National Cancer Strategy for Wales – BGS Response

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. (745)

To make the greatest difference to cancer outcomes in Wales, the National Cancer Strategy should place older adults with cancer at the centre of service design. Over one third (37%) of new cancer diagnoses in the UK are in people aged over 75 and services must be designed around the needs of this population group. If services work well for older people, they are more likely to work well for the rest of the population.

Healthy lifestyles must be promoted throughout the lifecourse with a particular focus on healthy ageing. Regardless of age, people should be encouraged to undertake physical activity, eat well, maintain a healthy weight, reduce alcohol consumption and to cease smoking. Efforts should also be made at a local and national level to reduce air pollution.

Improving survival and reducing cancer mortality will require earlier identification of factors that increase the risk of treatment complications. Older patients frequently experience problems such as polypharmacy, malnutrition, functional decline, frailty, falls risk and psychological distress. The strategy should invest in multidisciplinary assessment and optimisation services involving geriatricians, nurses, pharmacists, physiotherapists, occupational therapists, dietitians, psychologists and social workers. These services can address problems before treatment starts, improving fitness for surgery, systemic anti-cancer therapy and radiotherapy while reducing the risk of interruption or abandonment of treatment. Internationally, specialist Geriatric Oncology Services aim to reduce treatment toxicity, emergency admissions and treatment interruptions while improving treatment completion and functional outcomes.

The strategy should also strengthen personalised and shared decision-making. Many older adults value independence, cognition, quality of life and maintaining function as highly as traditional clinical outcomes. Cancer treatment decisions should therefore be informed by a holistic assessment of what matters most to the individual patient. Services should capture patient goals, preferences and priorities and ensure these are incorporated into multidisciplinary treatment planning. This approach improves the likelihood that patients receive treatments aligned with their values and can help avoid both under-treatment and over-treatment (Gomes et al 2020).

The strategy should support wider implementation of specialist geriatric oncology services that combine cancer expertise with Comprehensive Geriatric Assessment (CGA). CGA helps identify potentially reversible issues, optimise health before treatment, and ensure decisions are based on fitness, function and patient goals rather than age alone. The Cardiff and Vale (CAV) Geriatric Oncology Service was designed specifically to embed CGA into cancer treatment planning, support shared decision-making and improve treatment outcomes.

Improving patient experience should be a core objective of the strategy. Patients often report that cancer pathways can feel fragmented, particularly when multiple specialists are involved. The

strategy should support coordinated multidisciplinary clinics, streamlined referral pathways and clear communication between teams. Patients should have timely access to investigations, prompt advice, holistic assessments and support navigating uncertainty throughout the cancer pathway. Geriatric Oncology aims to improve patient experience through timely investigations, efficient communication, early multidisciplinary involvement and support for patients and carers from the point of diagnosis.

For many older people with cancer, quality of life may be more important than length of life. Many older people value living independently and retaining cognition. It is therefore important to consider the impact of therapy as well as the impact of the cancer and to ensure that the benefits of any proposed treatments outweigh the harms that may be caused.

Access to specialist geriatric oncology services currently varies across Wales. The CAV service is currently funded via the Moondance Cancer Initiative. The strategy should ensure that all older adults with cancer who are living with frailty or complexity can access CGA-based assessment regardless of postcode, tumour site or treatment intent. National implementation standards, workforce investment and sustainable funding will be required to achieve equitable access.

The strategy should place greater emphasis on measurement, evaluation and continuous improvement. Success should be assessed not only through survival and mortality statistics, but also through patient-reported outcomes, patient-reported experience measures, functional status, frailty, treatment completion, emergency admissions and one-year survival. Routine collection of these data would allow Wales to identify high-value interventions and continuously improve services for people with cancer. The CAV service was designed to collect data in relation to patient-reported outcomes, experience measures, frailty status, and impact of CGA on future health to demonstrate impact and guide future development.

The greatest improvement in cancer outcomes is likely to come from a strategy that combines early diagnosis with personalised, multidisciplinary, CGA-based care for older adults; reduces unwarranted variation in access; prioritises patient experience and quality of life; and uses robust outcome measurement to drive improvement across Wales.

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.

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

Maximum 750 words. (748)

One of the biggest delays for diagnosis and treatment is caused by the distance many older people are required to travel for diagnostics. This could be addressed by providing more diagnostic facilities in community-based settings and away from main centres. This aligns with the Community By Design programme which aims to take more services to communities, rather than requiring people to travel to major centres for diagnostics and treatment.

Older people account for the majority of cancer diagnoses, yet they are also the group most likely to present atypically, experience diagnostic delay, or come to attention only once they have required emergency care. A substantial proportion of cancers in older adults are diagnosed during emergency admissions, where outcomes are known to be poorer.

Wales should make better use of routine health data and digital innovation to identify older adults at risk. Existing electronic records already contain information relating to multimorbidity,

prescribing patterns, hospital attendance, functional decline and frailty. Developing systems that automatically identify frailty and flag appropriate patients for enhanced cancer assessment could support earlier referral and diagnosis.

Another important development would be greater integration between oncology, primary care, acute oncology, geriatric medicine and rapid diagnostic services. Older adults frequently move between these services, yet no single team may have oversight of the whole patient journey. Multidisciplinary models that combine oncology and geriatric expertise are designed to provide more holistic assessment of comorbidity, cognition, nutrition, functional status and psychosocial needs, enabling clinicians to distinguish changes due to ageing from changes that may indicate cancer.

Invitations for routine screening services stop once people reach a certain age. Many people can misinterpret this to mean that they are no longer at risk of developing that cancer and do not realise that they can self-refer to screening services. More education is needed to help older people to understand the signs and symptoms of cancer and to encourage them to self-refer to screening services when appropriate.

It is important for everyone to be able to access healthcare services in their preferred language. This is a particular issue for older people whose first language is Welsh. Some people with dementia revert to speaking their first language, forgetting other languages that they have learned subsequently; for example, people who speak Welsh as a first language, can forget English.

A key innovation would be the systematic integration of specialist geriatric expertise into cancer pathways, including rapid diagnostic, vague symptom, and site-specific services. Traditional diagnostic pathways are often focused on "red flag" symptoms, whereas older adults may present with weight loss, falls, delirium, reduced mobility, increasing dependency, cognitive decline, or a general reduction in resilience. These features are often manifestations of underlying frailty, but they may also represent the earliest signs of undiagnosed cancer. Embedding geriatric assessment and frailty identification at the point of referral could help identify high-risk individuals earlier and prevent missed diagnostic opportunities.

Improving awareness among healthcare professionals and the public is also critical. There remains a tendency to attribute new symptoms in older adults to ageing, frailty or existing long-term conditions. Educational initiatives should emphasise that unexplained weight loss, functional decline, falls, new dependency, frailty progression and cognitive change may be early cancer indicators. Greater awareness could encourage both clinicians and patients to seek investigation sooner.

Improving early detection should not be viewed in isolation from improving treatment readiness. Comprehensive geriatric assessment can significantly influence management decisions and optimise treatment pathways (Hamaker et al 2018). Earlier diagnosis has greatest value when patients are fit enough to benefit from treatment. By combining earlier diagnosis with proactive optimisation of frailty, nutrition, medicines, cognition and functional status, Wales can improve not only cancer stage at diagnosis but also the likelihood that older adults can undergo and complete potentially beneficial treatment.

More focus should be given to ensuring that older people with cancer are fit for treatment. This includes encouraging them to adopt healthier lifestyles by taking steps such as giving up smoking and losing weight. This can mean that older people are more likely to recover well from cancer treatment.

More cancers could be detected at an earlier stage by embedding frailty recognition into cancer pathways, integrating specialist geriatric expertise within diagnostic services, using digital tools to identify high-risk older adults, strengthening multidisciplinary working, and increasing awareness

that cancer in older people often presents through functional rather than disease-specific symptoms. These approaches would help ensure that older adults are not overlooked by traditional diagnostic models and would support more equitable cancer outcomes across the population.

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.

Maximum 750 words. (747)

One of the greatest challenges facing NHS Wales will not simply be delivering newer cancer treatments, but ensuring those treatments can be safely and effectively delivered to an increasingly older population. Cancer is predominantly a disease of ageing, and the number of older adults living with cancer is rising rapidly. Services that continue to be designed primarily around tumour type rather than patient complexity risk widening inequalities and limiting access to potentially beneficial treatments. Older adults frequently experience frailty, multimorbidity, polypharmacy, cognitive impairment and functional decline, all of which influence treatment tolerance and outcomes (Hamaker et al 2018).

It is important to remember that the older population is not homogenous, and not all older people are living with frailty and other long-term conditions. Cancer pathways should tailored to the individual. No older person should be denied treatment that would benefit them based on their age. Likewise, for some older people who are living with frailty and other long-term conditions, cancer treatment may cause more harm than good. A decision about whether or not to have cancer treatment should be made with the individual and their loved ones and based on what is likely to be most beneficial to them.

The NHS must therefore develop integrated Geriatric Oncology services across Wales. Comprehensive Geriatric Assessment (CGA) should become a routine component of cancer care for older adults, particularly those living with frailty. Treatment decisions should be informed by an individual's physiological reserve, functional status, cognition, nutrition, social support and personal goals. CGA-guided interventions have been shown to improve management in a significant proportion of patients and reduce treatment toxicity, reduce unplanned hospital admissions and improve outcomes (Li et al 2021; Mohile et al 2021; Soo et al 2022).

NHS Wales must also prepare for increasingly personalised and complex cancer treatments. Precision medicine, immunotherapy, targeted therapies and novel systemic treatments are expanding rapidly. However, older adults remain underrepresented in clinical trials, creating uncertainty about how best to use these therapies in routine practice. Future services should include dedicated mechanisms to assess treatment fitness, optimise patients before treatment, and monitor toxicities proactively. Geriatric oncology teams are ideally positioned to bridge this gap by helping clinicians distinguish which patients may benefit from treatment escalation and which may benefit from modification or alternative approaches. (Wildiers et al 2020). Trials are often conducted with a patient group that is younger and fitter than the average patient population which skews the results. Exclusion of older people from trials leads to exclusion of older people from treatment.

Digital transformation should be another major priority. Electronic health records should routinely identify frailty and other vulnerability markers, allowing automatic risk stratification and referral into

supportive services. Digital patient-reported outcome measures could enable early detection of treatment toxicity, functional decline and deterioration between appointments, reducing emergency admissions and improving patient experience.

Future cancer services must become more multidisciplinary and less hospital-centric. Older adults often require input from dietitians, pharmacists, physiotherapists, occupational therapists, psychologists, social workers and geriatricians alongside oncologists and cancer nurse specialists. Successful cancer treatment depends not only on the tumour but also on maintaining function, independence and quality of life. Investment in multidisciplinary workforce development is therefore essential.

NHS Wales should also prepare for increasing demand on urgent cancer and acute oncology services. Older adults are disproportionately represented among emergency cancer presentations and treatment-related admissions. Evidence from Wales demonstrates that emergency cancer diagnoses are associated with poorer outcomes and greater healthcare utilisation. Future services should focus on prevention of crisis presentations through earlier identification of vulnerability, rapid access to specialist advice, proactive management of complications and closer integration between community, acute and cancer services.

Importantly, future success should not be measured solely through survival metrics. For many older adults, preserving independence, cognition, mobility and quality of life may be equally important outcomes. The NHS should routinely collect patient-reported outcome and experience measures and adopt value-based healthcare approaches that reflect what matters most to older people living with cancer alongside traditional oncology measures.

NHS Wales should prepare for future cancer treatments by redesigning services around the needs of an ageing population. This means embedding geriatric oncology expertise, implementing routine frailty assessment, investing in multidisciplinary teams, embracing digital innovation, supporting personalised treatments, shared decision-making and measuring outcomes that matter to older adults.

If NHS Wales is to realise the full benefits of advances in cancer treatment over the next decade, older people living with frailty must move from the margins of cancer service design to the centre of it.

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. (709)

For many older adults, successful cancer care is about far more than diagnosis and treatment. Patients and families consistently report that uncertainty, loss of independence, psychological distress, caregiver burden and concerns about the future can be as challenging as the cancer itself. Over the next decade, we must adopt a more holistic model of cancer care that integrates psychological, supportive, palliative, geriatric and social care support from the point of diagnosis onwards, rather than introducing these services only when treatment options become limited.

Older adults with cancer frequently face anxiety, depression, loneliness, altered self-identity, fear of becoming dependent, concerns about cognitive decline and worries about burdening family

members. Family carers experience similar challenges, often whilst managing employment, financial pressures and their own health conditions. Despite this, psychological support remains variable and is often focused on crisis intervention rather than prevention. Everyone diagnosed with cancer, and their carers, should have access to timely psychological assessment and support throughout the cancer pathway.

The NHS should also recognise that uncertainty is one of the greatest burdens faced by people living with cancer. Many older adults live with uncertainty regarding prognosis, treatment benefit, future independence and the possibility of recurrence. Patients with cancer and co-existing conditions such frailty, cognitive impairment or multiple comorbidities often experience particularly prolonged periods of uncertainty. Services should provide structured support to help patients and families navigate this uncertainty through clear communication, continuity of care and access to key workers who can provide ongoing guidance and reassurance.

Older adults consistently report valuing discussions about what matters most to them, including maintaining independence, remaining at home, preserving quality of life and avoiding unwanted interventions. A proactive approach to advance care planning should become a core component of cancer care. Advance care planning should be introduced early and reviewed regularly as part of routine cancer care, regardless of prognosis. This approach supports shared decision-making and ensures care remains aligned with patients' goals and values.

The NHS must also strengthen the integration of supportive and palliative care across the cancer pathway. Palliative care is frequently misunderstood as care only for the final weeks of life. In reality, early supportive and palliative interventions improve symptom control, quality of life, patient experience and family wellbeing. Older adults commonly experience fatigue, pain, breathlessness, malnutrition, falls, frailty, cognitive impairment and functional decline alongside their cancer diagnosis. Access to specialist symptom management, rehabilitation, nutritional support and palliative care expertise should therefore be available from diagnosis onwards, based on need rather than prognosis alone.

Services must also address the wider psychosocial factors that influence outcomes. The evidence underpinning the Geriatric Oncology field highlights the importance of understanding the whole person rather than focusing solely on the tumour. Many older adults face challenges associated with social isolation, poverty, digital exclusion, housing, transport or caring responsibilities that directly affect treatment adherence and recovery. Support services should be designed to identify and address these issues proactively.

Dedicated support for caregivers is essential. Family members frequently serve as care coordinators, advocates, medication managers and providers of practical and emotional support, often with little formal training or assistance. Carers are at increased risk of psychological distress, burnout and physical ill health. Every carer should be recognised as a key partner in care and offered information, education, emotional support, assessment of their own needs and access to respite services where appropriate. Better caregiver support is likely to improve outcomes for both patients and families whilst reducing pressure on health and social care systems.

Success should be measured not only in terms of survival, but also quality of life, independence, dignity and caregiver wellbeing. For many older adults, maintaining function, avoiding hospitalisation, staying connected to family and preserving autonomy may matter as much as extending life. Future cancer services should routinely measure these outcomes and use them to guide service development and investment.

Older adults with cancer and their families need comprehensive support that extends beyond treatment itself. The NHS should prioritise psychological support, assistance with navigating uncertainty, proactive advance care planning, early supportive and palliative care, comprehensive assessment of psychosocial needs and dedicated caregiver support. By adopting a genuinely

person-centred approach, cancer services can improve not only survival, but also the quality of life, dignity and wellbeing of those living with and beyond cancer.

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. (749)

Wales has an opportunity to become a leader in cancer research and innovation by focusing on one of the fastest-growing and most underserved groups in oncology: older adults living with cancer. As the population ages, the majority of people with cancer will be older, often living with frailty, multiple long-term conditions, cognitive impairment and complex social needs. Yet cancer research, clinical trials and innovation have historically been designed around younger, fitter populations. If the Welsh Government is serious about improving cancer outcomes over the next decade, it must ensure that research reflects the patients seen in everyday clinical practice.

Older people remain significantly underrepresented in oncology studies despite accounting for most cancer diagnoses and deaths. This means clinicians are often forced to make treatment decisions based on evidence that may not be applicable to the patients they are treating. Wales should champion more inclusive trial designs, minimise unnecessary exclusion criteria and support dedicated recruitment strategies for older adults and underserved populations. Generating evidence that reflects real-world patients would improve clinical decision-making and reduce inequalities in cancer care. Research should move beyond asking "what treatment works?" to asking "for whom does it work, under what circumstances, and at what cost to quality of life and independence?"

Wales is also uniquely positioned to undertake high-quality population-based research. The nation's integrated healthcare systems and rich routinely collected datasets offer opportunities to study cancer outcomes across entire populations rather than selected trial cohorts. Linking cancer registry data with primary care, hospital, prescribing and social care datasets could improve understanding of cancer epidemiology, pathways to diagnosis, treatment variation and survivorship outcomes. Importantly, such research could help identify disparities affecting older adults, people living in deprived communities and rural populations, enabling targeted interventions to reduce inequalities.

Innovation should not be limited to new drugs; opportunities exist to evaluate innovative models of care. Research programmes should examine how multidisciplinary services, digital technologies, community-based interventions and integrated supportive care models affect patient outcomes, experience and healthcare utilisation. Traditional measures such as survival remain important, but future research should also focus on outcomes that matter to patients, including maintenance of function, independence, cognition, symptom burden and quality of life. These person-centred outcomes are particularly relevant for older adults and are increasingly recognised as essential measures of healthcare value.

Digital innovation represents another major opportunity. Wales should support research exploring how artificial intelligence, predictive analytics and electronic health records can improve cancer care. Routine healthcare data could be used to identify frailty, predict treatment toxicity, support earlier diagnosis and target interventions to those at greatest risk of adverse outcomes. Digital patient-reported outcome measures may also allow earlier identification of deterioration between appointments and facilitate more personalised care.

Closer collaboration between universities, the health service, charities and industry will be essential. Wales has internationally recognised expertise in ageing, cancer, palliative care, health services research and population health. Stronger partnerships could accelerate translation of discoveries from laboratory science into clinical practice. Academic institutions, healthcare providers and charitable organisations should work together to establish research networks capable of attracting external funding and supporting multicentre studies. Such partnerships could also strengthen opportunities for clinician researchers and the wider multidisciplinary workforce.

The NHS must also invest in implementation science. Many effective interventions fail to reach routine practice because insufficient attention is paid to how innovations are adopted and sustained. Research should therefore focus not only on discovering new interventions but also on understanding how best to implement evidence-based care across different healthcare settings. Wales can lead the way by ensuring that innovation is evaluated according to its real-world impact on patients, families and healthcare systems.

Cancer research should place greater emphasis on supportive, palliative and survivorship care. As more people live longer with and beyond cancer, there is growing need for evidence regarding symptom management, caregiver support, psychological wellbeing, rehabilitation, advance care planning and living with uncertainty. These areas remain underfunded despite their importance to patients and families. Investment in these fields would ensure innovation improves not only survival but also quality of life.

Wales has a unique opportunity to strengthen cancer research and innovation by becoming a leader in inclusive, person-centred and real-world research. Priorities should include increasing trial participation among older adults, expanding geriatric oncology research, harnessing population data, embracing digital innovation, strengthening academic and clinical partnerships, and investing in supportive care and implementation science. By focusing on the needs of the population most affected by cancer, Wales can develop research that is both internationally relevant and directly beneficial to its communities.

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.

Maximum 750 words. (540)

Most people diagnosed with cancer are older adults, many of whom live with frailty, multimorbidity, cognitive impairment, disability, social vulnerability and complex care needs. Future workforce, infrastructure and facility planning must therefore move beyond a tumour-focused model towards a

genuinely person-centred model that integrates oncology, geriatrics, supportive care, palliative care, psychological and social care.

Comprehensive Geriatric Assessment (CGA) enables patients to receive tailored treatments that are both effective and aligned with their goals and priorities. CGA-guided interventions frequently alter treatment decisions, reduce severe toxicity and improve outcomes. Workforce planning should therefore include specialist geriatric oncology expertise, including onco-geriatricians, advanced nurse practitioners, pharmacists, allied health professionals and social workers.

Every cancer centre should have access to a specialist frailty team, and older adults with cancer should be able to access multidisciplinary assessment regardless of where they live.

High-quality cancer care cannot be delivered by oncology and geriatric teams alone. Future services will need investment in psychological support. Anxiety, depression, loneliness, adjustment disorders, fear of recurrence and uncertainty about the future are common among people living with cancer. These challenges are particularly pronounced in older adults, who may also face bereavement, social isolation, declining independence or concerns about cognitive impairment. Psychologists should become core members of cancer multidisciplinary teams rather than optional additional services. Access to psychological support should be available from diagnosis onwards and extend into survivorship and palliative care pathways.

The future workforce must also include stronger social care integration. Many cancer outcomes are determined by factors beyond healthcare alone. Older adults may struggle with transport, personal care, meal preparation, medication management, financial pressures or maintaining independence at home. Delayed discharges, treatment interruptions and avoidable hospital admissions often reflect unmet social care needs rather than medical problems. Cancer services should therefore work closely with social workers, third-sector organisations and community care providers. Investment in social care should be regarded as an investment in cancer outcomes, not as a separate issue.

Future cancer facilities should be designed around accessibility and holistic care. Older adults often require multiple appointments with different professionals, creating significant burdens for patients and families. Wherever possible, services should move towards "one-stop" multidisciplinary models that bring together oncology, geriatrics, pharmacy, dietetics, physiotherapy, occupational therapy, psychology and supportive care within a single service. The COACH (Comprehensive Older Adult Cancer Hub) model at Cardiff and Vale provides an example of how this can be achieved through coordinated multidisciplinary assessment and intervention.

Cancer care can be delivered closer to home. Future facilities should include community diagnostic centres, outreach clinics, virtual consultations and home-based treatment models. Investment in digital technology will be essential, including systems that identify frailty, facilitate remote monitoring, support patient-reported outcome measures and enable better communication between primary, secondary and social care services. Existing work within Wales has highlighted the opportunity to use routinely collected healthcare data to identify frailty and support earlier intervention in vulnerable patients.

Modern equipment remains important, including advanced imaging, diagnostics, radiotherapy technologies and molecular testing capabilities. However, investment decisions should recognise that technology alone will not deliver better outcomes. New treatments, precision medicine and artificial intelligence can only achieve their full potential when supported by an appropriately skilled workforce capable of assessing the whole patient and addressing the complexities associated with ageing and frailty.

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. (750 words)

Cancer is largely a disease of ageing, yet current digital systems largely capture information about tumours, treatments and hospital activity, while providing limited insight into the factors that most influence outcomes for older people.

A key priority should be the development of integrated electronic health records that allow information to flow seamlessly across primary care, community services, hospitals, cancer centres, social care and third-sector providers. Too often, vital information about a person's functional ability, social circumstances, cognition, previous treatment wishes or caregiver support is fragmented across multiple systems. This creates duplication, inefficiency and missed opportunities for early intervention. A single, joined-up digital record would improve communication, reduce delays and support more coordinated care.

Wales should also make much better use of routinely collected data to identify frailty and vulnerability earlier. Current healthcare records already contain valuable information relating to hospital admissions, medication use, long-term conditions, falls and cognitive impairment. These data could be used to generate frailty scores and automatically flag patients who may benefit from enhanced assessment or referral to specialist services.

Digital systems should support the routine collection of Comprehensive Geriatric Assessment (CGA) data. Frailty, cognition, nutrition, functional status, psychological wellbeing and social support are often stronger predictors of treatment tolerance and outcomes than chronological age. However, these data are rarely collected consistently or made easily accessible to clinicians. Embedding CGA measures within electronic records would support better treatment decisions, facilitate research and allow healthcare teams to proactively identify patients at risk of complications.

Patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) should become a routine part of cancer care. Older adults frequently report symptoms, functional decline or psychological distress long before these problems become apparent during clinic appointments. Digital tools that allow patients or caregivers to report symptoms from home could identify deterioration earlier, trigger clinical review and reduce avoidable emergency admissions. Importantly, future systems should monitor outcomes that matter to patients, including independence, mobility, cognition, symptom burden and quality of life, rather than focusing solely on survival and tumour response.

Digital transformation must also recognise the central role of family caregivers. Many older people with cancer rely heavily on spouses, children and friends to manage appointments, medications and day-to-day care. Future systems should allow caregivers, where consent is given, to access relevant information, receive updates and contribute to symptom reporting.

Data systems should support service planning by capturing information far beyond traditional cancer metrics. Current national datasets often provide limited insight into frailty, functional outcomes, social care requirements, caregiver burden, psychological wellbeing or health inequalities. Wales should develop cancer dashboards that include these measures alongside treatment outcomes and

survival. This would provide a more complete understanding of what drives outcomes and where investment is most needed.

Artificial intelligence and predictive analytics also offer significant opportunities. By combining information from primary care, secondary care and social care records, digital systems could identify patients at high risk of emergency admission, treatment toxicity, functional decline or poor outcomes. This would support more targeted interventions and more efficient use of healthcare resources. However, such technologies should complement, not replace, clinical judgement and person-centred decision making.

As digital services expand, Wales must ensure older adults are not disadvantaged by digital exclusion. Many older people have limited access to technology, sensory impairment, cognitive difficulties or low digital confidence. Digital innovation should therefore be designed around accessibility and supported by alternative routes of access where needed. Technology should enhance equity rather than widen existing inequalities. At the same time, it is important not to assume that older people lack the equipment, skills and confidence to access services online. Many older people are confident using technology and should be able to use it to manage healthcare if they choose.

Wales has a unique opportunity to strengthen cancer research through better use of linked data. Combining cancer registry information with primary care, hospital, prescribing and social care datasets could generate valuable insights into diagnosis, treatment outcomes, survivorship and healthcare utilisation among older adults. This would support research into frailty, multimorbidity, quality of life and service innovation, areas that remain underrepresented in cancer research despite their importance to patients and families.

In summary, improvements in digital systems and cancer data should focus on creating integrated records, identifying frailty earlier, embedding CGA, collecting patient-reported outcomes, supporting caregivers, enabling predictive analytics and strengthening population-based research. For older adults living with cancer, better digital systems offer an opportunity to move from reactive, fragmented care towards proactive, coordinated and person-centred services that improve both outcomes and quality of life.

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. (665 words)

Reducing inequalities in cancer outcomes requires recognising that equal treatment does not always result in equitable outcomes. People living with frailty, disability, cognitive impairment, socioeconomic deprivation, rural isolation and other vulnerabilities often face additional barriers to

cancer diagnosis, treatment and recovery. In Wales, tackling these disparities will require services that are designed around need rather than tumour type or a patient's ability to navigate a complex healthcare system.

One of the most important actions is to ensure that older adults with cancer are recognised as a priority population. Most people diagnosed with cancer are older, yet many cancer pathways remain designed around younger and fitter patients. Older adults are more likely to experience frailty, multimorbidity, sensory impairment, cognitive difficulties, transport challenges and social isolation. These factors can delay diagnosis, limit access to treatment and contribute to poorer outcomes. The principles of Comprehensive Geriatric Assessment (CGA) should be used within cancer care in order to routinely assess frailty, functional status and social vulnerability alongside tumour characteristics so that support can be targeted to those most at risk.

The development of equitable, all-Wales integrated geriatric oncology services would be an important step towards addressing these differences. In Wales, access to specialist geriatric assessment and optimisation is currently limited to Cardiff. The Cardiff and Vale COACH (Comprehensive Older Adult Cancer Hub) model demonstrates how multidisciplinary assessment can identify frailty, cognitive impairment, psychological distress, malnutrition and social care needs that may otherwise go unnoticed. Evidence underlying geriatric oncology services shows that CGA can improve treatment planning, reduce treatment toxicity and support better outcomes (Wildiers et al 2020; Li et al 2021; Mohile et al 2021; Alibhai et al 2022; Soo et al 2022).

The NHS should also recognise the critical role of social care in influencing cancer outcomes. Many patients struggle not because of cancer treatment itself but because of practical challenges such as transport, finances, housing, personal care needs or lack of support at home. These issues disproportionately affect older adults, disabled people, those living in deprivation and rural communities. Better integration between healthcare, social care and voluntary sector organisations would help address these wider determinants of health and reduce inequalities.

Dedicated support for caregivers is inconsistent. Providing routine caregiver assessment, education, psychological support and respite opportunities would improve outcomes for both patients and families.

Digital systems and data should be used more effectively to identify inequalities and target resources appropriately. This would allow the NHS to understand where disparities exist, monitor progress and design interventions for populations experiencing poorer outcomes. Better data collection is particularly important for older adults, whose needs are often poorly represented within traditional cancer metrics.

Research and clinical trials must also become more inclusive. Current evidence gaps perpetuate inequalities in care. Wales should support more inclusive eligibility criteria, greater use of real-world evidence and research programmes that reflect the diversity of patients seen in routine clinical practice.

Cancer services should place greater emphasis on outcomes that matter to patients. For many older adults, maintaining independence, preserving cognition, avoiding hospital admissions and sustaining quality of life may be as important as survival. Measuring only traditional clinical outcomes risks overlooking inequalities in areas that patients value most. The Cancer Strategy should therefore include functional outcomes, quality of life, caregiver wellbeing and patient experience.

Reducing inequalities in cancer outcomes will require a shift from a one-size-fits-all approach to genuinely personalised care. Key actions include expanding integrated geriatric oncology services, reducing geographical variation in access to care, strengthening psychological and social care support, supporting caregivers, improving data collection, increasing inclusion in research and focusing on outcomes that matter to patients. By targeting support towards those with the greatest

needs, Wales can deliver more equitable cancer care and improve outcomes across all communities.

Wales should establish minimum service standards and equitable referral pathways so that all patients can benefit from evidence-based interventions regardless of where they live. A person's postcode should not determine whether they can access geriatric oncology, psychological support, palliative care, rehabilitation services or clinical trials.

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. (695 words)

The success of a future Cancer Strategy for Wales should not be judged solely by traditional metrics such as waiting times, treatment volumes and survival rates. While these remain important, they provide only a partial picture of what good cancer care looks like, particularly for older adults who now account for the majority of people living with and beyond cancer.

For many older people, the most important question is not simply "How long will I live?" but "How well will I live?" Success should therefore be measured through a combination of clinical outcomes, patient-reported outcomes, functional outcomes and personalised measures that reflect what matters most to individuals.

Survival, stage at diagnosis and treatment access are core national indicators. Improvements in early diagnosis, reduction in emergency presentations, equitable access to treatment and reductions in unwarranted geographical variation remain essential measures of system performance. However, these metrics should sit alongside a broader definition of success that reflects the realities of an ageing population.

A major priority should be routine measurement of functional status. Many cancer treatments can affect mobility, independence, cognition, continence, nutrition and the ability to undertake everyday activities. For older adults, preservation of function is often as important as extending survival. Success should therefore include measures such as maintenance of independence, ability to remain in one's own home, avoidance of institutional care and preservation of activities of daily living. These outcomes are often more meaningful to patients than traditional clinical endpoints.

Quality of life should become a central measure of success. Increasingly, healthcare systems recognise that longer survival is not always synonymous with better outcomes. Patients may value symptom control, energy levels, emotional wellbeing, social participation and the ability to spend meaningful time with family and friends as highly as additional months of life. Wales should routinely collect patient-reported outcome measures (PROMs) throughout the cancer pathway and use these data to drive service improvement.

Importantly, the strategy should go beyond generic quality-of-life measures and embrace personalised outcome measurement. Different people have different goals. One patient may prioritise attending a family wedding. Another may wish to continue caring for a spouse, remain independent at home, continue working, maintain mobility or preserve cognitive function. Success should be defined partly by whether healthcare services enable patients to achieve the outcomes that matter most to them.

This represents a shift from asking "What is the matter with you?" to asking "What matters to you?" At key points throughout their care, individuals should be supported to identify their personal priorities. Services should then measure the extent to which treatments and care have helped patients achieve these goals. Such an approach aligns strongly with personalised medicine, value-based healthcare and the principles underpinning comprehensive geriatric assessment and integrated geriatric oncology services.

Psychological wellbeing should also be measured routinely. Living with cancer frequently involves anxiety, uncertainty, depression and fear of recurrence. These issues may have a profound impact on quality of life even when treatment is successful. The Cancer Strategy must take a holistic view to providing care for people with cancer, focusing on emotional wellbeing, psychological distress and patient confidence in managing their condition as well as treating the illness.

The experiences of family caregivers should also form part of any assessment of success. Informal carers provide a substantial proportion of cancer care, particularly for older adults living with frailty. Yet current performance reporting rarely capture caregiver burden, wellbeing or satisfaction with services. A strategy that improves survival but leaves caregivers exhausted, unsupported or in poor health cannot be considered fully successful.

Measures of care coordination and patient experience should also be included. Patients frequently report that communication, continuity and feeling supported are as important as treatment itself. Success should therefore include whether patients know who to contact, whether they feel involved in decision-making, whether services communicate effectively with each other and whether care feels joined up rather than fragmented.

Success should be assessed through an equity lens. Outcomes should be routinely analysed according to age, frailty, disability, deprivation, ethnicity, geography and other characteristics. Improvements in average outcomes are important, but a truly successful strategy should also reduce disparities between different groups and ensure that benefits are shared across the whole population.

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
- 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. (165)

The success of future cancer services in Wales should be measured not only by how long people live, but by how well they live. Survival, diagnosis and treatment metrics remain important, but equal emphasis should be given to functional status, quality of life, psychological wellbeing, caregiver outcomes and achievement of individual patient goals. By measuring what matters most to people affected by cancer, Wales can create a truly person-centred cancer strategy that reflects the needs of an ageing population and delivers value that patients and families can genuinely recognise.

The National Cancer Strategy must recognise that due to the relatively small population of Wales and the geographic proximity to England, there will always be some treatments that are only available in England. While steps should be taken to ensure that people can receive as much treatment as possible close to home, this will not always be possible. Where treatment is only available in England, systems should be in place to enable this to happen seamlessly.