ICB Board

Cancer Overview – November 2026

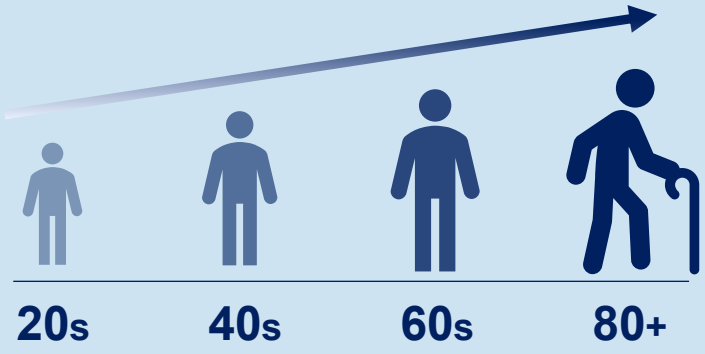
What increases the risk of cancer?

NHS
Lancashire and South Cumbria
Integrated Care Board

Whilst we do not know why one person gets cancer whilst somebody else does not, there are things that increase a person's risk of getting cancer.

Age

The risk of developing cancer increases as you get older, and this is the **biggest single risk factor.**



Risk Increases With Age

Lifestyle

A number of lifestyle factors can increase the risk of cancer, including:

- **Smoking**
- **Weight**
- **Diet**
- **Level of activity**
- **Sun exposure**
- **Alcohol intake**

About 4 in 10 cancers could be prevented



Over

2,500

cancer cases a week in the UK are **completely avoidable**

While we can't always prevent cancer, we can reduce the risk.

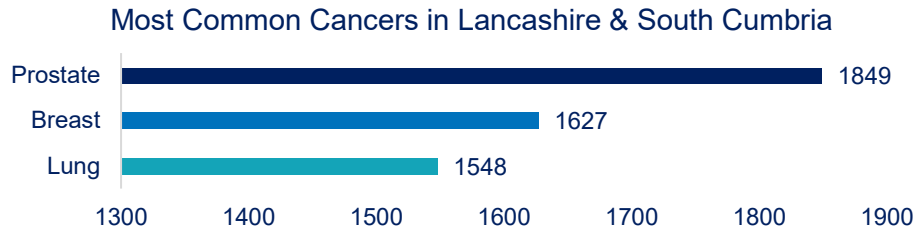
Source: Cancer Research UK calculated from 2015 cancer data.

Cancer Prevalence in L&SC

Over

11,500

cancers diagnosed in L&SC between Jun 25-May 26.



40%

of cancers are preventable and are linked to lifestyle-related risk factors.

This means

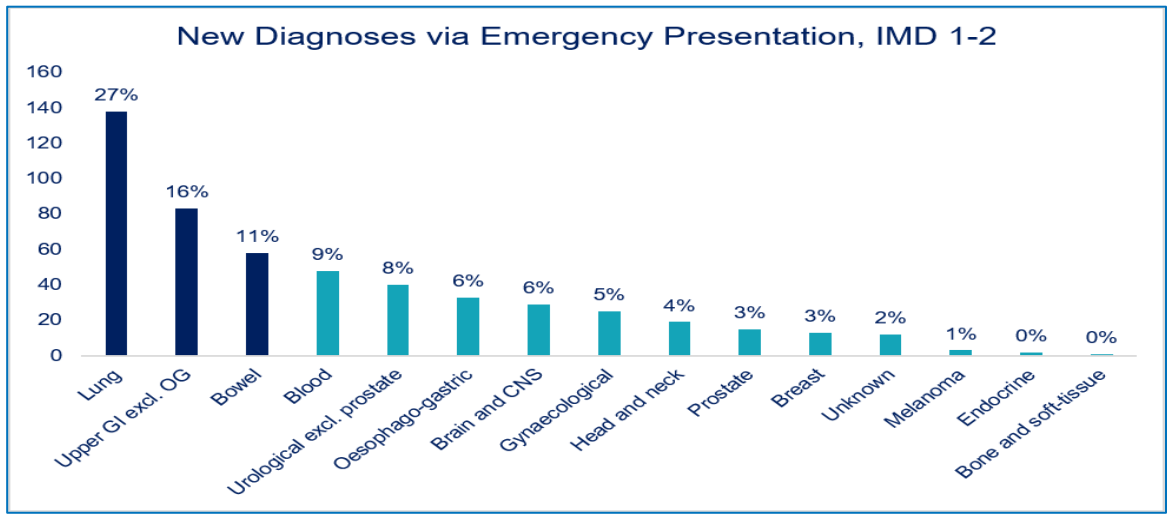
88

cancers per week are driven by preventable cancers

78%

of cancers diagnosed in L&SC are from people aged 60+

Over half of the cancers diagnosed in people below age 60 in L&SC are **Breast** cancers.



The **cancer burden** in Lancashire and South Cumbria **exceeds** the **national average**, with an incidence rate **10% higher** than England overall.

The **greatest burden** of cancer diagnoses in Lancashire and South Cumbria comes from **Prostate**, **Breast** and **Lung** cancer.

The **older age profile** of Lancashire and South Cumbria, particularly in **Fylde and Wyre** and **West Lancashire**, contributes to a **higher** burden of cancer and increased **referral** activity.

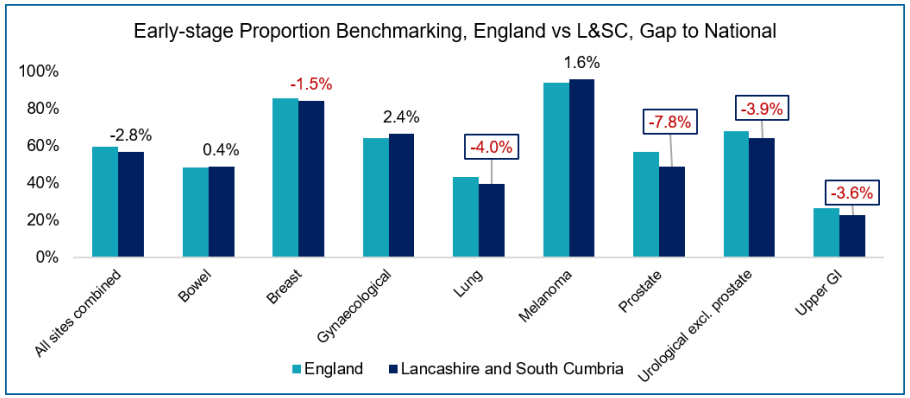
Lung, **Upper GI** and **Bowel** cancers are most common in **deprived** communities diagnosed via Emergency Presentation, indicating that **preventable** risk factors are driving **increased cancer incidence**.

The under-75 **mortality rate** from **preventable** cancers, Lancashire (**53.5**), Blackburn with Darwen (**69.1**) and Blackpool (**86.4**) are **significantly higher** than the England rate (**48.6**).

Emergency cancer diagnoses are almost **80%** higher in the **most deprived** communities than in the least deprived communities.

Source: NDRS Rapid Cancer Registration Dataset. DHSC Fingertips.

Cancer Staging in L&SC



L&SC is currently

19/20

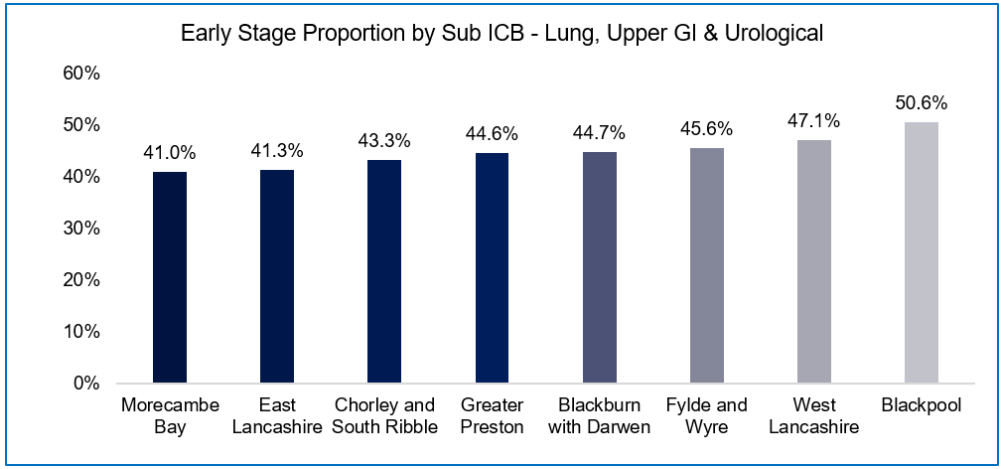
Cancer Alliances in cancers diagnosed at and early-stage.

IMD

Early-stage Proportion	1	2	3	4	5
All Routes	51%	57%	58%	58%	60%
Change from previous year	1.4%	4.9%	3.5%	2.2%	3.7%
Via Emergency Presentation	29%	31%	37%	34%	37%

51%

of the GP registered population of Lancashire and South Cumbria reside in the Morecambe Bay, East Lancashire and Chorley and South Ribble Sub ICBs.



As a Cancer Alliance, Lancashire and South Cumbria has the **2nd worst** proportion of **late-stage cancers** in England. However, we are the **most improved Alliance** area through our focused work

L&SC is **2.8%** behind the national average for early-stage diagnosis, with the largest gaps in **Prostate, Lung**, **Urological** and **Upper GI** cancers.

People living in the **most affluent** areas of L&SC are **9% more likely** to have their cancer diagnosed at an **early-stage** than those living in the **most deprived** areas.

Inequalities in early diagnosis **are widening**, with the gap between the **most and least** deprived communities increasing **2.2**% in the last 12 months.

Around **1 in 6** cancers in L&SC are diagnosed through an **emergency presentation**, with the highest proportions concentrated in **Blackburn with Darwen**, **Blackpool** and **East Lancashire**.

Late-stage diagnosis is more prevalent for Lung, Upper GI and Urological including Prostate cancers, with concentrations in our **most deprived communities**.

Source: NDRS Rapid Cancer Registration Dataset.

So what needs to happen?

Earlier presentation

- Targeted awareness campaigns both local and national, community outreach and trusted partnerships through our VSCFE sector will support people to recognise potential symptoms and seek help sooner.

Stronger primary care pathways

- Education for Health Care Professionals in primary care, Early Diagnosis Cancer Navigators who are patient facing roles that support individuals referred by primary care on a 2-week cancer pathway to help people to navigate through their journey. Targeted Cancer pathway reviews and clinical decision support will strengthen symptom recognition and allow better referrals and access. Referral safety-netting to manage clinical uncertainty when a patient's symptoms are non-specific or vague and follow-up to ensure the loop is closed.

Targeted pathway improvement

- Data and Learning Event Analysis will focus improvement on cancers with the greatest opportunity, including prostate, lung, bowel and pancreatic cancer, and on patients presenting with vague or non-specific symptoms.

Screening and proactive case-finding

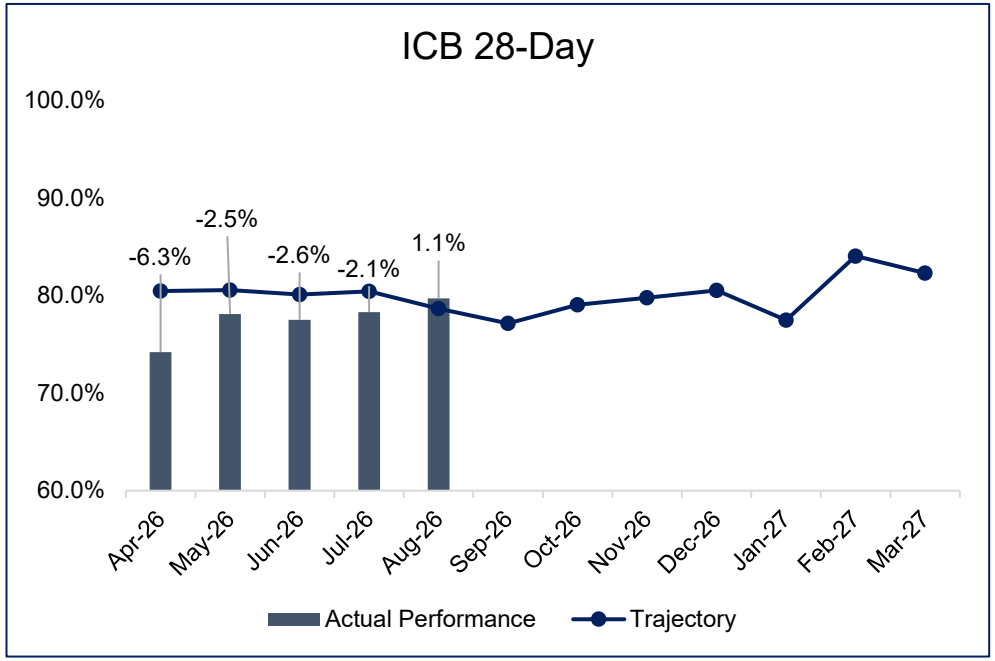
- Targeted action will improve equitable screening uptake, expand lung cancer screening and test risk-based approaches to identifying cancer earlier.

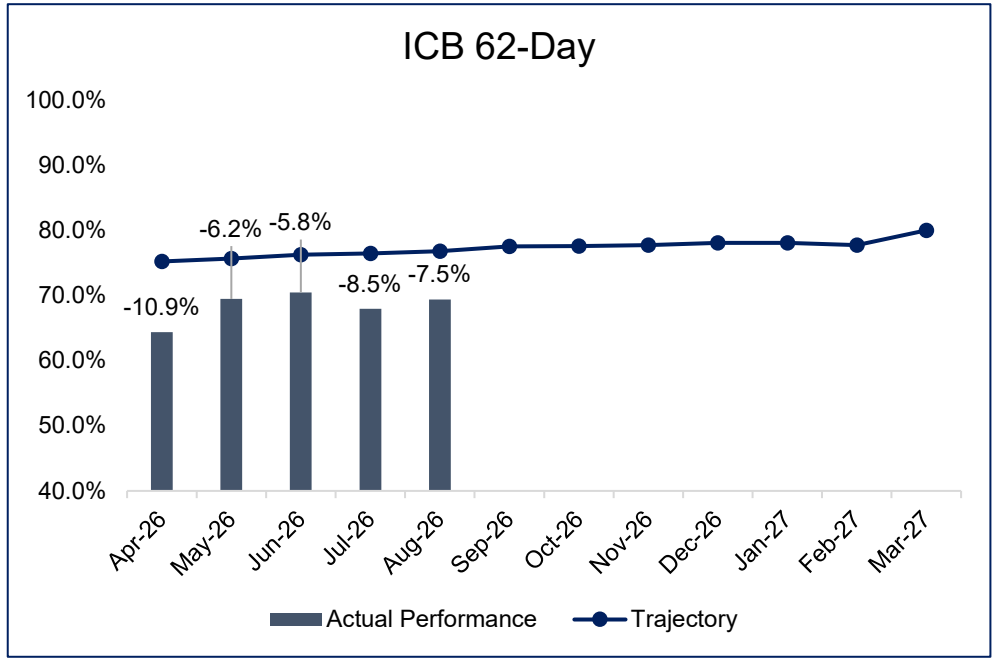
Innovation and improvement at scale

- Evidence-based tools and pathway innovations will be evaluated and scaled where they demonstrate measurable improvements in early diagnosis, experience or early staging.

The impact and aim of all the detailed actions will enable more cancers to be diagnosed through timely and optimal pathways, fewer emergency presentations, reduced variation and inequalities, and more people diagnosed at stages 1 and 2.

Cancer Standards Performance - ICB





Faster Diagnosis Standard (28-day standard) – Yearly Average of 80% Target

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	CA Ranking	YTD Comparison to 25/26
Q3	78%	13/20	+3%

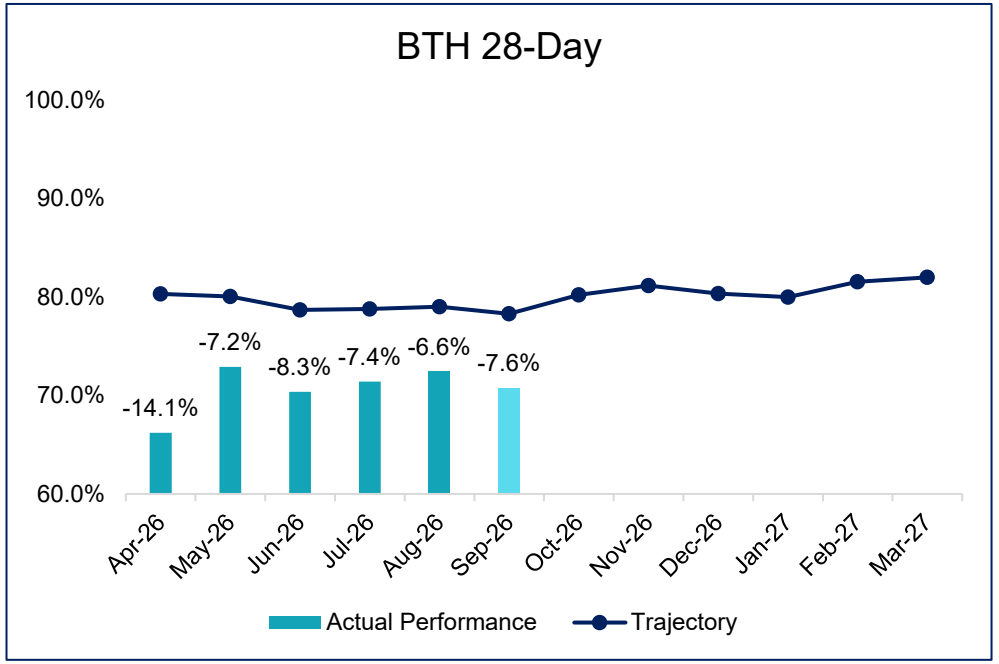
Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	CA Ranking	YTD Comparison to 25/26
Urological	Q4	56%	20/20	+1%
LGI	Q4	59%	18/20	0%
Gynae	Q4	59%	19/20	+2%
UGI	Q4	70%	18/20	+1%

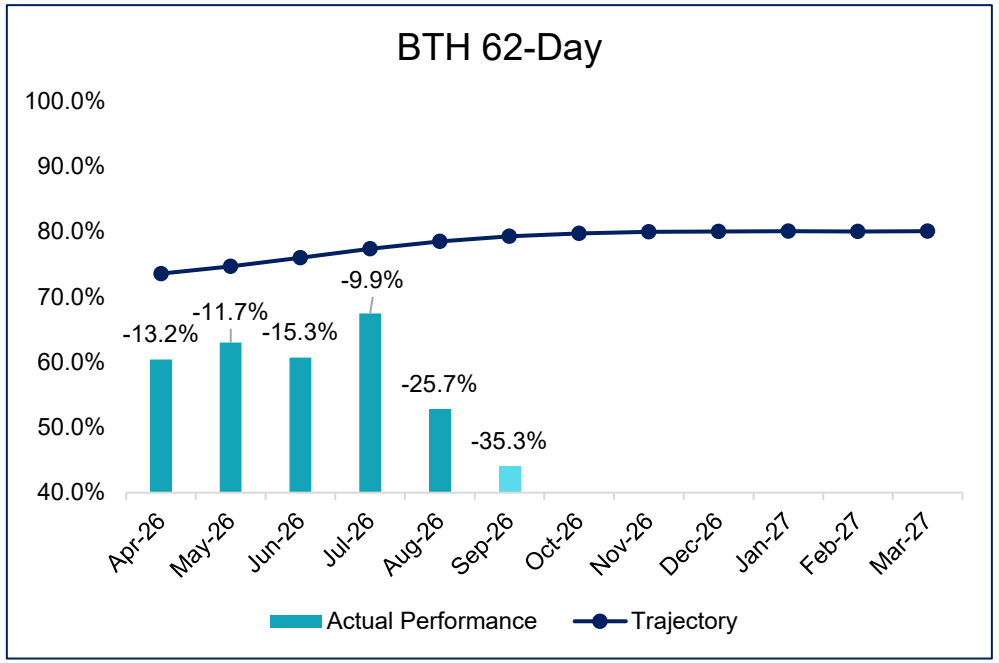
Referral to Treatment (62-day standard) – 80% Target by Mar-27

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	CA Ranking	YTD Comparison to 25/26
Q3	69%	13/20	+2%

Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	CA Ranking	YTD Comparison to 25/26
LGI	Q3	38%	18/20	-2%
Gynae	Q3	43%	11/20	-2%
Urological	Q3	51%	16/20	-2%
H&N	Q2	52%	7/20	+3%

Cancer Standards Performance - BTH





Faster Diagnosis Standard (28-day standard) – Yearly Average of 80% Target

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Q4	71%	125/152	+5%

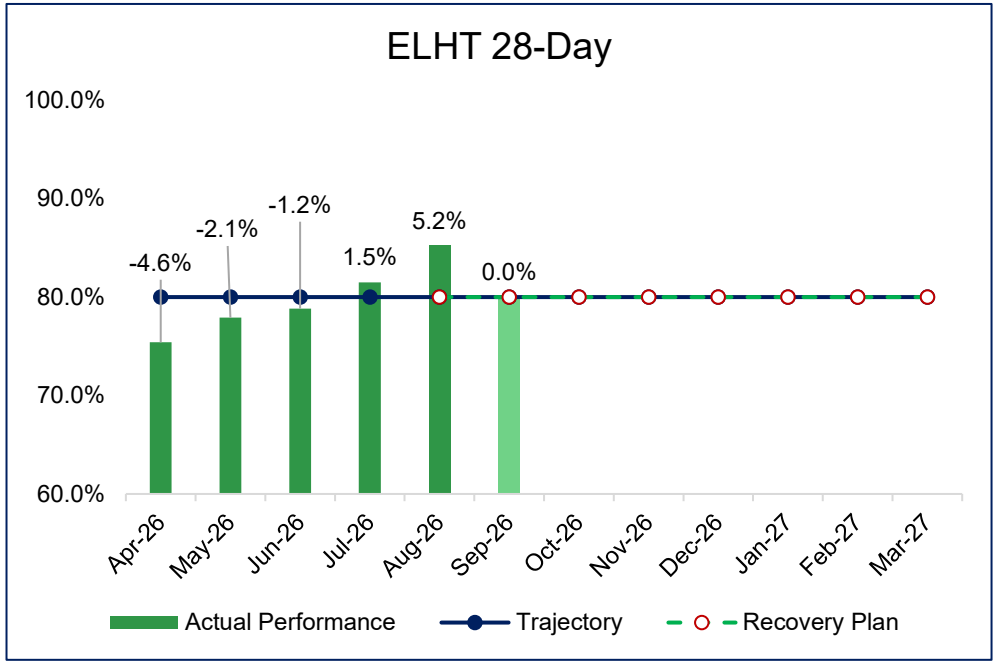
Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
LGI	Q4	49%	113/122	+2%
Urological	Q4	50%	105/121	+4%
Gynae	Q4	50%	112/123	+7%
UGI	Q4	59%	117/122	+6%

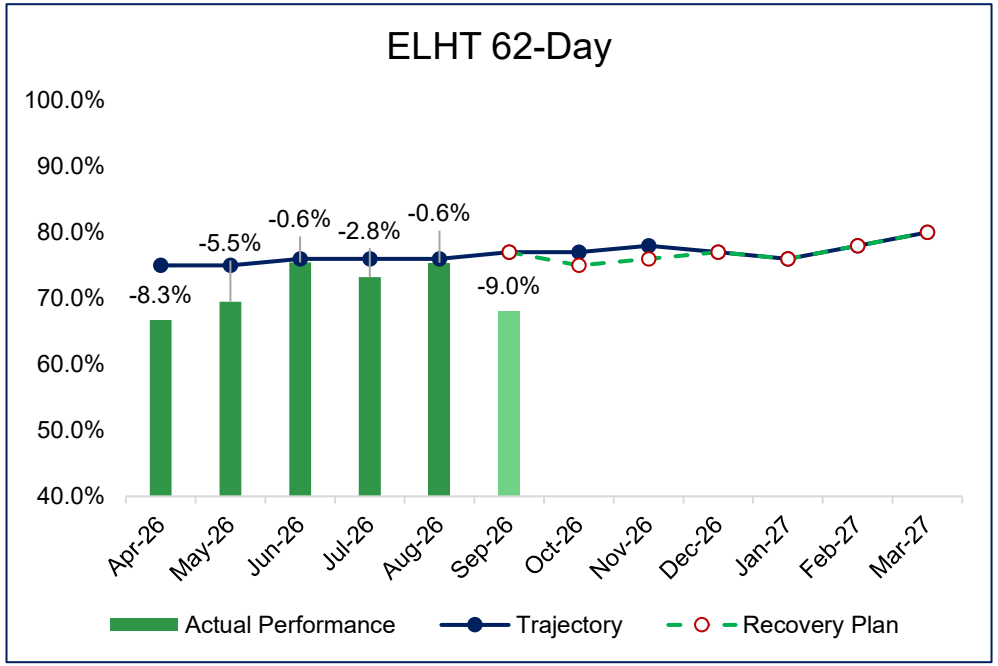
Referral to Treatment (62-day standard) – 80% Target by Mar-27

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Q4	59%	122/166	-1%

Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Breast	Q4	38%	113/127	-12%
LGI	Q4	43%	112/130	0%
Lung	Q4	51%	96/130	+6%
H&N	Q3	52%	64/123	+1%

Cancer Standards Performance - ELHT





Faster Diagnosis Standard (28-day standard) – Yearly Average of 80% Target

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Q3	80%	86/152	+5%

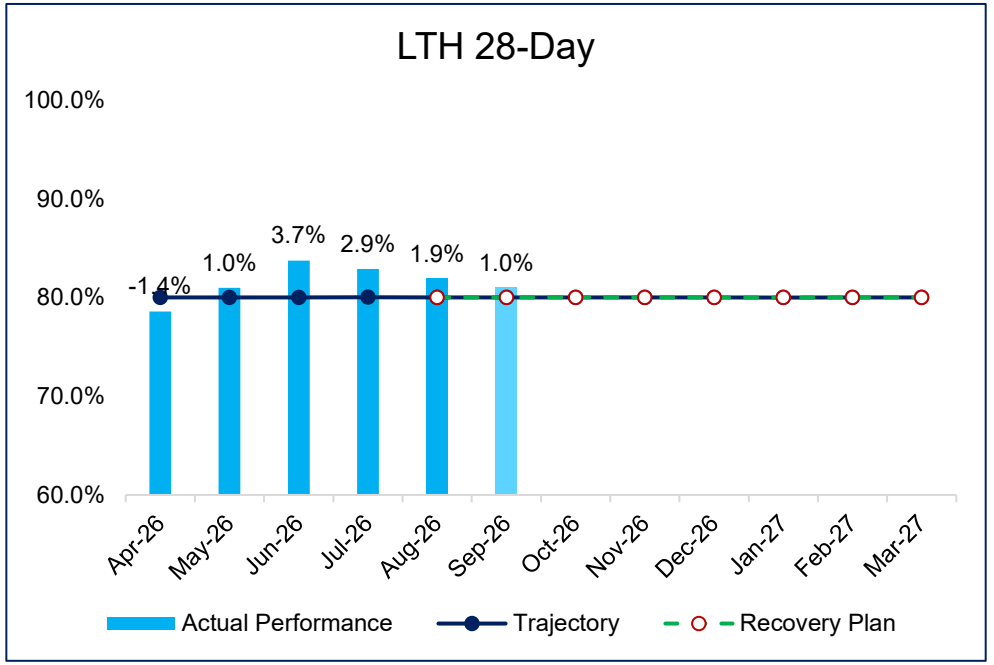
Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
LGI	Q4	38%	113/127	-12%
Urological	Q4	43%	112/130	0%
Gynae	Q4	51%	96/130	+6%
UGI	Q3	52%	64/123	+1%

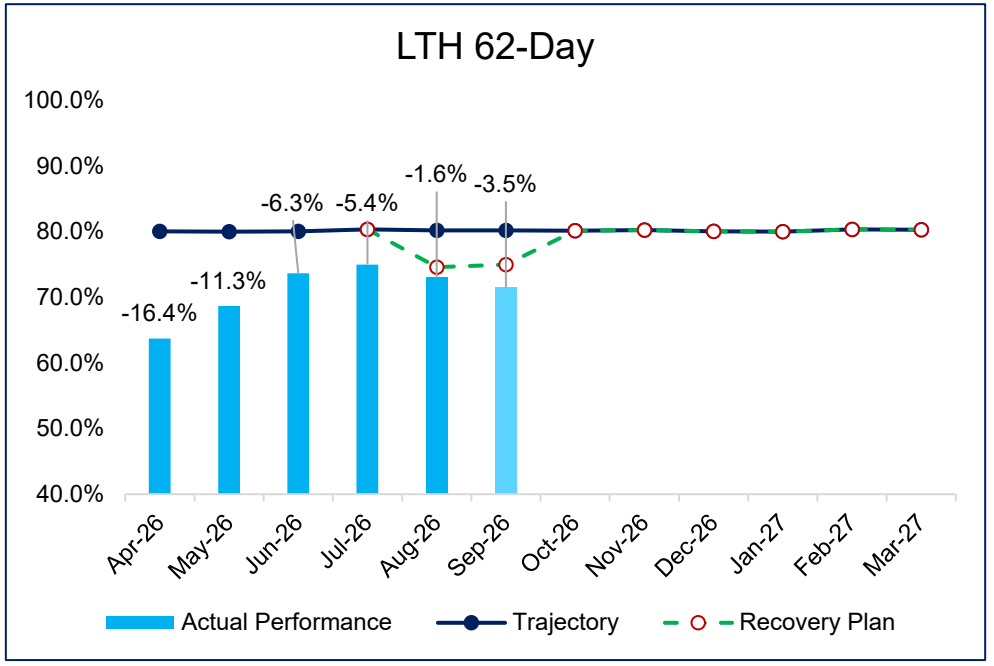
Referral to Treatment (62-day standard) – 80% Target by Mar-27

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Q3	72%	74/166	-1%

Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
LGI	Q4	50%	97/122	3%
Gynae	Q3	55%	69/123	-5%
Urological	Q4	60%	92/133	-5%
H&N	Q1	70%	11/123	5%

Cancer Standards Performance - LTHT





Faster Diagnosis Standard (28-day standard) – Yearly Average of 80% Target

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Q2	82%	47/152	+3%

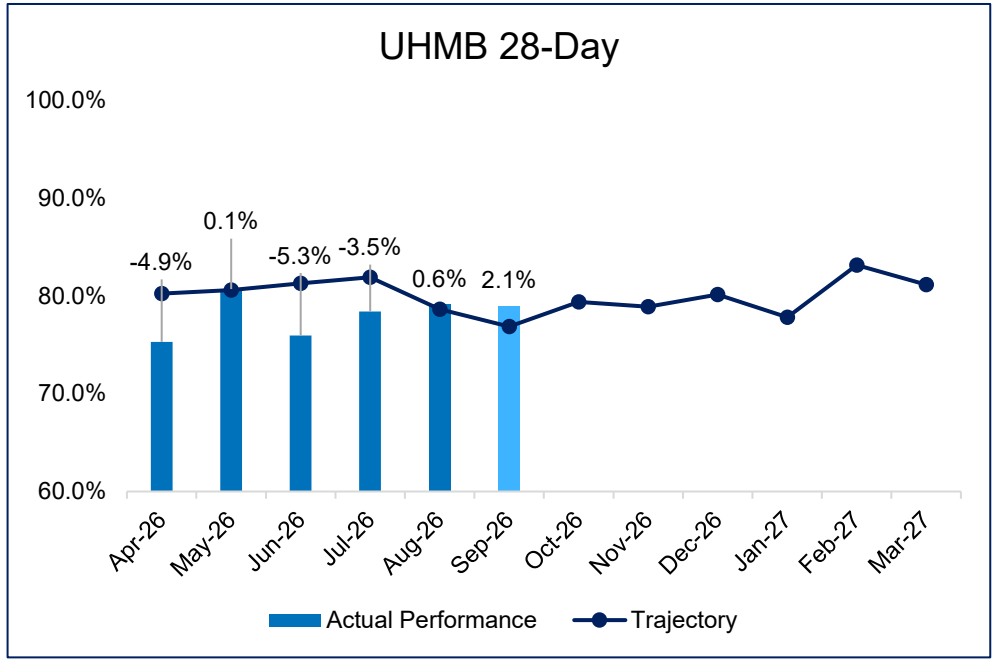
Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Urological	Q4	53%	102/121	+3%
LGI	Q2	70%	54/122	0%
Gynae	Q1	75%	28/123	-3%
UGI	Q3	78%	74/122	-4%

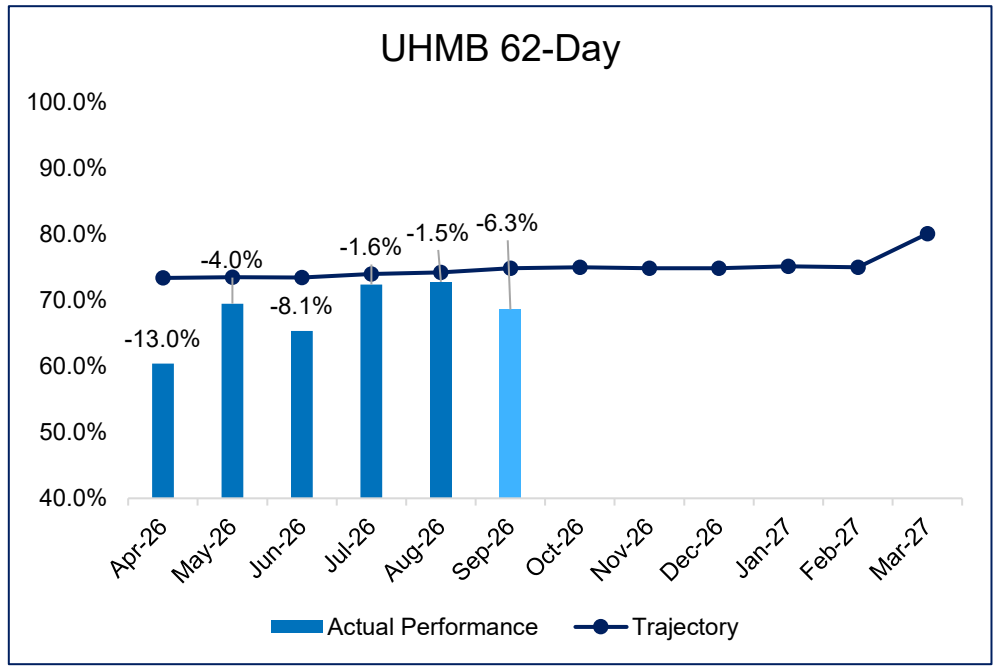
Referral to Treatment (62-day standard) – 80% Target by Mar-27

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Q3	71%	77/166	+7%

Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Gynae	Q4	50%	87/128	-15%
LGI	Q3	52%	89/130	+3%
Urological	Q3	60%	91/133	+1%
H&N	Q2	62%	44/123	+7%

Cancer Standards Performance - UHMB





Faster Diagnosis Standard (28-day standard) – Yearly Average of 80% Target

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Q3	78%	95/152	0%

Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Gynae	Q4	34%	119/123	-9%
Urological	Q3	62%	83/121	+2%
LGI	Q3	69%	63/122	-3%
H&N	Q3	74%	83/120	-3%

Referral to Treatment (62-day standard) – 80% Target by Mar-27

National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
Q3	68%	97/166	0%

Lowest Performing Tumour Groups	National Quartile – YTD Apr-Jul 26	YTD Performance – Apr-Aug 26	Trust Ranking	YTD Comparison to 25/26
H&N	Q3	42%	79/123	-10%
Urological	Q4	57%	97/133	+7%
LGI	Q3	60%	67/130	-12%
Gynae	Q3	62%	65/128	-4%

So what are we doing in LSC?

Transformation

- Non-surgical oncology (NSO) – strategic and operational case for change and commissioning hub and spoke model which will enable a more resilient workforce and reduce delays for cancer patients to see an oncologist
- Suspected Skin cancer – a new service model has been developed which will commence 2027. This model will save over 40,000 GP appointments and reduce hospital attendances by 40%. Patients will have images taken closer to home, be triaged quickly and be referred to the most appropriate setting for treatment.

System wide changes to maximise the benefits

- Gynae – to ensure a system-wide approach to our aim of ensuring patients are placed onto the correct pathway, investigated with the correct clinical urgency, and safely escalated through implementing clear referral criteria to support primary care to refer the right patients, developing a standardised clinical triage approach, implementing secure safety netting protocols and collaborative primary care engagement
- Lung – bundled diagnostics reduce delays where multiple tests are required, maximising utilisation of capacity to achieve faster diagnosis and staging, and a full understanding of the system demand and capacity requirements to support the right capacity, associated workforce and a sustainable service offer. Working to operational additional Endobronchial Ultrasound (EBUS) capacity and championing shared capacity models.
- Future of Faecal Immunochemical test (FIT) which is a non-invasive stool test to detect hidden blood in a stool sample used as a screening tool for colon or bowel cancer. A review has been undertaken, and the testing is changing to maximise the utilisation of testing, reduce demand and maximise referral of patients at the highest risk of cancer.
- Movement of cancer care into community settings through the neighbourhood health framework supporting care closer to home .

Local Improvement

- Data-driven, action-focused local improvement meetings with improvement plans in each provider to support delivery of the cancer ambitions specifically focused on 4 tumour groups Gynae, Lung, Lower Gastrointestinal and Urology. Variation identified and best practice used to ensure pathways are robust and clinically correct.
- Managing seasonal skin cancer demand - to maintain performance during spring and summer period when referrals increase by 31% between June and August.
- Pathology backlog reduction - some of the providers have had significant backlogs in reporting suspected cancer samples. The funding has supported waiting list initiatives and outsourcing to reduce backlogs.
- Urology – prostate best practice steps in place, action plans focusing on increasing demand and simplifying steps to shorten pathway and improve performance. Full Intensive Support Team model Pathway Analysis Tool undertaken in Bladder and kidney to inform revised approach in H2.
- Full roll out of International Ovarian Tumour Analysis (IOTA scanning) which more accurately differentiates between benign and malignant ovarian masses.
- Supporting the development of straight to test, nurse-led activity, and work of navigators to support more efficient pathway steps to improvement performance by

Key Risks

Workforce

- Fragile workforce across multiple specialities in primary and secondary care
- Competing demands for focus – cancer, urgent and emergency care, routine Referral to treatment targets
- Geographical recruitment challenges across all health-related aspects of our system.
- Challenges in capacity being able to keep up with demand with specific pressure points in diagnostics and pathology

Population

- Long-term solutions required to tackle underlying causes of higher cancer rate amongst our population, but investment required in meeting Governmental focus on return to constitutional standards in the immediate term.
- Population-level cancer risks driven by an interconnected mix of demographic trends, lifestyle behaviours, economic disparities
- Age as the biggest risk factor for cancer development poses significant risks for our populations – older demographic in South Cumbria results in higher crude incidence rates across South Cumbria
- Nearly one-third of the Lancashire and South Cumbria population lives in areas of high deprivation
- Higher than average rates of smoking

Supporting factors for delivery of the ambitions

- Without earlier diagnosis we will continue to see late-stage cancer presentations – screening disparities and low uptake of screening tools
- Diagnostic infrastructure backlogs and lack of capacity
- Meeting the needs of an increasingly complex population with 70% of cancer patients living with at least one other long term condition