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National Cancer Strategy for Wales

Call for evidence

Response from Moondance Cancer Initiative

Submitted October 2026

In response to the Welsh Government Call for Evidence issued 31 July 2026

Overview

The Welsh Government is developing a new National Cancer Strategy for Wales. The aim of the strategy is to improve the outcomes and experiences of people affected by cancer in Wales.

Cancer outcomes are the length of time people survive after a diagnosis of cancer, and the number of people that die from cancer each year.

We want to hear evidence-based insights from people and organisations in Wales about the future of cancer care.

We will use the responses from the call for evidence to inform what the strategy requires. We will publish a summary of the responses alongside the final strategy.

About Moondance Cancer Initiative

Moondance Cancer Initiative is a philanthropically funded not-for-profit organisation solely focused on improving cancer outcomes in Wales.

Since 2019, we have invested more than £6 million in activity across Wales, working alongside NHS colleagues and wider partners to introduce new diagnostics and treatments, improve cancer pathways, strengthen research and support people leading change within cancer services.

We often act as a catalytic funder, using targeted investment to help promising improvements become established in practice, generate evidence of value and create a route towards sustainable NHS delivery.



1. How should the national cancer strategy improve outcomes?

The aim of the strategy is to improve population outcomes for cancer. This includes:

- reducing the number of people per 100,000 who develop cancer
- improving survival after a cancer diagnosis
- reducing the number of people per 100,000 who die from cancer each year
- improving people's experience of NHS services

There are many ways to improve cancer outcomes. We want to know how you think the Welsh Government can make the greatest difference.

Maximum 750 words.

[Moondance Cancer Initiative](#) (MCI) is a philanthropically funded not-for-profit company, established in 2019 and solely focused on improving cancer outcomes in Wales. Funded by the [Moondance Foundation](#), we work alongside NHS Wales, clinicians, researchers and wider partners to find, fund and fuel people and ideas that can deliver meaningful and sustained change for patients.

Since 2019, MCI has [invested](#) more than £6 million to evidence-led work across Wales, from introducing new diagnostics and treatments and improving cancer pathways, to strengthening research and investing in the people leading change within NHS Wales.

We often act as a catalytic [funder](#), using targeted investment to pump-prime improvement, accelerate adoption and help the system move faster than would otherwise be possible. This includes supporting new approaches to become established in practice, generating the evidence needed to demonstrate their value and, where successful, helping create a route towards sustainable NHS delivery.

Alongside direct investment, our wider offer includes [CADARN](#), supporting all-Wales cancer research development and delivery; [CANLLAW](#), supporting NHS consultants leading change within cancer services; and [Keith James Grants](#), enabling NHS professionals to access learning and experience from elsewhere and bring that back into their work in Wales. MCI also undertakes [insight and evidence work](#), including publications that explore where and how Wales could improve cancer outcomes and help inform wider discussion about future priorities for the system.

MCI continues to invest in and work alongside NHS Wales. Our response to this consultation is therefore informed by several years of practical experience supporting change across different parts of the cancer pathway, across organisational boundaries and across Wales.



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MCI welcomes a National Cancer Strategy for Wales. To be effective in improving cancer outcomes the strategy must provide clear prioritisation around where Wales can make the greatest difference, with a focus on the changes most likely to deliver meaningful and sustained improvement.

Wales already has committed clinicians, strong examples of good practice, emerging technologies and research opportunities. From MCI's experience, the challenge is not simply identifying what could improve care. The greater challenge is ensuring that effective approaches can move into routine care consistently and at sufficient pace.

That implementation gap is rarely about evidence or clinical ambition alone. In practice, progress depends on whether the conditions needed to make change happen are in place, including workforce capacity, funding, procurement, estates, data, governance, service ownership and sufficient time for clinical and operational teams to implement new approaches alongside existing pressures. These factors often determine whether an agreed change moves beyond intention into routine delivery, is sustained over time and ultimately improves care and outcomes for patients.

The National Cancer Strategy should set strong expectations around collaboration and shared delivery where this is the most effective model and ensure that performance measures reinforce rather than work against that direction. When Health Boards are being asked to share workforce, infrastructure, specialist services or pathways, the way success is measured should encourage those behaviours rather than focus predominantly on individual organisational performance.

A ten-year strategy should also make clear how cancer services need to evolve over time, not only how current pressures should be managed. This includes creating the conditions for more cancers to be diagnosed earlier, improved access to optimal treatment, greater participation in research, faster adoption of effective innovation and more equitable access across Wales.

The value of the strategy will ultimately lie in whether it enables those priorities to translate into sustained improvement for patients. That will require clear expectations around collaboration, implementation and shared responsibility for delivery, alongside measures that reflect progress towards the future model of cancer care Wales is seeking to achieve.

2. How can more cancers be detected at earlier stages?

Most cancers can be staged based on how far they have progressed. Earlier-stage cancers are often easier to treat but can be harder to detect.



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We want to know what factors, developments, approaches or innovations could help more cancers be detected at earlier stages in Wales.

Maximum 750 words.

Earlier diagnosis will depend both on making better use of what is already available and adopting new approaches.

Wales already has established breast, cervical and bowel cancer screening programmes with a strong evidence base. Bowel screening demonstrates both the potential of screening and the consequences of taking too long to realise it. The programme is now offered to people aged 50–74, with the FIT threshold reduced to 80µg/g, but reaching that position took many years despite a clear optimisation plan and longstanding evidence for change. Even now, its full potential depends on improving participation and ensuring sufficient downstream colonoscopy capacity. Existing screening programmes should therefore continue to be actively optimised across the whole pathway.

It is essential that there is no further delay in the rollout of lung cancer screening across Wales. Lung cancer continues to be associated with poor outcomes because too many cancers are diagnosed at a later stage. Targeted screening offers a significant opportunity to shift diagnosis earlier, particularly for groups at higher risk, and improve both survival and equity of outcomes.

Public Health Wales is responsible for the delivery of cancer screening programmes, but much of the downstream diagnostic and treatment activity generated by screening sits within individual Health Board services. The benefits of screening will therefore only be fully realised if those pathways have the capacity and capability to respond effectively.

Lung cancer screening is a particularly important example. As rollout progresses, Health Boards will increasingly need to investigate small pulmonary nodules identified through screening. Robotic-assisted bronchoscopy will become an important part of that pathway because it can access and sample smaller, more peripheral nodules that are difficult to reach conventionally. There is currently no established provision in Wales, with a small number of patients referred from Cardiff and Vale UHB to London. Planning is therefore needed for how this capability could be introduced equitably, including where it should be based and how patients would access it.

Some opportunities to improve earlier diagnosis are pan-cancer and can strengthen diagnostic capacity across multiple pathways, while others are specific to particular cancer types.

Our current work on automated microtomy in pathology provides an example of the former. Automating a labour-intensive stage of histopathology processing could shorten the time from tissue sampling to diagnostic review, release skilled



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staff capacity and improve service resilience. MCI is progressing the first deployment with Betsi Cadwaladr UHB, offering to fund the equipment and first two years of running costs, while exploring how further time-limited investment could support wider adoption through shared and regional models across Wales.

Earlier diagnosis also requires better identification and management of people at inherited risk of cancer. Lynch syndrome is estimated to affect around 1 in 300 people, equating to approximately 10,000 people in Wales, yet only around 5% are thought to have been diagnosed. Identification enables surveillance, prevention and cascade testing of relatives, as well as informing treatment where cancer develops. England established a national Lynch Syndrome Registry in 2023 and has since developed this into a broader National Inherited Cancer Predisposition Registry. Wales does not currently have equivalent national infrastructure. [MCI has supported work with NHS colleagues to improve Lynch syndrome diagnosis in Wales](#), but the need for a national registry remains. We address this further in Question 7.

There are also pathway-specific changes where evidence is already sufficiently mature for implementation. MCI has supported the introduction of [transnasal endoscopy](#) and capsule sponge testing within upper GI pathways, both of which were already in use elsewhere in the UK but not routine in Wales when MCI first invested. Our funding enabled NHS teams to establish implementation clinics, develop workforce and training and adapt pathways. Transnasal endoscopy has since become part of routine pathways in Cardiff and Vale, Cwm Taf Morgannwg and Powys, while [capsule sponge testing](#) is now established within routine Barrett's oesophagus surveillance in North Wales.

At the same time, the diagnostic landscape continues to develop rapidly across molecular diagnostics, artificial intelligence and technology-enabled decision support. Examples such as WID-easy in endometrial cancer and the GALEAS Bladder urine test illustrate the potential for new approaches to support earlier triage, investigation and referral.

The strategic challenge is therefore not a shortage of possible solutions. It is ensuring that Wales can distinguish between what is ready for adoption and what still requires evaluation, while creating practical routes for effective approaches to move into routine care.

3. How should the NHS prepare to deliver future cancer treatments?

Healthcare services are constantly changing as new evidence about cancer treatment emerges. This means the NHS needs to prepare for new and innovative ways of treating cancer.

We want to know what major changes the NHS should prepare for over the next 10 years to ensure it can deliver future cancer treatments.



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Maximum 750 words.

Preparing for future cancer treatments requires more than identifying new therapies or technologies. The NHS also needs to consider the service model around them: where treatment should be delivered, the workforce and expertise required, supporting diagnostics and infrastructure, referral pathways, commissioning arrangements and how access will be provided equitably across Wales.

The [All-Wales Colorectal Peritoneal Metastasis Service](#) provides a useful example. Before 2022, there was no centre in Wales providing cytoreductive surgery, with or without HIPEC, despite this treatment being routinely available elsewhere in the UK for suitable patients. For some patients, the treatment can significantly extend life and in a proportion of cases can be curative. The absence of a Welsh service therefore created a postcode lottery in access, with eligible patients dependent on whether they could secure referral and travel to specialist centres in England.

MCI funded the establishment and development of the service in Cardiff and Vale University Health Board, including the specialist expertise, national MDT and referral pathway needed to provide treatment safely for patients from across Wales.

The service was deliberately funded to generate the clinical, operational and financial evidence needed for longer-term NHS adoption. That evidence demonstrated that the service was clinically effective, cost-effective and could be delivered in Wales at substantially lower cost than referring patients to England. It was subsequently assessed through the NHS Wales Joint Commissioning Committee process and prioritised highly for commissioning. However, no new services were funded through that process because there was no budget available to do so.

That created a significant gap between a service having demonstrated value and there being a practical route to fund it. MCI continued to support the service while an alternative solution was developed. Ultimately, Health Boards agreed an All-Wales Prior Approval model, which came into effect from April 2026 and enabled the service to continue without interruption. Eligible patients from across Wales can now be referred through the national MDT, with funding following the patient through their own Health Board.

The outcome is positive, but the route to get there was unnecessarily difficult. It raises an important question for the strategy about whether current commissioning arrangements are sufficiently equipped to support the specialist and cross-Health Board services that Wales is likely to need more of in future.

There is an inherent tension within the current model. The Joint Commissioning Committee brings together the seven Health Boards, and its membership includes



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their Chief Executives. This can leave decision-makers having to balance the collective case for investment in a new specialised or jointly commissioned service against the immediate financial pressures within their own organisations. Where there is no additional funding available for new commissioned services, even a service that has demonstrated strong clinical and financial value can struggle to find a sustainable route into provision.

As cancer care becomes more specialised and increasingly dependent on advanced diagnostics, technology and scarce expertise, there are likely to be more situations where regional or national models offer the most effective and sustainable approach.

The National Cancer Strategy should therefore be clear not only about how such services are assessed, but how those judged to offer significant benefit can move from evidence and initial implementation into sustainable NHS provision.

The lesson from the peritoneal service is that demonstrating that a service works is not enough if there is no practical route to fund and sustain it. Equitable access may increasingly depend on clear regional or national pathways, shared responsibility across organisational boundaries and commissioning arrangements that are capable of translating evidence into provision.

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

Healthcare services do more than treat cancer. They also provide advice, support and care during diagnosis, treatment and recovery.

We want to know what the NHS and other organisations should provide to improve the experience of people affected by cancer.

Maximum 750 words.

People affected by cancer need different forms of support across diagnosis, treatment, recovery and life beyond cancer, including clinical, rehabilitative, psychological, practical and social support for patients, carers and families.

MCI is currently funding several pieces of work that speak directly to this. One is the introduction of [Comprehensive Geriatric Assessment](#) within the colorectal pathway for older people living with frailty, initially in Cardiff and Vale UHB but with the ambition of informing wider adoption across cancer pathways in Wales. This brings a broader multidisciplinary team into treatment planning so that decisions reflect the wider needs, risks and priorities of the individual. We provide more detail on this in Question 6.



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We are also [funding improvements to nutritional support following upper GI cancer surgery](#). Cardiff and Vale UHB provide the centralised surgical service for patients from six Health Boards, and this work is designed to ensure that patients have access to a more consistent post-operative nutrition pathway regardless of where they live. It moves from reactive intervention after nutritional decline towards planned support at discharge, with the aim of improving recovery, fitness for further treatment and reducing avoidable readmissions.

In Cwm Taf Morgannwg, MCI is funding the development of a coordinated late-effects pathway for people experiencing swallowing difficulties following head and neck cancer treatment, improving referral, assessment and management. Taken together, these examples show how the right support around cancer care can directly influence outcomes for patients. Comprehensive assessment can help ensure that treatment is appropriate to an individual's fitness, frailty and wider needs, reducing the risk of both undertreatment and avoidable treatment-related harm. Proactive nutritional support after major cancer surgery can help prevent significant weight loss, support recovery and improve fitness for further treatment, while reducing the risk of complications and readmission.

The late-effects work shows equally clearly why support cannot end when treatment finishes. People treated for head and neck cancer can develop significant swallowing problems months or years later, affecting what and how they eat, their speech, confidence and quality of life. Without a clear pathway, patients can struggle to access the right expertise and may move between services before the underlying problem is recognised. A structured late-effects pathway can support earlier assessment and treatment, improve swallowing function and wellbeing, help patients make informed decisions about issues such as enteral feeding, and in some cases enable earlier identification of recurrent disease.

These forms of support can therefore affect not only people's experience of cancer care, but their ability to receive treatment, recover, maintain function and live well with and beyond cancer. Where they also reduce avoidable deterioration, readmissions, duplication, delay or inappropriate intervention, there is an important benefit for the NHS alongside the benefit to patients.

The National Cancer Strategy should recognise advice, support and care for patients, carers and families as an integral part of high-quality cancer care across diagnosis, treatment, recovery and life beyond cancer. It should set a clear expectation that these needs are identified and responded to in a timely, coordinated and equitable way, with access based on what people need rather than where they live or which part of the system they are in.

Success should be judged not only by treatment outcomes, but by whether people are supported to recover well, maintain function and quality of life, manage the ongoing consequences of cancer and its treatment, and live as well as possible during and after cancer.



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

Improving cancer care, treatment and outcomes requires a strong focus on research.

This includes:

- population studies
- laboratory-based research
- clinical trials of new treatments and tests
- adopting new and innovative practices

We want to know what developments, opportunities and approaches could strengthen cancer research and innovation in Wales.

Maximum 750 words.

Research should be seen as an integral part of high-quality cancer care, not as something separate from it. There is evidence that patients treated in research-active organisations can experience better outcomes even when they are not themselves participating in a trial. In a large English study of more than 200,000 people with colorectal cancer, patients treated in hospitals with sustained high participation in interventional research had lower postoperative mortality and better five-year survival, with an absolute difference in five-year survival of 3.8% between hospitals with no years of high research participation and those sustaining high participation for four or more years. More broadly, research-active NHS Trusts/Boards have also been associated with lower risk-adjusted mortality.

Wales has significant clinical and research expertise, but the wider research funding environment remains challenging. For context, UKRI investment in 2023-24 was £53 per person in Wales compared with £145 per person in England. While this figure covers research and innovation more broadly rather than cancer specifically, it illustrates the wider disparity in research investment available within the Welsh ecosystem. This makes it particularly important that Wales makes the best possible use of the expertise, infrastructure and research opportunities it already has, while strengthening its ability to attract and deliver further research investment.

MCI established [CADARN](#) in 2025 to help address some of these practical challenges within cancer research. Each CADARN round focuses on a different cancer type and brings together clinicians and R&D teams from every Health Board in Wales, alongside researchers and other relevant partners, around shared research opportunities and priorities. MCI funding pays for the dedicated coordination, evidence review, facilitation and study development support needed to identify suitable studies, work through barriers to opening them more widely, and help turn new research ideas into fundable and deliverable proposals.



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There have been two CADARN rounds to date. The first, focused on colorectal cancer, began in November 2025, followed by breast cancer in September 2026. Each round has combined consideration of existing research opportunities with the development of new ideas generated by clinicians and partners working across Wales.

Our experience so far reinforces that increasing research participation is not simply about asking more clinicians or Health Boards to take part. Opening and delivering studies requires staff time, R&D capacity, setup work, governance, pharmacy or diagnostic support, data requirements and, in some cases, additional funding. Where those conditions are absent, valuable research opportunities can remain unavailable to Welsh patients despite clinical interest.

CADARN is also creating space for clinicians from every Health Board in Wales to identify unanswered questions together and develop research ideas collaboratively, supported by researchers and other partners with the expertise needed to move those ideas forward. MCI funding supports the practical work needed to progress those ideas, including evidence scoping, study development, protocol and costing support, and preparation for external funding opportunities.

The National Cancer Strategy should recognise research as part of routine cancer care and stipulate that no eligible patient should be denied access to an appropriate clinical trial or research opportunity because of where in Wales they live.

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

The NHS delivers cancer treatment and care in a range of settings, including people's homes, GP surgeries, hospitals and specialist cancer centres.

Many clinical teams play a role in caring for people affected by cancer. For some specialist teams, such as oncology services and cancer specialist nurses, this is their primary role.

We want to know how NHS facilities, equipment and workforce planning should evolve to meet future cancer care needs.

The strategy provides an opportunity to think not only about future workforce numbers or additional equipment, but about how roles, technology and service models can develop together to increase capacity, resilience and quality.

This is particularly important given the workforce pressures already evident across specialties central to cancer diagnosis and treatment, alongside the proportion of experienced staff expected to retire over the coming decade. In Wales, the Royal



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College of Radiologists reported a 32% shortfall in clinical radiologists and a 15% shortfall in clinical oncologists in 2024, with both gaps forecast to increase by 2029. The Royal College of Pathologists' 2025 census also found that 47% of pathologists are aged 50 or over, highlighting the scale of potential retirement over the next decade alongside increasing demand.

Recruitment and retention will remain essential, but it is unlikely that future demand can be met by replacing existing roles on a like-for-like basis alone. Workforce planning should also consider how skills can be used differently, where roles can evolve, and where technology and automation can release highly skilled staff to focus on work that most requires their expertise.

Pathology is a good example. MCI's work on automated microtomy (detail in Q2) is not simply about purchasing equipment. Automating a repetitive and labour-intensive stage of tissue processing will release biomedical scientist capacity, shorten diagnostic turnaround times and improve the resilience of pathology services. Modernising services in this way can also help create the capacity and infrastructure needed to take advantage of further developments in things like AI-assisted diagnostics.

There is similar potential to use a broader range of workforce expertise differently within cancer pathways. MCI is funding work with Cardiff and Vale UHB to embed [Comprehensive Geriatric Assessment \(CGA\)](#) into treatment planning for older people living with frailty. The initial implementation is within the colorectal pathway, but the model is being evaluated with the potential for wider application across tumour sites. It brings geriatric medicine, nursing, pharmacy, physiotherapy, occupational therapy, dietetics, psychology and social care expertise into the pathway at the point when treatment decisions are being made. This enables decisions to take account of physiological fitness, frailty, comorbidities, medicines, cognition, nutrition, function and what matters to the individual, rather than relying on chronological age or tumour characteristics alone.

The potential benefit is significant for both patients and the NHS. Older people with cancer are more likely to experience frailty, multimorbidity and other factors that can affect treatment tolerance. Without appropriate assessment this can contribute both to undertreatment and to treatment that causes avoidable toxicity, interruption or loss of function.

Evidence underpinning CGA-based models shows the potential to reduce severe treatment toxicity, improve treatment completion and support safer, more personalised treatment decisions. For the NHS, better assessment and optimisation can also reduce avoidable admissions, treatment complications and pressure on acute services. The Cardiff and Vale model is therefore measuring not only clinical and patient outcomes, but hospital admissions, avoided bed-days and cost avoidance.



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This illustrates a wider workforce opportunity for the strategy. Future cancer care will not only depend on having more people in existing roles. It will also depend on bringing different expertise into pathways at the right point, developing the contribution of the wider multidisciplinary workforce, and using technology where it can safely release capacity.

Workforce, equipment and facilities should also be planned together. New technology will only deliver its full benefit where the necessary workforce, training, estates and operational arrangements are in place, while increasing workforce pressures make it more important to invest in technologies and service models that can create additional capacity.

The same principle applies geographically. Some specialist workforce, expertise and equipment will not be sustainable within every Health Board.

The National Cancer Strategy should identify where shared workforce, networked expertise and regional or national provision will be required to provide better access and make more effective use of scarce skills and infrastructure.

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

Data plays an important role in supporting individual care and helping the NHS plan services.

More accurate, integrated and accessible data can improve patient care, service delivery and planning.

We want to know how improvements in digital systems, technology and cancer data could support better care, service planning and outcomes.

Maximum 750 words.

Digital systems and data are most valuable when they enable services to identify patients, coordinate care and act on information reliably. MCI's work around Lynch syndrome illustrates a specific gap where national digital infrastructure could make a direct difference to cancer prevention and earlier diagnosis.

Lynch syndrome is an inherited condition associated with a substantially increased lifetime risk of several cancers. Once someone is identified as having Lynch syndrome, the clinical benefit depends on them remaining visible to services over many years so that appropriate surveillance, recall and cascade testing can take place.



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Wales does not currently have a national Lynch Syndrome Registry capable of supporting this consistently. An effective national registry would record people diagnosed with Lynch syndrome and their genetic variant; support reliable surveillance and recall; strengthen cascade testing of relatives; improve coordination between genomics, colorectal and other relevant services; and help identify eligible patients for research and emerging prevention or treatment opportunities.

This is not simply a matter of creating a database. For a national registry to be effective, it needs to operate as a live system that supports ongoing surveillance, recall and coordination of care. Establishing it requires agreement on ownership, governance, information governance, digital infrastructure and how it connects with existing clinical and screening services. These are issues that individual MDTs or Health Boards cannot resolve in isolation.

There is a clear precedent. England established a national Lynch Syndrome Registry in 2023 and has subsequently developed a broader National Inherited Cancer Predisposition Registry covering a wider range of cancer susceptibility genes.

The National Cancer Strategy should set a clear expectation that Wales establishes and sustains equivalent national registry capability, with the ownership, governance and digital infrastructure needed to support surveillance, recall, cascade testing, research and coordinated care across organisational boundaries.

Information governance is another area where current arrangements can limit the pace and consistency of change. Where a service, pathway or dataset is intended to operate regionally or nationally, having to work through separate information governance processes within individual Health Boards can create significant duplication, delay and variation. Similar challenges arise where information needs to move between primary and secondary care.

For developments that are explicitly regional or all-Wales in scope, **the National Cancer Strategy should support proportionate information governance arrangements that can be agreed once and applied consistently across organisational boundaries, rather than repeatedly recreated locally.** This would not remove the need for appropriate safeguards, but it could reduce avoidable delay and make it easier for effective approaches to be implemented consistently.

Where these barriers are not addressed, progress can depend on the capacity and processes of individual organisations, meaning patients in different parts of Wales may gain access to new pathways or services at different times. Digital infrastructure and information governance should therefore be designed to support



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equitable delivery across Wales, rather than inadvertently reinforcing organisational boundaries.

8. 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?

People affected by cancer can experience differences in:

- risk factors
- access to care
- the type of cancer they are diagnosed with
- outcomes following treatment

We want to know what the NHS can do to reduce these differences.

Maximum 750 words.

Reducing inequity in cancer outcomes requires detailed attention to the variation created by how services are organised and accessed.

From MCI's experience, geography can have a significant effect on whether patients are able to access specialist diagnostics, treatment and research opportunities. In some areas, more consistent access may be achieved through clearer national or regional pathways, shared expertise and better coordination across organisational boundaries.

The [All-Wales Colorectal Peritoneal Metastasis Service](#) is one example. Before the service was established, eligible patients in Wales faced significant barriers to accessing specialist treatment, including travel to England. Establishing a national MDT, referral pathway and treatment service in Wales created a more consistent route to care for patients regardless of where they lived. This service has also shown how patients with cancer are prepared to travel for specialist treatment.

The same principle applies to research. Access to clinical trials and research opportunities should not depend unnecessarily on whether an individual Health Board has the capacity or infrastructure to open a study. Through CADARN, MCI is working to create opportunities for clinicians and R&D teams from every Health Board in Wales to participate in shared research development and delivery.

There are also important inequalities linked to age, frailty and complexity. Older people with cancer may be more vulnerable to both undertreatment and treatment-related harm where decisions are not informed by a broader assessment of fitness, function and comorbidity. Embedding approaches such as Comprehensive



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Geriatric Assessment within cancer pathways can help ensure treatment decisions are based on individual need rather than age alone (more detail on this in Q6).

The National Cancer Strategy should set a clear expectation that geography should not determine the quality of cancer care or the opportunities available to patients.

People across Wales should be able to access the expertise, diagnostics, research opportunities and treatment appropriate to their needs, with national and regional pathways used where these provide a more equitable and sustainable route to care.

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

There are many different ways to measure cancer care and the success of this strategy.

We want to know how best to measure improvements over time and how the success of the strategy should be assessed.

Maximum 750 words.

The Single Cancer Pathway provides an important measure of timeliness through the cancer pathway, but it is by necessity a blunt measure. A single 62-day target cannot capture the quality of the pathway, whether patients received the most appropriate diagnostic or treatment intervention, whether access was equitable, or whether the system is making the longer-term changes needed to improve cancer outcomes.

The Single Cancer Pathway cannot remain the dominant measure of success if organisational attention is drawn primarily towards improving that metric rather than the wider conditions affecting outcomes. Health Boards are managing significant operational pressure to deliver against the Single Cancer Pathway while also being asked to redesign services, adopt innovation and respond to financial and workforce pressures. These objectives should reinforce one another, but in practice they often compete for the same clinical, operational and managerial capacity.

Greater collaboration between Health Boards should be a core feature of delivering the national cancer strategy. Wales will increasingly need to consider shared workforce, regional and national services, shared infrastructure and specialist provision if it is to improve outcomes equitably within finite resources. A performance framework focused predominantly on individual Health Board SCP



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compliance risks reinforcing organisational boundaries at precisely the point when the strategy needs to encourage more collective working.

The positioning of cancer within NHS Wales Performance and Improvement and the wider planned care agenda makes it especially important to balance short-term performance management with longer-term strategic development. Timeliness and accountability remain important, but the measures used to assess success must also demonstrate whether cancer services are evolving in the ways required to deliver the ambitions of the ten-year strategy.

This includes whether pathways are becoming more equitable, whether specialist services are being configured at the right geographical level, whether new diagnostics and treatments are being adopted, whether research is becoming more embedded in care, and whether workforce and infrastructure are developing in line with future need.

The National Cancer Strategy should therefore use a broader set of measures that distinguish between operational performance, implementation and outcomes. The SCP should remain part of that picture, but alongside measures that include stage at diagnosis, access to optimal treatment, survival and mortality, patient experience, variation in access and outcomes across Wales, participation in research, and whether evidence-based changes are successfully adopted and sustained.

Crucially there should also be metrics capable of demonstrating whether the strategy is changing how the system works. For example: are patients increasingly able to access specialist services and clinical trials irrespective of Health Board geography? Are successful innovations spreading beyond the organisation in which they were first established? Are national or regional pathways reducing unwarranted variation? Are changes being sustained after initial investment?

The National Cancer Strategy should create accountability not only for current operational performance, but for demonstrable progress towards the longer-term changes it is intended to achieve. Without that balance, there is a risk that immediate performance pressures continue to dominate attention while the changes needed to improve outcomes over the next decade receive less focus.

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

Are there any comments or suggestions that have not been covered by the previous questions?

For example:

- how services are commissioned or planned in Wales



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- how NHS organisations can best work together
- what should happen to services that can only be provided in England

We want to hear your views.

Maximum 750 words.

One of the strongest recurring lessons from MCI's work is that identifying what should change is only part of the challenge. The harder task is creating the conditions in which that change can actually happen and be sustained.

There can be an understandable assumption that once an intervention is supported by evidence, guidance or national policy, implementation should follow relatively quickly. In practice, moving something into routine care requires services to work through pathway design, workforce and training, equipment and estates, procurement, data and governance, operational ownership and recurrent funding. Local adaptation is often necessary, but this can create a long gap between something being shown to work and patients elsewhere benefiting from it.

Much of that work falls to clinicians and operational teams already delivering care under considerable pressure. Change often depends on committed individuals, supported by colleagues across their organisations, finding the time and capacity to work through the practical detail alongside their existing responsibilities. Implementation capacity therefore needs to be recognised as a genuine requirement for improvement, not something that can simply be absorbed within existing roles.

The way performance is managed also matters. As set out in Question 9, the Single Cancer Pathway remains important, but if the dominant conversation between Health Boards and Welsh Government continues to be month-to-month performance against that measure, there is a risk that the longer-term work needed to redesign services, adopt innovation and collaborate across boundaries is repeatedly displaced by immediate operational pressure.

For the National Cancer Strategy to make a material difference, it needs to cut through beyond national policy and be understood by the people actually delivering cancer services. Much of what needs to change is already recognised within services, while new priorities will continue to emerge over the next decade. The strategy should set a clear and credible direction for how cancer care in Wales needs to evolve, reinforce changes already understood to be necessary and help the system prepare for what comes next. Crucially, it should give clinicians and teams the confidence, permission, time and space to act on that direction at all points of the cancer pathway.

The strategy should also be clear that the future of cancer care will require greater collaboration across organisational boundaries. Workforce pressures, increasingly



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specialised expertise, new technologies and finite resources mean that services cannot always continue to be planned or delivered within individual Health Board boundaries. Shared workforce and infrastructure, networked expertise and regional or national models will increasingly be necessary if cancer services are to evolve and make best use of available capacity.

That requires more than strategic endorsement. Collaboration, shared provision and collective responsibility for outcomes need to be recognised as part of successful delivery.

MCI is privileged to work alongside people across NHS Wales who are deeply committed to improving cancer care, from those delivering and managing services day to day to those leading change across pathways, organisations and the wider system. Our experience is that significant progress is possible when people have the support, space and practical conditions to make change happen. The opportunity for the National Cancer Strategy is to make those conditions a more consistent feature of how improvement happens across Wales.

The National Cancer Strategy should therefore be designed not only around what Wales wants to achieve, but around what will enable NHS organisations and the people working within them to deliver it. It should create clear expectations for implementation, collaboration and longer-term change, while giving those delivering cancer services the support and authority to turn that direction into action.

Ultimately, a successful strategy should be visible not only in national policy, but in the priorities and decisions of Health Boards, in the ability of teams across the cancer pathway to make change happen, and most importantly in the improvements experienced by patients across Wales.