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Dear Russell

Thank you to the Committee for its constructive questioning during my appearance before the Committee Inquiry into Gynaecological Cancer. There were a number of areas on which I agreed to follow up in writing to the Committee.

Sarah Murphy MS asked what the Wales equivalent of the target in England for early-stage diagnosis of cancer is (England: 75% of cases diagnosed at stage 1 or 2 by 2028). Public Health Wales publishes cancer incidence figures by stage at diagnosis but there is no target in Wales for the proportion of cancers that are diagnosed at stage 1 or 2. The Quality Statement for Cancer recognises the vital importance of diagnosing cancer at earlier stages, as this will make the biggest difference to cancer survival rates. It includes a commissioning expectation for health boards to plan and deliver services that will detect more cases of cancer at earlier stages. We expect that ongoing developments in diagnostic services, referral practice, and improvement in screening provision will support the detection of earlier stage cancer. I do not feel that a target is required to drive this, as it is already the most significant area of national focus with regard to cancer services. It is also very difficult to judge the long-term change because the proportion of non-staged cancers has fallen significantly over time and impacts the proportions recorded as any particular stage.

Sarah Murphy MS also asked for information about the timeliness of official cancer statistics produced by the Wales Cancer Intelligence and Surveillance Unit. Updated cancer survival figures, to include 2020, are due to be published in October 2023. Updated cancer mortality figures, to include 2022, are due to be published in December 2023. Updated cancer incidence figures, including 2020, were published in August 2023. It is normal and routine across the UK for these statistics to be published with 2-3 years of delay. This is because it takes time for data to accrue in clinical systems, to be validated for accuracy, to be transferred and processed by Public Health Wales, and then to be published.

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With regard to survival data in particular, at least one year must have elapsed to calculate one-year survival, and several years of data is required to model five-year survival. The timeliness of these figures actually improved in the run up to the pandemic, due to the adoption of modelling techniques for reporting five-year survival. However, it is the case that the early years of the pandemic had a temporary impact on the capacity of the Unit, as staff were re-deployed to support the emergency response. This would have added some additional delay to the availability of the statistics. However, by the end of this year we will have available updated incidence (2020), survival (2020) and mortality figures (2022).

Public Health Wales is committed to improving the timeliness of cancer registry data and has for the first time published experimental statistics on cancer incidence using pathology system data. This data does not give a complete picture of all cancers, but it is available up to May 2023 to help give stakeholders more up to date insight into cancer incidence.

Although official cancer registry data is important for understanding cancer incidence and outcomes, at population level these figures are normally quite consistent, outside of a pandemic year. We are not reliant on registry data alone to deliver or oversee cancer service delivery. The NHS has a wealth of internal management data that is used on a day-to-day basis to guide the planning and delivery of services.

During the evidence session, the Deputy Chief Executive of NHS Wales referred to how we are supporting health boards to develop business intelligence tools to make better use of this management data. This work includes the development of data sets at cancer sub-type level (e.g. cervical, ovarian, uterine). This work is already underway for ‘closed’ pathways – pathways where treatment has commenced. However, it may not be possible to differentiate referrals for gynaecological cancer because around 1-in-20 of those affected will not have a gynaecological cancer, and also because the referral is made according to symptom or outpatient clinic type rather than cancer sub-type.

The potential for developing better data on referred cases is still under consideration, but improving the granularity of data on the diagnostic stage of the pathways is likely to be the focus of effort for so called ‘open’ pathways – where treatment has not yet commenced, or cancer has not yet been ruled out.

I hope this additional information is helpful to the Inquiry.

Yours sincerely

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