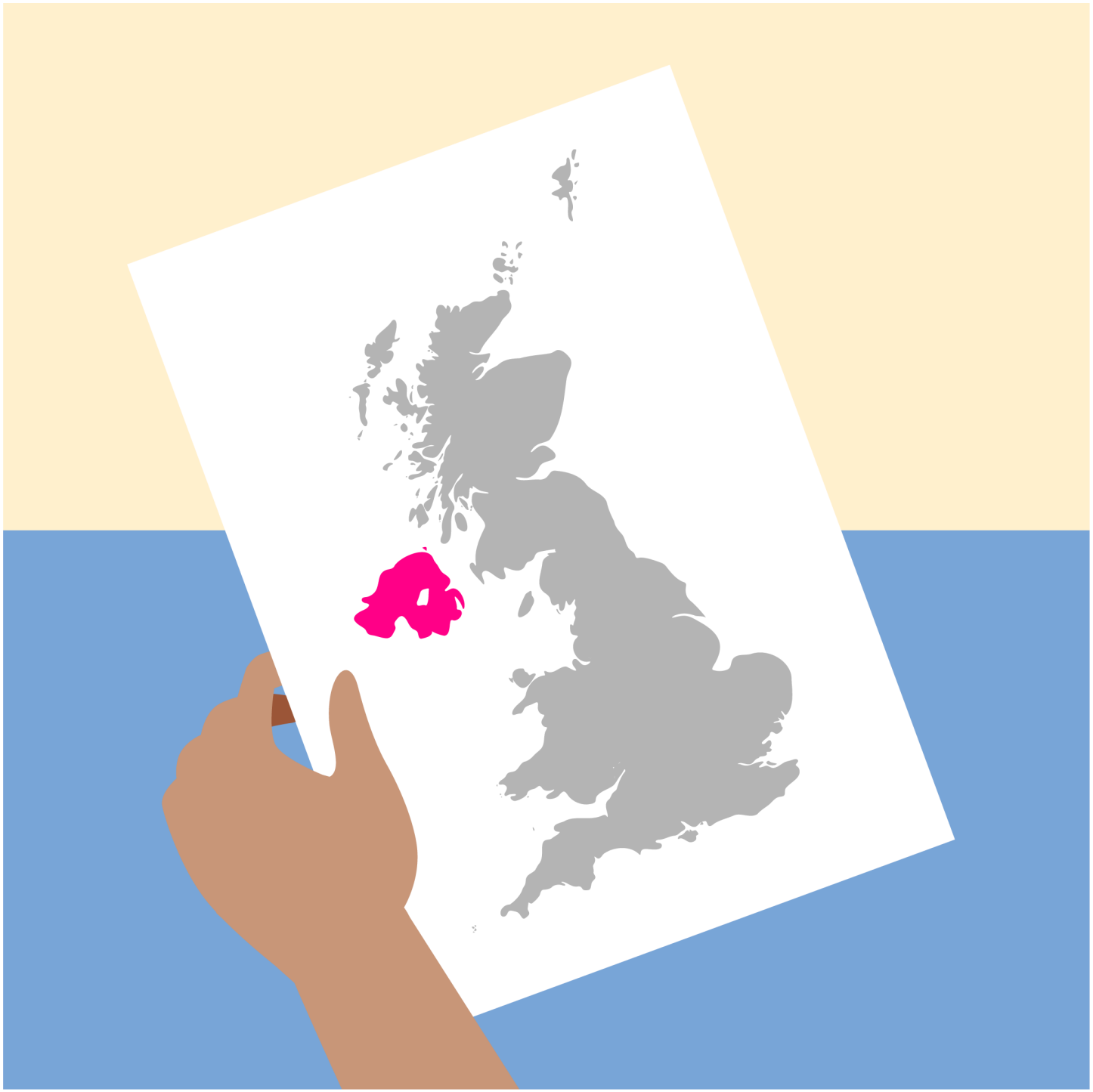

Cancer in the UK

Northern Ireland overview 2026

CANCER RESEARCH UK

Together we are beating cancer

Contents

About this report

Reference

This report should referred to as follows:

Cancer Research UK. Cancer in the UK: Northern Ireland Overview 2026. Published April 2026. **cruk.org/cancerintheuk2026-ni**

Authors

Produced by the Cancer Intelligence team in the Health Policy and Evidence department, Cancer Research UK, April 2026

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About Cancer Research UK

We're the world's leading cancer charity, dedicated to saving and improving lives with our research, influence and information. Over the past 50 years, our pioneering work has helped double cancer survival in the UK. And today it's continuing to save lives, here and around the world.

Our vision is a world where everybody lives longer, better lives, free from the fear of cancer. And step by step, day by day, our researchers are making this vision a reality thanks to our dedicated community of supporters, partners, donors, fundraisers, volunteers and staff.

Together we are beating cancer.

Introduction

This summary provides an overview of key data across the cancer pathway in Northern Ireland, as part of the Cancer in the UK: Overview 2026 report, which provides the full UK picture. It looks at where progress is being made and what challenges remain in Northern Ireland. Policy recommendations are set out in relevant sections to support action and drive further improvement.

Cancer survival has improved significantly in recent decades thanks to advances in diagnosis, treatment and the dedication of HSC staff, reflected in the positive experiences reported by people affected by cancer. However, cancer remains the defining health issue of our time.

Despite the hard work of staff across Health and Social Care (HSC), too many patients in Northern Ireland experience unacceptable waits for cancer diagnosis and treatment. Northern Ireland's cancer waits are by far the worst in the UK, worsening steadily over the last 16 years [1].

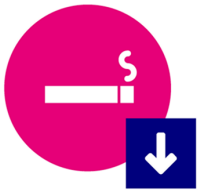
Cancer services in Northern Ireland have faced significant capacity and workforce shortages across diagnostics, surgery and oncology departments for many years. Even before the COVID-19 pandemic, waiting times were unacceptably long. With the additional impact of the pandemic, many years of Northern Ireland not having a functioning government and the lack of adequate funding, we have seen a significant decline in performance against cancer waiting time targets and far too many patients experiencing long waits for cancer diagnosis and treatment.

Urgent action is needed to drive a turnaround in the unacceptable waiting times for diagnosis and treatment.

Alongside this, sustained attention and investment is required to deliver the 10-year Cancer Strategy, including key medium- and long-term policies, such as implementing the Tobacco and Vapes legislation, reducing overweight and obesity through measures to tackle foods high in fat, salt and sugar and the development of a national targeted lung screening programme. Plus, a renewed focus on cancer research is required by funding and implementing the actions in the Cancer Research Framework for Northern Ireland.

Key statistics across the cancer pathway in Northern Ireland

Over the last 10 years...



Proportion of adults who smoke has **decreased**
22% to **12%** [1]

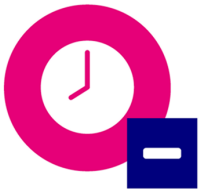
Incidence rates have **increased**
596 to **610** per 100k [5]

Proportion of adults who are living with obesity has **increased**
25% to **30%** [2]

5-year survival has **increased**
51% to **57%** [6]

Proportion participating in bowel screening has **increased**
57% to **67%** [3]

Mortality rates have **decreased**
289 to **261** per 100k [7]



Proportion diagnosed at an early stage has **shown little change**
55% to **54%** [4]*^

Geography and time periods:
1. 2014/15 to 2024/25
2. 2014/15 to 2024/25
3. 2013/14 to 2023/24
4. 2015-19 to 2018-22
5. 2010-12 to 2019, 21, 22
6. 2003-07 to 2013-17
7. 2012-14 to 2022-24

Figures are for all cancers combined.

Changes over time are statistically significant unless otherwise noted.

* Change in direction over time is not statistically significant.

^ Among cancer cases where stage is known. Short-term early diagnosis trend due to how data is aggregated over multiple years in Northern Ireland.

For further details about terminology used here, please see: **Cancer Statistics terminology explained**, Cancer Research UK.

More people than ever are being diagnosed with cancer each year

There are around 10,700 new cases of cancer every year in Northern Ireland – that's around 29 new cases per day [2]. Breast, prostate, lung and bowel cancers account for more than half (54%) of new cancer cases in Northern Ireland.

Cancer incidence rates in Northern Ireland have increased by 14% since the early 1990s [2]. Rates in females have increased by 18%, while rates in males have remained stable. This sex difference is mainly driven by smoking-related cancer types, where incidence rates have been falling for some time in men but not yet in women, because smoking prevalence started falling earlier in men than in women.

Cancer mortality rates have decreased over the past 50 years, but the number of deaths per year has risen

Cancer mortality rates in Northern Ireland are currently at their lowest recorded level, having fallen by 18% since the mid-1970s [3]. However, because of a growing and ageing population, more people in Northern Ireland are dying from cancer than ever before, with around 4,600 deaths every year, resulting in around 66,800 years of life lost due to cancer each year [4].

Cancer is the leading cause of death in Northern Ireland, causing 26% of all deaths – more than circulatory system diseases like heart disease (23%) or mental and behavioural disorders including dementia (8%) [5].

Survival varies by stage at diagnosis

Almost 6 in 10 (57%) people with cancer survive their disease for at least five years in Northern Ireland [6]. But this varies by stage of disease; 87% of people diagnosed at the earliest stage survive their disease for 5 years, compared to 16% at the latest stage. Five-year survival has improved over time – from around 40% for people diagnosed in 1993–1997, to around 57% for those diagnosed in 2013–2017 – but the rate of improvement has slowed over time.

Smoking still causes thousands of cancer cases every year

Smoking causes 1,500 cases of cancer every year in Northern Ireland, accounting for around 14% of all new cases, and is a risk factor for at least 16 types of cancer [7]. It is estimated that 21% of all cancer deaths each year in Northern Ireland are caused by tobacco [8]. Smoking levels are at their lowest recorded point, but more than 1 in 10 (12%) adults in Northern Ireland – more than 190,000 people – still smoke [9]. Northern Ireland is the only nation in the UK that hasn't set a target year by which to be smokefree.

Make sure all measures in the Tobacco and Vapes Bill, including the age of sale policy, are fully implemented in an evidence-based way and effectively enforced.

Continue to adequately fund stop smoking services in Northern Ireland, increasing the accessibility and promotion of services to make sure everyone who needs support to quit gets it.

Obesity prevalence continues to rise

Overweight and obesity is a risk factor for 13 different cancer types [10]. Around 6% of all cancer deaths in Northern Ireland are attributable to overweight and obesity [8].

Around two-thirds (67%) of adults in Northern Ireland have overweight or obesity (BMI 25+) [9]. Obesity (BMI 30+) is at its highest recorded level (30%). A quarter (25%) of children aged 4 to 5 in Northern Ireland have overweight or obesity [11].

Ensure implementation of the 'Healthy Futures' Obesity Strategic Framework to tackle obesity in Northern Ireland. Policies, including restrictions on the advertising and promotion of unhealthy foods, should be introduced to make it easier to maintain a healthier weight.

HPV vaccination coverage is low and has decreased

In Northern Ireland, 78% of girls and 72% of boys are fully vaccinated against human papillomavirus (HPV) by the end of year 10 (the academic year in which they turn 14) [12]. Coverage with a single dose is lower now than when the HPV vaccine programme started [13].

We urge the Public Health Agency to work to increase HPV vaccination coverage. Focus is needed on areas and groups with lower uptake to strengthen programme delivery, increase coverage rates and reduce inequalities. To facilitate this, the Public Health Agency should ensure that data on coverage by deprivation quintile and wherever possible, ethnicity, is collected and reported on.

Screening uptake varies between programmes

There are currently three national screening programmes in Northern Ireland, for bowel, breast and cervical cancer. In Northern Ireland, 6% of all cancer cases are detected through these screening programmes [14].

In Northern Ireland, 67% of people take up their bowel screening invitation. Bowel screening is not as widely offered or as sensitive in Northern Ireland compared to other UK nations. Bowel screening starts at age 60, which is higher than the recommended age of 50 [15]. It also uses a higher threshold for the amount of blood detected that would result in a follow-up test (120μg), compared to 80μg used in Great Britain. For breast screening, 74% of people take up their invitation [16]. Coverage of cervical screening is around 67%, but Northern Ireland only fully introduced HPV as the primary test in cervical screening in December 2023 [17].

In 2024, intention to 'definitely' or 'probably' attend the next breast or cervical screening appointments were self-reported at 79% and 67%, respectively [18]. Intention to complete the bowel cancer screening test kit the next time it is sent was 88%.

In 2022, the UK National Screening Committee recommended UK-wide targeted lung screening for people aged 55 to 74 with a history of smoking, as they are at an increased risk of lung cancer. Northern Ireland has not yet implemented a targeted lung screening programme. If fully implemented, Cancer Research UK estimates that around 210 extra patients each year across Northern Ireland could be diagnosed at an early stage rather than a late stage [19], and that around 60 lung cancer deaths could be avoided each year through the programme [20].

The NI Executive and HSC should work to make progress on rolling out evidence-based cancer screening programmes recommended by the UK National Screening Committee.

Where innovations in cancer screening are supported with robust evidence and evaluation, consideration should be given to resourcing requirements across the pathway, data requirements and IT infrastructure to support timely implementation.

It is critical that those invited to take part in cancer screening can make an informed decision about participating. Efforts across the system should focus on addressing barriers to participation, improving screening uptake through tailored interventions that help reduce the significant inequalities that exist across all screening programmes.

People recognise many potential signs and symptoms of cancer, but too many face barriers to seeking help

Cancer Research UK data shows that in Northern Ireland, people recognise on average 14 out of 18 cancer symptoms [18]. The most commonly recognised symptoms are an unexplained lump/swelling, coughing up blood and a change in the appearance of a mole.

While 45% of people had experienced a potential cancer symptom in the last twelve months, around a third (34%) of those had not contacted their GP surgery/practice within six months, which is concerning [18]. The biggest barriers to seeing a medical professional included thinking it would be or finding it difficult to get an appointment (including with a particular healthcare professional), not wanting to be seen as someone who makes a fuss and thinking the symptom was unlikely to be anything serious.

A commitment to sustained public campaigns to support timely help seeking is important. This should be matched by targeted communications and engagement that ensure this activity reaches and benefits underserved populations.

They should also support health systems to improve access to primary care and develop more accessible routes into healthcare, assessing how services could support help-seeking behaviours.

Reducing late-stage cancer diagnoses is vital

In Northern Ireland, almost 6 in 10 (55%) cancer cases are diagnosed at an early stage (stages 1 and 2) [6]. There is variation between cancer sites in the proportion diagnosed at early stage. Around 29% of lung cancer cases, 46% of bowel cancer cases, 57% of prostate cancer cases and 84% of breast cancer cases are diagnosed at an early stage.

Around a quarter (24%) of people with cancer in Northern Ireland are diagnosed through emergency referral routes [14]. This is concerning as people diagnosed through an emergency presentation compared to those diagnosed through more managed routes are more likely to be diagnosed at a late stage and have poorer survival, even accounting for stage at diagnosis [21].

Cancer services are struggling to keep up with demand

Endoscopy and radiology are two key types of tests used to detect and diagnose cancer. At the end of December 2025, around 11% of people were waiting more than 52 weeks for a diagnostic test, highlighting the huge pressure the service is facing [22].

The 31-day and 62-day cancer waiting times targets are two key ways to measure performance of cancer services. The 31-day target advises that at least 98% of eligible patients wait no more than 31 days from the decision to treat to beginning treatment. This target hasn't been met since 2013, with only 88% of patients starting treatment within 31 days at the end of September 2025 [23].

The 62-day target advises that at least 95% of eligible patients wait no more than 62 days from an urgent suspected cancer referral to begin treatment. This includes the time for all tests to diagnose cancer. This important target has never been met since introduction in 2008, and performance continues to decline steadily. At the end of September 2025, only 30% of patients started treatment within 62 days [23]. The 62-day target only reports on patients diagnosed through a red flag referral or a GP routine referral subsequently reclassified as urgent by a cancer specialist; only around a third (34%) of patients are diagnosed this way [14]. There is currently no publicly available data on how long patients diagnosed through other routes, including screening, routine referrals or emergency presentations, are waiting for diagnosis and treatment.

Cancer Research UK projects that around 30,700 people in Northern Ireland will start treatment following a red flag referral for suspected cancer over the next five years [24]; if 62-day performance remains as it is now, around 20,000 people won't start their treatment within the 62-day target over the next five years [25].

The Northern Ireland Executive needs to develop a crisis response and stabilisation plan for cancer to eliminate unnecessary risks of harm from delays and focus on reducing the total number of patients still waiting for cancer care.

The Department of Health needs to temporarily move focus in a planned way from the current waiting time metric and publicly prioritise reducing the number of long waiters through a targeted turnaround approach to address the urgent crisis state in cancer services.

Data on treatments is lacking in Northern Ireland

There is no routine data available on the treatments received by cancer patients in Northern Ireland. If we are to understand whether patients are receiving optimal treatment, and take action to address unwarranted variation, underpinned by strategic audit and quality improvement, treatment data must be reported routinely.

National Cancer Audits are a key tool in monitoring the quality of treatment that cancer patients receive. Northern Ireland should seek options to participate in audits and target quality improvement based on findings.

Cancer patients feel generally positive about the care they receive, but people are concerned about health service resources

People receiving cancer care in Northern Ireland in 2018 (the latest available data) scored their overall care experience positively, with a rating of 8.97 out of 10 [26]. Patients felt supported by staff, believed their clinical needs were met and that they had an adequate care plan. Improvements could be made in the primary care support offered throughout their treatment and more detail could have been given about the side effects from treatment.

Concerningly, in 2024 in Northern Ireland, 85% of people don't think the health service has enough staff or equipment to see all the people with cancer that need to be diagnosed, while 81% don't think the health service has enough staff or equipment to treat all the people with cancer that need to be treated [18].

Together we are beating cancer in Northern Ireland

Cancer Research UK welcomed Northern Ireland's 10-year cancer strategy published in 2022, which sets out 60 recommendations to transform services by tackling inequalities, preventing more cancers, diagnosing earlier and improving care.

However, despite the efforts of health and social care staff, cancer services remain under severe pressure due to long-term underfunding, repeated political instability and the impact of COVID-19. The lack of reform and sustainable investment has led to significant performance issues, with no Trust currently meeting the 62-day or 31-day cancer waiting time standards.

Our latest report No time to wait: Cancer Research UK position on the risk to patients from long waits for cancer diagnosis and treatment in Northern Ireland calls on the Northern Ireland Executive to urgently address unacceptable cancer waiting times and reduce the harm facing patients.

We believe a 12-month crisis response and stabilisation plan is needed to cut the backlog of people waiting too long for diagnosis and treatment. Similar emergency programmes elsewhere in the UK show this can be done with focused leadership, robust data-driven planning and coordinated action across all five Trusts.

A relatively small investment in transformation support could enable significant improvements. In the immediate term, priority must be reducing the number of long waiters, even if this temporarily worsens reported 62-day performance. Monitoring should shift to:

1. The total number of patients waiting over 62 days to start treatment
2. Median and 95th percentile waiting times from referral to diagnosis and treatment

Trusts should set and be held accountable for improvement trajectories by cancer site, guided by clinical leaders to focus on the highest-risk pathways.

With stronger leadership, transparent commitments to improvement and targeted turnaround action, the harm caused by delays can be reduced, and future recovery investment used more effectively. Patient safety must remain the overriding priority.

Cancer Research UK will continue to highlight this crisis and support the Northern Ireland Executive in taking the difficult decisions needed.

In the medium to long term, Northern Ireland must continue to invest more in cancer research, strengthen prevention policies – including introducing Tobacco and Vapes and High Fat, Salt and Sugar (HFSS) legislation, plus plan for a targeted lung cancer screening programme to help tackle the biggest cancer killer in Northern Ireland – lung cancer.

The cancer crisis is urgent. The time to act is now.

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3 Data are for Northern Ireland (ICD-10 C00-C97, 1975-77 to 2022-24). Similar data can be found at **Cancer Research UK**

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5 Northern Ireland Statistics and Research Agency. **Registrar General Annual Report 2024 Cause of Death**. 2025.

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19 Calculated by the Cancer Intelligence team at Cancer Research UK (2026). Estimates are looking at people aged 55-74 who were not part of the TLHC pilot in England and the proportion that would be diagnosed early if they were part of the pilot vs if they were diagnosed as part of standard care. Invitation eligibility and invitation uptake rate were assumed at 50%.

Calculated by the Cancer Intelligence team at Cancer Research UK (2025). Assuming 1) 50% of lung cancer deaths in 55–74-year-olds are in people who would have been eligible for targeted lung health checks (based on **Gracie et al 2019, Eur Respir J**), using incidence as proxy for mortality; 2) 50% of those eligible will take part in a targeted lung health check; 3) targeted lung health checks will reduce lung cancer deaths by 24% in males and 33% in females (based on **de Koning et al, N Engl J Med**).

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22 Northern Ireland Department of Health. **Northern Ireland waiting time statistics: diagnostic waiting times December 2025**. 2026.

23 Northern Ireland Department of Health. **Northern Ireland waiting time statistics: cancer waiting times July - September 2025**. 2026.

24 Calculated by the Cancer Intelligence team at Cancer Research UK (2026). Predicted patient volume was modelled by fitting a generalised linear model using 62-day patient volume data from May 2008 to September 2025 (excluding the 3-month period between April 2024 and June 2024 due to incomplete data) and applying the fitted model to the 5-year period from October 2025 to September 2030. Projected patient volume over this period was summed to give an estimate of the number of patients expected to be starting treatment following a red flag referral in Northern Ireland.

25 Calculated by the Cancer Intelligence team at Cancer Research UK (2026). Estimate is calculated by applying the latest 6-month average 62-day performance (31.2% between April to September 2025) to the predicted patient volume from October 2025 to September 2030 and summing to calculate the number of people who would not be treated within 62 days if performance remains at the current level.

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Our ability to understand and tackle cancer is heavily dependent on the quality of data we have. Much of the evidence presented here uses data that has been provided by patients and collected by the health service as part of their care and support. The data is collated, maintained and quality assured by different organisations, including the Northern Ireland Cancer Registry, which is managed by Queen's University Belfast.