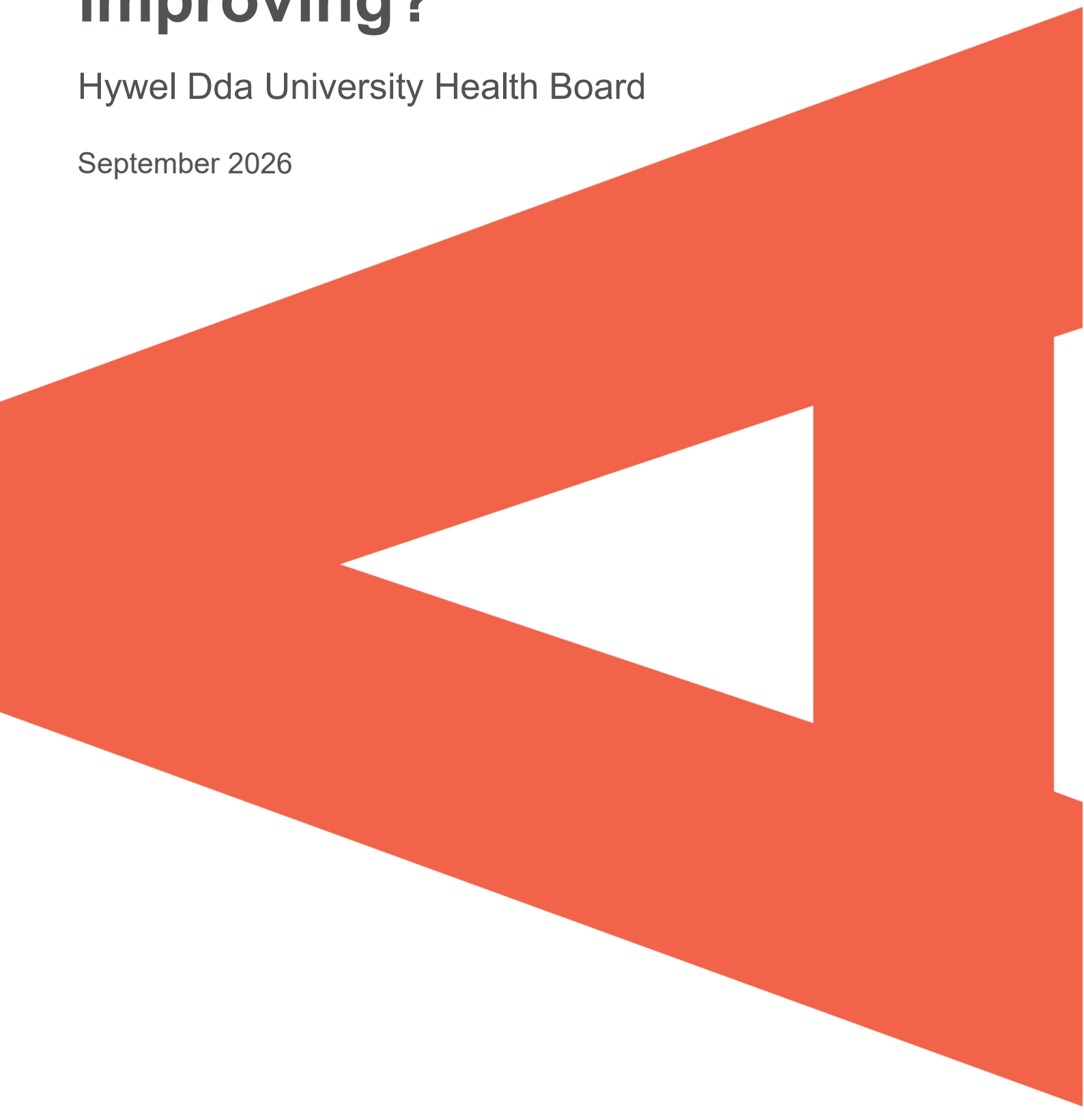


Are cancer services improving?

Hywel Dda University Health Board

September 2026



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Audit snapshot

What we looked at

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

Why this is important

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

What we have found

- 6 The Health Board has worked well to manage increasing service demand. Performance against cancer waiting time targets has improved but is still below the 75% target. In March 2026, performance was around 62%. There is wide variation in timeliness performance between tumour pathways, and some patients wait longer than others.
- 7 The Health Board is taking steps to manage rising demand and pressure. Actions include redesigning care pathways, increasing diagnostic capacity, and improving staffing. However, many actions are reactive, not well tracked, and not fully evaluated. As a result, they have not yet delivered sustainable performance improvements.
- 8 Leadership and governance provide clear oversight and escalation routes, but their impact is limited. There are gaps in coordination, inconsistent reporting, and limited use of data to support decision-making and Board scrutiny. This weakens accountability and reduces confidence that changes are improving patient outcomes.
- 9 The Health Board understands the challenges it faces. However, it does not have a single clear, long-term, joined-up strategy or costed improvement plan for cancer services. Financial pressures, workforce and capacity gaps, and limited use of outcomes and equity data reduce confidence in its ability to deliver timely, fair, and sustainable improvements.

What we recommend

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

- creating a costed improvement plan to deliver the strategy;
- improving how cancer improvement actions are tracked;
- ensuring consistent reporting of improvement activity;
- including a wider range of data in monitoring reports;
- working with partners to improve access to cancer screening data; and
- using cancer outcomes data to support planning.

Key facts and figures



The number of new suspected cancer referrals rose by 24% between 2022–23 and 2025–26.



Spending on cancer services rose from £70 million to £109 million between 2019–20 and 2023–24. This is £17 million more than if spending had kept pace with inflation over the same period.



In March 2026, most referrals were for suspected skin (511), urological (372), and lower gastrointestinal (313) cancers.



In March 2026, 60.2% of patients started treatment within 62 days, compared with the 75% target.



In March 2026, there was wide variation in treatment waiting times. Performance ranged from 96% for skin cancer to just 18% for urological cancer, against a 75% target.



Between 2002 and 2024, one-year cancer mortality rates have fallen by 18.5%.

Our findings

Cancer service improvement planning

No clear long-term improvement plan, weak co-ordination, and rising demand limit confidence that cancer services will sustainably improve waiting time performance

Cancer improvement plans

- 11 The Health Board does not have a single, overarching cancer strategy or forum to oversee it. Instead, it relies on annual plans and other documents. While these refer to national standards and priorities, they are fragmented and do not set out a clear long-term approach to cancer services. This reduces clarity on future direction and limits confidence in the Health Board's ability to deliver the improvements needed for timely and sustainable cancer care.
- 12 The Annual Plan 2026–27 sets out relevant priorities, including improving pathway timeliness, increasing diagnostic capacity, and meeting the Suspected Cancer Pathway (SCP) target. These priorities broadly align with national expectations and show a good understanding of key challenges. However, the plan is high-level. It does not clearly set out the workforce, financial, digital or estate requirements needed to meet demand in the short- or longer-term.

- 13 There is no single, integrated cancer improvement plan to deliver the Health Board's ambitions. Although many improvement activities are underway, they are not brought together into a clear programme. This makes it hard to show how they support priorities or drive progress. Many initiatives are poorly defined, lack evaluation, and are often reactive rather than focused on underlying system issues. Actions also lack clear ownership, timescales, measures of success, and links to performance recovery. As a result, the Health Board continues to rely on short-term measures, such as overtime and backlog initiatives, to manage pressures.
- 14 Planning assumptions are cautious about performance improvement. Current trajectories suggest the Health Board does not expect to meet the national target within existing resources. There is no clear plan for how it will achieve the target or reduce variation and inequities in access and outcomes. While equity is recognised at a strategic level, it is not well embedded in cancer planning. There is also limited evidence of targeted actions to reduce inequalities.
- 15 The Health Board does not expect to achieve the 75% target in 2026–27. Performance is forecast to level off at 66% by Quarter 2. Given the gap between planned performance and national expectations, and the lack of a clear, integrated delivery approach, there is limited confidence that current plans will lead to sustained improvement.

Cancer intelligence and data

- 16 The Health Board has well-established processes to monitor cancer demand and performance. Regular reporting and governance give a clear view of performance trends, pathway pressures and variation across tumour types. This helps identify areas under pressure and supports operational responses and targeted reviews.

- 17 However, the Health Board needs to improve how it uses data to support planning. Operational data is used routinely to manage demand in the short-term, but this approach is mostly reactive. It is not clearly linked to medium- and long-term planning. Although demand and capacity modelling is developing, there is limited evidence that it is used consistently to align workforce capacity or support sustainable services.
- 18 The Health Board collects detailed data across the cancer pathway, including performance against key targets, diagnostic pressures, backlogs, and reasons for delays. This is used well at an operational level to manage services and respond to immediate pressures. However, it is not always reported in enough detail to the Board and its committees. This limits oversight of where pressures are greatest and reduces its value for longer-term planning.
- 19 The Health Board is not making full use of outcomes data to inform decisions. While there is some awareness of measures such as stage at diagnosis, mortality and patient experience, this data is not used routinely in planning, management or Board reporting. As a result, the focus remains on process targets rather than patient outcomes, limiting the ability to prioritise actions and plans based on impact.

Supporting fragile services

- 20 Delays in cancer treatment vary across tumour pathways. The greatest pressures are in urology and lower gastrointestinal services. These pathways have the largest backlogs and the lowest performance. They also account for a high number of patients waiting longer than 62 days.
- 21 The causes of pressure on services are well understood and regularly monitored. Key constraints include limited diagnostic capacity, workforce shortages, and reliance on tertiary providers for some treatments, which can delay patient pathways. The Health Board has strong operational oversight, including tumour-specific reviews and targeted interventions. This shows a good understanding of risks and a clear commitment to improving performance.

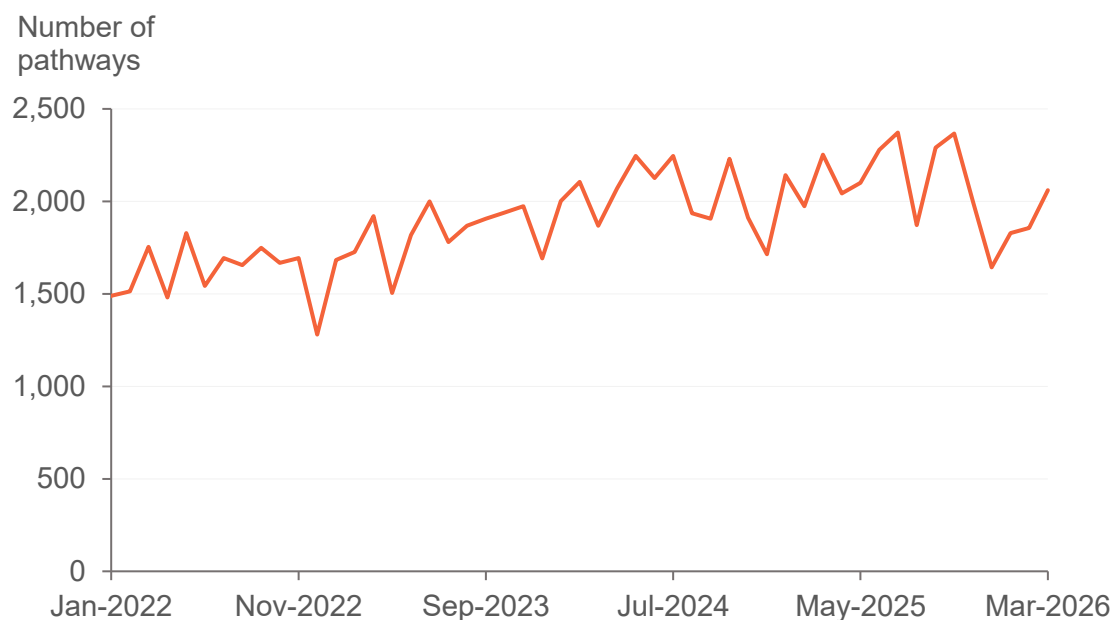
Financial and resource planning

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

Funding plans

- 22 The Health Board does not have a full picture of the total investment needed to improve cancer services. Financial planning is fragmented, although some areas have been costed in detail. Investment decisions are made through separate initiatives, often focused on high-pressure areas such as diagnostics. This limits visibility of overall resource needs across the full cancer pathway.
- 23 Wider financial pressures mean that current funding is not enough to meet national targets. Improvement plans rely on additional funding that is uncertain and may not be sustainable.
- 24 The following exhibits show the trend in cancer service demand and funding. **Exhibit 1** shows the number of new suspected cancer pathways opened each month. It highlights a continued rise in demand. There has been a marked increase in referrals between 2022–23 and 2025–26, particularly in skin (+100%), urological (+25%) and head and neck (+21%) tumour sites.

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



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

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

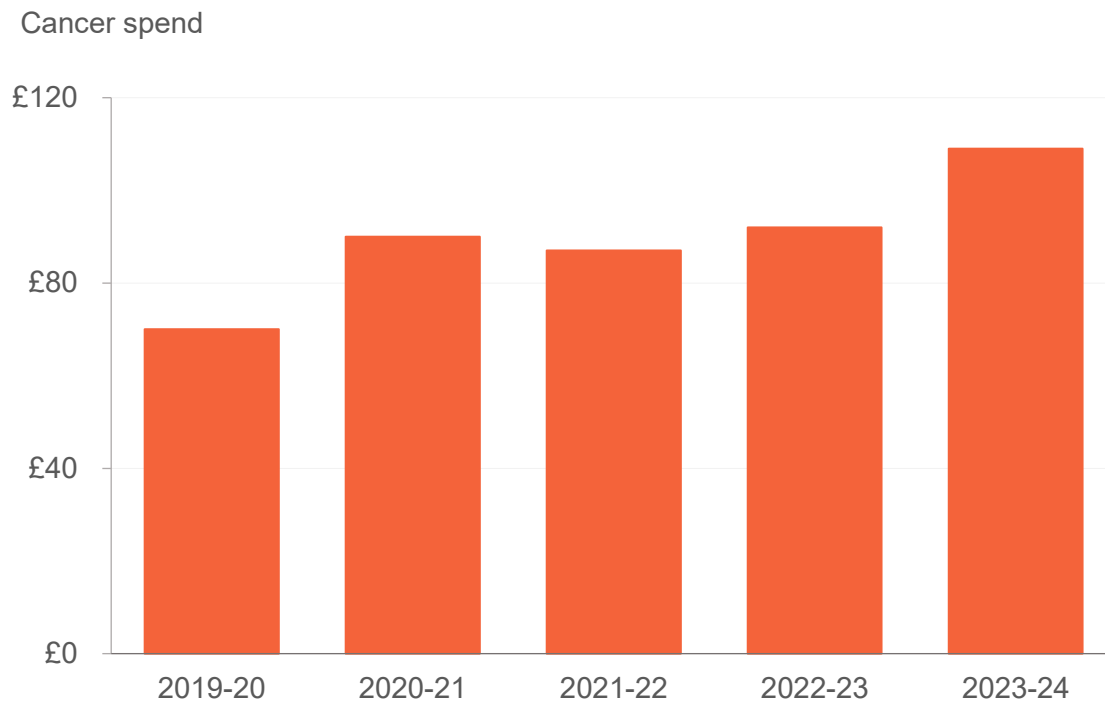
25 Demand is rising, and costs have increased faster than inflation. **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board’s cancer spending rose by around 31% above inflation¹. Spending on hospital cancer medicines has also increased. Between 2019–20 and 2024–25, it rose from £15.7 million to around £25.4 million^{2,3}. This is about £6 million more than if costs had increased in line with inflation (in 2024-25 prices).

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

² Some specialist medicine costs cover both cancer and other treatments but are included in the total. This is unlikely to have a significant impact on the overall figures.

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

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



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

- 26 Cancer service costs are not clearly set out, and there is no single view of total planned spending, despite rising demand and costs. Detailed costing and demand modelling exist for some parts of the cancer pathway, but this information is not brought together into one integrated financial plan. As a result, there is limited visibility of overall investment needs. This reduces assurance that funding is aligned, affordable, and enough to meet future demand and cost pressures across cancer services.

Wider resourcing requirements

- 27 The Health Board understands the workforce pressures affecting cancer services. These include staff shortages, hard-to-fill vacancies, and reliance on a small number of specialist staff, especially in diagnostics and oncology. It has completed a workforce review and introduced role redesign and changes to skill mix to address some of these issues. However, without a single, integrated cancer workforce plan, it is unclear how well this information informs longer-term decisions. This creates a risk that workforce actions are not well coordinated or sufficient to support future service capacity.
- 28 The Health Board has considered estates needs at a strategic level. It recognises that ageing buildings and facilities are a barrier to modern cancer care. While some service areas show forward planning, estate development is limited by capital funding. This restricts the pace and scale of improvement.
- 29 The Health Board does not have a clear, costed plan for cancer-specific equipment. Some planning exists at service level and links to demand and capacity modelling. However, the overall approach is gradual and shaped by funding limits rather than a proactive, system-wide strategy. This limits assurance that equipment will meet future demand or respond quickly to failures.
- 30 The Health Board recognises the value of digital technology and has made progress in using it to support cancer services. This includes real-time dashboards, digital radiology⁴, and innovative approaches such as virtual clinics and AI-supported tools.

⁴ The Health Board now uses the Welsh Radiology Information System. This system supports functions such as patient scheduling and clinical reporting of medical images.

Cancer prevention and population screening

The Health Board is taking targeted actions to improve prevention and screening uptake, but gaps in capacity, data and coordination limit the impact

31 The All-Wales Cancer Improvement Plan estimates that 38% of cancers each year are preventable. For context, if the Health Board prevented 20% of cancers, it could have saved £2.1 million in bed day costs in 2024-25, based on the most recent financial data. **Exhibit 3** shows the potential gains if the Health Board successfully implemented a cancer prevention strategy.

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

		2024-25 actual	-10% reduction	-20% reduction	-38% reduction
	Finished consultant episodes	12,572	11,315 (1,257 reduction)	10,058 (2,514 reduction)	7,795 (4,777 reduction)
	Admission episodes	11,742	10,568 (1,174 reduction)	9,394 (2,348 reduction)	7,280 (4,462 reduction)
	Bed days	21,074	18,967 (2,107 reduction)	16,859 (4,215 reduction)	13,066 (8,008 reduction)
	Bed day cost savings		(£1.1 million)	(£2.1 million)	(£4.0 million)

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

Notes:

- 1) The analysis outlines the broad impact of a 10%, 20% and 38% reduction in cancer cases, based on 2024–25 activity levels.
- 2) Savings calculation based on £500 per day cost of an NHS bed in Wales used in our [2025 National Cancer Services Report](#).

Public health risk assessment

- 32 The Health Board understands the main factors that increase cancer risk. It uses population needs assessments and national data to identify risks such as smoking, poor diet, low physical activity and alcohol use. Its '20Four7' prevention model aims to address deep-rooted health inequalities. It focuses on the most deprived communities and supports people to stay well. The model aims to reduce inequalities through cancer prevention, earlier diagnosis and more accessible, joined-up services.
- 33 However, population health information is fragmented. The use of data to target action is limited by data quality, data sharing and analytical capacity. The Health Board is committed to improving lifestyles and has introduced initiatives to reduce cancer risk and tackle inequality. However, prevention is not consistently part of day-to-day practice and is not well coordinated across services. Past underinvestment and workforce pressures have led to a reliance on national programmes, with limited targeted local action. As a result, there is no clear, joined-up approach to cancer prevention that is likely to deliver lasting improvements in outcomes.

Approaches to improving population lifestyles

- 34 The Health Board is delivering a range of programmes to reduce cancer risk and improve population health. Prevention is a strategic priority. There has been recent investment in health and well-being coaching, immunisation outreach, smoking cessation services, and support for screening programmes, including preparation for lung cancer screening.
- 35 For 2026–27, the Health Board have increased their investment in prevention by introducing a four-tier health coaching service. This targets GP practices in its most deprived communities, and offers digital, group and one-to-one support to help people change behaviours. This shows a renewed focus on prevention after a period of underinvestment.
- 36 However, funding remains relatively modest, and there are risks to the long-term sustainability of some programmes. Workforce pressures also limit delivery and the Health Board's ability to expand prevention across services. While there is a clear strategic intent and some positive initiatives, the overall approach is not yet well coordinated or well resourced. As a result, there is limited confidence that it will deliver lasting improvements in cancer outcomes or reduce health inequalities.

Targeted prevention and population screening

- 37 There are clear referral routes for patients whose cancer is detected through national screening programmes. The Health Board works closely with Public Health Wales NHS Trust through joint governance, data sharing, and screening improvement work. However, delays in access to screening data and capacity issues in colonoscopy, radiology, pathology and endoscopy mean that screening does not always lead to timely diagnosis and treatment.
- 38 The Health Board is building an understanding of the factors that affect screening uptake. It recognises the impact of deprivation, awareness, and access and social barriers. It has set up a dedicated screening forum to improve uptake among underserved groups. However, screening data is often out of date, and local analytical capacity is limited. This makes it harder to identify and respond to inequalities in participation.

- 39 The Health Board has introduced targeted human papillomavirus vaccination (HPV) campaigns through school and community outreach. Despite this, uptake remains below the national target, at around 77% compared with 90%. This suggests current actions have not yet achieved the coverage needed to maximise the prevention of this cause of cancer.

Cancer leadership and oversight

Limited strategic oversight and outcomes-focused scrutiny reduce accountability and make sustained improvement in cancer services harder to achieve

Managerial leadership

- 40 There are clear leadership arrangements for cancer services. The Chief Operating Officer (the COO) has overall responsibility. They are supported by a General Manager for cancer performance, and a Cancer Services Delivery Manager who oversees performance tracking and reporting. A new Clinical Lead for Planned Care and Cancer has strengthened clinical leadership, although the role is still developing and its impact is not yet fully realised. However, the absence of a dedicated Cancer Board creates a gap in strategic oversight and coordination.
- 41 Senior managers can make decisions and escalate issues through established governance processes. Weekly performance and executive panel meetings support timely decisions and risk management, using cancer performance reports. The recent de-escalation by the Welsh Government suggests these arrangements are helping to improve and oversee performance⁵.
- 42 Managers, clinicians and support staff work well together, supported by regular meetings and shared oversight of performance. The Health Board also works with partners such as Public Health Wales NHS Trust, NHS Wales Performance and Improvement, and the voluntary sector. However, the lack of a Cancer Board limits opportunities to bring together clinical, operational, and patient views in one place and weakens accountability for long-term improvement.

⁵ In February 2026, the Health Board moved from Level 3 (targeted intervention) to Level 1 (routine monitoring) for cancer performance. This followed three consecutive months with performance of at least 63% against the 62-day target, meeting Welsh Government criteria for automatic de-escalation.

- 43 Regional working is essential to cancer services, with some patients treated by other health bodies, including the South-West Wales Cancer Centre at Swansea Bay University Health Board. The Health Board works closely with these partners. However, delays in patient transfers, fragmented digital systems, funding approval processes, and unclear referral routes can reduce coordination and delay access to treatment across organisational boundaries.

Oversight and scrutiny

- 44 The Board and Finance and Performance Committee receive regular reports on cancer performance. These include SCP performance, backlogs, trajectories, risks and improvement actions. The reports give a good overview and support scrutiny. However, they lack detail on tumour-specific performance, pathway stages, and outcomes such as stage at diagnosis and mortality. This limits the Board's ability to understand variation, identify the greatest pressures, and assess whether services are improving patient outcomes.
- 45 The Board and its committees are aware of cancer performance challenges and receive regular updates on improvement work. However, actions are reported through both the Integrated Performance Assurance Report and Planning Objective updates. Differences in how actions are presented create a risk of confusion, reduce transparency, and make it harder to track progress and accountability consistently.
- 46 Although scrutiny is in place, it focuses mainly on targets rather than outcomes. There is also limited evidence of routine follow-up of improvement actions. As a result, governance provides oversight of performance but gives less assurance that decisions are leading to sustained improvement.

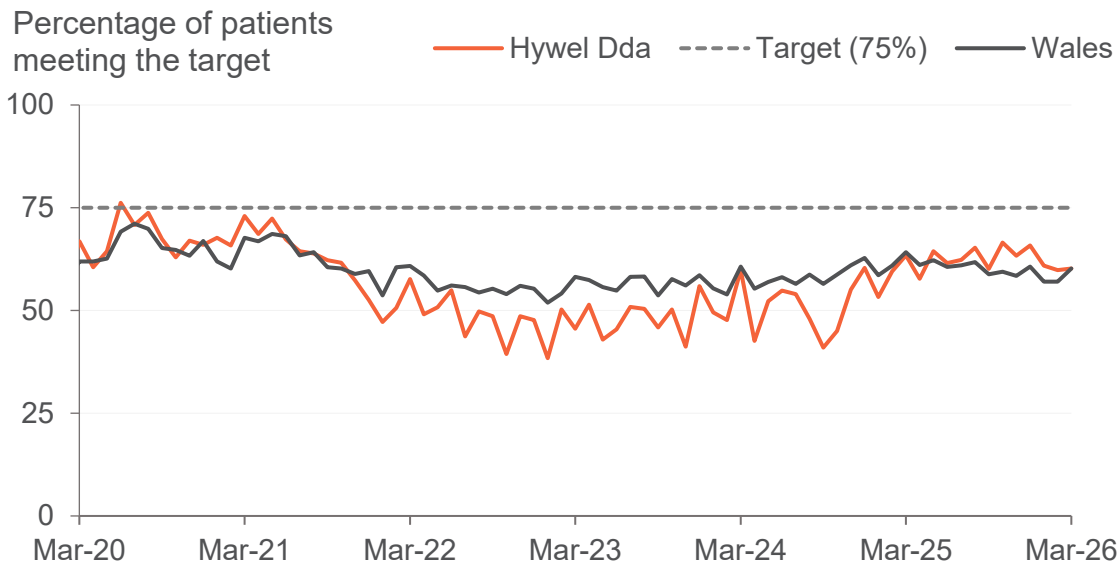
Cancer performance

Although improvement actions are underway, limited evaluation and reactive approaches are hindering sustained progress to meet the 62-day target

62-day cancer performance

- 47 The Welsh Government target is for 75% of patients to start their first treatment within 62 days of suspected cancer. 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.
- 48 **Exhibit 1**, outlined earlier in the report, shows that the number of new suspected cancer pathways opened each month has grown. Despite this, the Health Board has done well to ensure performance has not deteriorated. The Health Board's performance is in line with the Wales average but remains well below the national target (**Exhibit 4**). In March 2026, 60.2% of patients started treatment within 62 days. It is widely accepted that the number of cancer cases will continue to increase in Wales and service pressures are expected to grow.

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

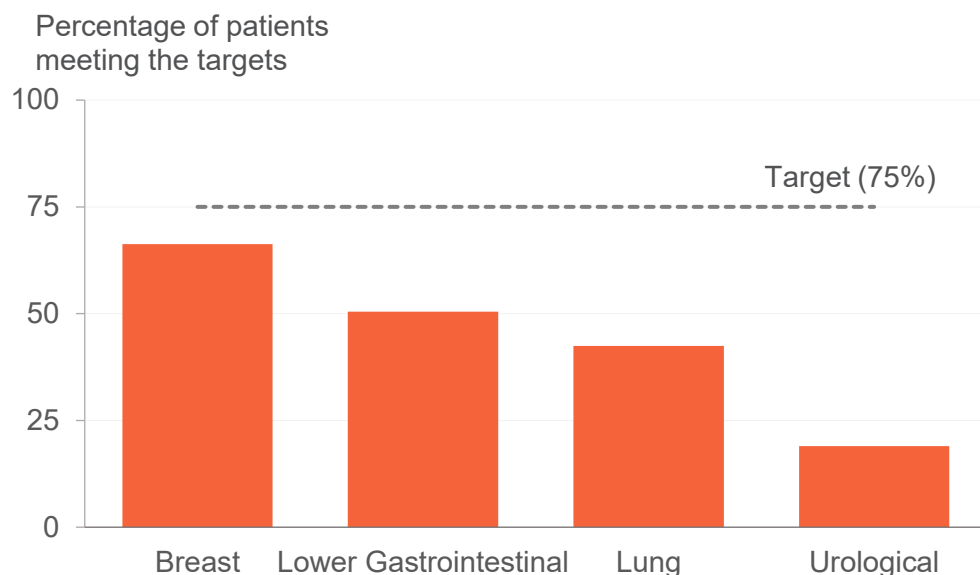


Source: Audit Wales analysis of Digital Health and Care Wales data

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

- 49 Overall performance also hides large differences between sex and tumour types. For example, for every month during 2025-26, performance against the 62-day target for men was worse than for women. The most significant difference recently was in December 2025, where around 75% women started treatment within 62 days, but only around 58% for men did. This is a gender gap of nearly 17%. It presents a picture of services that aren't adapting to changing demand.
- 50 Timeliness of access is related to the type of tumour. Some areas, such as skin cancer, are performing better. In March 2026, skin cancer pathways met the target, with 96% of patients starting their treatment within 62 days. **Exhibit 5** shows performance for four common cancers. It highlights concerning delays in urological, lung and lower gastrointestinal pathways.

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



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

Notes:

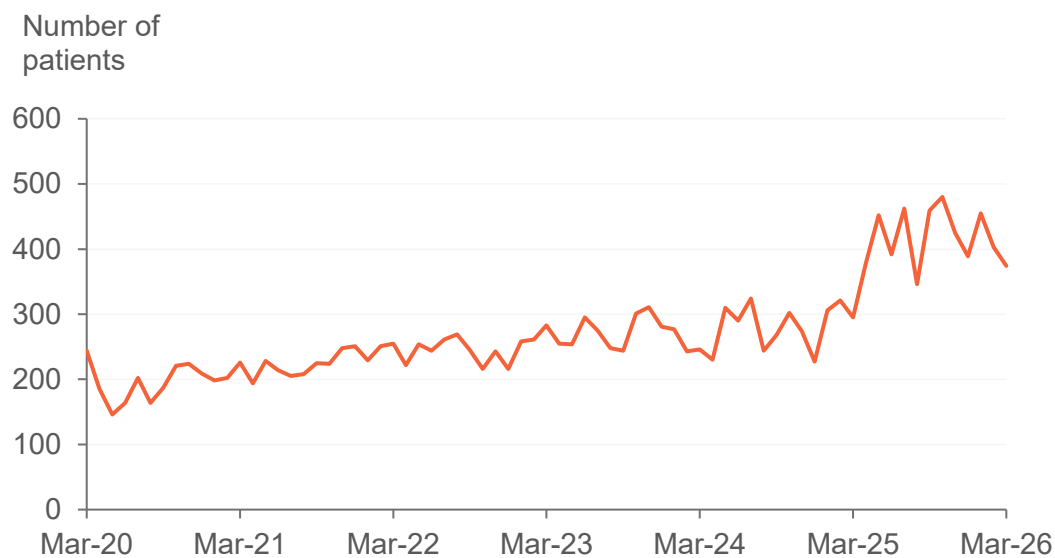
1. The data show average 62-day performance over the most recent 12 month period (March 2025 to March 2026).
2. The data includes patients who started treatment and those waiting for confirmation that they do not have cancer.

Impact of action to improve cancer services

- 51 The Health Board is taking a range of actions to improve cancer services. These include redesigning pathways, expanding diagnostic capacity, developing the workforce, and introducing new technologies. These actions show a clear understanding of the challenges and a commitment to improvement. However, they have not yet led to sustained improvements across all pathways, and performance remains below national targets.

- 52 The Health Board has made workforce and service changes to manage immediate pressures. These include expanding clinical roles, developing new clinics, and increasing diagnostic capacity. While these steps have helped in some areas, they are often focus on short-term issues and do not always address the root causes of limited capacity.
- 53 The Health Board continues to invest in improvement initiatives such as outsourcing diagnostics, using teledermatology, redesigning pathways, and increasing diagnostic activity. Planned actions aim to build on this work and respond to ongoing demand and capacity pressures. This shows an active approach to tackling barriers to better performance.
- 54 Performance against the 62-day target suggests these actions have not yet had enough impact. However, the number of patients starting treatment each month has positively increased since March 2025 (**Exhibit 6**).

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



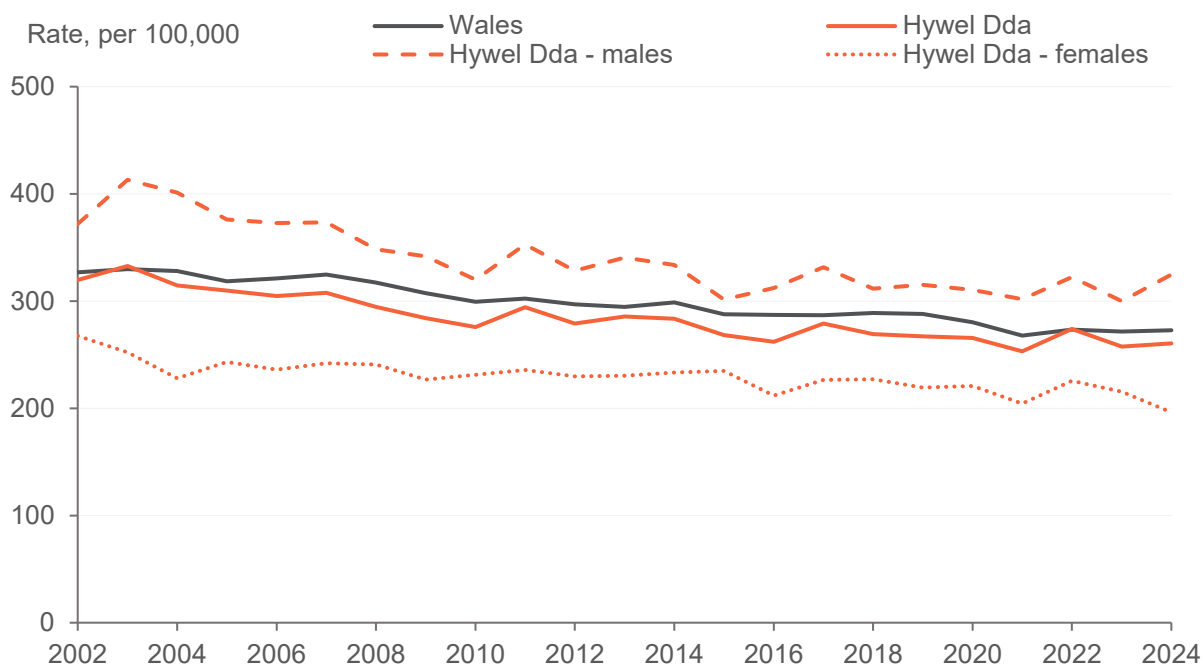
Source: Audit Wales analysis of Digital Health and Care Wales

- 55 The Health Board needs to improve how it plans, manages and evaluates improvement work. Actions are reported through several routes but are not always clearly defined, consistently owned or linked to measurable outcomes. There is limited evidence of regular evaluation, making it hard to assess whether actions are effective or to apply learning across cancer services.

Improving cancer outcomes

- 56 The Health Board has some awareness of key cancer outcome measures, such as stage at diagnosis, mortality and patient experience. However, it does not routinely use this data in day-to-day management or service improvement. As a result, outcomes data is reported but does not drive decision-making.
- 57 Cancer performance reporting focuses mainly on activity and waiting times, such as the SCP. Outcome measures, including mortality and stage at diagnosis, are not routinely reported to the Board or its committees. This limits oversight of the quality and effectiveness of care.
- 58 Limited use of outcomes data reduces the Health Board's ability to understand variation, assess whether changes are improving care, and prioritise actions based on impact. As a result, improvement work often focuses on processes rather than patient outcomes.
- 59 The Health Board needs to make better use of outcome data to support planning, prioritisation, and service improvement. A stronger focus on outcomes would provide greater assurance that performance gains lead to real benefits for patients.
- 60 Analysis of one-year mortality data from 2002 and 2024 shows a steady decline in cancer mortality rates (**Exhibit 7**). The Health Board's mortality rate is also lower (better) than the Wales average. However, outcomes remain worse for males than for females.

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



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

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

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

Recommendations

Cancer services planning

- R1** The Health Board should develop a fully costed, organisation-wide strategic cancer improvement plan to support sustainable delivery of the cancer strategy as demand increases. This should be aligned to the National Cancer Strategy which is due to be published in February 2027 (**paragraph 11- 13**).
- R2** The Health Board should improve how it tracks cancer improvement actions by ensuring each action has a clear owner, timeline, and expected outcomes. This will support better monitoring and strengthen accountability (**paragraph 13**).
- R3** The Health Board should work with Public Health Wales NHS Trust to agree, as soon as possible, a full set of data on screening services. This should include:
- Timeliness at each stage of all current cancer screening pathways, and lung screening once fully rolled out.
 - Date on screening uptake, with analysis by population groups (including age, location, sex (where relevant), and ethnicity (**paragraph 37**)).

Cancer reporting

R4 The Health Board should strengthen reporting of cancer improvement activity by adopting a single, consistent approach to reporting all improvement actions (**paragraph 44**).

R5 The Health Board should improve cancer reporting to the Board and its committees by including average waiting times, tumour-specific performance, and outcomes data. This will support stronger scrutiny and more targeted assurance (**paragraph 45**).

R6 The Health Board should make greater routine use of cancer outcomes data, such as stage at diagnosis, mortality, quality of life and patient experience, to inform decision-making, governance and improvement priorities (**paragraph 58**).

Appendices

1 About our work

Scope of the audit

We looked at the following areas:

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

We did not consider service quality, clinical governance or patient experience.

We have also not completed an audit of the data used in this review, but we have looked at the all-Wales data validation process.

Audit questions and criteria

Questions

We used the following questions to focus our fieldwork:

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

- Is the Health Board making progress to deliver timely and equitable access to cancer diagnosis and treatment?

Criteria

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

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

Methods

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

- Chief Operating Officer;
- Clinical lead for Cancer;
- Director of Public Health; and
- General Manager for Planned Care and Cancer.

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

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.
Cellular pathology	Laboratory analysis of tissue/cell samples (histology/cytology) critical for diagnosis and treatment decisions.
Colonoscopy	Endoscopic examination of the large bowel to diagnose/biopsy lower GI cancers.
European Age-Standardised Rate (EASR)	A rate adjusted to a standard European population age-structure to enable fair comparisons over time/places.

Term	Description
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.
National Cancer Improvement Plan	National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories.
Patient-Reported Experience Measures (PREMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PREMs focus on the experience of care (how it was received).
Patient-Reported Outcome Measures (PROMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PROMs measure the effectiveness of treatment on health status
Population health risks	Modifiable risk factors (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.
Stage at diagnosis	The extent of cancer spread at the time of diagnosis, strongly linked to outcomes and treatment options.
Systemic Anti-Cancer Therapy (SACT)	Drug treatments circulating via the bloodstream (e.g., chemotherapy, targeted and immunotherapies) to treat cancer

Term	Description
Screening	A preventive medical test designed to detect cancer early, often before symptoms appear, improving the chances of successful treatment
Teledermatology	The remote assessment of skin conditions using digital images or video, so a specialist can diagnose or triage patients without seeing them in person
Tumour site	The anatomical location/type of cancer (e.g. lower gastrointestinal, lung, breast, urological, skin).

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To be completed after receipt by Audit Committee

Recommendation	Commentary on planned actions	Completion date	Responsible officer

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

Management response form



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Audited body	Hywel Dda University Health Board
Audit name	Are cancer services improving?
Issue date	09 July 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should develop a fully costed, organisation-wide strategic cancer improvement plan to support sustainable delivery of the cancer strategy as demand increases. This should be aligned to the National Cancer Strategy which is due to be published in February 2027.	Agreed. Strategic Cancer Improvement Plan to support future year sustainable delivery to be developed, to align with the priorities and principles of the National Cancer Strategy due to be published in February 2027.	July 2027	Chief Operating Officer

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R2	The Health Board should improve how it tracks cancer improvement actions by ensuring each action has a clear owner, timeline, and expected outcomes. This will support better monitoring and strengthen accountability.	Agreed. Cancer pathway transformation is one of the 4 proposed workstreams which will report into the newly established Planned Care Transformation Group which commences in October 2026. Whilst the October meeting will focus on Outpatient and Theatre improvement workstreams, the Cancer Improvement workstream will commence in November 2026 and will track all related improvement actions.	November 2026	Director of Operational Planning & Performance
R3	The Health Board should work with Public Health Wales NHS Trust to agree, as soon as possible, a full set of data on screening services. This should include: • Timeliness at each stage of all current cancer screening pathways, and lung screening once fully rolled out.	Agreed. Data set to be agreed with PHW NHS Trust to be reflected within the Strategic Cancer Improvement Plan referenced in R1.	July 2027 (to align with development of the HDUHB Strategic Cancer Improvement Plan).	Director of Public Health

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	date on screening uptake, with analysis by population groups (including age, location, sex (where relevant), and ethnicity (paragraph 37).			
R4	The Health Board should strengthen reporting of cancer improvement activity by adopting a single, consistent approach to reporting all improvement actions (paragraph 44).	Agreed (as per R2). Cancer pathway transformation is one of the 4 proposed workstreams which will report into the newly established Planned Care Transformation Group which commences in October 2026. Whilst the October meeting will focus on Outpatient and Theatre improvement workstreams, the Cancer Improvement workstream will commence in November 2026 and will track all related improvement actions.	November 2026	Director of Operational Planning & Performance

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R5	The Health Board should improve cancer reporting to the Board and its committees by including average waiting times, tumour-specific performance, and outcomes data. This will support stronger scrutiny and more targeted assurance (paragraph 45).	Agreed. Regular deep-dive reports in respect cancer pathway transformation and performance to be reported to Finance & Performance Committee.	December 2027	Chief Operating Officer
R6	The Health Board should make greater routine use of cancer outcomes data, such as stage at diagnosis, mortality, quality of life and patient experience, to inform decision-making, governance and improvement priorities (paragraph 58).	Agreed (as per R1 & R3). Cancer outcome data to inform and be reflected in the Strategic Cancer Improvement Plan to be published by July 2027.	July 2027	Chief Operating Officer