

Cross-Party Group Minutes

Cross Party Group Details

Cross Party Group Title:

Cross-Party Group on Cancer

Date and time of meeting:

11:30am-12:30pm; Monday 28th April 2025

Location and state of holding (in-person/ remote/ hybrid):

Remote – MS Teams

Name of Group Chair:

David Rees MS

Name of Secretary and Organisation:

Ella Davies - Cancer Research UK

Purpose of the Session:

This meeting will discuss the evidence and rationale behind long-term cancer planning and the components that support such an approach. It will also visit the work of the International Cancer Benchmarking Partnership (ICBP) and its research within this area.

In attendance:

Name/title/organisation:

David Rees MS, (The Chair)

Ryland Doyle, Staff Cymorth yr Aelod | Member Support Staff for Mike Hedges MS

Samantha Harrison, Cancer Research UK, (SH)

Professor Ellen Nolte, London School of Hygiene and Tropical Medicine, (EN)

Simon Scheeres, Cancer Research UK, (SS)

Ella Davies, Cancer Research UK

Harriet Hall, Cancer Research UK

Tom Livesey, Welsh Conservatives

Ana Akhvlediani, Anthony Nolan

Hazel Jackson

Rhian Stangroom-Teel, Macmillan Cancer Support

Dr Peter Henley, Cancer Research Wales

Ellie Blake, Prostate Cancer UK

Dawn Casey, Cwm Taf Morgannwg UHB

Dr Jeff Turner, NHS Wales Executive

Tomos Jones, Audit Wales

Greg Pycroft, Tenovus Cancer Care

Tracey Burke, Cancer Aid Merthyr

Sally Anstey, Cardiff University

Lizzie Ellis, Prostate Cancer UK

Rachel Lawrence, Moondance Cancer

Omolade Adedapo, Macmillan Cancer Support

Ian Pendlington, Bowel Cancer UK

Thomas Jones, NHS Wales Executive

Drew, Kidney Cancer UK

Ceri Hogg, Cardiff and Vale UHB

Richard Daniels, British Liver Trust

Oscar Din, Pancreatic Cancer UK

Lowri Griffiths, Tenovus Cancer Care, (LG)

Heather Wilkes, NHS Wales Executive, (HW)

Andrew Reynolds, Young Lives vs Cancer

Sian Morgan, Cardiff and Vale UHB

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Minutes

Opening:

- David Rees MS (The Chair) starts the meeting by welcoming attendees and introducing the speakers.

Presentations:

The International Cancer Benchmarking Partnership (ICBP) – Speaker; Samantha Harrison, Cancer Research UK

- Samantha Harrison (SH) begins by providing a background to the ICBP, which was formed in 2009-2010 as a policy research partnership with the aim of exploring why differences existed in cancer survival across similar high-income countries, and crucially, it provides evidence to help shape policy and clinical practice for those countries that are involved in the partnership. It is made up of clinicians, researchers, data experts and policymakers.
- SH explains the ICBP has completed two full phases of research and has recently entered a third phase of research. It has also welcomed a number of new countries across the phases, with the partnership including Canada, parts of Europe, the UK, Ireland, parts of Australia, New Zealand and a small section of the US. The partners are chosen on their data, data availability and data quality. Initially the programme covered breast, colon, lung, ovarian and rectal cancer sites but has now expanded to include liver, oesophageal, pancreas, stomach and cervical.
- SH highlights that Wales has been part of the ICBP since its formation and has participated in every research module which has been undertaken, with Professor Tom Crosby as the programme board member. The ICBP has almost 80 academic publications. SH asks for attendees to get in touch with her if anyone would like to take a look at these publications.
- SH explains that for each phase, the ICBP does a survival benchmark to help them understand where the countries are compared to each other for each of the cancer sites. They also collect data on incidence, mortality, stage diagnosis and survival by stage, as well as work on demographics to understand different types of inequalities which exist. Once this benchmark is completed, they craft and create a research programme that unpicks hypotheses as to why the variation may exist. Phase one looked all the way from public awareness about cancer through to primary care readiness to refer and health systems in that space, measuring patient

pathways and cancer registration process to establish if there is any data on things which are driving some of the variation between countries.

- **SH** also provides information about phase two of the research, which included more cancer sites and dug deeper into parts of primary care and the post-diagnostic test, specifically looking at PET CT, as well as analysis looking at the differences in chemotherapy and radiotherapy usage. The final area of that phase looked into health systems, which is the topic Professor Nolte will be presenting on.
- **SH** notes that phase three has recently kicked off, which will involve revisiting the benchmark again, 9 cancer types and digging into different themes of the pathways, including models of care, care workforce and a deeper understanding of treatment.
- **SH** explains Wales' outcomes have been poorer compared to other countries and is often one of the lowest, alongside other UK nations, in terms of survival. The stage data has indicated this is probably a mix of late diagnosis and differences in access to treatment which are contributing to the variation. **SH** ends her presentation.

Health Systems; Phase 2 of ICBP – Speaker: Professor Ellen Nolte, London School of Tropical Medicine

- **EN** introduces phase two of the ICBP research into the role of health system factors for cancer survival across ICBP countries.
- **EN** explains that they wanted to look at the evolution of cancer policies and strategies over time to help better understand why cancer survival varies internationally and over time, and to generate hypothesis of what features of the healthcare system it might impact. This resulted in three elements of work.
- **EN** explains they developed a conceptual model, which visualises the components of the cancer care system and the relationship between them. They conducted interviews with almost 80 people in 13 jurisdictions across 7 countries to understand their perspectives on health system factors and how they impact cancer survival. They then undertook a systematic review of cancer plans and strategies across all of the jurisdictions over a 20-year period.
- **EN** uses a graph to demonstrate the conceptual model, which shows that isolated interventions are likely to lead to sustained improvement outcomes for cancer.
- **EN** explains that the consultation with stakeholders was undertaken just prior to the COVID pandemic, with the aim of seeking their views on cancer policies and services in the different jurisdictions. They agreed to focus on governance, in particular leadership and resources.
- **EN** explains the research found sustained success was much more likely when there had been the creation of a body to implement strategies and summarises by explaining that leadership matters in terms of improving cancer outcomes, but it needs to be sustained in order to make a difference. This often relies on giving a mandate to central bodies or individual leaders who have oversight of an authority in the system. However, leadership also needs the expertise and influence of clinicians advising on strategy and making changes on the ground.

- **EN** explains they then looked at capacity, concluding that better infrastructure for diagnosis and treatment improved cancer outcomes. This was defined into two elements – diagnostic infrastructure and equipment, and specialist care and access to treatment.
- **EN** explains diagnostic infrastructure is not sufficient without also enhancing skills, workforce development and standardisation of diagnostic pathways as well. Sustained investment proved to be really important. Workforce was seen to be a particular driver for progress or lack of progress, with smaller nations being impacted by issues such as the recruiting and retaining of nurses and specialists, particularly in rural settings, with many specialists moving to England following their training.
- **EN** explains the third element was the analysis of cancer plans and strategies over a 20-year period and highlights the methodology for undertaking this work. This involved several factors such as looking at published cancer plans or strategies, the establishment of a cancer institute and evaluations and progress reports. For a subset of ten of the 20 jurisdictions, they also developed a criterion for cancer policy consistency – for example whether there was a dedicated institute or oversight group and if a cancer plan was accompanied by an action or implementation plan with associated funding.
- **EN** explains they developed a cancer policy consistency scoring system – if a factor was absent, it was issued '0', or fully present with a '1'. Northern Ireland was issued an overall score of 0, compared to Denmark with a score of 5.25. This scoring system was critical to correlate improvements in survival over time.
- **EN** explains the research found that jurisdictions which had scored highest on policy consistency, also had large improvements in survival for most of the cancer sites which were explored, with very large improvements being linked to dedicated policies for particular cancer sites.
- **EN** explores what these findings mean for policymaking. She explains that investment in resources and staff, infrastructure and equipment for diagnosis and treatment, and service consolidation and surgical specialism, are likely to be linked to improved quality of care. However, the continued improvement in cancer outcomes will require sustained strategic investment in the plans to deliver and maintain workforce engaged in cancer care and the infrastructure on which they depend.
- **EN** concludes that these should be characterised by consistent oversight which have a clear development plan that systematically builds on what has come before and are linked to explicit and transparent investment and implementation over time. Strategic plans must recognise that systems for cancer care do not work in isolation from the rest of the health system. **EN** ends her presentation.

Questions:

- **Lowri Griffiths (LG)** gives her thanks to presenters and support for the ICBP. **LG** remarked that Welsh Government officials had visited Denmark, but this research reinforces the need for this approach in Wales.

- **Simon Scheeres (SS)** asks a point about how strategies can improve outcomes over time and whether there is a caveat for us talking about such strategies.
- **EN** answers by explaining that when there is a realisation that something needs to be done, often there is a quick cash injection with the view this would solve the issue. However, this analysis has really shown this is not the case, it has to be a consistent commitment over time with an ability to reflect and horizon scan at each stage.
- **SH** responds by highlighting that cancer wasn't viewed as much as a political issue in Denmark as every political party seemed to agree and sign up to the challenge. It was also important to not overpromise on outcomes and to recognise it would take 15/20 years.
- **The Chair** asks if there is any other nation in the UK putting forward a longer-term approach.
- **SH** responds by explaining that Scotland is applying a long-term cancer strategy over 10 years, which is a holistic plan, with implementation action plans every three years and a monitoring and evaluation framework. Although they are still facing budgeting and wider-health system workforce challenges.
- **Heather Wilkes (HW)** introduces herself as a GP and Deputy Clinical Lead for the Cancer Recovery Programme and was one of the Members from Wales which visited Denmark. She highlights that there was a culture in Denmark with common goals among leadership, and with complete working between primary and secondary care.
- **EN** responds to **HW** by agreeing on her point about collaboration and understanding between primary and secondary care and the recognition of needing to coordinate. Denmark stood out as willing to take risks such as over-referring which other countries may be less comfortable with.
- **The Chair** responds by asking whether the culture in the UK, not just in Wales, is too risk averse.
- **HW** answers by agreeing this is part of the answer but also recognising clinicians are all trying to protect their resource for their patients and it is the same in secondary care.
- **EN** also responds by suggesting there is an issue about ownership and culture.
- **SS** asks **SH** if this research is synthesised into the Leading on Cancer Report by Cancer Research UK or if it is available online if people would like to read in more detail.
- **SH** responds by explaining that Scotland has paid a lot of attention to EN's work and pointed out there may be opportunities to network and learn or convene with other partners to shape some of the recommendations being put forward.
- **The Chair** thanks the speakers for presenting their work at the session and ends the session.

The meeting closes at 12:35pm.