Archwilio Cymru
Audit Wales

Are cancer services improving?

Aneurin Bevan University Health Board

August 2026

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Contents

Audit snapshot

What we looked at

1 We looked at Aneurin Bevan University Health Board's (the Health Board)'s approach to managing cancer services. This includes how it plans services, prevents cancer, supports early detection, and leads and oversees service performance.

2 We also reviewed trends in cancer service performance. Our 2025 national report on cancer services highlighted data quality concerns and recommended improvements at a national level. We have not reviewed data quality as part of this review.

Why this is important

3 Demand for cancer services is increasing, driven by factors such as:

- an ageing population;
- rising levels of obesity and alcohol use;
- better survival rates, meaning patients need ongoing follow-up and monitoring; and
- the ongoing introduction of new tests and treatments.

4 Cancer outcomes are worse when patients wait too long for treatment. Long waits can shorten life expectancy and reduce quality of life after treatment. This increases pressure on health boards to deliver timely care.

5 Cancer services account for a growing share of NHS spending. This is driven by increasing demand and the costs of new tests and treatments.

What we have found

6 The Health Board has worked well to manage increasing service demand without a corresponding significant worsening of waiting times performance. However, actions to improve cancer services have not yet led to lasting improvement. Performance is still well below the 75% target. In 2025–26, only 61% of patients started treatment within 62 days. The overall average performance also hides wide differences between services. In particular, urology and gastrointestinal pathways are underperforming.

7 The Health Board has taken steps to manage immediate pressures. These include running extra clinics, filling staff vacancies, and changing care pathways. These actions have helped to steady demand in the short term. Whilst they have improved capacity for treating breast and skin cancer, they have not dealt with deeper capacity problems. As a result, overall performance has not improved. The Health Board expects to meet national targets by late 2026–27, but current progress suggests it is not on track.

8 The Health Board has strengthened its cancer service leadership and operational oversight. This has helped to increase focus on cancer care. However, gaps in reporting, limited use of intelligence, and weak Board and committee scrutiny mean that progress is slow. The Health Board is proactively taking steps to improve cancer prevention and screening, but we are concerned that the scale of these initiatives might not be sufficient to have the required impact.

9 The Health Board understands the challenges it faces. However, its approach is mainly reactive rather than planned ahead. Whilst its working on updating its cancer strategy, it does not have a clear, detailed improvement plan. This makes it harder to respond to rising demand and to meet treatment targets. This is a growing concern, as cancer service costs are rising faster than inflation and there is no clear long-term financial plan.

What we recommend

10 We have made seven recommendations to the Health Board in the following areas:

- approving a new Cancer Strategy;
- monitoring the delivery of the plan;
- developing a costed cancer improvement plan to deliver the strategy;
- developing a long-term cancer workforce plan;
- improving the tracking of cancer improvement actions;
- working with partners to improve analysis of cancer screening data; and
- including a wider range of data in monitoring reports.

Key facts and figures

The number of new suspected cancer referrals rose by 11% between 2022–23 and 2025–26.

Spending on cancer services rose from £90 million to £138 million between 2019–20 and 2023–24. This is £31 million more than if spending had kept pace with inflation over the same period.

In March 2026, most referrals were for suspected lower gastrointestinal (748), breast (392) and upper gastrointestinal (373) cancers.

In March 2026, 63.1% of patients started treatment within 62 days compared with the 75% target.

In March 2026, there was wide variation in treatment waiting times. Performance ranged from 91% for skin cancer to just 36% for gynaecological cancer, against a 75% target.

Between 2002 and 2024 one-year cancer mortality rates have fallen by 15.9%.

Our findings

Cancer service improvement planning

Cancer planning is not joined up leading to fragmented, reactive cancer improvement, rather than longer-term sustainability

Cancer improvement plans

11 The Board approved a Cancer Strategy for 2020–25 that aligned with national policy, national targets and person-centred care. However, the strategy is now out of date and, although a refresh is in progress, the Health Board does not yet have clear reporting mechanisms in place to routinely monitor delivery of the strategy and provide assurance to the Board and its committees that implementation is on track.

12 The Annual Plan 2026–27 sets out high-level priorities for the year. These include redesigning pathways, addressing underperformance, and improving Multi-disciplinary Team governance. While these priorities broadly align with national expectations, the links to the All-Wales Cancer Improvement Plan 2023–26 are unclear. The Annual Plan 2026–27 understandably does not provide detail on the enabling workforce, finances, systems or estate to meet cancer demand in the short or longer term. This is a clear gap which a stand-alone cancer plan would need to address.

13 There is no clear approach setting out how the Health Board will meet the Suspected Cancer Pathway (SCP) standard or strengthen services to meet growing demand and growing costs for diagnosis or treatment. Actions to address cancer inequalities are underway, but again these are not yet clearly built into service planning.

14 The Health Board does assess adherence to National Optimal Pathways, but planning assumptions appear too optimistic.[1] Recovery actions remain high level and lack clear timescales, ownership, measurable impact, and clear links to performance recovery. As a result, responses to pressures are often short term and rely on measures such as overtime and backlog initiatives.

15 The Health Board does not expect to meet national SCP targets until quarter 4 of 2026–27. However, the Health Board has not made sufficient progress against planned improvements to provide confidence that it will meet this aim.

Cancer intelligence and data

16 The Health Board needs to better use data analysis and intelligence to inform service planning. The Health Board uses referral data and projections to support day-to-day scheduling of services. However, this approach is generally reactive and not used to inform medium-to-longer-term planning. Intelligence shows a clear increase in cancer demand. However, this has not led to a matching increase in workforce capacity. This could make it harder to achieve the SCP targets and directly affect patient outcomes.

17 The Health Board regularly reports cancer demand and performance data.[2] Operational teams and Executives clearly understand the differing performance and risks for different cancers. This helps the Health Board to identify services that are under pressure and supports occasional detailed reviews.

[1] Standardised, evidence-based care pathways designed to improve cancer diagnosis and treatment.

[2] Cancer demand and performance data includes referral volumes, backlogs, waiting times, conversion rates and SCP compliance.

18 The Health Board collects data on different stages of the pathway, which it primarily uses for operational management. This includes time to first outpatient appointment, compliance with diagnosis within 28-days targets, and the time from decision to treat to treatment start. However, the Health Board does not routinely report this information to committees or the Board. This data would help the Board understand where pressures exist along the pathway to inform medium to long-term investment prioritisation.

19 The Health Board is not making the best use of outcomes data to inform decision making and targeted action. As a result, focus is on meeting cancer targets rather than whether the Health Board is improving patient outcomes. We understand that the Health Board is planning to introduce a set of outcomes-based metrics. This includes information on survival, stage at diagnosis and longer-term outcomes.

Supporting fragile services

20 The timeliness of cancer treatment depends on the type of cancer a patient has. Most of the patients waiting longer than 62 days on the suspected cancer pathway are in the lower gastrointestinal, upper gastrointestinal and urology pathways.

21 The main causes of pressure are well known and regularly discussed. These include limited diagnostic capacity, shortages of staff and reliance on specialist (tertiary) providers.[3] The challenge using tertiary providers is ensuring timely radiotherapy, chemotherapy and/or specialist procedures. The Health Board has set up Gynaecological, Urology and Colorectal services recovery groups to help address underperformance. This shows a strong understanding of where risks to delivery are highest, and a commitment to address the issues.

[3] Tertiary providers for the Health Board include Velindre University NHS Trust, Swansea Bay University Health Board, Cardiff & Vale University Health Board, and NHS England.

22 Cancer is a priority for regional working. The Health Board discusses issues that it cannot resolve locally with their partners through regional planning forums. Regional cancer service models are also being developed, including shared workforce planning, outreach services and joint multidisciplinary team working. However, these arrangements are still developing, and it is not yet clear how or if they will improve service capacity and efficiency.

Financial and resource planning

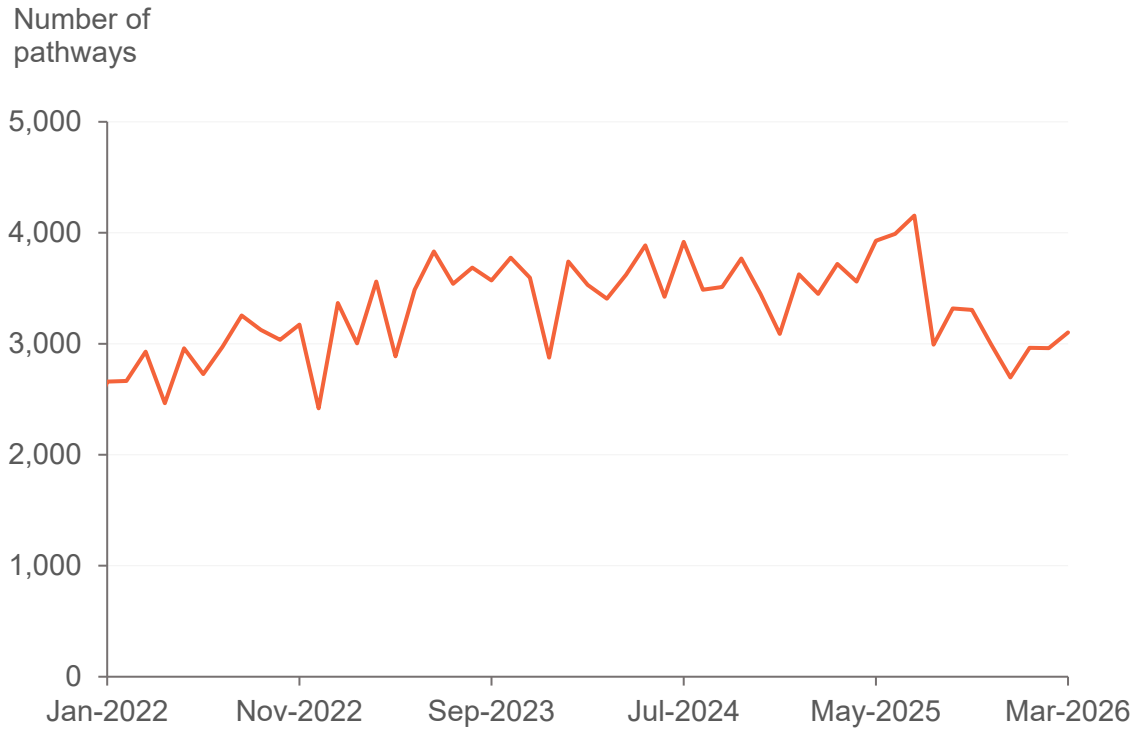
The absence of comprehensive financial and resource plans for cancer services limit assurance that resources can meet rising demand and national targets

Funding plans

23 The Health Board has not sufficiently costed the total investment required to fund its cancer service improvement actions. Instead, it relies on ad-hoc business cases and short-term funding for local developments. This makes it hard to see the full investment needed to drive service improvements to meet cancer standards and targets. It also does not provide the assurance that the totality of planned improvements needed to meet targets are affordable.

24 **Exhibit 1** shows the number of new suspected cancer pathways opened each month. This shows an ongoing increase until mid-2025, then a reduction. There has been a notable increase in referrals between 2022–23 and 2025–26 in head and neck (+26%), gynaecological (+16%) and breast (+15%) tumour sites. While new referrals are currently lower than a couple of years ago, the costs have risen faster than inflation (**Exhibit 2**).

Exhibit 1: newly opened suspected cancer pathways, Aneurin Bevan University Health Board, January 2022 to March 2026 (number)

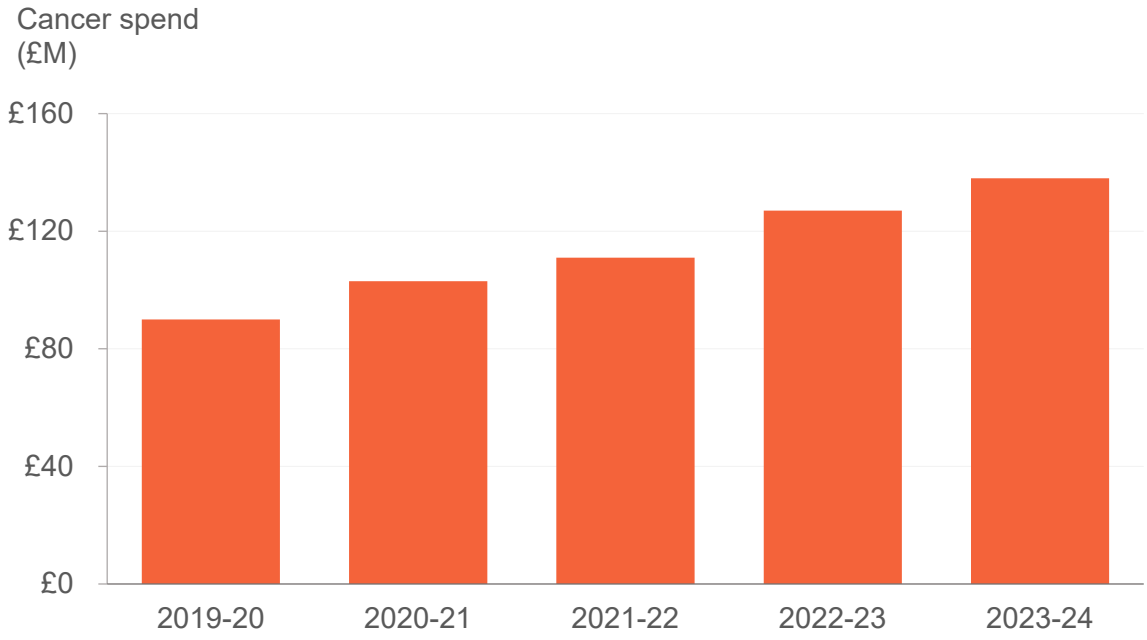


Source: Audit Wales analysis of Digital Health and Care Wales data

Note: Under the suspected cancer pathway (SCP), a pathway starts at the point of suspicion, for example, when a GP makes a referral. Pathways are closed, and waiting times end, when patients start their first definitive treatment, are downgraded (told they do not have cancer), choose not to have treatment or if the patient died. Note that patients can be on more than one pathway.

25 **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board's cancer spending rose by around 29% above inflation.[4] Hospital cancer medicines spending has also risen. Between 2019–20 and 2024–25, spending on cancer medicines increased from £10 million to around £15.4 million.[5,6] This is about £3.1 million more than if costs had increased in line with inflation (2024–25 prices).

Exhibit 2: actual cancer services spend, Aneurin Bevan University Health Board, 2019–20 to 2023–24, (£million)



Source: Audit Wales analysis of Health Board data, sourced from the Welsh Government

[4] Inflation is calculated using 2023-24 as a baseline and HM Treasury inflation data.

[5] Some speciality medicine costs cover both cancer and other treatments but are included in the total. This is unlikely to have a substantial impact on the overall figures.

[6] Medicine figures cover hospital spending by the Health Board only and exclude costs for patients treated elsewhere.

26 Cancer service costs are not set out in the Annual Plan 2026–27. While the Health Board has set out costs in divisional budgets, it is difficult to identify the totality of the planned cancer spend. This is a significant weakness given the scale of cancer services, rising demand, and ongoing cost pressures, including high-cost drugs. **Exhibits 1** and **2** broadly show that increases in cost align to increased demand. However, cost growth is exceeding inflation and needs to be effectively planned for.

27 The Health Board does not have a single costed delivery programme for cancer services. There is evidence of finance reporting to inform planning at individual service level, including forecasts, pay and non-pay costs, savings schemes, and known financial risks and pressures. However, this information is not used to inform a consolidated, costed plan for cancer.

Wider resourcing requirements

28 The Health Board clearly understands its workforce pressures. This includes vacancies, skills shortages, and limited capacity. These challenges are particularly evident in breast, gynaecology, and urology. It has taken action to manage current risks. This includes recruiting specialist staff and redeploying staff.

29 Workforce challenges are not confined to cancer services, with many staff contributing across both cancer and planned care pathways. While recognising these interdependencies, the Health Board does not have a clear workforce plan that sets out how it will develop and sustain the workforce needed to meet future demand. As a result, workforce planning remains focused largely on addressing immediate pressures rather than building longer-term capacity and resilience.

30 The Health Board includes cancer estates plans in its corporate estates strategy. Major developments, such as cancer centre designations and the Satellite Radiotherapy Unit, show that cancer is a priority for estates investments.[7]

31 The Health Board has an established five-year diagnostic equipment replacement programme, including processes to prioritise additional capacity and replacement needs. However, equipment planning is managed separately from cancer service delivery planning and is not brought together within a single cancer delivery plan. As a result, there is limited assurance that future equipment requirements are systematically aligned to anticipated growth in cancer demand.

32 The Health Board recognises that digital capability is important. Live cancer tracking dashboards support day-to-day oversight. However, digital in the main supports day-to-day tracking, rather than service transformation.

Cancer prevention and population screening

While taking positive and innovative action, the Health Board is not maximising the benefits of cancer prevention

33 The All-Wales Cancer Improvement Plan estimates that 38% of cancers each year are preventable. To give this context, if the Health Board prevented 20% of cancers, it could have saved £2.3 million in bed day costs in 2024–25, based on the most recent available financial data. **Exhibit 3** shows the potential gains if the Health Board successfully implemented a cancer prevention strategy.

[7] The Radiotherapy Satellite Centre at Nevill Hall Hospital in Abergavenny is funded by the Welsh Government. This investment is part of a wider package announced in 2023 to upgrade radiotherapy services in Southeast Wales, with the facility designed to bring care closer to patients' homes. It is staffed by Velindre University NHS Trust.

Exhibit 3: potential capacity gains from cancer prevention, Aneurin Bevan University Health Board, based on 2024–25 activity

	2024–25 actual	-10% reduction	-20% reduction	-38% reduction
Finished consultant episodes	**16,755**	**15,080** (1,676 reduction)	**13,404** (3,351 reduction)	**10,388** (6,367 reduction)
Admission episodes	**14,842**	**13,358** (1,484 reduction)	**11,874** (2,968 reduction)	**9,202** (5,640 reduction)
Bed days	**22,947**	**20,652** (2,295 reduction)	**18,358** (4,589 reduction)	**14,227** (8,720 reduction)
Bed day cost savings		(**£1.2** million)	(**£2.3** million)	(**£4.4** million)

Source: Audit Wales analysis and modelling of Digital Health and Care Wales data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets for Welsh providers

Note:

1) The analysis outlines the broad impact of a 10%, 20% and 38% reduction in cancer cases, based on 2024–25 activity levels.

2) Savings calculation based on £500 per day cost of an NHS bed in Wales used in our 2025 National Cancer Services Report.

Public health risk assessment

34 Population health intelligence is strong and well understood but this is not yet driving large-scale cancer prevention initiatives. The Health Board has developed a Population Health Cancer Dashboard, which has received national recognition. The dashboard brings together data on cancer rates and key risk factors, such as smoking, alcohol use, and body mass index. It also shows differences by age, gender, deprivation, and location. This helps the Health Board understand cancer risk, variation, and inequalities across the population. It also provides assurance that there is understanding of where targeted prevention work would be beneficial.

35 The Health Board has set up a Cancer Board as a strategic forum for overseeing cancer service delivery. The Cancer Board uses the intelligence to inform discussions and decisions. However, beyond the Cancer Board, the Health Board does not sufficiently use population health data to inform cancer prevention planning, priorities and delivery plans.

Approaches to improving population lifestyles

36 The Health Board is delivering a range of programmes to promote healthy lifestyles that reduces cancer risk. However, the long-term impact of local cancer prevention initiatives is limited due to insufficient funding and prioritisation. The Health Board's Annual Plan 2026-27 clearly sets prevention and population health as priorities. However, interviewees indicated that spending on prevention is a small part of overall Health Board funding and more could be invested to improve overall impact.

37 Ongoing funding supports key programmes such as smoking cessation, healthy weight services, vaccination, and screening uptake. Programme uptake and outcomes are monitored by Public Health team, and some metrics at Finance and Performance Committee. This shows that the Health Board manages and evaluates prevention programmes.

38 The Public Health team also develop local prevention initiatives, along with targeted campaigns in areas of low uptake. These business cases go to the Executive Team for approval and are tested for alignment with priorities. Initiatives such as Alcohol “Try Dry” take an evidence-based approach to address lifestyle risks linked to cancer. However, some activities, such as the community-based skin cancer prevention initiative, depend on short-term funding or have limited staff capacity. This makes it harder to manage and may limit the positive impact that the schemes were designed to achieve.

39 The Health Board also participates in National public health programmes, including Help Me Quit and Healthy Weight Healthy You, which strongly shape how prevention funding is used. These programmes support cancer prevention and focus on high-risk groups.

Targeted prevention and population screening

40 There are clear referral routes to diagnosis and treatment for patients whose cancer is detected through each of the national screening programmes. The Health Board has limited access to timely screening data. Screening data is not available in real time, which restricts the Health Board’s ability to monitor and plan to meet demand resulting from screening. Performance data also shows that screening is not consistently leading to timely diagnosis and consequently starting treatment, particularly for colorectal cancer, due to limited colonoscopy capacity.

41 The Health Board has some understanding of inequalities of screening uptake. The Health Board’s Public Health team analyses uptake by deprivation, geography, age and sex. They consider barriers such as access and health literacy to identify targeted actions. These actions include predicting non-attendance, active patient follow-up and the use of patient stories to address fear and disengagement.

42 Human papillomavirus vaccination (HPV) rates are below the Health Board’s national target of 90%, last reported at around 77% in September 2025. The Health Board has introduced school-based delivery, community outreach, and other actions set out in the Vaccine Inequity Strategy. Despite this, these actions have not yet led to sustained improvement.

Cancer leadership and oversight

While leadership are supporting operational improvements, there is a need for better oversight of the strategic direction of cancer services

Managerial leadership

43 There is now clear leadership for cancer services, after a period of instability. The Chief Operating Officer has overall responsibility, supported by a Senior Responsible Owner and a Clinical Lead. This provides a clear and more joined-up approach to leadership. Prior to this, the COVID pandemic, changes in senior staff, service changes and regional tensions disrupted leadership stability and continuity. While recent appointments and executive focus aim to address this, the effects are still visible in cancer performance and progress.

44 Senior managers make decisions on priorities and spending within agreed limits. The Health Board's Divisional Management Team meetings are supporting timely decision making, when needed. In the past, this has included approving funding for extra clinics and other short-term actions to meet demand.

45 The Health Board's Cancer Board includes staff, primary care, third-sector partners, and patient representatives. This helps to promote openness and joint working to solve problems. This collaborative approach is also evident at operational level. Structured forums, including assurance meetings and tumour-specific recovery groups help teams keep track of performance and waiting lists and take shared action where needed.

46 Regional working and leadership are essential to make sure that patients get the right cancer care at the right time. In south-east Wales whilst health boards plan and deliver many parts of the cancer diagnosis and treatment pathway, they commission and fund Velindre University NHS Trust to provide non-surgical specialist cancer services for most patients.[8] It is imperative that joint working ensures effective planning, referral, and continuity of cancer care across organisational boundaries.

Oversight and scrutiny

47 The Board and the Finance and Performance Committee regularly review cancer performance information. Reports include performance against the target for 75 per cent of patients to start treatment within 62 days of suspicion. The reports also include, waiting list backlog levels, performance trajectories, key risks, and key actions. This gives a good high-level view. However, reports are missing measures such as average waiting times, tumour-specific performance and cancer outcomes. This is important because the average performance can mask significant variation across tumour sites. This may limit the Board and Finance and Performance Committee's ability to seek targeted assurance on services that have the greatest impact on patient outcomes.

48 Finance and Performance Committee minutes suggest that there has been limited scrutiny when cancer performance targets are missed. Equally, Board and committee minutes show that challenge on the proposed actions needed is weak. This is a greater concern because reported improvement actions are often high level and lack detail.

49 The Health Board has an established Cancer Board, chaired at Executive level (Chief Operating Officer), which has met bi-monthly since 2020 with consistent clinical engagement. Furthermore, they produce a comprehensive and well-structured Annual Cancer Report that provides assurance that improvement work is ongoing. However, it lacks detail on whether those activities are translating into sustainable improvements in performance and outcomes.

[8] Including radiotherapy, chemotherapy, and other systemic anti-cancer treatments (SACTs).

Cancer performance

Some patients are facing unacceptably long waits, and the actions to improve are not enabling the Health Board to meet its targets

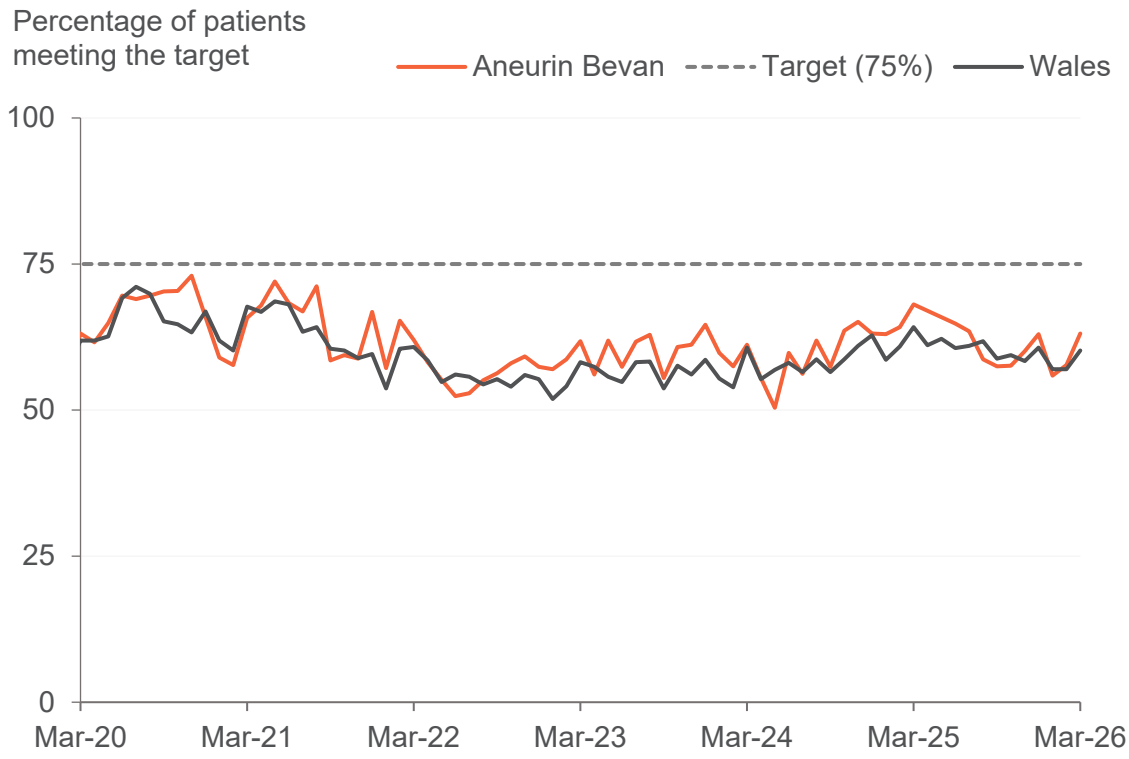
62-day cancer performance

50 The Welsh Government target is for 75% of patients to start their first treatment within 62 days from the first point where cancer is suspected.

51 Early diagnosis and prompt treatment improve outcomes. They increase survival rates and enhance quality of life. Long waits can lead to more advanced cancer. This may reduce life expectancy, limit treatment options and affect physical health after treatment.

52 **Exhibit 1**, outlined earlier in the report, shows that the number of new suspected cancer pathways opened each month has grown. Despite this, the Health Board has done well to ensure performance has not deteriorated. However, the Health Board's performance, although reflecting the average achieved in Wales, is falling well short of meeting the national cancer target (**Exhibit 4**). It is widely accepted that the number of cancer cases will continue to increase in Wales and service pressures are expected to grow.

Exhibit 4: patients meeting the 62-day cancer treatment target, Aneurin Bevan University Health Board, March 2020 to March 2026, (percentage)



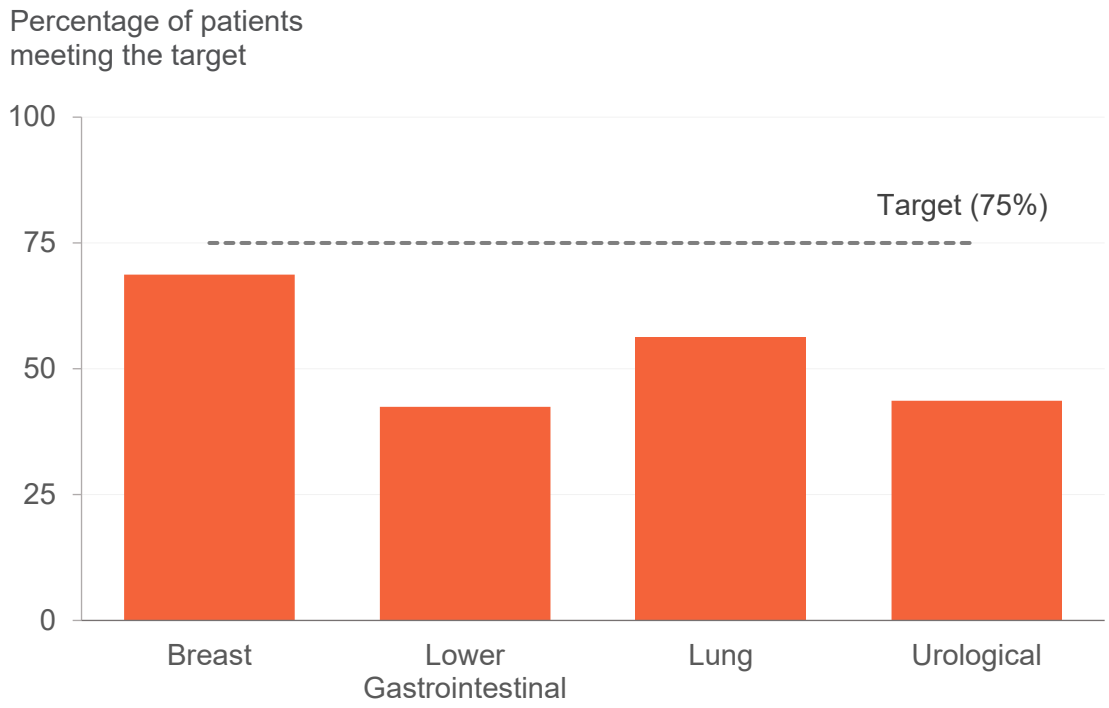
Source: Audit Wales analysis of Digital Health and Care Wales data

Note: The data includes patients who started treatment and those waiting for confirmation that they do not have cancer.

53 The Health Board is not meeting the 62–day Welsh Government target. However, overall performance also hides large differences between sex and tumour types. For example, between December 2025 and March 2026, between 8% and 14% more men than women waited beyond the target.

54 Some areas, such as skin cancer, are performing better. In March 2026, skin cancer pathways met the target with 88.3% of patients starting their treatment within 62 days. **Exhibit 5** shows performance across four common cancer tumour sites. It raises significant concerns about urological and lower gastrointestinal cancer case timeliness.

Exhibit 5: patients meeting the 62–day cancer treatment target by tumour site, Aneurin Bevan Health Board, 12-month average during 2025–26 (percentage)



Source: Audit Wales analysis of Digital Health and Care Wales data

Notes:

1. The data shown average 62- day performance over the most recent 12-month period (March 2025 to March 2026).

2. The data includes patients who started treatment and those waiting for confirmation that they do not have cancer.

Impact of action to improve cancer services

55 The action taken by the Health Board is helping to manage short-term risks. But this is not significantly improving performance overall or addressing significant underperformance for some tumour sites. This is likely to be affecting the outcomes for some groups of patients.

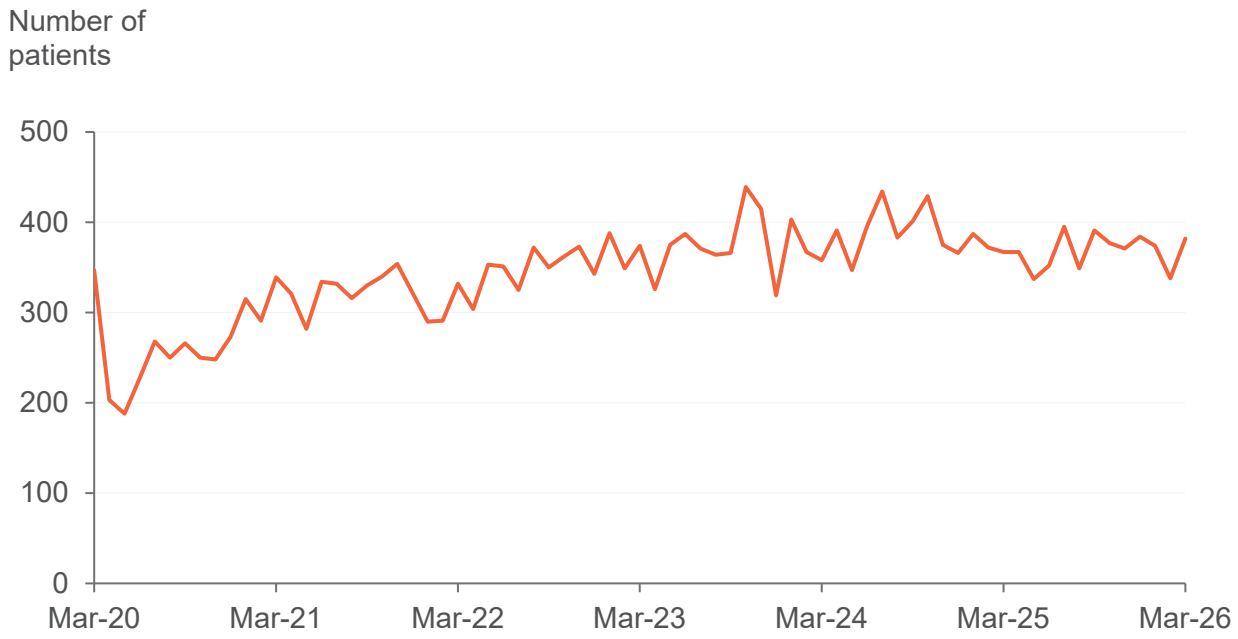
56 Workforce pressures are a major challenge for cancer services. Managers have reactively responded to immediate risks. These include recruiting consultants and cancer nurse specialists, using locums and changing clinic scheduling. However, these actions do not close underlying capacity gaps or sustainably match capacity to demand.

57 The Health Board is trying to address diagnostic and treatment capacity shortfalls. Its actions include redesigning care pathways, speeding up pathology results and waiting list initiatives. If there are issues that teams cannot solve locally, they develop business cases to seek extra funding. This has supported investment in specialist equipment, such as surgical robots, new endoscopy solutions and specialist testing.[9]

58 Performance against the 62-day target suggests that the actions taken have not had sufficient impact to improve capacity. The number of new patients starting treatment each month has not notably increased since 2023 (**Exhibit 6**). However, the Health Board has indicated that wider overall treatment activity throughout the pathway has increased.

[9] HER2 testing identifies if breast or stomach cancers have high levels of the HER2 protein or gene, which drives cancer growth. Testing helps determine eligibility for targeted therapies.

Exhibit 6: cancer patients starting treatment each month, Aneurin Bevan Health Board, March 2020 to March 2026 (number)



Source: Audit Wales analysis of Digital Health and Care Wales data

59 The Health Board needs to do more to reflect on the impact of the actions that it is taking. Improvement actions are not clearly prioritised and do not have realistic improvement targets. There is no routine evaluation of the impact of action taken and the resulting impacts. There is little evidence that learning from previous initiatives, including 'Lean systems' training, is consistently applied through formal improvement methods such as PDSA cycles.[10]

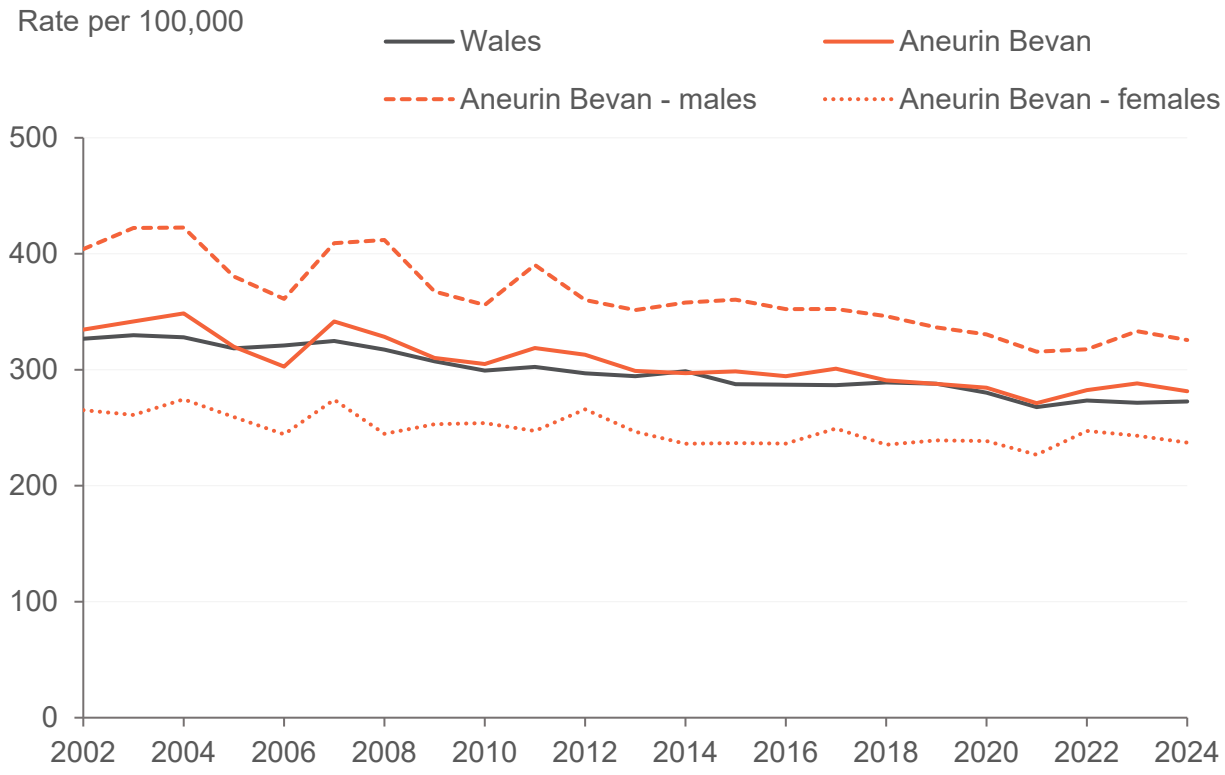
[10] PDSA cycles (Plan-Do-Study-Act) are a four-stage, iterative problem-solving model used to test, implement, and refine changes for process improvement.

Improving cancer outcomes

60 Mortality, stage at diagnosis, PROMs and PREMs data are reviewed in specialty clinical effectiveness meetings. However, there is little evidence that services use outcomes data to inform priorities, recovery planning, or system-wide improvement.

61 **Exhibit 7** shows the one-year mortality rate for the Health Board.

Exhibit 7: one-year cancer mortality, Aneurin Bevan University Health Board 2002 – 2024 (rate per 100,000 population)



Source: Audit Wales analysis of Public Health Wales NHS Trust data

Note: Deaths where cancer is the primary cause, using the European Age Standardised Rate to enable fair comparisons over time and place.

62 Analysis of one-year cancer mortality data from 2002 to 2024 in **Exhibit 7** shows a consistent reduction in one-year mortality over the last 20 years. This represents a positive long-term trend and suggests that improvements in cancer prevention, early detection and treatment are having a beneficial impact. The Health Board's cancer mortality rate is also lower than the Wales average. However, outcomes for males remain worse than for females.

Recommendations

Cancer services planning

R1 The Health Board should prioritise the completion and Board approval of its new Cancer Strategy **(paragraph 11)**.

R2 The Health Board should ensure reporting mechanisms are in place to operationally monitor the delivery of the cancer strategy and provide assurance to the Board and committees that delivery is on track **(paragraph 11)**.

R3 The Health Board should develop a fully costed organisation-wide cancer improvement plan to ensure sustainable delivery of the cancer strategy as demand increases **(paragraph 12)**.

R4 The Health Board should ensure that the cancer improvement plan includes SMART cancer improvement actions with defined responsibilities for delivery **(paragraph 14)**.[11]

[11] Specific, Measurable, Achievable, Relevant, and Time-Bound

R5 The Health Board should develop a clear, long-term cancer workforce plan that sets out how it will address capacity and skills gaps to build sustainable workforce provision tailored to future demand **(paragraph 29)**.

R6 Health boards should work collectively with Public Health Wales NHS Trust to agree as soon as possible a comprehensive set of data analysis on screening services, including:

- timeliness across each part of the current three cancer screening pathways and lung screening once it is fully rolled out;
- information on uptake screening rates and variations by population groups (including age, location, sex (where applicable), and ethnicity.

(paragraph 40).

Cancer progress reporting

R7 The Health Board should improve cancer reporting by including average waiting times, tumour-specific performance, and outcomes to better support Board scrutiny and targeted assurance **(paragraphs 47 to 49)**.

Appendices

1 About our work

Scope of the audit

We looked at the following areas:

- How well the Health Board plans its cancer services and whether they align with the National Cancer Plan, Quality Statement and Cancer Recovery Programme.
- How the Health Board seeks to reduce cancer prevalence by targeting preventative actions and supports screening programmes to detect cancer sooner.
- How cancer services are led and managed to drive improvements.
- How services are performing and the actions that the Health Board is taking to drive service improvement and achieve better patient outcomes.

We did not consider service quality, clinical governance or patient experience. We have also not completed an audit of the data used in this review, but we have looked at the all-Wales data validation process.

Audit questions and criteria

Questions

We used the following questions to focus our fieldwork:

- Has the Health Board clearly set out how it will achieve timely and equitable access to cancer diagnosis and treatment?
- Has the Health Board set out a coherent approach to cancer prevention?
- Is the Health Board providing strong leadership and governance for timely and equitable access to cancer diagnosis and treatment?
- Is the Health Board making progress to deliver timely and equitable access to cancer diagnosis and treatment?

Criteria

We assessed the Health Board's arrangements against the following criteria:

- The Health Board has clear funded plans based on sound business intelligence which sets out cancer services priorities and objectives, and the approach it is taking to achieve them.
- The Health Board has a clear approach to target population health improvements as means to reduce cancer prevalence in the longer term.
- The Health Board's leadership for cancer services work collaboratively and are empowered to drive cancer service improvements in the short and longer term.
- The Health Board is making continuous improvement on 62-day cancer performance, successfully addressing underperforming services and driving improvements to achieve better outcomes for patients.

Methods

Our audit methods included document review, data analysis, and interviews. We interviewed the following:

- Cancer Services Manager;
- Chief Operating Officer;
- Clinical Lead for Cancer;
- Division Director for Clinical Support Services;
- Head of Public Health; and
- Strategic Lead Cancer Nurse.

We also held a focus group with the operational specialty management leads.

2 Key terms in this report

Term	Description
Admission episodes	The first period of care under a consultant with a health provider's episode of care.
Bed days	A day during which a patient occupies a hospital bed and stays overnight in the hospital.
Bed days cost savings	The financial benefits gained from reducing the number of hospital bed days.
Cancer Quality Statement	National statement outlining quality expectations for cancer care and outcomes across NHS Wales.
Cancer Recovery Programme	Programme of actions intended to restore/improve cancer services post-disruption (eg COVID-19), focusing on waits, pathways and outcomes.
European Age-Standardised Rate (EASR)	A rate adjusted to a standard European population age-structure to enable fair comparisons over time/places.
Finished consultant episodes	Refer to the periods of patient care under a consultant's supervision that have concluded due to discharge, transfer, or death.
Multidisciplinary Team	Multidisciplinary Team working is where health and care professionals from different specialisms work together to agree a patient's care.
National Cancer Improvement Plan	National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories.

Term	Description
Patient-Reported Experience Measures (PREMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PREMs focus on the experience of care (how it was received).
Patient-Reported Outcome Measures (PROMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PROMs measure the effectiveness of treatment on health status.
Population health risks	Modifiable risk factors (eg smoking, obesity, alcohol) associated with cancer incidence in local populations.
Real terms spend	Expenditure adjusted for inflation to reflect true purchasing power over time.
Stage at diagnosis	The extent of cancer spread at the time of diagnosis, strongly linked to outcomes and treatment options.
Suspected Cancer Pathway (SCP)	The all-Wales performance standard that 75% of patients should start their first definitive treatment within 62 days from the point of suspicion.
Systemic Anti-Cancer Therapy (SACT)	Drug treatments circulating via the bloodstream (eg chemotherapy, targeted and immunotherapies) to treat cancer,
Screening	A preventive medical test designed to detect cancer early, often before symptoms appear, improving the chances of successful treatment.
Tumour site	The anatomical location/type of cancer (eg lower gastrointestinal, lung, breast, urological, skin).

Term	Description
Waiting list initiatives	Waiting list initiatives are targeted actions or interventions designed to reduce patient waiting times and manage waiting list backlogs (e additional clinics, extra sessions, outsourcing or insourcing).

3 Management response form

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R1 The Health Board should prioritise the completion and Board approval of its new Cancer Strategy.	The Health Board has completed an evaluation of the 2020–2025 Cancer Strategy, which will be considered by the Executive Committee in July 2026. Development of a new Gwent Cancer Plan, aligned to the Gwent 2035 Strategy, is underway. Engagement workshops are being undertaken to inform the six strategic pillars of the plan, which will be submitted to the Executive Committee for approval. Following publication of the Welsh Government National Cancer Strategy, expected in February 2027, the Gwent Cancer Plan will be reviewed and, where necessary, updated to ensure alignment with the national strategic direction, priorities and implementation requirements.	31 March 2027	Chief Operating Officer Supported by: Assistant Medical Director for Cancer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R2 The Health Board should develop a fully costed organisation-wide cancer improvement plan to ensure sustainable delivery of the cancer strategy as demand increases.	The Health Board accepts this recommendation and will develop a fully costed Cancer Improvement Plan aligned to the current Welsh Government Quality Statement for Cancer, Single Cancer Pathway requirements, National Optimal Pathways and the Gwent Cancer Plan. The plan will identify the workforce, digital, infrastructure, service redesign and investment requirements necessary to support sustainable improvement in cancer services. It will include clear priorities, delivery milestones, affordability assessments, expected benefits and defined governance arrangements for implementation and monitoring. Following publication of the Welsh Government National Cancer Strategy, expected in February 2027, the Improvement Plan will be reviewed and updated, where necessary, to ensure alignment with the national strategic direction and implementation requirements.	31 March 2027	Chief Operating Officer **Supported by:** Senior Responsible Officer and Senior Programme Manager for Cancer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R3 The Health Board should ensure that the cancer improvement plan includes SMART cancer improvement actions with defined responsibilities for delivery.[12]	Cancer Improvement Plans will include defined actions, measurable outputs, named responsible leads and delivery timescales. Action logs will be developed for each tumour site and approved by tumour site leads and divisional teams to support implementation. Progress and delivery against actions will be monitored and reported through Cancer Board governance arrangements.	31 October 2026	Chief Operating Officer Supported by: Cancer Services Manager
R4 The Health Board should develop a clear, long-term cancer workforce plan that sets out how it will address capacity and skills gaps to build sustainable workforce provision tailored to future demand.	Directorates will develop integrated workforce plans to support sustainable service delivery and future cancer demand. Plans will include workforce baselines, capacity gap assessments, demand modelling, skills mix reviews and recruitment and retention actions. The workforce plan will inform the 2027/28 IMTP process.	31 March 2027	Chief Operating Officer Supported by: Deputy Director of Workforce

[12] Specific, Measurable, Achievable, Relevant, and Time-Bound

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R5 The Health Board should ensure reporting mechanisms are in place to operationally monitor the delivery of the cancer strategy and provide assurance to the Board and committees that delivery is on track.	Oversight of delivery will be provided through Cancer Board reporting to the Executive Committee, with periodic assurance reporting and annual deep dives to the Public Board. Re-established and strengthened the Health Board Cancer Board with clear terms of reference, executive leadership and multidisciplinary membership. Evidence of regular meetings and action tracking is in place. Cancer Programme formally designated as one of the Health Board's priority programmes with executive sponsorship from the COO. This will ensure regular updates into Public Board, and scrutiny via our annual plan / IMTP process. Cancer performance is now reviewed routinely through: • SRO Led performance meetings • Cancer Board • Divisional Performance Reviews • Executive oversight arrangements • Board Deep Dives and Board reporting.	Completed July 2026	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
	A dedicated Cancer Programme Deep Dive has been presented to Board setting out achievements, risks, performance and future priorities. Tumour-specific action plans and programme reporting are being developed to support delivery monitoring and accountability.		
R6 The Health Board should work with Public Health Wales NHS Trust to agree as soon as possible a comprehensive set of data on screening services, including: • timeliness across each part of the three cancer screening pathways; and • information on uptake rates and variations by	Public Health Wales now provides quarterly screening reports to Health Board representatives. The Health Board will continue to work with Public Health Wales to develop an agreed dataset covering screening timeliness, uptake rates and variation across population groups. Opportunities to enhance reporting through more accessible and interactive platforms will also be explored. Progress is monitored through screening pathway improvement meetings and reported through established cancer governance arrangements.	Ongoing	Chief Operating Officer Supported by: Head of Public Health Team ABUHB

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
population groups (eg age, location, sex (where applicable), and ethnicity.			
R7 The Health Board should improve cancer reporting by including average waiting times, tumour-specific performance, and outcomes to better support Board scrutiny and targeted assurance.	Existing cancer reporting will be enhanced to include average waiting times, tumour-specific performance measures and conversion-to-cancer rates by tumour site. Following approval of the Cancer Plan, a revised performance framework will be developed which includes a broader range of outcome measures aligned to the plan's strategic priorities.	31 March 2027	Chief Operating Officer Supported by: Cancer Services Manager and Senior Responsible Officer for Cancer

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.