

Are cancer services improving?

Betsi Cadwaladr University Health Board

September 2026



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Audit snapshot

What we looked at

- 1 We looked at Betsi Cadwaladr University Health Board's (the Health Board's) approach to managing cancer services. This includes how it plans services, prevents cancer, supports early detection, and leads and oversees service performance.
- 2 We also reviewed trends in cancer service performance. Our 2025 [national report on cancer services](#) highlighted data quality concerns and recommended improvements at a national level. We have not reviewed data quality as part of this review

Why this is important

- 3 Demand for cancer services is increasing, driven by factors such as:
 - an ageing population;
 - rising levels of obesity and alcohol use;
 - better survival rates, meaning patients need ongoing follow-up and monitoring; and
 - the ongoing introduction of new tests and treatments.
- 4 Cancer outcomes are worse when patients wait too long for treatment. Long waits can shorten life expectancy and reduce quality of life after treatment. This increases pressure on health boards to deliver timely care.
- 5 Cancer services account for a growing share of NHS spending. This is driven by increasing demand and the costs of new tests and treatments.

What we have found

- 6 Access to cancer services remains well below the national standard. In March 2026, 54% of patients started treatment within 62 days of cancer first being suspected. The Health Board was once among the better performers in Wales but is now among the worst. As a result, many patients are waiting too long to start cancer treatment.
- 7 The Health Board has put recovery actions in place, but these have not led to sustained improvement. Progress relies heavily on temporary measures, such as insourcing and overtime. The Health Board mainly uses data to monitor current performance. It makes less use of data to predict demand, plan capacity and guide investment.
- 8 The Health Board provides prehabilitation support before, during and after cancer treatment. However, access to these services varies across sites. The Health Board does not always use learning from this work to improve services.
- 9 Senior leaders closely monitor cancer services, and staff work across teams to address delays. However, most effort focuses on current performance issues rather than long-term improvement. The Health Board does not have a single, costed plan for cancer services. As a result, it is not clear how it will address prevention, staff shortages, limited diagnostic capacity, ageing equipment and rising demand.
- 10 The Health Board knows that many cancers can be prevented. However, cancer leaders focus mainly on waiting times and performance. Prevention and early diagnosis are not given the same priority.

What we recommend

- 11 We have made six recommendations to the Health Board in the following areas:
 - developing a costed integrated cancer strategy and delivery plan;
 - monitoring the delivery of the plan;

- improving demand and capacity forecasting;
- establishing a long-term workforce and infrastructure plan to create the capacity to meet current and future need;
- developing a sustainable cancer prevention programme; and
- strengthening the Cancer Board.

Key facts and figures



The number of new suspected cancer referrals rose by 6% between 2022–23 and 2025–26.



The spend on cancer services increased from £135 million to £188 million between 2019–20 and 2023–24. This is £28 million more than if spend had increased with inflation over the same period.



In March 2026, most referrals were for suspected skin cancer (969), lower gastrointestinal (735) and upper gastrointestinal (595) cancers.



In March 2026, 54% 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 69.4% for skin cancer to just 40% for lower gastrointestinal cancer, against the 75% target.



Between 2002 and 2024 one-year cancer mortality rates have fallen by 16.2%.

Our findings

Cancer service improvement planning

Cancer plans are spread across different documents. There is no clear long-term plan to improve services, increase capacity or meet rising demand.

Cancer improvement plans

- 12 The Health Board has several plans for cancer services. The Cancer Roadmap (2024–2029) sets out its main aims. Other plans focus on reducing waits, improving cancer care and supporting services such as dermatology, breast, colorectal and urology. The Integrated Medium-Term Plan (IMTP) also includes actions to improve diagnostics, staffing and service capacity. However, there is no single consolidated plan that brings all of this work together and shows how services will improve over time. While cancer priorities are set out across several plans, it is not clear how these plans work together to manage long-term risks and improve services.
- 13 The Suspected Cancer Pathway (SCP) Delivery Plan sets out the Health Board's priorities for improving performance against the SCP target to start treatment within 62 days of first suspicion of cancer. The plan focuses on reducing pathway delays by increasing diagnostic and treatment capacity. However, many actions rely on short term measures, such as insourcing and overtime. The plan also does not set out the workforce, funding and infrastructure needed to sustain improvement. Actions to reduce inequalities are not a clear part of the plan.

- 14 The Health Board uses National Optimal Pathways¹ to check whether patients move through cancer services in a timely way. It reviews how well services follow these pathways. However, planning assumptions are often too optimistic. Some recovery plans include clear actions and named leads, but this is not consistent. Plans do not always show when actions will be completed or how they will improve services.
- 15 The Health Board works closely with hospitals in North-West England to provide cancer care. However, its plans do not clearly explain this dependency or how it affects service delivery. Plans also provide limited detail on how the Health Board oversees the quality and outcomes of care provided by other organisations. There is also limited evidence that the Health Board routinely uses learning from previous improvement work or best practice to shape future plans.

Cancer intelligence and data

- 16 The Health Board needs to make better use of cancer data and intelligence. It uses data on pathway performance, long waits, differences between tumour sites, diagnostic delays and demand from screening services to manage current pressures. This helps staff understand where problems exist and manage services day to day.
- 17 However, the Health Board makes limited use of data to predict future demand, plan capacity or support long-term improvement. Also, the way services use data is not consistent across the Health Board. Some services, such as dermatology, breast and urology use data to support planning and improvement, while others use it mainly to manage day-to-day pressures. As a result, the Health Board is missing opportunities to improve planning, make best use of capacity, and respond to future demand.

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

Supporting fragile services

- 18 The Health Board understands the main challenges facing cancer services and knows which services perform poorly. These challenges include staff shortages, delays in testing, ageing equipment and limited facilities. However, the level of risk varies between services and across North Wales.
- 19 The IMTP, Cancer Service Plan, SCP Delivery Plan and tumour-site plans all highlight cancer services risk. However, many actions focus on short-term fixes, such as extra clinic sessions, temporary staff and waiting list initiatives. These actions help services cope with current pressures, but they have not led to lasting improvement in cancer performance.
- 20 Some planned changes aim to help patients get diagnosed and treated more quickly. These include straight-to-test services, nurse-led triage and teledermoscopy. The Health Board is also helping more patients prepare for treatment through prehabilitation and receive radiotherapy closer to home. The changes have potential to deliver benefits in the longer-term. However, many are at an early stage, and it is too soon to know whether they will reduce current pressures and provide a sustainable solution. While some actions relate to longer-term solutions, these are often still being developed or depend on uncertain future funding and recruitment.
- 21 The Health Board works with partner organisations to help meet demand for cancer services. In the West, dermatology services rely on insourced staff because there are not enough permanent staff. The Health Board also works with specialist centres in North- West England so patients can receive specialist treatment.

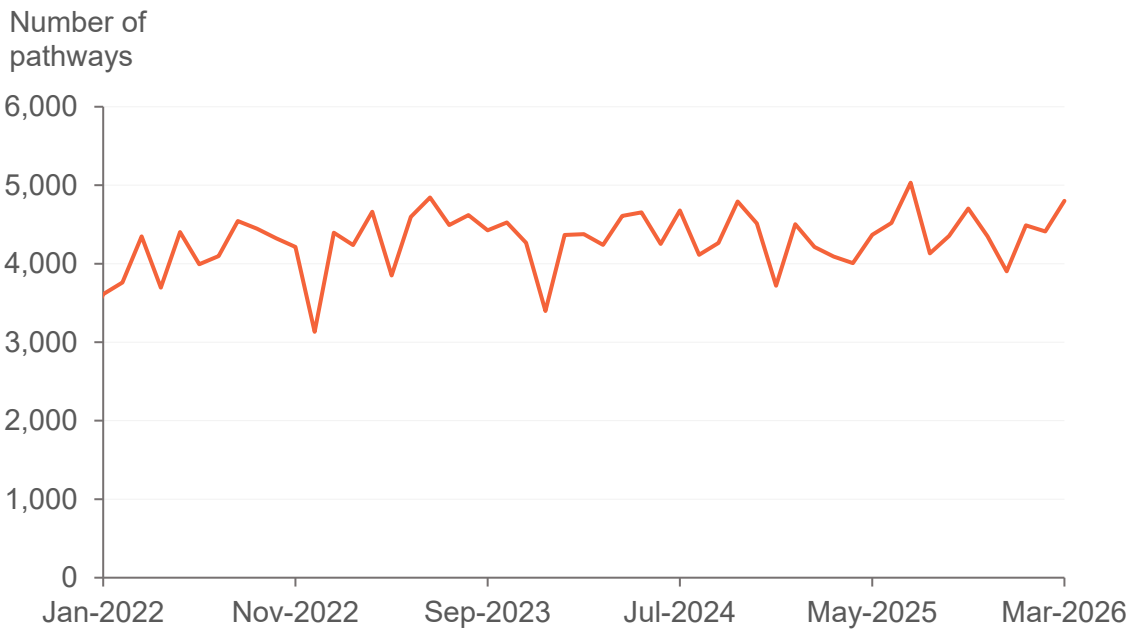
Financial and wider resource planning

There is no clear, balanced, financial or wider resource plan for cancer services

Funding plans

- 22 The Health Board has not identified the total funding that it needs to deliver its cancer improvement plans. Instead, it relies on individual business cases and short-term funding to support service developments. This makes it difficult to understand the full cost of improving cancer services and meeting national standards and targets. It may also mean that the Health Board will not be able to sustainably fund all planned improvements.
- 23 The IMTP includes funding to improve cancer services. This includes diagnostics, radiotherapy and more staff capacity. Funding comes from several budgets, so it is hard to see the total spend on cancer services. Some proposals still need national funding and business case approval before work can start.
- 24 **Exhibit 1** shows the number of new suspected cancer pathways opened each month. This shows a slow but ongoing increase in demand. Changes in demand are not uniform across services though. The Health Board has seen a notable increase in referrals between 2022–23 and 2025–26 in urological (+21%), head and neck (+20%), and gynaecological (+19%) cancers.

Exhibit 1: newly opened suspected cancer pathways, Betsi Cadwaladr University Health Board, January 2022 to March 2026 (numbers)

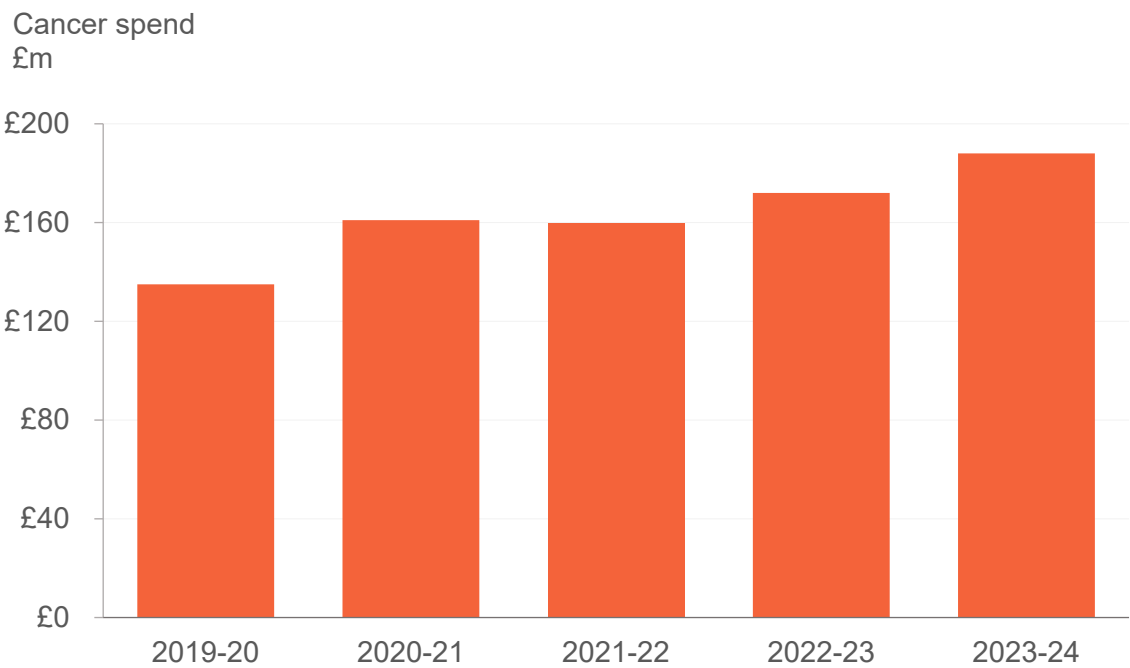


Source: Audit Wales analysis of Digital Health and Care Wales data

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 dies. Note that patients can be on more than one pathway.

- 25 New demand is increasing and the costs have increased faster than inflation. **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board’s cancer spending rose by about 17% above inflation². Spending on hospital cancer medicines has also increased. Between 2019–20 and 2024–25, the Health Board’s spend rose from £135 million to around £188 million³⁴. This is about £28 million more than if costs had increased in line with inflation (in 2023–24 prices).
- 26 The expenditure analysis is based on the cancer expenditure dataset reported to Welsh Government and should be interpreted as an indicator of overall spending trends.

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



² Inflation is calculated using 2023–24 as a baseline and HM Treasury inflation data.

³ Some specialty 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.

⁴ Medicine figures cover hospital spending by the Health Board only and exclude costs for patients treated elsewhere.

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

- 27 **Exhibits 1 and 2** show that spending has increased alongside rising demand. They also show that spending has grown faster than inflation, increasing the importance of effective financial planning. This limits assurance that cancer services will remain affordable and sustainable over the longer term.
- 28 There is evidence that services use financial information to support planning. This includes forecasts, staffing costs, other running costs, savings plans and known financial pressures. However, the Health Board has not brought this information into a single, costed plan for cancer.

Wider resourcing requirements

- 29 The Health Board understands the main challenges facing cancer services. These include staff shortages, limited space, ageing equipment and gaps in services such as robotic surgery. These issues are recognised in the IMTP, Cancer Roadmap and tumour-site plans. However, these plans provide limited detail on future demand, resource needs and delivery timescales. While key requirements are identified, it is not clear how the Health Board will address them in a joined-up way or manage the long-term risks facing cancer services.
- 30 The Health Board uses tools such as teledermoscopy, Chemocare and electronic triage to support cancer services. However, many systems do not link well together. Staff still use spreadsheets and enter data by hand. The Health Board plans to introduce new systems, including electronic patient records and digital diagnostics. These projects aim to reduce pressure on services and improve performance.
- 31 Teams across cancer services, diagnostics and surgery work together to improve care. This has led to nurse-led triage, straight-to-test pathways and changes to multidisciplinary team working. The Health Board also works with specialist centres in North-West England so patients can access treatments that are not available in North Wales.

Cancer prevention and population screening

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

32 The All-Wales Cancer Improvement Plan sets out that 38% of cancers each year are preventable. For context, if the Health Board prevented 20% of cancers, this could have saved £2.6 million in bed day costs⁵. **Exhibit 3** gives an example of potential gains if the Health Board successfully implemented a cancer prevention strategy.

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

		2024-25 actual	-10% reduction	-20% reduction	-38% reduction
	Finished consultant episodes	23,450	21,105 (2,345 reduction)	18,760 (4,690 reduction)	14,539 (8,911 reduction)
	Admission episodes	22,632	20,369 (2,263 reduction)	18,106 (4,526 reduction)	14,032 (8,600 reduction)
	Bed days	26,581	23,923 (2,658 reduction)	21,265 (5,316 reduction)	16,480 (10,101 reduction)
	Bed day cost savings		(£1.3 million)	(£2.6 million)	(£5.0 million)

⁵ Based on 2024-25 activity data, and the most recent current financial data.

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

- 33 The Health Board understands the main factors linked to cancer, including smoking, excess weight, poverty and unequal access to care. It uses this information to target support, including help to stop smoking, manage weight, and increase vaccination and screening uptake. However, the Health Board is not making enough use of this data to plan for future demand. As a result, planning focuses more on current pressures than future needs.
- 34 The Health Board is working closely with its Public Health Directorate, alongside Public Health Wales NHS Trust, to understand local health needs. However, cancer forums focus mainly on current demand, long waits and cancer treatment targets. They don't give enough attention to prevention and early diagnosis.

Approaches to improving population lifestyles

- 35 The Health Board provides services to help reduce the risk of cancer. These include supporting people to stop smoking, manage weight, increase vaccination uptake and improve healthy lifestyles. However, limited funding and competing demands reduce the reach and impact of these services.

- 36 The Health Board is targeting some services at people most at risk of cancer, and some have achieved good results. For example, smoking cessation services, which have exceeded national targets. However, limited funding and staff shortages restrict what these services can achieve. Many programmes rely on short-term funding, making it hard to plan for the future. The Health Board does not always use learning from this work to develop long-term funded plans.
- 37 Data shows that screening does not always help patients get diagnosed and treated quickly. Delays are common in bowel and breast cancer services, where increasing demand, diagnostic capacity constraints, workforce shortages and wider service pressures mean patients do not always receive follow-up tests and treatment within expected timescales.
- 38 The Health Board works with its Public Health Directorate, alongside Public Health Wales NHS Trust, to review screening rates, delays and differences between groups. It uses this information to identify where uptake is low and target improvement actions.
- 39 The Health Board does not make full use of this information when planning for the future. The IMTP recognises that higher screening uptake will increase demand for tests and treatment. However, there is little evidence of plans to provide the extra capacity needed. As a result, existing delays may reduce the benefits of screening programmes.
- 40 Human papillomavirus vaccination (HPV) uptake is 72% against the Welsh Government 90% target. The Health Board has plans to improve uptake through targeted action. This includes work with schools, primary care and groups with lower participation.

Cancer leadership and oversight

Cancer leadership manages current performance and risks but is less focused on longer-term service improvement and redesign

Managerial leadership

- 41 The Health Board has clear leadership for cancer services. Cancer service managers, clinicians, diagnostic teams and oncology staff oversee cancer care. They review performance, manage risks and address delays. Most of their work focuses on current services and waiting times. However, they give less attention to the changes needed to create a sustainable workforce, expand services and improve care over the longer term.
- 42 Leadership capacity varies between tumour sites. Some services do not have enough clinical leadership support. This can make it harder to improve services and manage change. As a result, joint working often focuses on current pressures and waiting times. There is less evidence of teams working together to improve services over the long term, improve patient pathways, or reduce differences in access, experience and outcomes.
- 43 Several teams manage cancer services, including cancer, diagnostic and oncology teams. As a result, services may not always work together in a consistent way to address problems that affect patient care.
- 44 The Health Board works with third sector organisations to support patient care and wellbeing. While these arrangements provide additional support for patients, there is limited evidence of the role that third sector partners play in wider cancer planning and service improvement.

Oversight and scrutiny

- 45 The Health Board has governance arrangements in place to oversee cancer services. They monitor performance and risks, but there is limited evidence that they are driving improvement. Board and committees oversee cancer performance, pathway delays, service risks and performance against national targets. This helps the Health Board to identify and escalate risks and performance concerns. However, their impact on improving services and performance is less clear.
- 46 The Board and committees do not always track whether the Health Board has delivered the agreed actions, and if so, whether the actions have resolved underlying problems. As a result, governance is stronger at identifying issues than demonstrating sustained improvement.
- 47 Attendance at the Cancer Board is mixed, which may limit its ability to drive improvement. Interviews suggest that the Cancer Board is not always used effectively to support change. Discussions tend to focus on performance targets and day-to-day pressures. There is less routine focus on patient outcomes, inequalities or the impact of improvement work.
- 48 Several governance groups and committees share responsibility for cancer services. While this provides oversight from different parts of the organisation, it can make accountability for the whole cancer pathway less clear. It can also make it harder to coordinate improvement work across services and ensure that actions are joined up.

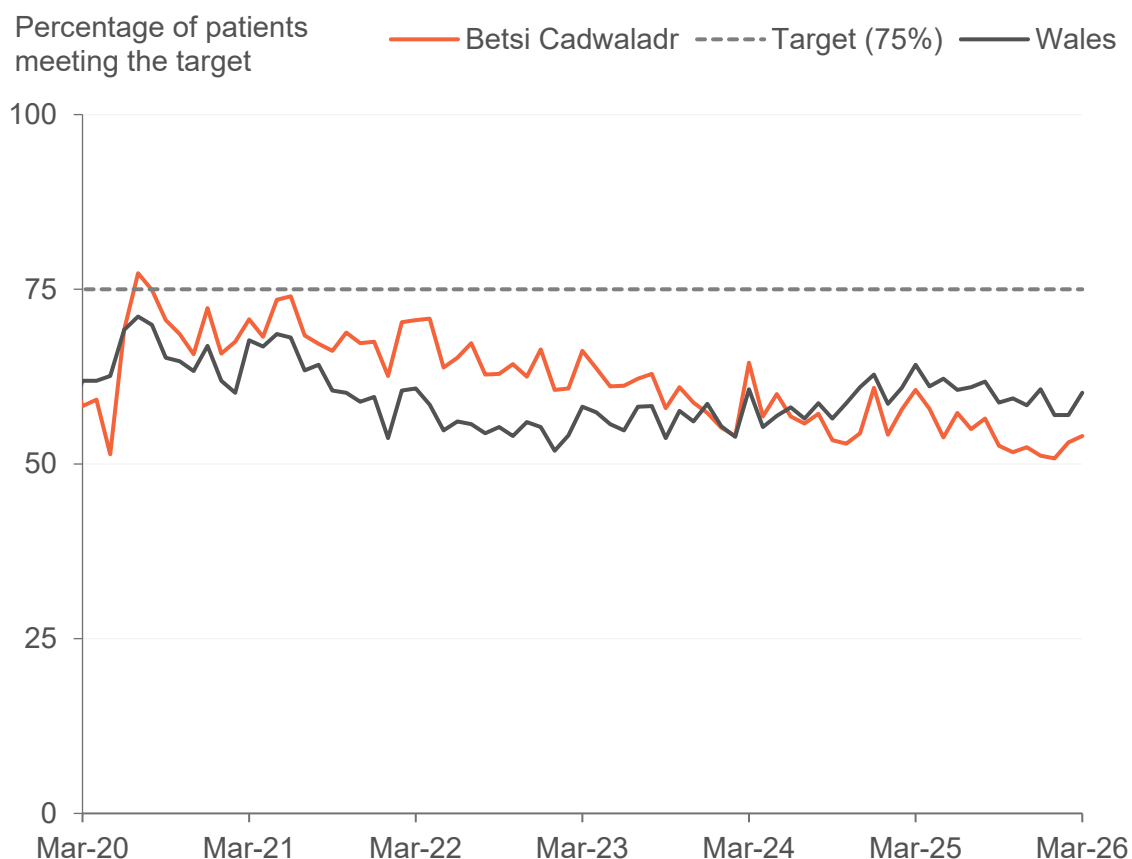
Cancer performance

Actions to improve services have not led to lasting improvements against national targets

62-day cancer performance

- 50 The Welsh Government target is for 75% of patients to start their first treatment within 62 days of cancer first being suspected.
- 51 Early diagnosis and prompt treatment improve outcomes. They increase survival rates and enhance quality of life. Long waits can lead to more advanced cancer. This may reduce life expectancy, limit treatment options and affect physical health after treatment.
- 52 The Health Board's cancer performance is significantly below the national cancer target of 75% (**Exhibit 4**). While fluctuating, performance has shown a general deterioration over the last 4 years. This has seen the Health Board moving from one of the best performers in Wales to one of the worst.

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

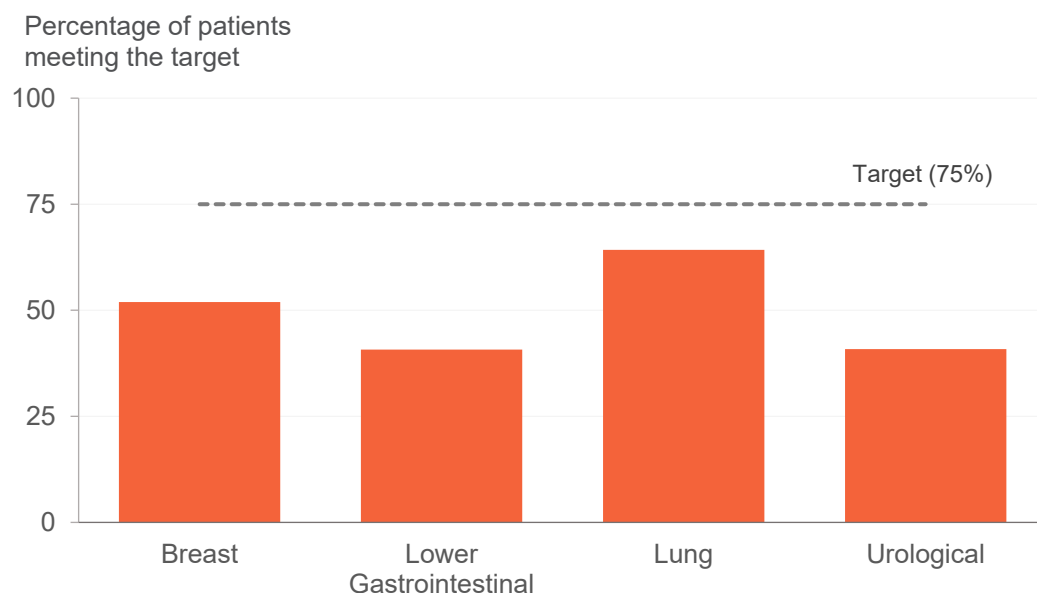


Source: Audit Wales analysis of Digital Health and Care Wales data

Note: The data includes patients who started treatment and confirmed that they do not have cancer.

- 53 Overall performance also hides large differences between tumour types. Some services, such as skin cancer, perform better with a greater proportion of patients starting treatment within 62 days. However, performance is weaker in other areas. **Exhibit 5** shows performance across four common cancer tumour sites. It highlights very concerning lower gastrointestinal and urological and breast cancer wait performance, in particular.

Exhibit 5: patients meeting the 62-day cancer treatment target, Betsi Cadwaladr Health Board, 12-month average during 2025–26



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

Notes:

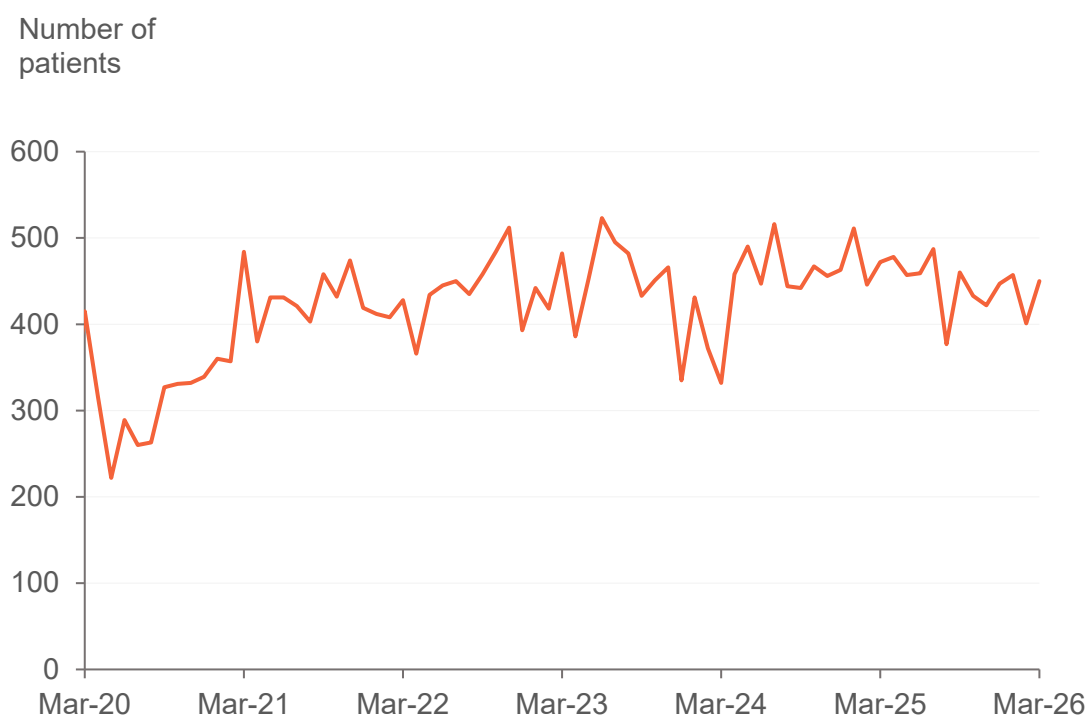
1. The data shows average 62- day performance over the most recent 12-month period (March 2025 to March 2026).
2. Note: The data includes patients who started treatment and confirmed that that they do not have cancer.

Impact of action to improve cancer services

- 54 The Health Board has taken action to reduce some of the longest waits and manage immediate service pressures. However, performance is still below national targets which is likely to result in poorer outcomes for some patients. These actions include teledermoscopy, nurse-led triage, straight-to-test pathways, and more diagnostic support. It has also bought in extra clinical support to reduce waits. These actions have reduced backlogs and improved some services, especially skin cancer services. However, performance is still below target in many areas.

- 55 The Health Board knows why performance is still below target. Demand is rising, there are not enough staff, and patients face delays waiting for tests. The Health Board is recruiting staff, using temporary workers and adding extra capacity to reduce these pressures. However, many of these actions rely on short-term funding. They help in the short term but do not address the problems causing delays.
- 56 The Health Board's actions have improved access in some areas however, overall, the pace of improvement is slow. Service treatment levels overall are not increasing (**Exhibit 6**). This is resulting in 62-day waiting list performance remaining well below the national target.

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

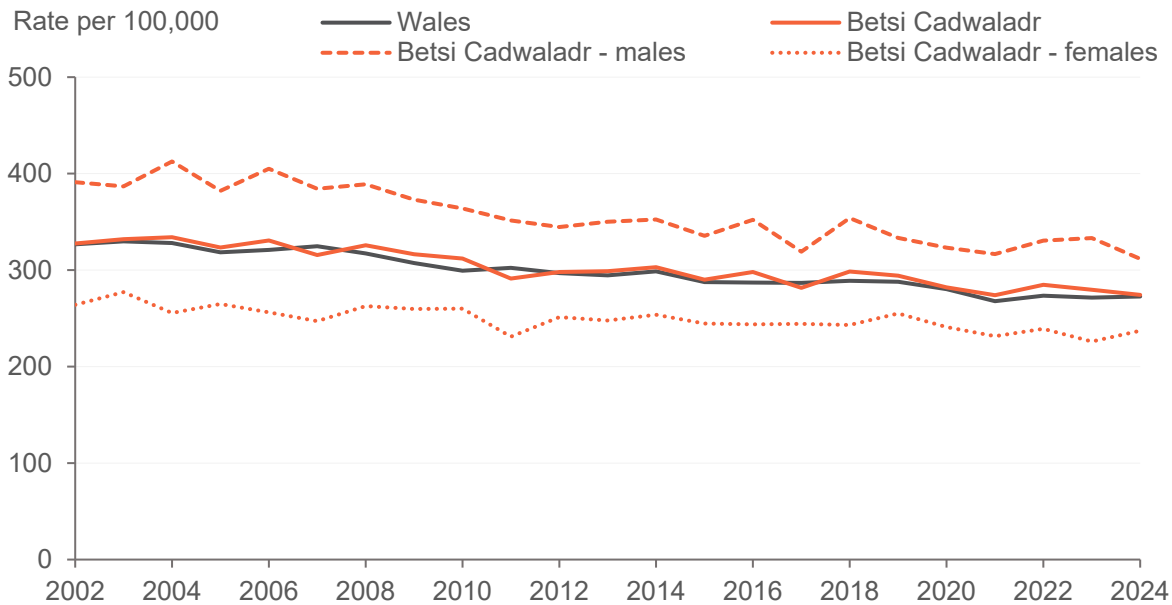


Source: Audit Wales analysis of Digital Health and Care Wales data

Improving cancer outcomes

- 57 The Health Board does not make consistent use of cancer outcomes data. There is little evidence that it uses patient feedback, survival data or stage of diagnosis data to understand whether services meet patients' needs. There is also little evidence that it uses this information to improve services.
- 58 Some services make better use of data. The prehabilitation service tracks patient fitness, complications, readmissions and length of stay. Breast cancer services also use audit results, survival data and patient feedback. Staff use this information to improve care.
- 59 Evidence also shows that findings from national audits have led to changes in some lung and colorectal cancer pathways. However, these improvement approaches are not used consistently across cancer services. While a few services are learning from outcomes, there is little evidence that the Health Board is sharing this good practice more widely across all cancer services.
- 60 Analysis of one-year cancer mortality data from 2002 to 2024 (**Exhibit 7**) shows an ongoing reduction in mortality over the past 20 years. The Health Board's rate is similar to the Wales average. Men are still more likely to die from cancer than women, although the gap is narrowing.

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



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

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

- 61 While long-term trends are improving, our national report found that cancer outcomes are still poor compared to other countries. The Health Board needs to place greater focus on outcomes data to help identify priorities and target improvement work.

Recommendations

Cancer services planning

R1 Develop an executive led single, costed plan for cancer services. The plan should align to the new National Cancer Strategy which will be published in February 2027. The plan should show how the Health Board will improve performance, reduce differences in access to care, and meet the suspected cancer pathway target. It should include clear actions, timescales, named leads and measures of success. (**paragraph 13**)

R2 Put in place clear arrangements to monitor the cancer plan. Set out who is responsible for each action. Report progress regularly and track whether actions are improving services. (**paragraph 15**)

Cancer intelligence and data

R3 Improve forecasting across cancer services. Use this information to understand future demand, identify pressures earlier, and plan staff and services more effectively. This should help the Health Board target investment where it will have the greatest impact. (**paragraph 17**)

Wider resourcing requirements

- R4** Develop enabling workforce and infrastructure plans that align the Health Board's capacity and demand analysis (see **recommendation 3**). The plans should address workforce shortages, estate and equipment constraints in the short-term. They should also target areas of expected growth in demand and create capacity to ensure that services are fit for the future. (**paragraph 28**)

Cancer prevention and population screening

- R5** Develop a clear plan to help prevent cancer. The plan should increase screening uptake, support early diagnosis and reduce differences in access to care. It should include clear priorities, measures of success and long-term funding. (**paragraph 31**)

Oversight and scrutiny

- R6** To strengthen the role of the Cancer Board, it should oversee the whole cancer pathway and be represented by all cancer services to improve care. It should make clear who is responsible for each action and regularly review progress against agreed plans and targets. (**paragraph 46**)

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 not audited the data received by the Health Board or third parties.

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:

- Health Board's cancer lead.
- Executive lead for cancer services.
- Clinical lead for cancer services.
- 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.
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.
Genomic cancer therapies / genetic testing	Testing and treatments guided by tumour or inherited genetic information to better target care and risk reduction.

Term	Description
Integrated Medium-Term Plan (IMTP)	A Health Board's three-year plan setting out service, workforce, finance and delivery objectives.
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.
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

This table will be completed after the report is received by Audit Committee

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	Develop an executive led single, costed plan for cancer services. The plan should align to the new National Cancer Strategy which will be published in February 2027. The plan should show how the Health Board will improve performance, reduce differences in access to care, and meet the suspected cancer pathway target. It should include clear actions, timescales, named leads and measures of success. (paragraph 13)	The Chief Operating Officer as Executive lead will oversee the development of a single costed plan for cancer, aligned to the forthcoming National Cancer Strategy, and in line with the development of the Health Board's broader Clinical Services Plan. The plan will consolidate existing cancer improvement programmes into one overarching framework with clear priorities, milestones, accountable leads, resource requirements and success measures. The plan will specifically address Single Cancer Pathway performance recovery, reduction of unwarranted variation and inequalities in access, and delivery of	Q2 2027-28	Chief Operating Officer

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		sustainable improvements across the cancer pathway. Annual review and refresh arrangements will be established to ensure alignment with national priorities.		
R2	Put in place clear arrangements to monitor the cancer plan. Set out who is responsible for each action. Report progress regularly and track whether actions are improving services. (paragraph 15)	Each action in the above plan will be assigned to a named lead and monitored through a clear reporting schedule. Progress will be reviewed through the Cancer Partnership Board and escalated through existing corporate governance arrangements as required.	Q2 2027-28	Chief Operating Officer
R3	Improve forecasting across cancer services. Use this information to understand future demand, identify pressures earlier, and plan staff and services more effectively. This should help the Health Board	The Health Board will ensure cancer demand, capacity and activity forecasting is built into its existing forecasting models. Outputs will inform workforce planning, service redesign and investment decisions, supporting proactive	Q4 2026-27	Chief Operating Officer

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	target investment where it will have the greatest impact. (paragraph 17)	management of demand and prioritisation of resources to areas of greatest need and impact.		
R4	Develop an enabling workforce and infrastructure plan that aligns the Health Board's capacity and demand analysis (see recommendation 3). The plan should address workforce shortages, estate and equipment constraints in the short-term. It should also target areas of expected growth in demand and create capacity to ensure that services are fit for the future. (paragraph 28)	The Health Board will ensure cancer needs are included within its Workforce and Infrastructure planning informed by the demand and capacity modelling above. These plans will identify current and future workforce requirements, recruitment and retention priorities, succession planning opportunities, and training needs. They will also assess estate, diagnostic and treatment capacity constraints, identifying short-term mitigations and longer-term investment requirements to ensure services remain sustainable and responsive to future demand.	Q2 2027-28	Chief Operating Officer supported by: Director of Estates and Environment and Director of Workforce and Organisational Development

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R5	Develop a clear plan to help prevent cancer. The plan should increase screening uptake, support early diagnosis and reduce differences in access to care. It should include clear priorities, measures of success and long-term funding. (paragraph 31)	The Health Board will build on existing work to develop a Cancer Prevention, Screening and Early Diagnosis Improvement Plan, working collaboratively with public health, primary care and community partners. The plan will focus on increasing screening uptake, improving awareness of cancer symptoms, supporting earlier diagnosis and reducing health inequalities. It will include measurable objectives, targeted interventions for underserved populations and identification of sustainable funding opportunities to support delivery.	Q2 2027-28	Chief Operating Officer
R6	To strengthen the role of the Cancer Board, the Board should oversee the whole cancer pathway and bring services together to improve care. It should make clear who is responsible for each action and	The Health Board will review the Cancer Partnership Board's terms of reference, membership and reporting arrangements to ensure the agreed structure provides oversight of the entire cancer pathway.	Q4 2026-27	Chief Operating Officer

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	regularly review progress against agreed plans and targets. (paragraph 46)	Clear accountability for delivery of actions and performance outcomes will be established. This will be taken forward as part of the Foundations for the Future organisational development programme		

About us

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

The Auditor General carries out 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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