A turning point for cancer in Wales

CRUK Response to the 10-year cancer strategy call for evidence

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CANCER RESEARCH UK

Together we are beating cancer

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Foreword

Just over 20,000 people in Wales are diagnosed with cancer every year, and this will grow to nearly 25,000 by 2040. These numbers are not just statistics: every diagnosis is a person's life changed, friends and family impacted.

Major advances in diagnosis and treatment mean that cancer outcomes have improved dramatically in the last 50 years. Dedicated people across Wales work to improve outcomes by providing care, and through research and innovation.

However, the Welsh Government must respond to a stark reality. Cancer survival in Wales has not kept pace with improvements in comparable nations over the last 20 years, patients often wait too long for diagnosis and treatment, and there are significant inequalities in cancer risk and outcomes.

This means that the commitment to a 10-year cancer strategy for Wales is a critical moment – a landmark opportunity to turn things around. Other nations, like Denmark, have used long-term plans to drive real improvements for cancer, and with the right focus, the Welsh Government could do the same.

Outcomes will be improved by taking opportunities along the whole cancer pathway. More than 1 in 3 cancers could be prevented. Work on screening programmes, help-seeking, and access to diagnostic tests could drive down late-stage diagnoses. With a nationwide focus on meeting treatment standards and investing in research, patients across Wales could have better outcomes from their treatment.

But to take these opportunities, the Welsh Government must engage with the reasons that Wales has fallen behind. NHS services are under sustained pressure, and successive national reports have shown the work of brilliant NHS staff has been undermined by uncertainty, fragmentation, and a lack of clear priorities.

A vision for improving cancer outcomes is an important first step, but the success of cancer strategies ultimately depends on implementation. This means putting in place strong leadership, funding and incentives, coupled with strong priorities, a roadmap for NHS organisations and accountability for delivery in every area.

These systems will not be in place by February 4th 2027. Publication of the strategy must therefore be a milestone, not the end goal. Welsh Government must continue to build the infrastructure to deliver for cancer patients over the next 10 years.

Cancer Research UK teams work with NHS organisations across the UK to help bring cancer strategies to life, and we remain committed to working constructively with Welsh Government to help harness this strategy, and work towards longer, better lives, free from the fear of cancer.

Executive Summary

By prioritising and driving the right actions the Welsh Government could prevent over 5,000 deaths from cancer by 2040. The cancer strategy can drive improvements through a focus on the following areas:

1. Build an infrastructure capable of delivering the cancer strategy for the long term
2. Reduce future generations' cancer burden through prevention
3. Reduce the rate of emergency presentations and late-stage diagnosis
4. Improve survival through innovation, research, and optimal treatment for all
5. Protect funding for cancer workforce and equipment to meet rising cancer demand

What success could look like

- **At 3 years:** reduction in smoking prevalence, improvements in screening uptake, improvements in meeting national cancer audit standards, reductions in emergency presentations, improvements in patient experience
- **At 5-7 years:** reduction in risk factors, reduction in rate of late-stage diagnosis, improvements in survival by stage, improvements in mortality
- **At 10 years:** improvements in international rankings on cancer survival

We recommend that the following metrics are used to monitor progress and hold organisations to account for the cancer strategy.

Prevention	Achieve a smokefree Wales by 2040
	Reduce overweight and obesity rates
	Increase HPV vaccination uptake
Diagnosis	Increase screening uptake
	Reduce age-standardised incidence rate of late-stage diagnoses
	Reduce rates of emergency presentation
Treatment	Meet audit standards and reduce variation in care
	Increase stage-specific survival
Outcomes	Move up international rankings on cancer survival
	Improve patient experience and outcomes
Performance	Meet the Suspected Cancer Pathway target by 2030
	Reduce investigative and diagnostic waiting times
	Reduce the number of very long waits for cancer treatment

Recommendations Summary

Below is a summary table of actions we recommend for the 10-year cancer strategy.

Area	**Recommendation**
Earlier Diagnosis	Fully implement a national lung cancer screening programme, supported with sufficient workforce, diagnostic capacity and smoking cessation services.
	Address inequalities in screening uptake by using tools to identify targeted approaches and by supporting the upcoming Screening Equity Action Plan.
	Set out resources within Public Health Wales (PHW) to prepare for improvements in screening programmes now and in the future.
	Deliver tailored campaigns to improve timely presentation by the public to health services.
	Deliver a package of immediate support to improve cancer recognition, assessment of cancer risk, and address diagnostic wait times.
	Strengthen primary care readiness for innovation by optimising coding and reporting systems, and improving data linkage.
Treatment	Increase and consider reconfiguration of treatment capacity to ensure equitable access to optimal treatment.
	Harness National Cancer Audit, supporting data collection, and backing quality improvement initiatives to close treatment variation.
	Ensure treatment decision making is fit for increasing treatment complexity by supporting implementation of the MDT charter and equitable access to prehabilitation.
	Prepare for changes in treatment demand by planning for increased surgical and radiotherapy activity and ensuring genomically-enabled tests and personalised treatments are available to everyone who could benefit.
Patient Support	Restart regular National Cancer Patient Experience Surveys (CPES), ensure every patient is allocated a Clinical Nurse Specialist (CNS) or other Key Worker, and are given a Holistic Needs Assessment (HNA) if needed.
	Ensure people affected by cancer are involved in meaningful ways, and include them in oversight arrangements for cancer pathways.
	Work closely with the third sector, to meet the needs of patients everywhere in Wales.
Research	Increase quality-related (QR) funding for Welsh Universities.
	Set clear direction and expectations, through NHS Planning and Accountability frameworks, for Health Boards to protect staff time and resources for clinical research.
	Hold NHS organisations accountable for delivering to clinical research activity metrics, through quality and performance arms of the NHS Wales Accountability Framework.

	Support the Cancer Innovation Adoption Pathway, to prioritise to bring the most promising innovations to patients across Wales.
Health System	Set out support for primary care access and cancer practice.
	To meet rising demand, funding must increase for cancer service workforce and equipment.
	Increased investment to treat cancer is needed to improve outcomes.
	Create national clarity on workforce and capital planning for cancer.
Digital and Data	Invest in analytical resource across the National Cancer Team, DHCW and WCISU for routine publication of key cancer data.
	Routine data must be reported with demographic and regional breakdowns.
	Maintain and build on successful research and quality improvement initiatives, making data easier to link, access and use.
	Patients should remain at the centre of improvements in digital systems and cancer data, with data shared where it can improve patient experience.
Inequalities	Improve data collection, and linkage of and access to demographic data across healthcare, to understand and tackle inequalities other than deprivation.
	Embed a focus on inequalities across all strategy actions, and hold NHS organisations to account for closing gaps.
	Act on screening as an important and addressable driver of inequalities.
	Focus on understanding variation in access to services.
Metrics	The strategy should adopt a broad set of specific ambitions and targets, alongside the current SCP target. Addressing cancer inequalities must be baked into these metrics. Mechanisms to monitor hold health systems accountable to delivering these key metrics are key.
Delivery	Continue working after strategy publication to build a system capable of delivering the cancer strategy.
	Build National Cancer Leadership and Teams with a remit to deliver the strategy.
	Deliver a resourcing and implementation plan.
	Deliver a data and evaluation plan.

Full Response

How should the national cancer strategy improve outcomes?

By prioritising and driving the right actions Wales could prevent over 5,000 deaths from cancer by 2040:

Cancer is the leading cause of death in Wales, and by 2040, the number of new cases is projected to rise by more than a tenth. Analysis by the International Cancer Benchmarking Partnership (ICBP) also shows that Wales has historically fallen behind comparable countries in survival.

This submission details actions needed to improve outcomes. However, this strategy must also focus on the systems and structures that are needed to deliver those actions. Cancer strategies are made successful by leaders and teams overseeing them, funding to enact them, incentives and accountability for delivery, and effective prioritisation for NHS organisations to follow. The new Welsh Government must make the commitments and put in place the mechanisms to continue work after publication.

Reduce late-stage diagnosis

CRUK have modelled how many deaths could have been avoided over 5 years in Wales, if patients diagnosed with cancer in 2022 were caught one stage earlier. For bowel, stage 4 to 3 this is around 320, 3 to 2 is 160, 2 to 1 is 60. For lung these figures are around 100, 100, and 40. For female breast, around 80, 50, 80. For prostate, around 340 deaths could be avoided by moving from stage 4 to 3.

Reducing rates of late-stage diagnosis requires action across multiple fronts, discussed further in **Question 2.**

Improve survival at each stage by delivering innovation, research, and optimal treatment for all

Closing the gap in access to optimal treatment across regions and groups in Wales will contribute to an improvement in survival. This means access not only to standard high-quality care but also access to clinical trials and the latest innovations. We know that Wales delivers lower levels of treatments for patients diagnosed at the same stage, than countries where patients survive their cancer longer. Wide variation in access to clinical research, use of optimal treatment, and outcomes, must be closed. We discuss optimal treatment in detail in **Question 3**, and research access in **Question 5**.

Protect funding for cancer workforce and equipment to meet rising cancer

demand

New cancer cases in Wales will increase by >10% over the course of the strategy. Cancer Waiting Times targets (a key component of Patient Experience, **Question 4**) have never been met across Wales. Alongside optimising new diagnostic tools and pathways, the strategy must meet this reality by protecting investment in cancer services and equipment. It must also support primary care through their vital role in improving cancer (**Question 6)**.

Build an infrastructure capable of delivering the cancer strategy

Effective strategies catalyse joined-up plans and activities and build these together to improve outcomes.

For example, an effective strategy could join up efforts across different NHS bodies to fund smoking cessation, roll out lung screening, invest in diagnostics, SABR and surgery capacity, and protect clinical research time for advancing care. Efforts across the system could transform lung cancer into a less common and more survivable disease, reducing inequalities in outcomes (**Question 8**).

Joined up progress is what changes cancer outcomes. It has been seen in other nations, but held back in Wales by fragmentation and uncertainty.

The strategy must also be coproduced with public, patients, and carers, to ensure it represents the views of people affected by cancer in Wales.

The Welsh Government must keep working after strategy publication, to build a coherent national approach. It must invest in data analysis capacity (**Question 7**) and hold organisations accountable to metrics across the cancer pathway (**Question 9**). It must refresh National Leadership with a remit to oversee and support delivery of the strategy, and invest in implementation, meeting our six pillars of an effective strategy (**Question 10**).

Reduce future generations' cancer burden through prevention, addressing the 33.9% (unpublished analysis) of cancer cases attributable to avoidable risk factors.

14.7% of all cancers are caused by smoking. Implement and enforce the Tobacco and Vapes Act, and fully fund smoking cessation tools and services.

7.3% of all cancers are caused by overweight/obesity (unpublished analysis). 27% of children aged 4-5 are overweight/obese, which substantially increases the risk of being overweight/obese as an adult. Implement The *Healthy Weight: Healthy Wales* strategy.

Almost all cases of cervical cancer are caused by human papillomavirus (HPV) infection. Improve HPV vaccination uptake in areas and groups with lower uptake.

How can more cancers be detected at earlier stages?

Accelerate progress on reducing late-stage diagnosis.

Reducing late-stage diagnosis represents one of the biggest opportunities to improve cancer survival in Wales. As well as reducing cancers diagnosed at late stage, the strategy must aim to reduce diagnosis via emergency presentation, which is associated with later-stage disease, poorer outcomes and worse patient experience.

The strategy must lay out actions across multiple fronts to reduce late-stage diagnosis and emergency presentation through:

Screening

Cancer screening programmes are one of the most effective ways to reduce late-stage diagnosis and improve outcomes. However, inequalities in uptake and delayed adoption of screening recommendations means some will not benefit from this.

Fully implement a national lung cancer screening programme, supported with sufficient workforce, diagnostic capacity and smoking cessation services.

With full national coverage, and 60% uptake, lung screening in Wales could save around 120 lives each year. Wales has committed to a national lung cancer screening programme starting 2028 and has undertaken important preparatory work. The strategy should commit to a fully funded national rollout, delivered at pace, to a timeframe similar to England's 2030 target to reduce disparity across nations and save lives sooner.

Address inequalities in screening uptake by using tools to identify targeted approaches and by supporting the upcoming Screening Equity Action Plan.

There is lower screening participation for some groups, including those from the most deprived areas. Different groups experience different barriers. Using tools like Cancer Research UK's Bowel Grid, which maps evidence-based interventions to participation barriers, allows a targeted approach to addressing inequalities. The upcoming Screening Division Equity Action Plan will also detail actions to address inequalities, and the strategy should support this plan through investment and accountability for delivery.

Set out resources within Public Health Wales (PHW) to prepare for improvements in screening programmes now and in the future.

Previous changes to screening programmes have highlighted challenges in implementing innovation and recommendations at pace (e.g., with cervical self-sampling). We know that the screening landscape will continue to change and develop as research and innovation progress (e.g. risk stratified approaches for

breast screening). The strategy needs to ensure that PHW, working with relevant system stakeholders e.g. Health Boards and DHCW, is ready to implement those changes to avoid delays in screening advancements.

Help-seeking

Delays in help-seeking for potential cancer sign and symptoms can contribute to late diagnosis and poorer outcomes. Research shows help-seeking behaviours and barriers to presentation, including access to primary care, vary across regions and sociodemographic factors. Almost 1 in 5 people who tried to contact their GP about a potential cancer symptom reported being unable to make an appointment.

Deliver tailored campaigns to improve timely presentation by the public to health services.

The strategy should draw upon behavioural evidence and population insight, like CRUK's Cancer Awareness Measure 'Plus', to deliver targeted approaches that support help-seeking, particularly for those most at risk of delayed presentation. This could include delivery of national and local campaigns, or working in specific communities with a range of tactics to target barriers.

Improve access to primary care.

Most patients receive a cancer diagnosis following a GP referral. It is therefore important that the strategy lays out actions to improve primary care access as the main route to diagnosis.

Recognition, referral and diagnosis

Evidence shows that many more cancers could be diagnosed at an early stage through timelier symptomatic presentation. It is therefore essential to support primary care to recognise symptoms quickly, and optimise existing referral pathways, to detect these patients earlier, while preparing for innovations that will support timely referral and diagnosis.

Deliver a package of immediate support to improve cancer recognition, assessment of cancer risk, and address diagnostic wait times.

This should include actions to support GPs referral and safety netting practice, improve cancer awareness across the primary care workforce, and the piloting and evaluation of evidence-based triage tools and pathways (e.g. breast pain pathways) to support the identification of those at higher risk of cancer and safely reassure those with a low risk. The strategy should also consider service redesign to streamline investigations through diagnostic elective hubs and remote triage to reduce diagnostic waits.

Strengthen primary care readiness for innovation by optimising coding and

reporting systems, and improving data linkage

This will expedite the adoption process and enable primary care to fully leverage innovations, such as risk stratification tools that depend on integrated data sets, allowing more patients to benefit sooner.

How should the NHS prepare to deliver future cancer treatments?

Increase and consider reconfiguration of treatment capacity to ensure equitable access to optimal treatment.

Almost 1 in 5 people in Wales are projected to be aged 70 or over by 2038. This demographic shift is expected to drive an increase in cancer incidence and prevalence, while also contributing to higher levels of multimorbidity. By 2040, an estimated 1 in 5 adults could be living with a major illness, increasing the complexity of cancer treatment and care.

At the same time, efforts to reduce late-stage diagnosis and the adoption of novel treatments will change patterns of treatment activity.

Wales needs to be ready to meet this rise in treatment demand and complexity. However, compared to similar countries, Wales delivers lower levels of chemotherapy and radiotherapy for cancer patients diagnosed at the same stages, and has lower overall and stage-specific survival.

The strategy must outline actions to organise and equip services to meet rising demand while delivering increasingly complex care. To achieve this, the strategy should explicitly link to wider mechanisms that would enable reconfiguring services, balancing the potential for improved outcomes in hospitals that treat more cancer patients, with risks this might generate such as reduced accessibility with a lack of transport. Wales can take inspiration here from examples across the UK, such as the Christie NHS Foundation Trust.

Harness National Cancer Audit, supporting data collection, and backing quality improvement initiatives to close treatment variation

Audits such as NATCAN are a valuable source of data on treatment. Despite data quality issues in Wales, they show that there is significant variation in treatment delivery, with key treatment standards across multiple cancer sites not currently being met.

The strategy must firstly set out how Health Boards and Trusts will support cancer service staff to minimise duplication with new digital systems, and aim to improve the quality and completeness of data submitted for audit.

Secondly, it must back quality improvement responding to audit findings, by establishing a national oversight role and strong clinical leadership to drive improvements in quality cancer care.

Ensure treatment decision making is fit for increasing treatment complexity by supporting implementation of the MDT charter and equitable access to

prehabilitation.

Every patient should receive coordinated, high-quality decision making to ensure they get the most appropriate treatment and care.

The strategy should support widespread implementation of the MDT charter and consider the development of standards to ensure that the right patients are discussed by the right MDT, at the right time, with the right information, enabling high-quality treatment decisions and timely care.

Prehabilitation is important for helping patients prepare for treatment and improves recovery and outcomes. We welcome the inclusion of prehabilitation into all national optimal pathways for cancer. However, delivery and access vary widely in Wales across regions and patient groups. The strategy should support Health Boards address gaps in provision to ensure access to prehabilitation is equitable.

Prepare for changes in treatment demand by planning for increased surgical and radiotherapy activity and ensuring genomically-enabled tests and personalised treatments are available to everyone who could benefit.

Services are under pressure and struggling to provide timely treatment for patients. In 2024-25, while SCP performance was highest among patients treated with surgery (64%), followed by SACT (45%), and lowest in radiotherapy (33%), no treatment modality met the target of 75% (data provided by DHCW on request). The strategy must address these challenges for patients now as well as planning for increasing treatment demand in the future.

Early diagnosis initiatives, including lung screening, will increase the number of cancers diagnosed at an earlier stage. Because early-stage cancers are more likely to be treated with surgery or radiotherapy such as SABR, demand for these treatments is expected to rise. The strategy must plan for this increase through upgrading and replacing kit and software, as well as the adoption and national roll-out of proven interventions that will support efficiency and timeliness e.g. AI for radiotherapy planning.

Advances in targeted and personalised therapies also mean more patients are eligible for genomically enabled tests and treatments. Wales should build on the success of the QuicDNA project to maintain timely test results that can be integrated into treatment decisions. The strategy should consider actions to prepare services for future innovations, including tests in new cancer sites and emerging treatments like cancer vaccines.

What support should individuals, carers and families receive during and after cancer treatment?

Restart regular National Cancer Patient Experience Surveys (CPES), ensure every patient is allocated a Clinical Nurse Specialist (CNS) or other Key Worker, and are given a Holistic Needs Assessment (HNA) if needed.

Cancer patient experience surveys are a crucial tool for understanding the support people affected by cancer want and receive.

In the 2021 CPES, 19% of patients reported that they were not given access to a CNS or key worker, around 30% of respondents did not find it easy to contact their CNS or key worker, and only 42% of patients were given the opportunity to discuss their needs.

This matters: being allocated a CNS point of contact affects how likely a patient is to receive different treatments and influences their clinical outcomes.

HNAs are an important tool to identify patient needs, which if acted upon, can improve outcomes. Support following on from a HNA, like collaborative conversations, patient literature, and access to transport solutions play an important role in enabling patients to undergo treatment.

Wales is currently only able to act on data collected from patients treated in 2020. The strategy must prioritise new, regular national CPES, encouraging benchmarking and shared learning across Health Boards. It can also encourage more Health Boards to undertake local survey work and deeper dives to better understand local patient experience issues.

Ensure people affected by cancer are involved in meaningful ways, and include them in oversight arrangements for cancer pathways

CRUK welcomes commitments made in the Cancer Quality Statement and Cancer Improvement Plan 2023-26, such as for all patients to be provided with a CNS point of contact and for support to be available 24/7, as well as embedding patient reported measures into national optimal pathways. We also welcome recent work to formalise a core set of National Quality Standards for person-centred care.

However, to speak to what matters for people affected by cancer, the strategy must engage in coproduction with public, patients, and carers when developing these priorities.

Further, for commitments to translate to impact, consideration must be given to how they will be measured, evaluated, and NHS organisations held to account for improvements against them.

Work closely with the third sector, to meet the needs of patients everywhere in

Wales

The strategy must enable close working with the third sector as valued partners, providing services which improve patient experience. For example, CRUK provide several resources to support communication with patients, the CRUK Nurse Helpline, alongside the Cancer Chat forum.

Other examples include Maggie's hubs, Tenovus Mobile Support Units, and 5k Your Way. Improving the Cancer Journey (ICJ) in Powys form a partnership between Macmillan Cancer Support, Powys Council, and Powys Teaching Health Board, connecting people with support across prescriptions, health and wellbeing, finance, transport, etc.

We know that not every patient in Wales is informed about these offers, and that this support is not equitably available to everyone affected by cancer in Wales.

The new cancer strategy must invest in communicating to patients the support offer available to them, and work closely with the third sector, to scale support services and make them available for every patient in Wales.

What opportunities exist to strengthen cancer research, clinical trials and innovation in Wales?

Research and innovation (R&I) drive breakthroughs in cancer prevention, detection and treatment. There are examples of strong cancer R&I in Wales, like QuicDNA, a cross-sector collaborative which drove forward scaling and evaluation of an innovative test to support treatment selection for lung cancer. Targeted investment and coordination from the Welsh Government is essential to ensure that the strengths demonstrated in these programmes are replicated system-wide.

Increase quality-related (QR) funding

To unlock long-term growth in Welsh R&I activity, **Welsh Government should increase foundational research investment in universities.** QR funding is crucial for universities to support the infrastructure and workforce that makes research possible. It also rewards, and therefore incentivises, research excellence. However, between 2010-11 and 2023-4, real-terms QR funding fell by over 20% in Wales, a larger drop than in England and Scotland. Further support from Welsh Government would strengthen the Welsh university research base, support the development of cross-sector partnerships, and attract funder investment.

Embed clinical research in the NHS in Wales

Patients who are treated in research-active institutions have better outcomes than those who aren't, even if they're not participating in research. Research should become a routine part of care in Wales, and Welsh Government should engage with all measures to facilitate research, like the Health Data Research Service (HDRS), which has invested in a number of Technical Transformation Projects in partnership with SAIL Databank.

Set clear direction and expectations, through NHS Planning and Accountability frameworks, for Health Boards to protect staff time and resources for clinical research.

Our Clinical Research Workforce survey identified limited NHS time for research as a major barrier to research, a fact reflected in responses from Welsh researchers. Efforts to strengthen clinical research, such as the Tackling Cancer Through Research initiative, are welcome, but are constrained by unclear governance and accountability. To deliver real change, clear expectations must be set for protected clinical research time.

Hold NHS organisations accountable for delivering to clinical research activity metrics, through quality and performance arms of the NHS Wales Accountability Framework.

R&D-specific metrics would incentivise Health Boards to make research a core part of care, while also allowing the Welsh Government to identify variation in research activity across the country, and hold NHS organisations accountable for delivering research. We understand that work in this area is currently being developed by the Welsh Government- which is welcomed.

These measures will not only help to embed research into the NHS in Wales, but will improve the attractiveness of the Welsh research environment for investment into commercial and non-commercial research. This will stimulate greater activity in the sector, helping to create a stronger R&I ecosystem.

Support the Cancer Innovation Adoption Pathway, to prioritise to bring the most promising innovations to patients across Wales

Currently, routes to adoption for proven innovations in Wales are poorly defined, subject to local decision-making, barriers, and resource availability. Evaluations and pilots are often uncoordinated across localities, concentrated in centres of excellence, and driven by enthusiastic individuals rather than strategic need. Adoption of innovations is slow and uneven across Wales, and opportunities for alignment are missed.

The Cancer Innovation Adoption Pathway, established by the NHS Wales Joint Commissioning Committee (NHSWJCC) presents an opportunity to deliver a nationally-coordinated approach to adopting proven cancer innovations. To have the maximum impact for people affected by cancer in Wales, **the NHSWJCC requires commitment of long-term funding and a national mandate from the Welsh Government, to deliver a robust process for selecting innovations and to support system-wide implementation.** The pathway should take inspiration from Scotland's Accelerated National Innovation Adoption (ANIA) pathway by embedding:

- A needs-led approach, identifying priority areas of unmet need.
- Robust and transparent identification, assessment, and prioritisation processes supported by partnerships, such as with ongoing work with CRUK on impact assessment.
- Clear mechanisms for adoption, creating resources to support implementation, and with planning, accountability, and funding arrangements to ensure delivery.
- Robust real-world evaluation processes, supported by effective data flows, to generate relevant evidence.

Ensuring clear governance and accountabilities between the entities responsible for innovation adoption in Wales, alongside a well-resourced and prioritised research infrastructure, will accelerate the use of new technologies and reduce inequalities in access and uptake. This would not only benefit people affected by cancer, but could drive economic growth. Clear routes to delivery for new innovations would attract investment into emerging innovation ecosystems.

What future workforce, equipment and facilities will be needed to deliver high-quality cancer care in Wales?

Set out support for primary care access and cancer practice

General practice is centrally important to cancer improvement, across screening participation, healthier behaviours, and in promptly recognising, referring, and safety netting patients with suspected cancer. In UK nations, most cancer diagnoses are made following a GP referral. The strategy must consider how it will support GPs with education, information, and tools.

It must also recognise that providing this cancer best practice is difficult at a time when FTE GP numbers have fallen by 19.5% since 2012. In 2024, almost 1/5 in Wales people who tried to contact their GP over a suspected cancer symptom reported being unable to make an appointment

We acknowledge Welsh Government's commitments on primary care, and response to the Senedd inquiry into the future of general practice. If met, commitments to move health board funding into primary care, and to review core funding for general practices, could help to improve the situation for primary care. The success of the new cancer strategy is interwoven with this wider policy area, and it must be aligned to take advantage of coming changes.

To meet rising demand, funding must increase for cancer service workforce and equipment

Cancer Waiting Time targets in Wales have never been met. This indicates that cancer services capacity is already insufficient to meet demand for diagnosis and treatment, which will rise over the course of this strategy. CRUK projects around 24,800 new cases every year in Wales by 2038-40, alongside more people living longer and requiring continuing care after a cancer diagnosis.

International evidence shows that cancer strategies are more likely to succeed when they catalyse sufficient investment in cancer service workforce and equipment. Current limitations in cancer service funding mean that Health Boards are often unable to recruit to meet demand, even when diagnostics professionals have been trained within Wales.

Key workforce groups needing focus include Radiologists, with a 42% shortfall in consultants in North/West Wales, versus 22% in South Wales, Clinical Oncologists, with shortfalls for 39% and 11%, respectively, and Pathologists, where 74% of pathology consultants in Wales do not believe staffing levels are adequate to ensure long-term stability of pathology services.

The workforce needed to deliver cancer care is complex, and the strategy must also consider staff outside of only 'cancer services', such as for smoking cessation

services. CRUK are currently working to develop definitions of the cancer workforce to support policymaking.

Increased investment to treat cancer is needed to improve outcomes

Countries that have accelerated survival improvements over time have shared characteristics, including greater use of optimal treatments such as chemotherapy and radiotherapy than in Wales.

This suggests that the Wales may need to plan to deliver more treatments per person than it currently does if it is to match the outcomes achieved in other countries. This will require data-led investment in workforce, training, and equipment.

The strategy can also play a key role in securing investment to support new services. For example, introducing lung screening will result in increased demand for radiology, surgery, and the surrounding system such as oncologists, cardiothoracic surgeons, and MDT coordinators. Building a genomics-capable oncology workforce is also a central plank of delivering new and more effective drugs.

Create national clarity on workforce and capital planning for cancer

Investment in cancer workforce and equipment is presently fragmented, and without a clear, shared view across Wales of where investment is needed to meet demand. The strategy must contain actions to clear the path, such as:

- Publishing data and insights, modelling cancer demand and capacity across Wales, and where workforce/capital investment is needed.
- Clearly setting out the responsibilities of HEIW and Health Boards/Trusts to plan the cancer workforce, and ensuring Health Boards and clinical networks have sufficient expertise and support to utilise well-evidenced career development frameworks like ACCEND.
- Ensuring new capital investment, and new infrastructure such as surgical hubs from Government are well-integrated with local cancer pathways.

To ensure focus on this vital area, we recommend including cancer services as part of the workforce pillar in the new NHS Wales Accountability and Support framework.

What improvements in digital systems and cancer data will support improved care and outcomes?

Invest in analytical resource across the National Cancer Team, DHCW and WCISU for routine publication of key cancer data

Data is a crucial tool to measure improvement and drive cancer strategies forward. However, Wales has fewer staff and systems for routine cancer data analysis than other countries such as Scotland. As a result, Wales publishes fewer crucial data insights than other nations and is among slowest of UK nations for publishing core data on cancer incidence, survival, and mortality.

With more analytical resource, Wales must look to routinely publish a new set of data to guide cancer improvement, including:

- **Routes to diagnosis** (RtD) reporting where and how patients are diagnosed is crucial to targeting earlier detection through screening and symptomatic pathways. Every other UK nation publishes RtD data.
- **Time to diagnosis** – More detailed monitoring of cancer waiting times, looking at time to diagnosis or having cancer ruled out would provide better understanding of pressures on diagnostic capacity and strong accountability for patient experience.
- **Treatment Use** gives crucial insights into changing demand for modalities such as SACT, radiotherapy, and surgery.
- **Any new metrics** introduced to monitor and hold NHS organisations to account for progress against the strategy (Question 9).

More resource will also allow Wales to publish core cancer data, such as cancer incidence and stage at diagnosis, faster. Timely availability of this data is crucial for tracking progress and trends.

Thew strategy must clearly set out the role of DHCW, WCISU, and the National Cancer Team with regards to cancer data, and how they fit under cancer governance structures (Question 10).

Cancer Research UK would be happy to discuss where we could offer support and collaboration on projects that could drive progress faster to enable more specific monitoring.

Routine data must be reported with demographic and regional breakdowns

Breakdowns in data are critical for identifying where focus is needed. The routine collection and reporting of data on demographics, diagnosis, treatment and outcomes for every patient is invaluable in improving cancer outcomes for everyone.

Across all routinely reported cancer data, breakdowns should be available across groups such as: Age, Sex, Deprivation, and Ethnicity. This will also require close working to support cancer service teams across Health Boards on consistent capture of demographic data.

Data should also always be available by cancer site and health board. For stage at diagnosis and emergency presentations, case-mix adjusted data should be produced to facilitate regional comparisons and better analysis of trends over time.

Where small numbers risk identifying patients, data should be aggregated to larger timeframes to avoid this, whilst still championing visibility**.**

Maintain and build on successful research and quality improvement initiatives, making data easier to link, access and use

National Cancer Clinical Audits are a good example of linking and analysing data to identify unwarranted variation in treatment and where it can be addressed. The SAIL databank is also a valuable resource to link data in Wales for cancer research and improvement.

However, more must be done to integrate health data and research, clarifying the roles of resources like the SAIL databank and National Data Resource, and making access easier. This would support publication of key data, analysis and research which improves our understanding of cancer.

Patients should remain at the centre of improvements in digital systems and cancer data, with data shared where it can improve patient experience.

Effective safeguards remain essential to maintain the confidentiality and security of patient data, and for analysis and research to be undertaken in a transparent way. Any changes to how health data is used for research must be accompanied by meaningful public engagement to ensure that health systems retain public trust. Mistakes, real or perceived, have the potential to undermine any positive advances.

However, there are also examples of where increasing data availability by centring patients could improve care. For example, data sharing across the border with England would help patient care feel more cohesive for those undergoing tests, diagnosis or treatment.

What actions will help address differences in outcomes between people with protected characteristics, people living in different health board areas, or people affected by different types of cancer?

Improve data collection, and linkage of and access to demographic data across healthcare, to understand and tackle inequalities other than deprivation.

Inequalities in cancer outcomes faced by people with different characteristics, with different types of cancer, and in different health boards, occur for different reasons, and have different solutions. To tackle unwarranted variation in outcomes and care, improvements must be driven across multiple fronts.

For example there is evidence that:

- People with learning disabilities experience higher cancer risk, less access to optimal treatment, and poorer survival.
- People from different ethnic groups also experience different rates of cancer incidence across multiple cancer sites.
- People of different ages experience variation in access to cancer treatments, some of which may be unwarranted.
- Geography also influences access to optimal treatment, and increased time travelling to a cancer centre has been associated with increased risk of mortality.

However, relatively little data is available to understand where these inequalities are arising in Wales, and how they might be addressed, and previous work has identified issues in collection of characteristics data such as ethnicity.

Embed a focus on inequalities across all strategy actions, and hold NHS organisations to account for closing gaps

People in the most deprived areas of Wales have a 20% increased incidence of cancer, reflecting increased exposure to risk factors, and an overall 50% increased rate of cancer mortality, reflecting factors such as poorer access to services, lower screening participation, more emergency presentations. CRUK estimates that around 1,400 deaths from cancer in Wales per year are attributable to differences in outcome due to deprivation. Nearly half (46%) of these deprivation-associated deaths are from lung cancer, again reinforcing the importance of funded stop smoking services, and implementation of the tobacco and vapes bill.

Previous work to tackle cancer inequalities, such as recommended in the All Things Being Equal Report has stalled, as few mechanisms have been put in place to deliver action.

The new strategy must ensure that well-understood opportunities to close inequalities in cancer outcomes are delivered into real practice, with robust mechanisms to drive, monitor, and hold NHS organisations to account for actions.

Screening is important and addressable driver of inequalities

Screening participation is higher amongst people in the least deprived areas of Wales, compared to the most deprived, across the bowel (16.9 pp higher), breast (17.3pp higher), and cervical (14.6pp higher) programmes.

The strategy must look to close inequalities through evidence-based interventions, such as telephone outreach, that can be taken to reduce inequalities in participation. The CRUK bowel grid tool synthesises this evidence to help health systems prioritise and target interventions, based on their potential to improve participation in specific groups. Local-level action and accountability through Health Boards, using data such as in the CRUK Local Bowel Screening Tool for England, must underpin this work.

As people who live in more deprived areas are more likely to be diagnosed with and die from lung cancer than those in less deprived areas, lung screening has the potential to benefit these communities the most. But people from more deprived areas also face the biggest barriers to participation, as they're less likely to respond to an invitation for screening and more likely to decline it. The Cwm Taf Morgannwg pilot embedded strategies to overcome barriers to participation and achieved a 58% uptake rate – higher than other previous UK trials and pilots.

Focus on understanding variation in access to services

There are several signals, in survey data of cancer workforce, cancer audits, and levels of clinical research activity, of disparities in the cancer services available across Wales. However, because Health Boards and Trusts across Wales are largely independent, with a mixture of different agreements underpinning patient pathways (such as different commissioning models for all three tertiary cancer centres), there is no comprehensive map of which patients in Wales can access what services. The strategy must focus on understanding and addressing this variation.

How can success in improving cancer services and outcomes be measured?

The strategy should adopt a broad set of specific ambitions and targets, alongside the current SCP target. Addressing cancer inequalities must be baked into these metrics.

While mortality and survival remain important measures of success, they are slow to change and report. The strategy should therefore include short-medium term indicators of progress that look at the drivers of cancer death and survival.

Mechanisms to monitor hold health systems accountable to delivering these key metrics should be included in performance and accountability frameworks. Such metrics should be reported on a national and health board level and will be critical to maintaining momentum, guiding investment, and ensuring the NHS continues to deliver effective cancer care.

Below is a suite of metrics that could be used. CRUK is happy to work with Government to inform development of these metrics, as we did for England's National Cancer Plan.

Prevention metrics

- **Achieve a smokefree Wales.** Wales's ambition – as set by the previous administration - is to achieve this by 2030, but based on current trends, this isn't expected until the early 2040s. The UK's Smokefree Action Coalition recommends a target of reducing UK smoking prevalence to under 1% by 2040.
- **Reduce overweight and obesity rates.** Healthy Weight Healthy Wales has set the ambition to see a sustained reduction in both childhood and adult obesity levels. There is scope for increased ambition during the 2030s.
- **Increase HPV vaccination uptake.** Meet WHO target that by 2030, 90% of girls should be fully vaccinated against HPV by age 15; and develop a target and plan to reach cervical cancer elimination.

Diagnosis metrics

- **Increase screening uptake** across Wales for each screening programme. This metric should consider different patient groups and targets should align with the Screening Equity Strategy and be part its monitoring and evaluation process.
- **Reduce age-standardised incidence rate of late-stage diagnoses (stage 3/4)**. This metric is linked to reducing cancer mortality, and reduces the risk of encouraging unnecessary investigations and overtreatment, which may

be incentivised by targets focussing on only increasing the proportion of cancers diagnosed at stage 1/2.

- **Reduce rates of emergency presentation.** This metric can be used as a proxy for late-stage diagnosis for unstageable cancers, ensuring that efforts to improve diagnosis and outcomes are monitored across all cancer types.

Treatment & care metrics

- **Meet audit standards and reduce variation in care.** Audits provide timely evidence for some cancer sites on system performance and variation in care. It can be used to monitor and guide quality improvement efforts in health systems and patient outcomes.
- **Increase stage-specific survival.** Stage-specific survival assesses whether access to care and clinical management has improved, and whether treatments have become more effective.

Outcome metrics and ambitions

- **Prevent over 5,000 cancer deaths between now and 2040.**
- **Move up the international rankings on cancer survival.** Wales has historically fallen behind comparable countries in survival. The latest wave of ICBP data is due to be published by early 2027 and can be used to benchmark success by tracking improvements in international rankings over the course of the strategy's lifetime.
- **Improve patient reported outcomes and experience.** Monitoring this metric will be important for understanding whether the strategy is having an impact on improving what is important to patients and can be used by Health Boards to support the delivery of NOPs.

Performance metrics

- **Meet SCP target by 2030.** Across Wales, the national target has never been met since its introduction in 2019.
- **Reduce investigative and diagnostic test waiting lists.** This metric will allow the tracking of efforts to effectively manage capacity and triage patients for investigative tests and support timely diagnosis.
- **Reduce the number of very long waiters for cancer treatment.** In England, this is defined as any patient waiting for more than 104 days to begin treatment after an urgent referral.

What success could look like?

- **At 3 years:** reduction in smoking prevalence, improvements in screening uptake, improvements in meeting audit standards, reductions in emergency presentations, improvements in patient experience

- **At 5–7 years:** reduction in risk factors, stage shift, improvements in survival by stage, improvements in mortality
- **At 10 years:** improvements in international rankings on cancer survival

Are there any other comments or suggestions you would like to make?

Continue working after strategy publication to build a system capable of delivering the cancer strategy

Wales is falling behind in survival improvements, and change will not happen because it has been written down. Cancer strategies are made successful by leaders and teams enabling the transformation, funding to enact them, incentives and accountability for delivery, and effective prioritisation for NHS organisations to follow. NHS Wales is under strain, with an ageing, more complex population, and many competing demands. Without adequate support, the strategy will fail to catalyse improvements.

Denmark succeeded in improving cancer outcomes because of implementation arrangements, sustained investment and rigorous monitoring of progress.

Wales is not meeting this challenge. Reports from Audit Wales and a Ministerial Advisory Group, highlighted uncertainty, fragmentation, and discoordination which has held back cancer improvement.

To ensure delivery and momentum, the strategy must be accompanied by a new set of clearly articulated arrangements, establishing roles and responsibilities for implementation through the system, and what mechanisms (such as Performance and Escalation) will be used to ensure progress. This means taking the time after launching the strategy February 4th to convene and consider key questions around prioritisation, implementation, accountability, monitoring and resourcing.

Delivery arrangements must also set out how the strategy will respond to the structural issues hindering cancer improvement in Wales:

- Years of disruption to the National Cancer Team, and an uncertain remit and future form within NHS P&I.
- Variation in the governance, leadership, and planning underpinning cancer across Health Boards.
- Variation in commissioning arrangement across all three tertiary cancer centres, without a population-level view of needs or access for treatment.
- Health Boards not held to account for a range of national cancer priorities, such as tackling screening inequalities.

To meet our 6 tests for an effective cancer strategy, the Welsh Government must continue work in this area through 2027, with a focus on **how** to deliver, working towards the following milestones:

National Cancer Leadership and Teams with a new remit to deliver the strategy

National Cancer Leadership must clearly establish lines of reporting, governance, and priority setting across groups pursuing improvement, such as the Tackling Cancer Initiative, and Wales Cancer Industry Forum.

The National Cancer Team should have a clinical and a managing director, should appoint a set of visible leaders at the national and local level, and deploy teams aligned to strategy delivery areas, such as cancer performance, earlier diagnosis or optimal treatment. Crucially, it must clearly establish a remit to support Health Boards and Trusts to locally implement national policy, and their role in holding NHS accountable for delivery.

Across the UK, we see that dedicated, resourced structures, with close links to NHS providers (Health Boards, Trusts) make it much more likely that national strategy translates into real action on the ground and progress being made. Welsh Government can learn from examples across the UK and internationally, in how cancer strategies have been governed and implemented. Cancer Alliances are one such structure in England, which are embedded regional ICBs/Trusts, and through annual planning, play a crucial role translating national ambitions into local action.

A resourcing and implementation plan

This plan must be developed alongside Health Boards and Trusts, setting out priority actions for the next three years, and how these will be delivered through funding, planning cycles and performance frameworks. Welsh Government could seek to replicate work in Scotland, where the 10-year cancer strategy is underpinned by 3-year action plans, with prioritised delivery expectations for NHS organisations.

The implementation plan must also give clarity on **funding**. This could be delivered through a mix of a dedicated strategy fund, changes to planning arrangements for existing NHS allocations, or other routes. In England, some improvements are funded through a Service Development Fund to deliver transformation and improvement through Cancer Alliances into ICBs and Trusts. In Northern Ireland, the 2022-32 Cancer Strategy was accompanied by a dedicated funding plan.

A data and evaluation plan, setting out key metrics to be used in monitoring the strategy, how these will be collected and published, and an investment in analyst capacity through DHCW, WCISU, and the National Cancer Team to do so. Metrics across the cancer pathway are discussed in Question 9, and the case for investment in cancer analytical capacity in Question 7.