer care has the potential to use data and technology to be much more precise, improve early diagnosis and resolve inequality issues. But it’s important to bear in mind that some screening tests have the potential to do harm as well as good.”

Luigi Sedda said: “We have a huge amount of data, but we can do more with it. For example, in Lancaster, the largest risk is from colorectal cancer, but that’s not the same for the whole area.

Sarah Drake, Founder and Managing Director of Elephant in the Room Training

In Grange-over-Sands, the larger risk is head and neck cancer. It's something completely different, but do they know that? We need to use data in order to target our limited resources better."

Sarah Drake, Founder and Managing Director of Elephant in the Room Training, said: "I started a project of men's engagement with farmers. I was there with nurses doing the drop in, and one of the biggest issues they had was that their appointments were on their phone. I saw farmers come in and give the phone to the nurse, saying 'I don't know how to get my appointment out of this. Can you help me?'

"I did a huge piece of work on it, but where did that outcome go? We also did a huge piece of cancer care work with the Gypsy travelling community. We got them to be part of the panel, and we provided laptops for them. But there was no outcome to it. It's great having all these projects and all these discussions, but what is done at the end of it?"

Lizzi Collinge said: "There was a brilliant project in Morecambe focused on two streets with some of the worst health outcomes. It only cost about 30 grand and was a brilliant project but it didn't get more funding. We need to see a more consistent approach to funding and getting long-term outcomes."

Andrew Giles said: "I have a concern that technology, whilst a great enabler, can also be a resource sink if we're not careful. There was a pilot called Grail Galleria in which people would give blood in primary care, close to where they lived, that blood was then taken by courier to Heathrow and flown to California to be tested. While this was using incredible technology that could pick up 50 different cancer markers through DNA fragments, it was an incredibly wasteful model. We must be careful that we don't scamper down the route of technology at the expense of sensible investment. Because we've got constrained resources, we must target them."

# Putting patient voices first

# Putting patient voices first


Andrew Giles, CEO at the Morecambe Bay GP Federation

The roundtable discussed how treatment needs to be focused on patients and be responsive to what they are saying. Sarah Drake shared her experience: "I was diagnosed with breast cancer 12 years ago when I was 34. My GP didn't regard 34 as being old enough to have that sort of diagnosis. I'd also just had a baby and I'd been breastfeeding but had to stop because he had a tongue-tie. So, it was put down to that.

"I kept returning to the GP because I wasn't happy that this was what it was. On the third visit, she said, 'I will refer you to the breast unit, but not because I think there's a problem. I just think that I can't reassure you any more than I have done'. I went to the breast unit, and I passed all the tests and was about to leave when I asked for a biopsy. I was granted one and two weeks later was told that they needed to do a full biopsy. Two weeks after that, I walked into the room with my husband and was presented with a gown. At that point I knew exactly what was coming. And so fast forward. I had a double mastectomy, six grams of chemotherapy, 10 years of hormone treatment, and I took advice off my breast nurse and sought some extra support from a local cancer care charity, which I ended up working for.

"I've done a lot of work with hospitals and cancer nurses, helping them run their workshops because with a lived experience I could wear two hats. I've heard so many horror stories of people returning to work or working alongside a cancer diagnosis or working while looking after somebody who's had a cancer diagnosis. I recognised that there was a gap here and it wasn't in the strategy for the charity I was working for to do this kind of training. So, I resigned and did it myself. And that's what I do, I go out and I talk to businesses about how to manage this and to have a plan in place."

Sarah added: "There is this focus on the physical side of cancer, but not the mental health consequences. I had surgery six weeks ago to have reconstruction, and this is 12 years down the line. If I was employed, would my employer say that that's okay? And there's a lot of employers that don't realise that cancer patients are classed as disabled for life, even in remission, and that they must create reasonable adjustments in the workplace.

"I want employers to recognise that people are their biggest assets, and if they want to work, they can help them do that. And it's not even rocket science stuff. It's being empathetic and emotionally intelligent."

Andrew Giles commented that: "We need to see the individual rather than just the disease, and access to psychological therapies is a real enabler to help people cope with what is a hugely disorienting time in their lives. It'd be really useful to think about barriers to psychological therapies and how we can align the NHS around these individuals, not just focusing on the disease, but instead focusing on the wider person."

Sakthi Karunanithi agreed, saying: “Practitioners are increasingly realising that the person who knows best about someone’s health is the person themselves. And if there’s something wrong and they keep repeating themselves, they need to stop and reflect.

“Another aspect to this is that we need to look after our practitioners better and create working conditions that don’t put them in a position of being on a treadmill, ticking boxes and watching the clock for eight minutes then going to the next patient. There’s lots of research telling us that if you are in a state of mind that isn’t worrying about yourself, but about the job you’re doing, then the likelihood of listening and caring for somebody else improves significantly.”

Ailsa Brotherton said: “We absolutely need to spend much more time as leaders in the NHS listening to our patients and their experience. There’s nothing more profound than the patient experiences shared here today.”


Ailsa Brotherton, Executive Director of Improvement, Research and Innovation at Lancashire Teaching Hospitals NHS Foundation Trust

# Policy and the 10 Year Health Plan

# Policy and the 10 Year Health Plan

Lee Threlfall, Associate Director of Performance and Planning at Lancashire and South Cumbria Integrated Care Board

Lizzi Collinge, said: “It’s a tricky balance the government is having to manage, and in the cancer plan I would really like to see a focus on the key pillars of treatment which includes earlier diagnosis, prevention, and getting treatment quicker.

“We need to look at the really big picture - those wider determinants of health. If we don’t get housing right, if we don’t get access to green space and exercise right, if we don’t get rid of poverty, then we can diagnose as much as we like, but people are still going to get sick. For me, I’d really like to see links out to the other departments and how we can connect that into the bigger picture to empower wider prevention and support very specific cancer work.”

Sakthi Karunanithi said: “What gets measured is what gets the attention when it comes to resource allocation and holding people to account. What has come to the fore is waiting lists, but clinical quality is not at the forefront.

“There are several things that we need to see in Lancashire for improving outcomes. We need to see cancer and communities together and not see cancer on its own. And we need to see professionals and people working together across sectors. We need to maintain a focus on funding between housing professionals, leisure professionals, surgeons, GPs, social care workers, therapists, and monetary sector workers, collaborating to put communities and people at the centre. We have a risk of being very focused on the disease and forgetting that it is about people.”

Ailsa Brotherton said: “It’s important we understand the structure we need in the NHS and the leadership required to actually deliver on a new plan. I’ve currently got a role with the National Improvement Board, and we’ve just published a report called *The Missing How*. We were asked by NHS England to look at how we can do something different. We found that we need a difference in leadership, a difference in scale, and a difference in scope.

“The really important thing to put in our new cancer plan would be to look at prevention and early diagnosis. For me, this is about using the right technology and looking at the translational research work we started across Langston, South Cumbria, into how we can speed up the process of moving from research into practice. If we could collectively work with the people who make the policy at the centre and at organisations like NICE for the guidance then we could speed up getting a clear focus on prevention and early detection through non-invasive diagnostics.”

Sakthi Karunanithi said: “As much as the choices we make in cancer care are based in professional knowledge, it’s also a political choice, and politics is at the heart of most things related to the NHS.

I'm stressing this because some estimates suggest that 30-50% of cancers are preventable. Before we even get to early detection, there are things like tobacco, unhealthy diets, environmental hazards, and vaccination that we can work on.

"Let's make smoking history and let's tackle putting profits before people when it comes to unhealthy foods. There is a choice that we face as a society that's beyond just what we can do at the front line and as a patient, and that is an important aspect that I'd like to see in the cancer plan and in the national government's mission."

Mick Fleming said: "I would say to Mr. Streeting, target the money to the people that need it the most. Think about dignity. Don't think about votes. Think about need. I would also say that what we do at Church on the Street ministries is very successful. We've got a medical room set up that we paid for, and the work is life saving. And you'd save money by investing in organisations like us, because it stops people going to A&E. We've had hundreds of people diagnosed because of having a conversation with us."

Sarah Drake stressed the need to factor education into the cancer plan: "Why aren't we teaching children how to check for signs of cancer. Testicular cancer can start from the age of 11. And I don't mean to be scaring them, just making them aware of what's going on from a much earlier age. This would help them advocate for themselves, present earlier and have some knowledge of what's going on."

On how resources are used and decisions made, Andrew Giles said: "We've loaded so much responsibility on politicians shoulders, and I don't necessarily think that's always fair. We have agency ourselves. We spend billions of pounds in our local area, and we can do better. I worry that we will wait for the cavalry to come rather than trying to take control of this ourselves. I would like to see a 10-year plan, but I would like to see concerted effort by local commissioners and local leaders to drive this forward as well."

Daren Subar agreed, saying: "We have to take some responsibility for our own actions, and part of the process is understanding how we address our situation. We need to ask how we address economically deprived areas, and how do we get to those hard-to-reach communities."

Lee Threlfall said: "We need national policy to enable us locally to do the things we know we need to do. We know we should have left shifted years ago, but we didn't do it, and there are organisational boundaries that have fed into this. We need to work collectively to do the right thing for our population, but we need the policy nationally to support that to happen locally."

Alastair Richards wrapped up these points. He said: "What we've heard about is patient experience, clinician experience, lived experience, and a set of ideas around solutions to change the situation. We've talked a lot about left shift, and we all think that's the right answer, but it's got to be enabled using technology, and bringing that technology to patients by working within communities and addressing issues at a much lower level than we currently do.

"Crucially we need to know what success looks like. And I think that will be when we can shift the conversation among politicians and the media from concern about the NHS to concern about the state of public health. This is because the NHS is the answer to when the problem has occurred, and the problem itself is the health and wellbeing of our communities. If we can work with communities and individuals through public health initiatives and education, then actually you can address a lot of the problems before they come down the line."

# Key takeaways

Left to right: Mick Fleming, Dr Luigi Sedda, Professor Ihtesham ur Rehman, Lizzi Collinge, Chris Maguire, Sarah Drake, Andrew Giles, Daren Subar, Lee Threlfall, Ailsa Brotherton, Alastair Richards, Sakthi Karunanithi

# Key takeaways

1

### Geography, demographics and deprivation

The region has a diverse geography and populations, from rural North Lancashire to deprived urban areas like Morecambe and the 'four Bs'. Significant health inequalities and access barriers exist, with high smoking, alcohol use, and obesity rates, while rural communities face challenges accessing healthcare services.

Using data on local cancer rates can inform targeted interventions and risk-based screening approaches, rather than uniform methods. For example, recognising that deprived populations often die 15-20 years younger and therefore need earlier interventions. However, there are clear difficulties in implementing differential healthcare approaches.

Community engagement is crucial, and health advice is more effective when delivered by trusted community members. There are also extreme challenges facing homeless and addicted populations, where poverty creates fatal access barriers.

2

### Pushing for a left shift

Implementing a left shift approach to boost prevention and early diagnosis is essential to improving regional cancer rates. However, significant resource constraints make changing the strategy very difficult, as the government is addressing multiple healthcare crises simultaneously.

Key challenges include funding paradoxes where preventative investments could save significant costs but require upfront resources that aren't available. System inefficiencies and wastage as well as practical barriers, including technology gaps for vulnerable populations and GP capacity constraints, also need to be accounted for.

Ultimately, the NHS faces fundamental challenges requiring difficult decisions about resource allocation, which requires brave leadership to prioritise prevention despite political difficulties in explaining reduced acute services to the public.

3

### Leveraging technology and data

Emerging technology can help with a number of challenges, such as overcoming access barriers by bringing diagnostics to patients. To facilitate the use of new solutions and breakthroughs, the healthcare system and its stakeholders need to better utilise data as well as accelerate the development and translational pathway of innovative solutions.

Effective initiatives and projects need to be backed by sufficient long-term funding to make a real impact. While technology offers significant potential for early detection and addressing health inequalities, careful targeting and sustainable implementation are crucial given constrained resources.

4

### Putting patient voices first

The need to view patients holistically rather than focusing solely on disease is essential and patients should be at the centre of their treatment as they know their bodies best. To achieve this, practitioners must listen when concerns are repeatedly raised. Additionally, an awareness of cancer and patient issues needs to extend outside the clinical environment into wider society.

The broader impact of cancer beyond physical symptoms must be understood, including long-term mental health consequences and workplace challenges. Better working conditions for clinicians will enable more attentive, caring consultations and minimise the risks from an “eight-minute treadmill” approach during consultations.

5

### Policy and the 10 Year Health Plan

A comprehensive cancer plan needs to emphasise prevention and early intervention while being aligned with cross-departmental government action to address the wider determinants of health, including housing, green spaces, reducing poverty, and limiting the impact of adverse lifestyle factors such as smoking and unhealthy diets.

This approach needs to be combined with education in schools starting from a young age as well as targeted campaigns designed to inform communities of issues in their area. Local leaders must also take responsibility for implementing community-based solutions rather than waiting for external intervention.

It is essential the plan is given the funding, political capital, and time to be effectively implemented. A key marker of success will be when the focus shifts from NHS crisis management to public health prevention.

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# Get in touch

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

**nwcr.org**

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