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# Unlocking Cancer Recovery in Northern Ireland

# Foreword

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Cancer Research UK (CRUK) published the No Time to Wait report in January 2026. The report voices our concern that, despite the dedicated work of brilliant staff throughout HSC, patients in Northern Ireland are waiting far too long for cancer care. These extended delays can result in patients becoming sicker or limit their treatment options. In the worst cases, patients may be dying unnecessarily.

Following our report, we asked a team of elective care operational specialists at MBI Health to look into barriers to improvement, identifying practical actions which could be taken by HSC, building the foundations for more timely and safe cancer services. We are thankful for the engagement of staff across the Department of Health, Northern Ireland Cancer Network, and Trusts with this work. It is thanks to their contributions that this report can make positive, practical recommendations which if taken, could build on good practice already in place, start to reduce cancer waits, and protect patient safety.

Ultimately, sustained and focused investment into the future will be needed for Northern Ireland to keep pace with improvements in cancer care and an ageing population. However, the recommendations made in this report are a necessary step to stabilise and recover services. Based on my experiences of working with cancer services across all four UK nations, HSC needs more management capacity and clinical time protected for improvement to make progress at the pace the people of Northern Ireland deserve. Going forward, CRUK will offer our constructive support, encouraging the Department of Health, HSC leaders and clinicians to implement this report's recommendations.

Every year, around 10,300 people in Northern Ireland are diagnosed with cancer. Each diagnosis is a life changed, a family affected, a community impacted. We will continue to be a strong voice for people affected by cancer waits in Northern Ireland, raising the profile of this issue, and holding the system to account for delivering timely cancer services, alongside investing for improvement into the future.

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# 1. Executive Summary

Cancer performance in Northern Ireland is significantly below expected standards, with long waits now a sustained feature of the system rather than an exception. For patients, this translates into prolonged periods of uncertainty, anxiety, and in some cases a deterioration in outcomes while awaiting diagnosis and treatment. This is not driven by a lack of effort, commitment or understanding. Across every organisation, we found capable teams and clear examples of good practice already delivering better outcomes in parts of the system.

There is broad agreement on what needs to change. The issue is ensuring agreed changes are implemented consistently, across the whole system, and with clear accountability for delivery.

There is no single root cause. Performance is being constrained by a combination of factors: rising demand, diagnostic bottlenecks, workforce pressures, variation in pathways, and a loss of operational grip following the implementation of Encompass. However, none of these challenges are unique, and in many cases, solutions already exist within the system itself.

Across multiple tumour pathways and organisations, we observed practical, proven approaches that are improving flow, reducing delays, and making better use of existing capacity. The opportunity now is to systematically identify, standardise and scale these approaches across Northern Ireland.

While the Northern Ireland Cancer Strategy provides a strong set of ambitions that should improve cancer outcomes, it is not yet supported by a sufficiently detailed, delivery-focused plan with defined accountabilities, prioritised actions and mechanisms to drive implementation at pace.

There is an acknowledgement of the actions being delivered through the Elective Care Framework (ECF) Implementation and Funding Plan, which is operating as the primary mechanism through which red flag cancer waits are being addressed. It is understood that this funding is being used to expand core capacity across diagnostics, endoscopy and elective specialties, particularly within urology, breast, dermatology, ENT, plastics and gynaecology services — all of which contribute directly to performance against the 62-day cancer standard.

Furthermore, through the ECF, significant investment is being directed into endoscopy, alongside multi-year expansion of CT, MRI and non-obstetric ultrasound (NOUS). These actions are targeting the

early-pathway bottlenecks that most affect timely diagnosis. It is also noted that short-term stabilisation measures, including additional in-house clinics and independent sector support, are also being used to ensure patients are seen as early as possible.

However, we still believe there is a need for a 12-month crisis intervention plan focused on in-year improvement actions that harness existing capacity across Northern Ireland which are not dependent on additional funding alone.

There is a significant amount of work that needs to be done, much of which will require design and consensus across organisations, staff groups and government. The co-ordination of these activities would benefit from regional oversight. It is noted that a number of new appointments, alongside changes to regional cancer care delivery responsibilities, are positive steps forward.

Without this, improvement efforts risk remaining fragmented, locally driven, and insufficient to shift overall system performance.

The opportunity is substantial. Northern Ireland operates within a single, shared digital infrastructure through Encompass, and a relatively small, connected network of providers. This creates the conditions to standardise pathways, align data and reporting, and deploy workforce and capacity more flexibly than in many other systems, not to mention the huge opportunity that exists around research and academia.

With strengthened system leadership, clearer accountability, and a focused programme of delivery, there is a credible path to recovery. This will require a dual approach: immediate turnaround actions to stabilise performance and reduce long waits, alongside longer-term reform to redesign pathways, optimise workforce models, and embed consistent operational discipline.

This report sets out a practical route to achieving that recovery, grounded in frontline insight, existing good practice, and a clear understanding of the system's current constraints and opportunities.

## 2. Purpose & Scope

In January 2026, Cancer Research UK published *No Time to Wait*, setting out a clear and evidence-based assessment of cancer waiting times in Northern Ireland. The report highlighted both the scale of current performance challenges and the underlying strengths within the system, concluding that meaningful

improvement is achievable through a combination of immediate turnaround actions and longer-term reform.

This report builds directly on that foundation, with a specific focus on how recovery can be delivered in practice.

While *No Time to Wait* defines the case for change and outlines a strategic direction, this review is concerned with execution. It examines how existing system structures, provider arrangements and governance can be mobilised to translate ambition into measurable improvements in cancer waiting times.

To inform this, MBI Health undertook structured interviews with stakeholders across the Northern Ireland health system, including clinical, operational and leadership perspectives. These discussions explored current performance challenges, the feasibility of the proposed turnaround approach, and the practical barriers and opportunities to implementation.

Although initial analysis focused on four tumour pathways—bowel, gynaecology, lung and haematology—the insights generated extend beyond these areas, highlighting system-wide themes that impact performance across all cancer services.

The scope of this report is to identify the critical actions, enablers and delivery mechanisms required to improve performance at pace. It focuses on what can be implemented within current system constraints, drawing on existing good practice and the lived experience of those responsible for delivering care.

## 3. Current Performance Position

Cancer services in Northern Ireland operate within a regionally coordinated network of five Health and Social Care Trusts. While elements of care are delivered locally, key services such as radiotherapy and complex surgery are centralised in Belfast, meaning that most cancer pathways span multiple organisations and depend on effective system-wide coordination.

Despite this structured model, performance against cancer waiting time standards has deteriorated over a sustained period and now sits well below expected levels.

Northern Ireland currently reports against three core standards which differs from the rest of the UK: treatment within 62 days of red flag referral, treatment within 31 days of decision to treat, and a 14-day standard for urgent breast referrals. Performance against these standards, particularly the 62-day measure, is significantly below both constitutional targets and comparable performance in other UK nations.

In 2025, only around 30% of patients began treatment within 62 days of referral. A substantial number of patients are waiting considerably longer, in some cases exceeding 200 days. These delays are not isolated or short-term pressures but reflect a system that has been unable to recover performance over more than a decade. From a patient perspective, this often means extended periods of uncertainty between referral, diagnosis and treatment, with repeated appointments, delays in communication, and increased anxiety for both patients and their families.

Performance also varies by tumour type and by Trust, indicating inconsistency in how pathways are designed, managed and delivered. This variation means that patient experience and outcomes are not equitable across the system.

Importantly, published performance may understate the true scale of delay. Patients diagnosed outside red flag GP referral routes are not captured within headline metrics, limiting visibility of total pathway performance and reducing the system's ability to respond effectively.

The impact of these delays is significant. Longer waiting times are associated with poorer clinical outcomes, increased complexity of treatment, and a deterioration in patient experience. The current position therefore represents not only a performance issue, but a direct challenge to the quality and timeliness of cancer care.

# 4. System Diagnosis: Why Performance is Not Improving

Cancer performance in Northern Ireland is not constrained by a single issue, but by a set of interdependent challenges that combine to slow pathways, limit productivity and prevent consistent delivery at scale. This has a direct and cumulative impact on patients, who experience delays, uncertainty and variation in care depending on where they are treated.

Across all areas reviewed, we found evidence of capable teams, committed staff and examples of good practice already improving performance locally. However, these are not yet being applied consistently across the system.

The core challenge is not the absence of solutions, but the absence of coordinated execution with clear delivery grip.

## 4.1 Aligning Leadership and Governance with Delivery

Delivering sustained improvement in cancer performance requires clear system-level ownership, coordinated delivery, and the ability to implement change consistently across organisational boundaries. Whilst individual organisations should be accountable for the management and outcomes of their own patients, there is a need for stronger performance management and agenda setting from the system. Senior leadership in all organisations face a complex task in balancing competing operational, financial and quality priorities. The scale of this challenge should not be underestimated.

The *No Time to Wait* Report presented a framework, first shown to MLAs in 2025, which focused on 'Leadership for recovery' that would breakdown organisational boundaries to diagnose and challenge poor performance. An example of this is reflected in the recent decision to merge regional responsibility for cancer care under a new joint directorate in SPPG, which now includes elective care regional responsibilities. The 'Acute Planning and Performance' directorate is now regionally responsible for delivering more effective joint working across both elective pathways and 62-day cancer pathways. We have observed many examples of proactive leadership at an organisational and regional level with existing governance that is already focused on progressing initiatives to improve more timely care for cancer patients. However, we believe this existing governance should be more focused on a clearer set of incremental delivery priorities that plot a path to recovering cancer performance.

Furthermore, we are aware of the current Trust board development programme and are very supportive of this as a method of achieving greater accountability and ownership whilst enabling sustained service improvement. We also acknowledge the recent appointment of a new permanent DoH SPPG Cancer Programme Director, which will also support greater accountability and ownership across the system.

Whilst the Northern Ireland Cancer Strategy outlines a vision for recovery of performance, a more detailed, delivery focussed plan has not, yet, followed. A detailed implementation plan is required, backed up by strong governance and leadership focus. We would expect this plan to set clear recovery trajectories for 62-day backlogs, incremental improvements to performance against the targets and key KPIs at tumour site level that drive improvement.

At present, responsibility for delivery is distributed across organisations, with variation in how priorities are interpreted and implemented locally.

Where direction has been clear and coordinated, progress has been made consistently across Trusts. For example, regionally led implementation of an upper GI straight to test pathway and regional breast assessment service, where the direction was given by NICaN for its implementation. In other areas, similar opportunities have progressed at different speeds, reflecting the complexity of operating across organisational boundaries. This has led to a system where good practice exists and is delivering impact in part but is not yet consistently adopted or scaled across Northern Ireland.

Existing governance structures provide a foundation for improvement, particularly through regional forums such as quarterly Trust level performance meetings, the Cancer Strategic Advisory Forum and NiCAN Clinical Reference Groups.

There is an opportunity to build on and strengthen these structures to set clearer delivery priorities, align approaches across organisations, and support more consistent implementation. Through an integrated performance management approach across all levels of the system, clear expectations need to be set, progress against those expectations tracked, with consequences for non-delivery in place.

Strengthening system and Trust-level ownership and accountability for cancer pathway performance will be critical. This will enable a more coordinated approach to delivery, ensuring that agreed priorities are translated into action and that progress is monitored consistently across the system.

By moving from a shared strategic intent to a more aligned and delivery-focused model, Northern Ireland is well positioned to accelerate improvement and realise the full benefit of the capability that already exists across its cancer services.

In particular, the current Cancer Waiting Time Guidance was consistently highlighted as an area of concern by operational staff. The guidance has not been updated since its inception in 2008, since which a major system wide organisational change has occurred with the implementation of Encompass. Updating the guidance documentation (including the technical guidance) should provide clear instruction as to what data needs to be entered, collected and reported at a tumour site level, ensuring consistent definitions and coding are applied.

The operating procedures for doing so should also be standardised to ensure consistency and clarity across all organisations. For example, the process of Inter Trust Transfers (ITT) of patients is not currently clear within Encompass, which in turn results in unwarranted variation in patient pathways between organisations. Clear guidance is required on the management of such patients, including details on breach allocation, minimum data set requirements and transfer protocols.

Additionally, and closely aligned to **Section 4.6**, current national standards need review and then backed up with realistic recovery trajectories to achieve performance and reduce the backlog.

The gap between current performance and compliance is wide. A continued focus on target compliance without phased improvement milestones, supported by clear actions as to how those milestones will be achieved, are limiting engagement as staff simply see the targets as “unachievable”.

Getting this in place will require more improvement and project management resource. Additionally, we would highly recommend improving operational leadership capability through a development programme specifically targeted at improving cancer performance and waiting times overall.

Setting more achievable, phased performance improvement milestones would foster a more positive approach within operational and clinical teams, as actual progress could be monitored and small wins banked.

### Recommendations

- Setting more achievable, phased performance improvement milestones and trajectories to enable a more positive approach within operational and clinical teams.

- Prioritising the update to the current Cancer Waiting Time Guidance so that roles and responsibility expectations are clear across the system which will facilitate a more coordinated approach to delivering tangible improvements.
- Continuing the current system-wide Trust Board development programme to strengthen leadership capability and enabling sustained service improvement.
- Develop and launch an operational manager development programme to strengthen the operational leadership capability on the shop floor to further enable sustained service improvement.
- A detailed implementation plan is required, backed up by strong governance and leadership focus. We would expect this plan to set clear recovery trajectories for 62-day backlogs, incremental improvements to performance against the targets and key KPIs at tumour site level that drive improvement.

### 4.2 Demand and Referral Management

Demand for cancer services has increased significantly in recent years, particularly through urgent 'red flag' referrals from primary care. This reflects a system under pressure, but also a strong commitment from General Practitioners to ensure patients are not exposed to avoidable delay. In many cases, referral behaviours represent a rational response to wider system constraints, with clinicians appropriately prioritising patient safety in the face of uncertainty. More data and insights are required to better understand these trends, however, they do align with long term increases in urgent referrals and cancer incidence seen across several nations.

Updating referral guidelines with the latest evidence, and ensuring GPs use them appropriately, are important areas for development. Northern Ireland uses NICaN red flag criteria, as opposed to the more recently updated NICE Guideline NG12 in England and Wales, or the new Scottish suspected cancer referral guidelines. Clinical judgement should be used alongside guidance when making referral decisions, making it challenging to assess the extent to which primary care are using guidelines. However, there are some useful metrics which could be monitored, such as the proportion of Lower GI red flag referrals accompanied by a FIT test.

The relationship between primary and secondary care is a critical enabler in this area. Where there is open dialogue and shared clinical understanding, there is greater alignment on referral thresholds and more effective management of demand. We observed significant efforts to strengthen this alignment in one organisation but found significant variability across Trusts. We acknowledge the recent

appointment of a new Primary Care Medical Director as part of the NICaN programme team, who will be instrumental in facilitating this open dialogue and shared clinical understanding. Without greater alignment, there is a risk that increasing demand will continue to outpace system capacity, regardless of improvements made elsewhere in the pathway.

Addressing this challenge does not require a restriction of access, but a more clinically aligned and system-aware approach to referrals. By strengthening collaboration, refining referral criteria, and improving access to diagnostic tools at the front end of the pathway, there is a clear opportunity to improve flow, reduce unnecessary variation, and support more timely care for patients.

### Recommendations

- Local systems should encourage and facilitate regular engagement events between primary care and secondary care clinicians to share their experience of the referral process to gain consensus on opportunities to improve the pathway for the benefit of patients. Active participation from secondary care providers would enhance existing regional efforts.
- Secondary care providers should offer the opportunity to primary care clinicians to shadow secondary care cancer clinics in-person to increase the shared understanding of the patient's cancer pathway across organisational boundaries. The reciprocal opportunity should also be made available to secondary care clinicians in primary care.
- Leveraging this improving dialogue between secondary care and primary care clinicians locally should inform a clinical and evidence-based review of existing NICaN red flag criteria to establish a renewed consensus and updated guidance primary care management of symptoms, including testing within primary care, red flag referral criteria and safety-netting.

## 4.3 Service Capacity and Workforce

The growth in demand for cancer services has placed sustained pressure on services and workforce capacity across multiple tumour pathways.

Interviewees consistently identified diagnostic stages as the most significant sources of delay, with a number of stakeholders pointing to sustained under investment in diagnostic and imaging capacity as a root cause of these delays.

Confirming a patient diagnosis and then getting a clinical decision to treat, rather than scheduling the treatment itself, were both recognised as the most significant drivers for cancer patient pathway delays. This is critical to patient experience. These delays are often experienced as prolonged periods of anxiety without a confirmed diagnosis or clear treatment plan.

Pathology, endoscopy and imaging turnaround times (including reporting) were frequently cited as major constraints. We would strongly recommend a detailed demand and capacity assessment is carried out in these areas, if they have not been done already recently.

We were pleased to see the improvements being made around imaging, particularly with the introduction of Regional Diagnostic Centres which have demonstrably improved waiting times for key imaging tests. Whilst certain modality challenges (e.g. MRI) remain, the addition of 30 new radiology students graduating in 2027 will represent a significant increase in the workforce and resilience for the future.

This is aligned with planned expansion of advanced practice and specialist training for radiological technicians for example with staff being able to undertake ultrasound guided neck biopsy, increases in radiographer lead reporting rates within breast cancer pathways and other interventional radiological procedures. The team described a situation where there had been a change to the historic underinvestment within imaging services in recent times, which has led to a marked improvement in the ability to strategically plan the workforce and support future service expansion.

Whilst these positive steps in radiology are welcomed, they are not widespread.

The provision of a consistent, skilled and motivated workforce is the central pillar of any healthcare system. Ensuring a sustainable workforce remains a well-recognised challenge within Northern Ireland.

It is however important to note that capacity constraints alone do not fully explain the variation in performance observed across the system. More money and staff are not what we are recommending generally.

In several areas, services facing similar levels of demand and workforce availability are achieving different outcomes. This suggests that how capacity is organised, deployed and supported is as important as the overall level of resource.

Current models of care remain heavily reliant on consultant-**delivered** activity, with limited adoption of alternative approaches that could improve pathway flow without compromising safety or quality. Opportunities to move towards more flexible, consultant-**led** models—supported by advanced practitioners, specialist nurses and redesigned roles—are well recognised within the system but not yet consistently implemented.

A good case study highlighted at several Trusts was the adoption of the NHS Forth Valley breast cancer symptomatic assessment pathway to prevent delays in patient diagnosis.

The original case study was a Cancer Research UK funded initiative in Scotland, delivered through the Test Evidence Transition Programme, and placed breast Advanced Nurse Practitioners at the heart of delivering the pathway rather than breast Consultants. In the Scotland case study, the pathway allows people who discover a breast lump to refer themselves directly to a nurse-led one-stop breast assessment clinic, removing the need for an initial GP appointment.

An evaluation by the University of Stirling showed that this streamlined approach prevented delays in diagnosis while maintaining clinical outcomes in line with previous standards. Importantly, patient feedback was strongly positive, particularly regarding faster access, improved clarity of the process, and overall convenience compared with the traditional GP-led referral route.

On the strength of these findings, NHS Forth Valley in Scotland has implemented the nurse-led pathway across all GP practices in the health board area, demonstrating its potential as a sustainable model for improving cancer care capacity and timeliness.

In Northern Ireland, nurse-led breast cancer symptomatic assessment clinics have been adopted to balance and build capacity and resilience into the system with primary care direct access a part of future pathway development plans. This model of care in Northern Ireland has been advanced further with a regionally coordinated breast cancer symptomatic waiting list, which aims to balance available capacity for patients waiting for a first appointment across the system.

In addition, workforce planning is often constrained by short-term funding arrangements and limited flexibility in how roles are configured or replaced. This can restrict the ability to trial new approaches, rebalance resource across pathways, or respond dynamically to areas of greatest pressure.

Encouragingly, examples were identified where services have improved performance through the reallocation of existing staff, the introduction of extended roles, and more coordinated workforce planning. These demonstrate that progress is possible without solely relying on additional resource.

We were particularly impressed with the SPPG-led Regional Pressure Group approach taken to tackle immediate workforce pressures within specific tumour sites. This collaborative approach, which brings together a wide range of stakeholders from different organisations and perspectives, facilitates a whole system resolution to immediate workforce pressures informed by qualitative and quantitative analysis of; referral demand growth, demand and capacity misalignment, unwarranted patient pathway variation, and existing workforce models. This tried and tested approach resulted in the sharing of resources across organisations and focused investment decisions from commissioners to mitigate immediate workforce challenges.

This approach offers a potential model for replication with other tumour sites, with haematology identified as a tumour site with particular and urgent need alongside Head & Neck. Maintaining a coordinated regional approach would enable consistent oversight of workforce risk and support services that are struggling to recover.

The opportunity is therefore twofold: to continue addressing underlying capacity constraints where they exist, while also improving how existing workforce and capacity is utilised. This includes reducing unwarranted variation, accelerating the adoption of alternative workforce models, and supporting more coordinated, system-wide approaches to workforce planning.

By focusing on both capacity and productivity, there is a clear opportunity to improve pathway flow and reduce delays without necessarily relying entirely on additional funding, although undoubtedly in some areas funding may be required.

### Recommendations

- Undertake detailed demand and capacity reviews of pathology, endoscopy and imaging services to reduce variation in turnaround times and improve flow from referral to diagnosis.
- Prioritise targeted workforce reviews in high-risk services (haematology), using existing whole system collaborative models to rebalance resource and improve resilience.
- Expand the use of advanced practitioners, specialist nurses and alternative workforce models to support a shift from consultant-delivered to consultant-led care.
- Design and implementation of a rolling programme of detailed workforce reviews across each tumour site, using the Rapid Pressure Group model as a blueprint.

## 4.4 Restoring Operational Grip & Visibility

Effective cancer pathway management depends on timely, accurate and accessible operational data. In a system where patients move across multiple organisations, specialties and diagnostic stages, maintaining clear visibility of pathway progress is essential to ensuring timely care.

At present, this visibility is not consistently available.

Following the implementation of Encompass, there has been a recognised reduction in the availability of granular, real-time operational data to support pathway management. While this reflects the scale and complexity of transitioning to a new system, it has created practical challenges for teams responsible for managing patient flow. Detailed, patient-level data allows operational teams to identify exactly where pathways are stalling, whether in imaging capacity, pathology turnaround, outpatient scheduling, or treatment readiness.

Furthermore, the implementation of Encompass has also created significant issues with administrative tracking of patients through pathways. These challenges were described as centering on two key areas:

- An increased administrative burden of associated data entry requirements in the new system
- A lack of a standardised guidance detailing the required recording of specific data points.

This results in variation in practice across sites leading to difficulties in assessing resource requirements to deliver timely patient pathway tracking.

Trusts have indicated that they are currently unable to track patients in anything approaching real time, with examples of pathway tracking up to 8 weeks behind. This will inevitably lead to unacceptable delays, as patients requiring action are unlikely to be progressed in a timely manner which can lead to patients waiting for extended periods without clear communication on next steps, increasing anxiety and the risk of deterioration while awaiting care. Patients should be being tracked in real-time as a non-negotiable minimum.

Granularity also enables a more accurate understanding of variation between tumour sites, providers, and patient cohorts, which is often significant in cancer care due to differing diagnostic complexities and treatment pathways. Without this level of detail, organisations risk focusing on headline

compliance metrics while missing systemic bottlenecks such as delays between biopsy and histopathology reporting or gaps between MDT decision and treatment start that ultimately drive-up waiting times.

Encouragingly, we did note positive examples of local development around this topic, with reports and dashboards that produce operational information at individual pathway milestone level. These demonstrate what is achievable within the current system. The milestones have been set locally, and a forum where such developments can be presented and shared would no doubt be of benefit.

At a regional level, there is limited visibility of drivers of performance. Prior to the Encompass programme, a detailed cancer performance dashboard was available with a sufficient level of granularity to inform service improvement priorities. We understand a regional dashboard has been reestablished for 14, 31 and 62 day reporting, but is missing the full suite of historic functionality that existed prior to the Encompass programme.

The opportunity is to build on these foundations by restoring system-wide visibility of patient pathways, standardising reporting and operational processes, and ensuring that teams have the tools and information required to manage pathways proactively.

Given the time Encompass has been in place and its relative cost, it is not acceptable that required data processes and outputs are not in place to enable real-time patient tracking or milestone monitoring at individual patient level. The lack of a regional cancer dashboard based on these local datapoints is a major obstacle to improvement and will be further exacerbated by our recommendations for enhanced governance and performance monitoring if not remediated urgently.

The data challenges are particularly frustrating given the opportunity Encompass represents. Current performance levels, combined with financial constraints, mean that recovery cannot be achieved through capacity expansion alone. A more strategic and holistic approach is required. Data has a key role to play in enabling this.

MDT processes similarly require adequate resourcing and proceduralising. Inconsistent processes for ensuring patients are added to MDT lists at the appropriate time can add weeks to pathways due to the relative infrequency of discussion. Equally, patients being added to lists who are not yet ready waste resource that could be used for other patients and again lead to an increase in waiting times.

Alongside data challenges, some core operational processes that underpin pathway flow—such as patient tracking, MDT coordination and pathway progression—are not yet consistently standardised across the system. Where these processes are well established, services demonstrate stronger control over patient pathways and improved flow.

We believe there would be benefit in facilitating a system-wide operational fundamentals training programme to support the ongoing knowledge and development of service managers responsible for timely cancer pathway delivery.

This is important because these operational fundamentals are the foundations on which timely cancer care depends and are critical to the effective working relationships between operational staff and clinical staff to ensure the needs of each service are being met.

With the recognition across several interviewees that there has been significant turnover of experience operational staff in services that have cancer pathways within their scope, establishing an operational fundamentals development programme offers a great opportunity to invest in a staff group that is often overlooked.

Strengthening operational grip in this way will be critical to improving performance, enabling earlier intervention, reducing delays and supporting more consistent delivery of care across the system.

### Data as a strategic asset

There is significant opportunity to use integrated data to support earlier detection through risk stratification, improved diagnostic accuracy and the enablement of more personalised treatment through genomics and longitudinal patient records. For patients, this represents the potential for earlier diagnosis, more targeted treatment, and improved long-term outcomes. In addition, better use of real-world outcomes data can support continuous optimisation of pathways and more effective service planning.

Data also provides a critical foundation for addressing inequalities in cancer care. Variation in access, experience and outcomes can be more clearly identified and understood through linked datasets, enabling more targeted and effective interventions.

Beyond its clinical value, cancer data should also be considered as a significant strategic asset to Northern Ireland. In line with the wider 'Health and Wealth' agenda, there is an opportunity to leverage high-quality, real-world data to support research, innovation and economic growth.

Northern Ireland is well positioned in this regard. Its population size, established culture of collaboration, and ongoing investment in digital health infrastructure create favourable conditions for the development of robust real-world evidence. This has potential applications in understanding treatment effectiveness, supporting regulatory processes, and attracting research and commercial partnerships.

Improved data infrastructure also has the potential to increase participation in clinical trials, delivering benefits for patients through earlier access to innovative treatments, while also reducing system costs and contributing to wider economic activity. However, the lack of legislation on secondary use of data is a significant barrier here.

## Recommendations

- Operational staff should be given a standardised operational reporting suite for cancer services within the Encompass system building on the good practice already developed across a number of Trusts in the absence of standard Encompass functionality.
- Create clear system-level ownership for cancer data, with responsibility for aligning existing data sources (Encompass, primary care, diagnostics, registries) into a prioritised, integrated dataset that supports frontline decision-making. Initial focus should be on high-impact operational use cases, including real-time pathway tracking, identification of delays, and management of variation. This should be supported by standardised reporting, improved data access for clinical and operational teams, and clear governance arrangements to ensure consistency, trust and scalability.
- Sharing operational fundamentals good practice by establishing an operational fundamentals training programme to support and develop existing frontline operational staff.
- Position cancer data as a strategic and economic asset through the development of linked, longitudinal cancer datasets that support advanced use cases, including early detection through risk stratification, personalised treatment, inequality analysis, and real-world outcomes tracking. This capability should be aligned with wider research, clinical trials and life sciences strategies, enabling Northern Ireland to leverage its data assets to improve patient outcomes while supporting innovation, partnership and economic growth.

### 4.5 Reducing Variation and Pathway Inconsistency

Variation in pathway design and delivery is evident across tumour sites and organisations. While some degree of variation is expected in a complex clinical system, the level observed suggests that patients are not consistently experiencing the same pathway or standard of care across Northern Ireland. This means that patients with similar clinical needs may experience very different waiting times and pathways depending on where they enter the system, which is not something that should be acceptable.

Importantly, this variation exists despite many examples of effective practice already being in place. In short, the system isn't short on ideas, the question is how to implement them consistently.

Across the system, several initiatives are demonstrating clear benefits, including straight-to-test pathways, rapid diagnostic clinics, and streamlined pre-operative processes. These approaches are improving flow, reducing delays and making better use of available capacity.

However, these models are not yet consistently implemented across all relevant services.

In several cases, pathways that have been successfully adopted in one tumour site or organisation have not been replicated elsewhere, despite clear similarities in clinical requirements. This has resulted in different approaches to managing comparable patient cohorts, contributing to variation in waiting times and overall performance. A good example of where consistent pathways have been embedded consistently across organisations is the regionally led implementation of an Upper GI straight to test pathway.

There is also limited evidence of consistently defined tumour-specific pathways with agreed standards and associated performance metrics. Without this, it is difficult to ensure alignment in how care is delivered or to monitor adherence to best practice. There was no clear evidence of associated performance metrics to support or monitor adherence.

Best Practice Timed Cancer Pathways (BPTPs) have the potential to improve cancer care by standardising processes, reducing delays, enabling proactive performance management, and supporting more effective demand and capacity planning, ultimately leading to a more timely and consistent patient experience. Clinical Reference Group leads should be encouraged to review existing documentation and evidence to assess suitability of BPTPs within Northern Ireland.

Encouragingly, there are established forums, such as NICaN Clinical Reference Groups, that provide a strong foundation for greater alignment. There is a clear opportunity to use these structures to review existing models of care, identify what is working well, and agree standardised pathways for each tumour site.

A consistent theme discussed by interviewees was the need to return to the UK NATCAN Cancer Audit and Peer review. This process is critical to identifying variation in clinical practice and enabling benchmarking of services in Northern Ireland to the rest of the UK, whilst driving quality improvement. We would wholeheartedly support this initiative.

By focusing on reducing unwarranted variation and scaling proven approaches, the system can improve consistency of care, reduce delays and make more effective use of existing capacity.

### Recommendations

- Adequately support Clinical Reference Groups to regularly meet and lead a review of known models of care and best practice cancer pathways within Northern Ireland to assess the suitability of creating standardised cancer pathways by Tumour site.
- A return to the UK NATCAN Cancer Audit and Peer review process across each Tumour site to deliver a stocktake which identifies and explains variation in care, benchmarks performance against current standards and sets the foundations for further quality improvement.

## 4.6 Supporting Culture & Readiness for Change

Sustained operational pressure over several years has had a noticeable impact on staff across the system. Many teams have been managing high demand and performance challenges over a prolonged period, often alongside repeated attempts at service improvement.

This has contributed to a degree of fatigue, particularly where previous initiatives have not been fully implemented, sustained, or have not delivered the anticipated impact. In some cases, work has progressed to an advanced stage but has not translated into operational change, which can reduce confidence in future improvement efforts.

However, it is important to recognise that this does not reflect a lack of commitment or willingness to improve.

Across all organisations, there remains a strong sense of purpose and a clear desire among clinical and operational teams to deliver better outcomes for patients. The challenge is therefore less about willingness, and more about creating the conditions that enable change to be delivered and sustained.

At present, there are limited mechanisms to consistently support, incentivise or recognise the adoption of new ways of working. In an already stretched system, this can make it difficult for teams to prioritise improvement activity alongside day-to-day operational pressures.

There is an opportunity to rebuild momentum by focusing on achievable, phased improvements, supported by clear leadership, appropriate resourcing, and the ability to demonstrate early and visible progress. Strengthening this approach would help to restore confidence that change is both possible and worthwhile.

By aligning ambition with realistic delivery plans and supporting teams to see the impact of their efforts, the system can build a more positive and sustainable foundation for ongoing improvement.

## 5. Implementation: Turning Insight into Delivery

The findings of this review are clear. Northern Ireland does not lack the building blocks required to make progress on improving cancer performance. There are committed staff and clear examples of effective practice already delivering impact in parts of the system. The challenge now is to translate these strengths into consistent, system-wide delivery.

This requires a focused and coordinated programme of action, built around a small number of priorities that directly address the key drivers of current performance. The emphasis should be on improving governance and data, strengthening operational grip, reducing variation, and enabling delivery at scale.

A dual approach is required: immediate actions to stabilise performance and reduce long waits, alongside medium-term changes to redesign pathways and improve system resilience.

This programme of work will require investment in leadership, expertise and project management capacity and capability. Ensuring the right level of expertise to oversee the programme will be critical to its success.

The programme should have a realistic set of expectations underpinned with clear set of milestones backed up by actions that are clearly accountable to individuals and organisations. It should be agreed regionally and endorsed by each Trust Board with a nominated SRO for each organisation.

Relentless focus on driving down backlogs and improving performance will require data to be effective. Rectifying reporting and data processes in Encompass needs to be urgently addressed.

To be clear, whilst investment may be required in certain areas, a significant proportion of the programme should be devoted to remodelling existing processes, pathways and staff allocation.

***Ultimately, success will be measured not only in improved performance metrics, but in delivering faster, more consistent and more transparent care for patients.***

### 5.1 Short-Term Priorities (0-12 months): Stabilise & Build Momentum

The immediate focus should be on restoring control of cancer pathways, improving visibility of performance, and accelerating the adoption of approaches that are already proven to work.

| # | Priority | Description |
|---|---|---|
| 1. | **Strengthen system leadership and delivery coordination** | Establish clear system-level ownership of cancer pathway performance, using existing governance structures to define priorities, align organisations, and ensure consistent implementation through the update of Cancer Waiting Time and Technical Guidelines, improvement in data tracking and underpinned with a detailed implementation plan focused on reducing backlogs initially but progressing to incremental improvements across all areas of the cancer pathway.<br><br>Reintroduce regional quarterly assurance meetings to focus on service stocktakes and pathway improvement initiatives rather than retrospective reviews. |
| 2. | **Reset performance expectations and trajectories** | Introduce realistic, phased improvement trajectories at tumour site level, enabling teams to focus on achievable progress while building towards full compliance with national standards. |
| 3. | **Restore operational grip and visibility** | Implement a standardised, automated reporting suite within Encompass, providing real-time insight into patient pathways, waiting times and bottlenecks. Prioritise functionality that supports frontline operational management. |
| 4. | **Target diagnostic bottlenecks** | Undertake detailed demand and capacity reviews of pathology, endoscopy and imaging services to reduce variation in turnaround times and improve flow from referral to diagnosis. |
| 5. | **Improve demand management at the front door** | Ensure compliance with referral criteria and processes, supported by stronger collaboration between primary and secondary care and expanded use of direct access diagnostics. |
| 6. | **Stabilise workforce pressures in critical areas** | Prioritise targeted workforce reviews in high-risk services (haematology), using existing Rapid Access Group models to rebalance resource and improve resilience. |

### 5.2 Medium-Term Priorities (13-36 months): Embed & Sustain Improvement

Alongside immediate actions, there is a need to address underlying structural challenges to support sustained improvement in performance.

| # | Priority | Description |
|---|---|---|
| 1. | **Support and prioritise audit and peer review** | Support and prioritise cancer audit and peer review processes to identify variation, benchmark performance and support continuous improvement. |
| 2. | **Develop a sustainable workforce model** | Expand the use of advanced practitioners, specialist nurses and alternative workforce models to support a shift from consultant-delivered to consultant-led care. |
| 3. | **Workforce Reviews** | Design and implementation of a rolling programme of detailed workforce reviews across each tumour site, using the regional Rapid Access Group model as a blueprint. |
| 4. | **Strengthen diagnostic capacity and networks** | Deliver coordinated investment and planning across pathology and radiology services to improve resilience and meet future demand. |
| 5. | **Standardise pathways and models of care** | Use Clinical Reference Groups to define and implement consistent, tumour-specific pathways across all organisations, reducing variation and improving equity of access. |
| 6. | **Enhance system-wide planning and commissioning** | Review current service configuration and commissioning approaches to ensure they support efficient, coordinated delivery of cancer care across the region. |
| 7. | **Introduce phased diagnostic and treatment standards** | Develop realistic trajectories towards enhanced standards, such as Faster Diagnosis, aligned with system capacity and delivery capability. |
| 8. | **Continue leadership and capability development** | Build on and expand existing leadership programmes to strengthen system-wide capability for service improvement, operational delivery and change management, particularly focussing on cancer operational management. |
| 9. | **Position cancer data as a strategic and economic asset** | Develop longitudinal cancer datasets that are aligned and integrated into academia, clinical trials and life sciences strategies to improve patient outcomes whilst supporting innovation and economic growth. |

# 6. Appendices

## Appendix 1: References

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## Appendix 2: Interviewees

This report was informed by detailed interviews with a wide range of stakeholders from across the health system in Northern Ireland. We had the opportunity to speak with individuals from:

- Northern Trust
- Southern Trust
- South Eastern Trust
- Belfast Trust
- Western Trust
- Northern Ireland Cancer Network
- Department of Health
- Queens University Belfast

We would like to thank each individual interviewed for their open and honest observations as we explored current performance challenges, the feasibility of the proposed turnaround approach, and the practical barriers and opportunities to implementation.