Archwilio Cymru
Audit Wales

Are cancer services improving?

Cardiff and Vale University Health Board

August 2026

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Audit snapshot

What we looked at

1 We looked at Cardiff and Vale 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 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.

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 monitoring; and
- the 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. 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 new tests and treatments.

What we have found

6 The Health Board is not making enough progress to ensure timely and equitable access to cancer diagnosis and treatment. Performance against the Suspected Cancer Pathway (SCP) remains below the 75% target. In 2025–26, only 63.2% of patients started treatment within 62 days. The Health Board has however, managed a substantial increase in cancer service demand without a corresponding significant worsening of waiting times performance. Although short-term recovery actions have helped the Health Board manage demand growth, they are not delivering lasting improvement.

7 The Health Board's approach to planning cancer services lacks focus. It has set priorities in its Cancer Strategy, but has not produced a single, costed delivery plan. Instead, it relies on annual plans, limiting long-term impact. Planning is reactive, focusing on immediate pressures rather than future capacity and demand. Cancer costs continue to rise faster than inflation, without a long-term financial plan.

8 The Health Board uses data to monitor current performance but makes limited use of forecasting, capacity planning, and experience and outcomes data. Consequently, it is unable to demonstrate that its actions will improve services or meet expected levels of performance.

9 The Health Board identifies cancer risks and targets preventative action at higher-risk groups. However, it lacks good quality screening uptake data, limiting its ability to target inequalities. Financial pressures also reduce the scale and long-term impact of prevention work.

10 The Health Board has clear leadership arrangements overseeing current performance. However, it has not appointed a clinical leader for cancer services or maintained a Cancer Board. This weakens clinical input and makes it harder to co-ordinate long-term improvement.

What we recommend

11 We have made six recommendations in the following areas:

- developing a costed improvement plan to deliver the strategy, with supporting resource plans and delivery actions and milestones;
- working with partners to improve availability of cancer screening data;
- make better use of data to support prevention, intervention, and screening uptake;
- appointing a clinical lead for cancer services;
- strengthening governance and improving accountability by re-establishing the Cancer Delivery Board; and
- collecting and using patient experience and outcomes data to inform planning.

Key facts and figures

The number of new suspected cancer referrals rose by 25% between 2022–23 and 2025–26.

Spending on cancer services rose from £73 million to £111 million between 2019–20 and 2023–24. This is £18 million more than if spending had kept pace with inflation over the same period.

In March 2026, most referrals were for suspected breast (453), skin (404), lower gastrointestinal (387), and upper gastrointestinal (363) cancers.

In March 2026, 63.2% 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 95% for skin cancer to just 41% for lower gastrointestinal cancer, against a 75% target.

Between 2002 and 2024, one-year cancer mortality rates have fallen by 20%.

Our findings

Cancer service improvement planning

The Health Board manages short-term pressures, but its reactive approach and weak planning fail to deliver sustained improvement or ensure it can meet future demand

Cancer improvement plans

12 The Health Board's Cancer Strategy (2023–28) aligns with national expectations and sets out high-level priorities. However, the strategy does not include specific actions, milestones, or clear accountability arrangements. As a result, there is limited evidence that the strategy drives improvement.

13 The Health Board does not have a cancer improvement plan to support its long-term goals or drive lasting improvement in Single Cancer Pathway (SCP) performance. Instead, it is relying on its Annual Plan 2026–27, which on its own is not enough.

14 The Annual Plan for 2026–27 sets out the Health Board's main priorities, including improving cancer performance, redesigning care pathways, and strengthening team working. These priorities align with national expectations, including the All-Wales Cancer Improvement Plan.

15 However, recovery plans remain high-level. They lack clear ownership, timescales, and measurable outcomes. Links to performance improvement are weak.

16 Actions in the Annual Plan 2026–27 focus on short-term measures, such as extra clinics and overtime, rather than changes that support lasting improvement. There is also limited evidence that planning draws on learning from previous improvement work or best practice.

17 The Annual Plan for 2026–27 does not explain how the Health Board will meet the Suspected Cancer Pathway (SCP) target. It does not show how the Health Board will manage rising demand and treatment costs. It also lacks detail on the staff, funding, systems, and facilities needed. Actions to reduce cancer inequalities are not defined in service plans.

18 The Health Board does not expect to achieve the national SCP target until quarter 4 of 2026–27. However, the Health Board has not made sufficient progress against planned improvements to provide confidence that this aim will be met.

19 Regional partners have arrangements in place to support joint working. However, there is no clear planning approach that sets out how they will respond to expected growth in cancer demand. As a result, it is not clear how future service needs and capacity pressures will be managed across the region.

Cancer intelligence and data

20 The Health Board needs to strengthen how it uses cancer data and intelligence. The Health Board's current use of data is reactive, as it focuses on monitoring day-to-day service pressures rather than supporting planning to sustainably meet future demand.

21 There is little evidence that the Health Board is using data to forecast demand, plan capacity, or support medium-term decisions. This could make it harder to achieve the SCP target and directly affect patient outcomes.

22 The Health Board reviews a wide range of data, including referral numbers, tumour site performance, waiting list backlogs, and reasons for SCP breaches. However, delivery teams do not make enough use of outcome data to guide decisions or improve services. They also do not use data effectively to plan medium-term and long-term capacity. As a result, the focus remains on meeting cancer targets rather than improving patient outcomes. The use of patient experience data in cancer planning is also inconsistent.

Supporting fragile services

23 The timeliness of cancer treatment depends on the type of cancer a patient has. Most patients waiting longer than 62 days on the SCP are in breast, urology, and gastrointestinal pathways.

24 The Health Board knows which cancer pathways are fragile. It uses data, tumour-site reviews, and escalation routes to spot risks and take action. Actions include changes to pathways, extra capacity, and workforce adjustments to reduce pressure. There are some signs of improvement in specific areas. For example, changes to demand and capacity planning and pathway management in dermatology improved performance in the short-term.

25 However, there is little evidence that these actions lead to lasting improvement. While the Health Board responds quickly to fragile services, most of the actions are short-term and focus on managing pressure, rather than fixing the root causes. Performance reports do not clearly show if the changes are leading to improved performance over time. As a result, overall performance remains below the SCP standard and varies across tumour sites.

26 Diagnostic capacity limits progress against the SCP target. The main pressures are well known. These include rising demand, limited diagnostics, workforce gaps, and capacity pressures in regional services.

27 The Health Board has clear arrangements to manage these risks. Teams meet regularly through operational groups, tumour-site reviews, and Cancer Delivery Group meetings. These forums help identify fragile services and focus action. There is a strong focus on the highest-risk areas.

28 Cancer is a priority for regional working. The Health Board discusses issues that it cannot resolve locally with its partners through regional planning forums. Regional cancer service models are also being developed, including shared workforce planning, outreach services, and joint multidisciplinary team working. Regional partnerships are still developing but do not yet show clear benefits.

Financial and resource planning

No clear long-term plan, weak coordination, and rising demand and costs limit progress, reducing confidence that cancer services will improve performance or meet future needs.

Funding plans

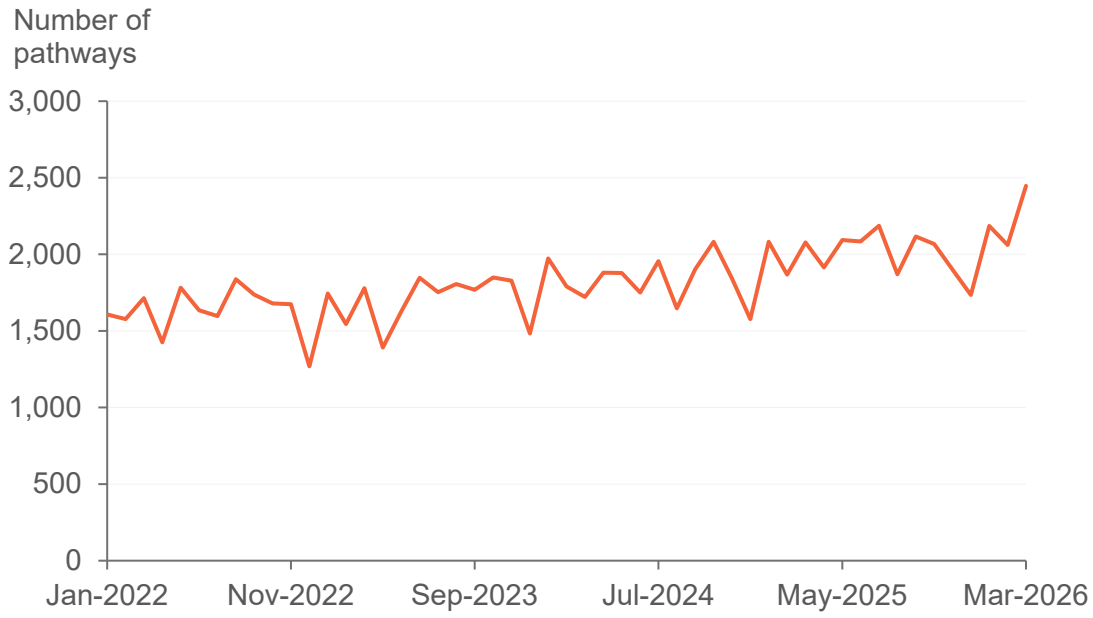
29 There is no single, costed plan for cancer delivery or recovery. It is not clear if all planned improvements are fully funded. Without a clear and costed plan, the Health Board cannot define the level of investment needed to improve services and meet cancer standards and targets. It also does not give assurance to the Board that all planned improvements needed to meet targets are affordable.

30 The Health Board considers cancer costs as part of its overall financial planning. However, the Annual Plan 2026–27 does not set out the current or projected cost of cancer services, despite rising demand and treatment costs.

31 Finance and Performance Committee papers focus on the wider financial position and provide limited information on cancer service costs and sustainability. As a result, the Health Board cannot clearly demonstrate how it plans to meet future demand and deliver its cancer priorities.

32 **Exhibit 1** shows the number of new suspected cancer pathways opened each month. This illustrates an ongoing increase through the period. There has been a notable increase in referrals between 2022–23 and 2025–26 in skin (+49%), head and neck (+38%), upper gastrointestinal (+32%), and urological (+26%) tumour sites.

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

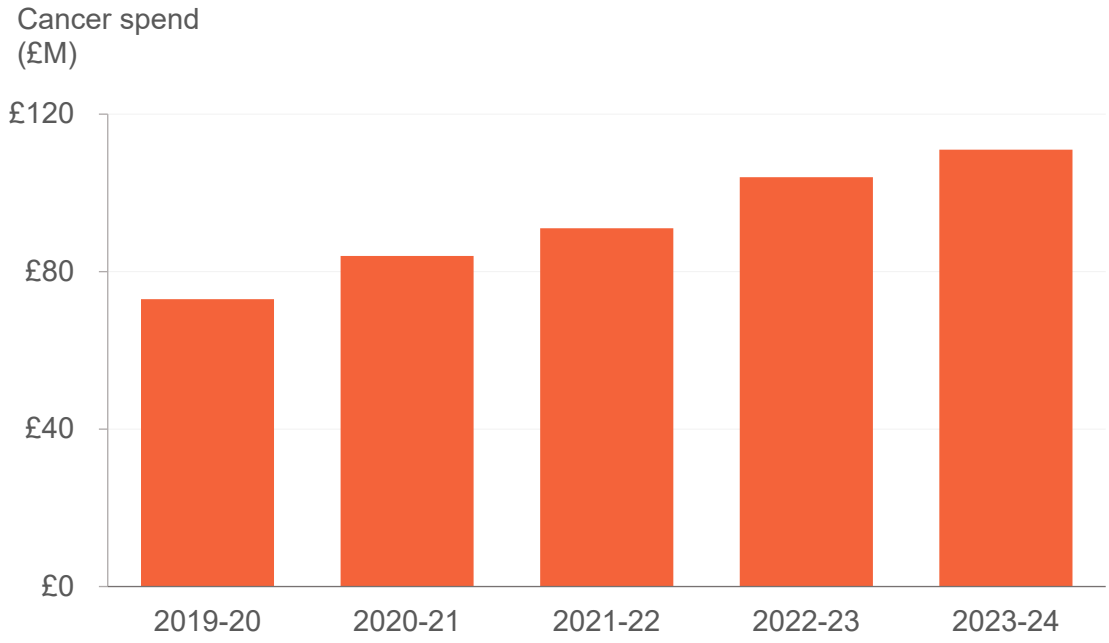


Source: Audit Wales analysis of Digital Health and Care Wales data

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.

33 Cancer care costs have increased faster than inflation. This makes effective planning and cost control increasingly important. **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 28% above inflation[1]. Spending on hospital cancer medicines has also increased. Between 2019–20 and 2024–25, the Health Board's spend rose from £17 million to around £25 million[2,3]. This is about £4 million more than if costs had increased in line with inflation (in 2024–25 prices).

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



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

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

[2] 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.

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

34 **Exhibits 1** and **2** broadly show that increases in cost align to increased new demand. However, cost growth is exceeding inflation and needs to be planned. The Annual Plan 2026–27 does not set out the costs for cancer services. While the Health Board includes cancer costs within divisional budgets, it cannot clearly identify the total planned spend on cancer services. As a result, it cannot easily assess whether funding is sufficient to deliver its cancer priorities and meet future demand. This is a major gap, especially given the scale of cancer services, increasing demand, and ongoing financial pressures, including high-cost treatments and drugs.

Wider resourcing requirements

35 The Health Board clearly understands its workforce pressures. These include vacancies, skills shortages, and limited capacity. Pressures are greatest in diagnostics, such as endoscopy and radiology, and in tumour sites including breast, urology, and gastrointestinal services.

36 The Health Board manages these pressures through regular operational meetings, tumour site reviews, and Cancer Delivery Group oversight. These forums help teams identify risks and resulting actions.

37 The Health Board's workforce planning focuses on addressing current challenges. Staffing gaps in areas such as breast radiology, urology, and gastrointestinal services are monitored and managed through specialist recruitment, pathway redesign and, where possible, additional staffing.

38 Workforce gaps remain and are expected to continue. There is no clear cancer workforce plan. As a result, workforce planning focuses on short-term fixes rather than building sustainable capacity to meet the suspected cancer pathway target.

39 The Health Board recognises the importance of its estate. However, there is no clear estates strategy showing how it will sustainably meet cancer service estate needs.

40 Equipment risks are recognised, but planning to address them is limited. The Health Board does not have clear cancer specific plans for equipment maintenance, replacement, or investment. Key equipment, including endoscopy, is ageing and requires significant investment. While the Health Board makes some individual investments, it does not plan for future demand growth.

41 Cancer services face significant digital challenges. Current systems support basic patient tracking and day-to-day oversight, but there is a heavy reliance on manual data entry into Excel spreadsheets. As a result, real-time tracking of cancer performance is constrained.

42 Automation of data collation is limited, and systems do not integrate well with national platforms or partners. These issues limit visibility across the patient pathway, and data availability delays lead to delayed responses to problems.

43 Digital in the main supports day-to-day tracking, rather than service transformation. The use of Artificial Intelligence to support cancer services is in its infancy across the health sector. However, the Health Board could consider how technology could improve outcomes for patients and drive service efficiencies.

Cancer prevention and population screening

The Health Board is not maximising the benefits of cancer prevention or using data effectively to take targeted action and improve screening uptake

44 The All-Wales Cancer Improvement Plan estimates that 38% of cancers each year are preventable. Even a modest reduction would release significant capacity and reduce costs. For context, if the Health Board prevented just 20% of cancers, it could save around £2.2 million[4] in bed days. **Exhibit 3** shows the potential gains if the Health Board successfully implemented an effective cancer prevention strategy.

[4] Based on 2024-25 activity data, the most recent financial data.

Exhibit 3: potential capacity gains from cancer prevention, Cardiff and Vale University Health Board, based on 2024–25 activity.

	2024–25 actual	-10% reduction	-20% reduction	-38% reduction
Finished consultant episodes	**10,054**	**9,049** (1,005 reduction)	**8,043** (2,011 reduction)	**5,610** (4,444 reduction)
Admission episodes	**9,730**	**8,757** (973 reduction)	**7,784** (1,946 reduction)	**5,429** (4,301 reduction)
Bed days	**22,374**	**20,137** (2,237 reduction)	**17,899** (4,475 reduction)	**13,872** (8,502 reduction)
Bed day cost savings		(**£1.1** million)	(**£2.2** million)	(**£4.2** 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

Notes:

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

45 Population health intelligence is well developed, but it is not being used by the Health Board to drive large-scale cancer prevention initiatives.

46 The Health Board uses a wide range of public health data to understand cancer risk. This includes data on smoking, obesity, alcohol use, and vaccination. It also looks at differences by age, gender, deprivation, and location. This helps the Health Board understand where cancer risk is higher and where inequalities exist.

47 This data is used by the Health Board to support its targeted prevention work. For example, smoking cessation and vaccination programmes focus on areas of highest need. This shows a clear understanding of risk and variation across the population.

48 The Health Board understands key risk factors, including population growth, ageing, and inequalities. However, it does not sufficiently use population health data to inform cancer prevention planning and prioritisation. Financial constraints also limit prevention activity. This reduces the scale of prevention work and makes it harder to maintain in the long term.

49 There is also little evidence that population health data shapes service design, cancer service planning, or future demand modelling.

Approaches to improving population lifestyles

50 The Health Board delivers a range of programmes to promote healthy lifestyles and reduce cancer risk. However, their overall impact is limited.

51 The Annual Plan 2026–27 includes prevention at a strategic level. The plan focuses on improving population health and reducing inequalities, such as vaccination and screening uptake. However, it gives only a high-level view of prevention and lacks detail on cancer specific actions.

52 The Health Board takes part in national prevention programmes, such as smoking cessation and healthy weight schemes. These shape local prevention work and help direct resources to where they are most needed. There is also targeted local activity, including outreach and adapted approaches to improve access for seldom heard groups.

53 Despite this, funding challenges limit the scale and effectiveness of these programmes. As a result, current activity is unlikely to deliver population-level change. In addition, the Health Board should be doing more to learn from previous prevention work to improve future delivery.

54 The Health Board monitors preventative activity and reports on these in Board and performance reports. This provides an understanding of trends and highlights where improvement is needed. However, the Health Board needs to consistently review outcomes data to understand the impact of programmes over time.

Targeted prevention and population screening

55 The Health Board has clear referral routes for patients whose cancer is identified through national screening programmes. However, it does not routinely hold or use screening uptake data, which limits its ability to understand participation patterns, identify groups less likely to attend, and take targeted action to improve uptake. Better use of screening data would help identify non-attendance and address barriers to engagement.

56 Performance data also shows that the timeliness of screening services are negatively impacting on overall timely diagnosis and treatment in some areas, particularly for bowel cancer pathways.

57 The Health Board uses population data to target HPV vaccination uptake, including mobile services for Gypsy, Roma and Traveller communities. This shows a proactive approach to improving access. HPV uptake is close to the Wales average, although there remains scope to increase uptake further to maximise protection against HPV-related cancers.

Cancer leadership and oversight

Operational leadership supports short-term improvement, but strategic oversight of cancer services needs strengthening

Managerial leadership

58 The Health Board has clear executive and operational leadership for cancer services. The Chief Operating Officer has overall responsibility, supported by a Cancer Manager who oversees day-to-day performance. Senior managers make decisions on priorities and spending within agreed limits. The Chief Operating Officer and senior leaders support timely decision-making when needed. This includes agreeing additional clinics and other short-term actions to manage performance pressures.

59 There is no current Cancer Board. A similar group operated previously, bringing together managers and executive leads, but it is no longer active. This reduces cross-organisation coordination and focus on long-term improvement. Establishing a Cancer Board which included staff, primary care, third-sector, and patient representatives, could help the Health Board promote openness and joint working to solve problems.

60 Overall, leadership is strongest at an operational level. Teams work well together to manage immediate pressures. Regular meetings and tumour-site reviews help them monitor performance and waiting lists and take swift action when needed. However, the focus on day-to-day pressures limits the capacity to develop and implement longer-term changes that could improve access and support future service demand.

61 Regional working and leadership are essential to make sure that patients get the right cancer care at the right time. In South-East Wales, health boards plan and deliver many parts of the cancer diagnosis and treatment pathway. But they also commission and fund Velindre University NHS Trust to provide non-surgical specialist cancer services[5] for most patients.

62 The Health Board participates in regional arrangements to improve cross-boundary working. While these arrangements demonstrate a shared commitment to addressing workforce and service sustainability challenges, progress in delivering the agreed regional workplan has been limited. Consequently, there is no clear evidence that regional collaboration has yet translated into improvements in SCP performance or timely access to cancer services.

Oversight and scrutiny

63 Cancer governance arrangements are in place, but they are not brought together in a clear cancer-specific framework. There is no single group that brings together clinical, operational and senior leaders to oversee cancer services.

64 Wider governance arrangements do not consistently drive action or support effective challenge. The Health Board has not appointed a clinical lead for cancer services, limiting clinical input into decision-making. As a result, accountability for cancer improvement is unclear.

65 The Board receives regular updates on cancer performance through the Integrated Performance Report. The report includes performance against the target for 75% of patients to start treatment within 62 days of cancer suspicion. The report also includes information on backlog levels, key risks, planned actions, and progress. This helps keep Board members informed about SCP performance and wider system pressures.

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

66 However, the reports do not provide consistent or comprehensive information on tumour-site performance, backlog recovery, or cancer outcomes. While some tumour-site performance is reported, it is not presented in a consistent way across reports. This is important because overall performance can mask variation between cancer pathways. As a result, the Board may find it harder to identify areas of sustained underperformance and assess whether improvement actions are delivering the intended benefits.

67 The Board shows active engagement and challenges key areas of underperformance, including cancer pathways and capacity pressures. Members ask relevant questions and request further updates, which supports oversight of performance. However, Board scrutiny remains high-level and focuses on system-wide issues rather than variation within pathways. While the Board approved the Cancer Strategy, there is limited evidence of ongoing monitoring or delivery tracking.

Cancer performance

The Single Cancer Pathway target is not being met, and its current actions are not effective in reducing waiting times or improving outcomes

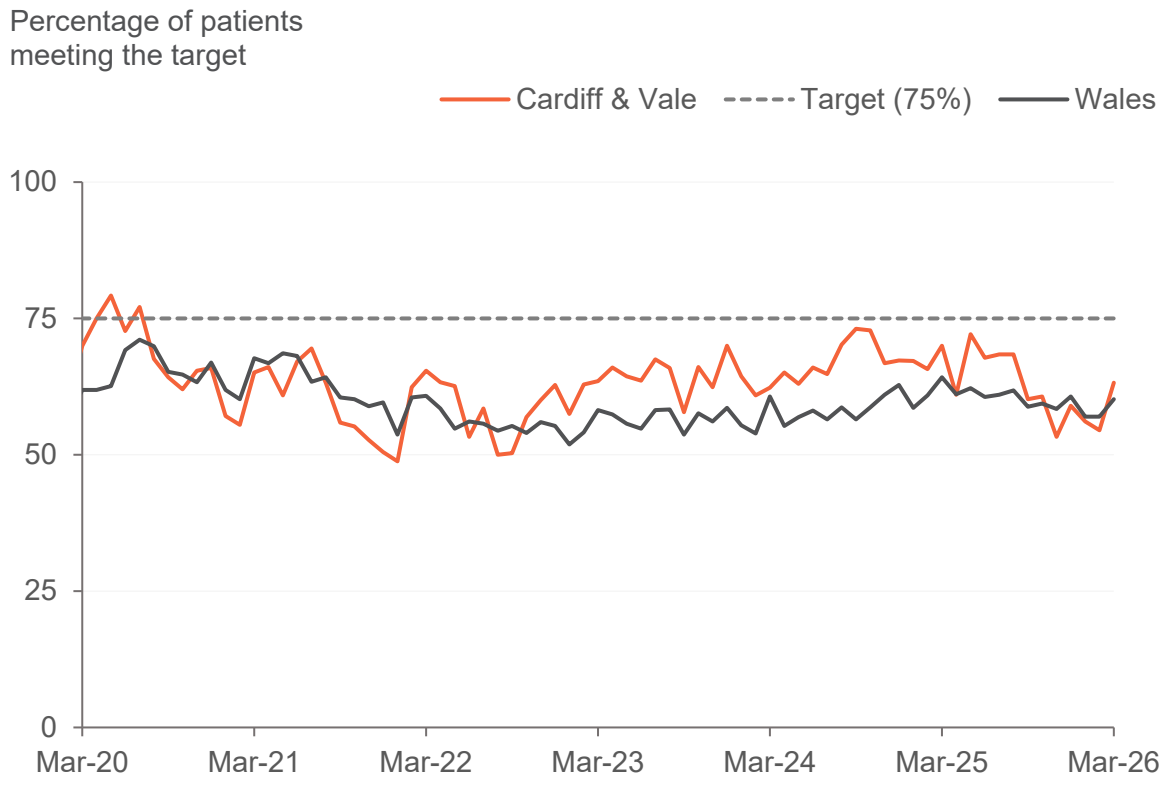
62-day cancer performance

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

69 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.

70 **Exhibit 1**, outlined earlier in the report, shows that the number of new suspected cancer pathways opened each month has substantially increased. Despite this increase over the last four years, the Health Board has done well to ensure performance has not deteriorated. However, the Health Board's performance is falling well short of meeting the national cancer target (**Exhibit 4**), despite broadly reflecting or occasionally exceeding the Welsh average. 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, Cardiff and Vale University Health Board, March 2020 to March 2026 (percentage)



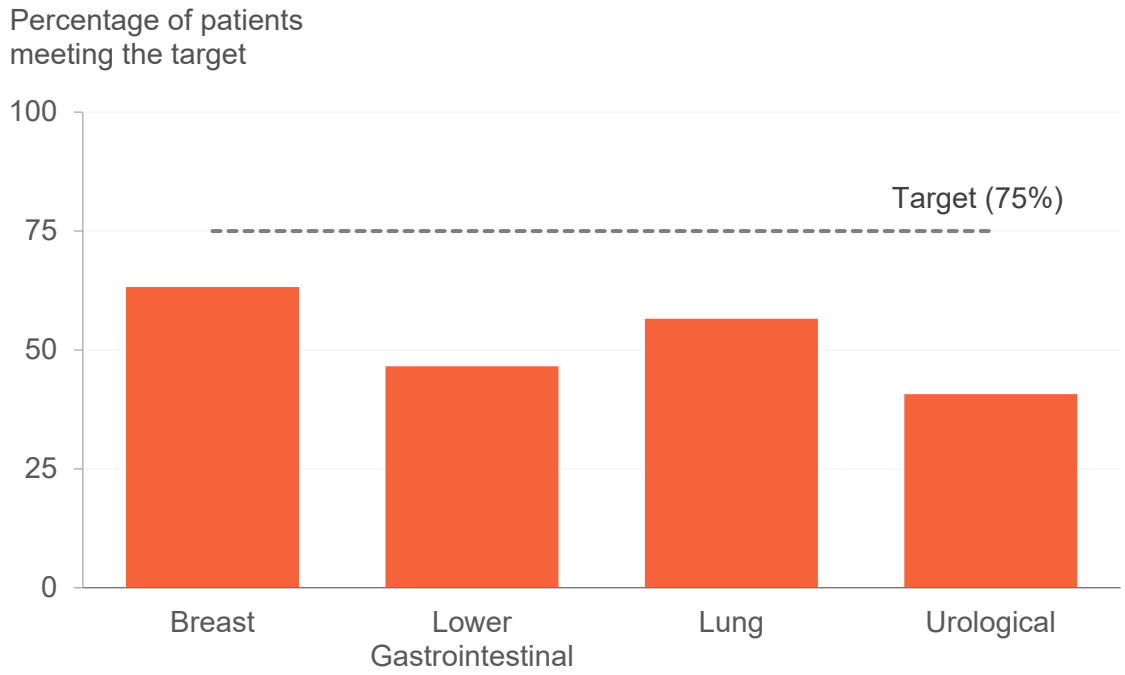
Source: Audit Wales analysis of Digital Health and Care Wales

Note: The data will include patients that waited more than 62 days to be told they do not have cancer, as well as those starting cancer treatment

71 Overall performance also hides large differences between sex and tumour types. In most months during 2025-26 a higher proportion of men than women waited more than 62 days. At its extreme, in December 2025, 73.7% of women started treatment within 62 days. In that same month, that figure for men was 48%.

72 **Exhibit 5** shows performance across four common cancer tumour sites and highlights significant concerns about urological and lower gastrointestinal cancer waits. Some areas, such as skin cancer, are performing better. In March 2026, skin cancer pathways met the target, with 95% of patients starting their treatment within 62 days.

Exhibit 5: patients meeting the 62-day cancer treatment target by tumour site, Cardiff and Vale University Health Board, 12-month average during 2025-26 (percentage)



Source: Audit Wales analysis of Digital Health and Care Wales data. The data will include patients that waited more than 62 days to be told they do not have cancer, as well as those starting cancer treatment.

Notes:

1. The data shown average 62- day performance over the most recent 12-month period (March 2025 to March 2026).
2. Note: The data includes patients who started treatment and confirmed that that they do not have cancer.

Impact of action to improve cancer services

73 The action taken by the Health Board is helping to manage some short-term risks, and performance is closely monitored by leadership. However, this has not led to significant improvement in overall performance or addressed underperformance in some tumour sites. As a result, the focus remains on managing immediate pressures rather than improving services for the longer term.

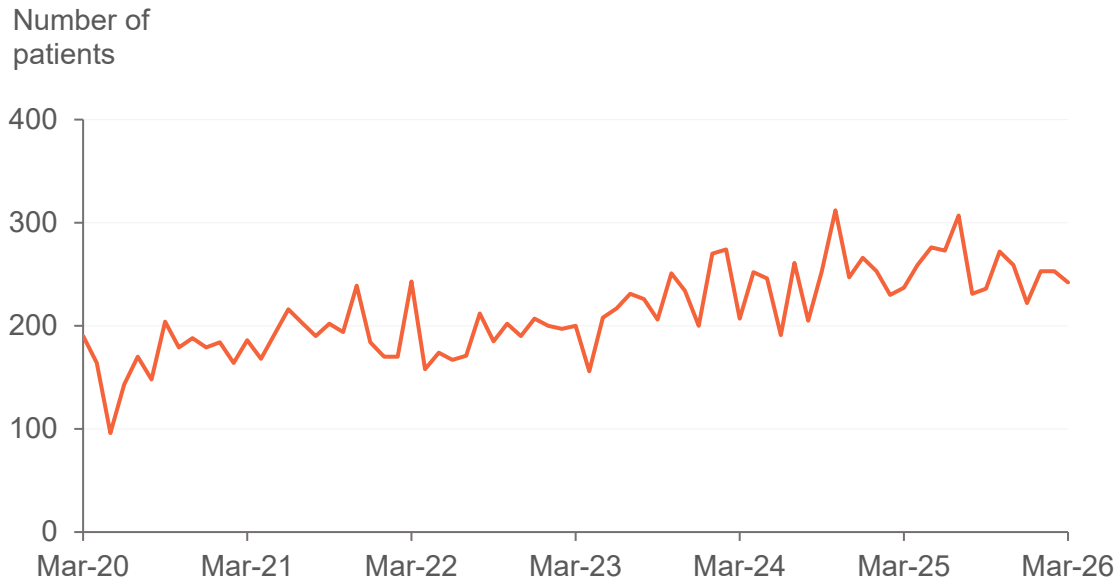
74 The Health Board understands the main causes of poor performance, including rising demand and workforce pressures. Current actions focus on managing these pressures. These include targeted recruitment in key specialties, short-term workforce changes, new roles to support improvement work, and extra clinics and weekend working.

75 Teams respond proactively to performance pressures and adapt their actions to support delivery. They implement a range of improvements, including pathway redesign, extra clinics and sessions, and targeted action in fragile service areas. These actions help manage demand, improve patient flow, and support short-term performance recovery.

76 However, there are no clear milestones or outcome measures linked to these actions. As a result, it is not clear if these actions deliver lasting improvement or achieve the intended results. Overall, improvement activity is visible but does not yet provide assurance that services can maintain progress and meet the 62-day SCP standard.

77 Performance against the 62-day target shows that current actions are not yet having enough impact on improving capacity. The number of patients starting treatment each month has increased gradually since 2020. However, overall activity is not rising at the pace needed to deliver consistent improvement against the 62-day standard (**Exhibit 6**).

Exhibit 6: cancer patients starting treatment each month Cardiff and Vale University Health Board, March 2020 to March 2026 (number)

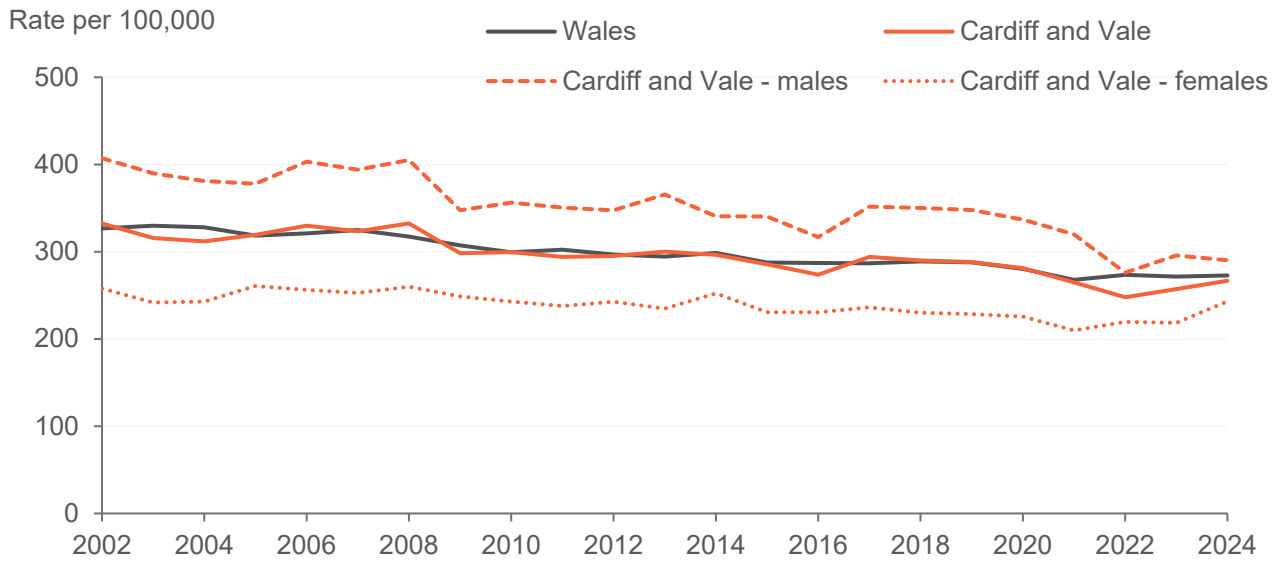


Source: Audit Wales analysis of Digital Health and Care Wales data.

Improving cancer outcomes

78 The Health Board does not use outcomes data effectively to drive improvement. Outcomes data are not reported to senior leaders or the Board. This limits oversight of patient outcomes, and the impact of improvement activity to make related improvements. Also, there is little evidence that services use outcomes data to inform priorities, recovery planning, or system-wide improvement. However, plans are in place to introduce outcome and experience measures.

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



Source: Audit Wales analysis of Public Health Wales NHS Trust

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

79 Analysis of one-year cancer mortality data from 2002 to 2024 (**Exhibit 7**) shows a consistent reduction in mortality over the last 22 years. While the Health Board's cancer mortality rate is in line with the Wales average, outcomes for males remain worse than for females, although improving.

80 While long-term trends are improving, our national report found that cancer outcomes in Wales remain poor compared to other countries. The Health Board needs to focus more on outcomes to develop targeted and prioritised improvement actions.

Recommendations

Cancer services planning

R1 The Health Board should urgently develop a costed cancer improvement plan, to ensure sustainable delivery of the cancer strategy as demand increases. The plan should:

- be based on current and projected future demand;
- include capacity plans aligned to projected demand;
- be costed, at a minimum, over the medium-term (three to five years);
- be supported by resource plans, including: finance, workforce and infrastructure (estates, equipment);
- include specific, measurable, achievable, relevant and time-bound (SMART) improvement actions and milestones;
- include clear arrangements for monitoring delivery, evaluating impact, and reporting progress against planned actions and outcomes; and
- be approved by the Board.

(**Paragraphs 13-41**).

Prevention and screening

R2 The Health board should work collectively with other Health Boards and Public Health Wales NHS Trust to agree, as soon as possible, a comprehensive dataset for analysing screening services. This should include:

- Timeliness across each part of the current three national cancer screening pathways and lung screening, once fully rolled out.
- Information on screening uptake rates and variations across population groups, including age, location, sex (where applicable), and ethnicity (**paragraph 55**).

R3 The Health Board should make better use of screening and population data. It should use this information to identify groups with lower uptake, target support and improve screening rates **(paragraph 55)**.

Managerial leadership

R4 The Heath Board should, as a priority, appoint a clinical lead for cancer services to ensure appropriate clinical input in decision making (**paragraph 64**).

R5 The Health Board should urgently re-establish the Cancer Delivery Board to strengthen governance, improve accountability, and drive cancer performance improvement (**paragraph 59**).

Cancer progress reporting

R6 The Health Board should collect and use patient experience and outcomes data as soon as possible to inform cancer planning (**paragraph 78**).

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:

- Managerial cancer lead;
- Executive lead for cancer services;
- Clinical nurse for cancer services; and
- Director of Public Health.

We also held a focus group with the operational specialty management leads for lung, lower gastrointestinal, urological, and breast tumour sites.

2 Key terms in this report

Term	Description
62-day 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.
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 (e.g., COVID-19), focusing on waits, pathways and outcomes.
Colonoscopy	Endoscopic examination of the large bowel to diagnose/biopsy lower GI cancers.
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.

Term	Description
HPV vaccine	The HPV vaccine helps protect against the human papillomavirus (HPV), a common virus that can cause several types of cancer, including cervical cancer. It works by helping the body's immune system prevent HPV infection.
National Cancer Improvement Plan	National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories.
Population health risks	Modifiable risk factors (e.g. smoking, obesity, alcohol) associated with cancer incidence in local populations.
Real terms spend	Expenditure adjusted for inflation to reflect true purchasing power over time.
Seldom heard	Seldom-heard groups are patients whose voices are often missed when services seek feedback, make decisions, or plan improvements.
Stage at diagnosis	The extent of cancer spread at the time of diagnosis, strongly linked to outcomes and treatment options.
Systemic Anti-Cancer Therapy (SACT)	Drug treatments circulating via the bloodstream (e.g., 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 (e.g. lower gastrointestinal, lung, breast, urological, skin).

3 Management response form

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R1 The Health Board should urgently develop a costed cancer improvement plan, to ensure sustainable delivery of the cancer strategy as demand increases. The plan should: • be based on current and projected future demand; • include capacity plans aligned to projected demand; • be costed, at a minimum, over the medium-term (three to five years); • be supported by resource plans, including: finance, workforce and infrastructure (estates, equipment); • include specific, measurable, achievable, relevant and time bound (SMART) improvement actions and milestones; • include clear arrangements for monitoring delivery, evaluating impact, and reporting progress against planned actions and outcomes; and • be approved by the Board.	A costed cancer plan will be created that aligns with the current Strategic Plan for Cancer. It will include the appropriate demand and capacity plans along with supporting infrastructure and workforce plans. This will be done to the best of our ability given the current digital systems available to us. This will be submitted to the board for approval. The timeline for this action has been chosen to give enough time for the national Cancer Strategy to be released in Feb 2027 and for us to read, understand and align our local plans accordingly.	June 2027	General Manager – Cancer Services

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R2 The Health board should work collectively with other Health Boards and Public Health Wales NHS Trust to agree, as soon as possible, a comprehensive dataset for analysing screening services. This should include: • Timeliness across each part of the current three national cancer screening pathways and lung screening, once fully rolled out. • Information on screening uptake rates and variations across population groups, including age, location, sex (where applicable), and ethnicity.	We will take this collective action through the Cancer Network and NHS Wales Performance and Improvement to ensure we contribute to a national solution.	March 2027	General Manager – Cancer Services
R3 The Health Board should make better use of screening and population data. It should use this information to identify groups with lower uptake, target support and improve screening rates.	Cancer Services within CAV UHB will work with local Public Health teams to maximise the use of population level data to help inform future cancer services including screening rates. This will also form part of a wider UHB structure around cancer than is built on the reinstatement of the Executive Cancer Board.	March 2027	General Manager – Cancer Services & CAV Public Health Consultant

	Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R4	The Heath Board should, as a priority, appoint a clinical lead for cancer services to ensure appropriate clinical input in decision making.	This process is already under way and the advert is live.	December 2027	Director of Operations for Clinical Diagnostics and Therapeutics, Cancer, Diagnostics and Regional Partnerships
R5	The Health Board should urgently re-establish the Cancer Delivery Board to strengthen governance, improve accountability, and drive cancer performance improvement.	We will re-establish the Cancer Delivery Board in conjunction with recommendation 4 (appointing a clinical lead). We will also have the appropriate workstream structures to support the board.	December 2027	Executives

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R6 The Health Board should collect and use patient experience and outcomes data as soon as possible to inform cancer planning.	We will take advantage of the existing patient experience and outcome data we have available within the UHB to inform cancer planning. We will, where possible, strengthen the information we collect. We will also develop a specific workstream that aligns to the wider cancer governance structure which focuses on patient voice and experience. This will provide valuable lived experience data that can help shape our services and inform our wider cancer plans.	March 2027	Lead Cancer Nurse & wider Cancer Services

About us

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The Auditor General carries out their 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.

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