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National Cancer Strategy Call for Evidence – Claire's Campaign Response

1. How should the national cancer strategy improve outcomes?

Claire's Campaign welcomes the ambition to improve cancer outcomes across Wales. We believe that while outcomes and waiting times for gynaecological cancers remain poor (in the latest waiting times reporting for August 2026, only 35% of women started their treatment within 62 days of suspicion), the Welsh Government's strategy must continue to prioritise this tumour site. The Welsh Government must also insist that this is planned and delivered holistically and in collaboration with partners since many responsibilities and actions will fall outside the responsibility of the National Cancer Team. Improved overall co-ordination is critical. The strategy also needs a strong focus on earlier diagnosis, timely access to treatment, tackling variation and addressing inequalities across Wales. All these steps throughout the pathway should contribute to improving women's holistic experience of cancer – from symptom awareness through to living beyond cancer, and end of life care.

Earlier diagnosis is particularly important for gynaecological cancers. Cervical cancer is currently the only gynaecological cancer with a national population screening programme. For ovarian, womb, vulval and vaginal cancers, recognising symptoms, accessing primary care and receiving timely investigation and referral are therefore critical.

Women should feel listened to and taken seriously when they raise concerns about their bodies. However, the responsibility cannot sit with women to recognise that something may be cancer or to advocate more strongly for themselves when they seek help. GPs and other primary care professionals need the knowledge and support to recognise potential signs and symptoms of gynaecological cancers, respond to persistent or concerning symptoms and know when further investigation is needed. For too many women, delays in accessing the suspected cancer pathway manifest as multiple visits to primary care, until symptom progression is such that their prognosis following diagnosis is poor, or diagnosis occurs via the emergency presentation route.

Support for primary care needs to be backed up by sufficient diagnostic and specialist capacity. There is little benefit in recognising a potential cancer sooner if a woman then faces a long wait for the scan, test or specialist appointment.

We would also like to see greater priority given to reducing emergency presentations; this is an area of work Tenovus Cancer Care has focused on recently. Where a cancer is diagnosed following an emergency presentation, there may have been earlier opportunities to recognise, investigate or refer symptoms.

The strategy should also address variation across Wales. Where a woman lives should not determine how quickly her symptoms are investigated, how long she waits for treatment or the support available to her. National improvement needs to translate into improvement across every health board, with enough transparency to identify where progress is being made and where further action is needed.

There also needs to be a clear relationship between the National Cancer Strategy and the Women's Health Plan. Gynaecological cancers cross women's health, primary care, diagnostics, gynaecology and cancer services. Without clear ownership, there is a risk of responsibility becoming fragmented between different plans and parts of the NHS. This will be particularly important as women's health hubs develop across Wales. Where a woman presents with symptoms that could indicate cancer, there should be clear routes from these services into appropriate investigation, gynaecology and cancer pathways.

Finally, the strategy needs to be clear from the outset about what improvement should look like and how it will be measured. Success should not simply mean that training has been delivered, a service established or an action completed. We need to know whether women are being diagnosed sooner, whether fewer cancers are being diagnosed through emergency routes, whether access to timely treatment is improving, whether variation across Wales is reducing and whether women themselves report a better experience of care.

Women affected by gynaecological cancers have already given their time and shared difficult and deeply personal experiences to help improve services in Wales. Their experiences should continue to shape this work. Continued transparency is also critically important; women should also be able to see what has changed because they spoke up.

For Claire's Campaign, the ambition is clear: women should be diagnosed as early as possible, receive timely and high-quality care wherever they live in Wales, and feel listened to, informed and supported throughout their cancer journey.

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

For Claire's Campaign, detecting more gynaecological cancers at an earlier stage must include improving what happens when women first present with symptoms.

Cervical cancer is currently the only gynaecological cancer with a national population screening programme. For ovarian, womb, vulval and vaginal cancers, earlier diagnosis relies heavily on women recognising that something is wrong, seeking help and receiving an appropriate response when they do.

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GPs and other primary care professionals therefore need the training, information and support to recognise potential signs and symptoms of gynaecological cancers and know when further investigation is needed. Some symptoms can be vague, persistent or overlap with more common conditions, but women should not have to return repeatedly before the possibility of cancer is considered.

We would particularly like to see stronger safety-netting for women with symptoms that persist, recur or worsen. If symptoms do not resolve, or a woman returns several times with the same or related concerns, there should be clear routes for review, investigation or escalation. This is important both for women whose symptoms may initially have a more likely benign explanation and for those whose symptoms change over time. We recommend adoption and implementation in Wales of Jess's Rule, which asks GP teams to '**reflect, review and rethink**' if a patient presents three times with the same or escalating symptoms.

Repeated presentations before diagnosis should also be used as an opportunity to learn. Where a woman has sought help several times before being diagnosed with cancer, services should be able to look back at her pathway and understand whether there were opportunities to investigate or refer her sooner. This should be about system improvement rather than attributing blame to individual clinicians.

The same applies when a cancer is diagnosed following an emergency presentation. Data on emergency cancer diagnoses should be routinely collected, validated, examined and analysed to understand the patient pathway prior to cancer suspicion and whether there were opportunities for earlier recognition, investigation or referral. Over time, this learning should be used to improve pathways and reduce the number of women reaching diagnosis through an emergency route.

Earlier recognition also needs to lead to timely investigation. Improving knowledge in primary care will only take us so far if diagnostic and specialist services do not have the capacity to respond. A woman whose symptoms are recognised as concerning should not then face an unnecessary wait for the scan, test or specialist assessment needed to find out whether she has cancer. Earlier diagnosis needs to be treated as a whole-pathway issue, from the first presentation with symptoms through to investigation and diagnosis.

Women need clear and accessible information about the potential signs and symptoms of gynaecological cancers, including when persistent or changing symptoms should be discussed with a healthcare professional. However, awareness campaigns cannot become a substitute for improving what happens after a woman asks for help. We should encourage women to know their bodies and seek advice when something does not feel right, but the responsibility for securing an earlier diagnosis cannot sit primarily with them.

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We also need to get better at learning from the cancers that are diagnosed later. Data on routes to diagnosis, emergency presentations and repeated presentations could help identify where opportunities are being missed and whether particular pathways need attention. This should recognise that ovarian, womb, cervical, vulval and vaginal cancers are different, and the barriers to earlier diagnosis may not be the same for each.

Women's experiences should form part of that learning. Women who have experienced a delayed diagnosis can often tell us what happened before they were diagnosed: how many times they sought help, whether their symptoms changed, whether they felt their concerns were taken seriously and where they felt the pathway broke down. Their experiences should be considered alongside clinical and service data, with a clear route for turning what is learned into improvements.

New technologies and innovations may create further opportunities for earlier detection over the lifetime of the strategy and should be adopted where the evidence points to improved outcomes. However, innovation cannot replace getting the fundamentals right: recognising concerning symptoms, listening to women, acting when symptoms persist or change, providing timely access to investigation and learning from cases where cancer was diagnosed later than it might have been.

For Claire's Campaign, earlier diagnosis should mean that when a woman knows something is not right and asks for help, there is a system around her that is able to listen, recognise when further investigation is needed and act in time.

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

Claire's Campaign welcomes continued innovation in cancer treatment. Over the next 10 years, the challenge for Wales will not only be having access to new treatments, but making sure the NHS has the workforce, infrastructure and capacity needed to deliver them safely, quickly and fairly.

Advances in treatment can only improve outcomes if patients are able to benefit from them. For women with gynaecological cancers, preparing for future treatments therefore needs to be holistic and go beyond the treatment itself, considering everything required around it, from diagnosis and testing through to the staff and services needed to deliver treatment and support patients afterwards.

Investment in new treatments needs to be matched by investment in the services required to use them effectively. As treatments develop, the NHS will need to make sure that diagnostic services, pathology and other parts of the cancer pathway have enough capacity to support their introduction without creating additional delays elsewhere.

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Workforce planning will be equally important. New treatments can require new skills, different ways of working and additional monitoring. We know from recent experience that NICE approval for a cancer drug does not immediately mean clinical use. Workforce skills and capacity are known hurdles that also need to be overcome before a patient can benefit. The NHS needs to be better prepared to anticipate and plan for these advances, rather than waiting until a treatment is approved to identify gaps in capacity. This will require a more systematic planning approach across oncology, pathology, diagnostics, surgery, pharmacy, specialist nursing and other parts of the cancer workforce.

Equitable access should be built into that planning. As treatments become more specialised, it may not be possible or appropriate to provide every treatment in every health board. However, where a woman lives should not determine whether she can benefit from an advance in cancer treatment.

Where specialist services are provided regionally, nationally or outside a patient's local health board, pathways need to be clear and coordinated. The practical impact on patients also needs to be considered. Travelling further for treatment can mean additional costs, time away from work, disruption to caring responsibilities and more time spent travelling while already unwell. Where centralisation is clinically necessary, patients should be supported to access that care.

Preparing for the future should also mean making sure people in Wales can benefit from cancer research and clinical trials. Where a relevant trial is available, eligible patients should have a fair opportunity to find out about it and consider taking part, regardless of where in Wales they receive their care. We explore the wider opportunities around research and clinical trials elsewhere in our response, but access to innovation should be considered as part of future treatment planning.

For gynaecological cancers, it will also be important to understand whether advances in treatment are reaching women affected by different cancer types. Ovarian, womb, cervical, vulval and vaginal cancers have different treatments and outcomes, and progress for one should not mask a lack of progress for another. As new treatments are introduced, Wales should be able to understand who is benefiting from them and whether there are gaps in access.

Innovation also needs to be introduced in a way that supports patients to understand their care. New and more complex treatments can mean more information to process and more decisions to make. Women should receive clear and accessible information about why a treatment is being recommended, the potential benefits and risks, any alternatives available and what treatment may mean for them personally. They should have the time and support needed to make informed decisions about their care.

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Finally, Wales needs a clear and timely approach to adopting treatments and technologies once there is sufficient evidence that they improve care. Innovation should not remain concentrated in individual centres or depend on where someone happens to be treated. Where new approaches are shown to benefit patients, there should be a clear route for making them available across Wales as fairly and consistently as possible.

For Claire's Campaign, being prepared for the next decade of cancer treatment means more than having access to the latest medicine or technology. It means having the workforce, services and capacity to deliver advances well, and a system that makes sure women can benefit from them wherever they live in Wales.

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

Cancer affects far more than someone's physical health. It can change how people feel about themselves, their relationships, family life, work and finances, and many of those effects do not simply disappear when treatment ends.

People need clear and honest information from the point they are diagnosed. They should understand what their treatment will involve, the possible side effects, what happens next and who they can contact when they have questions or concerns. There is already so much to process following a cancer diagnosis. Patients and their families should not also have to work out how to navigate the system or search for support themselves.

Emotional and psychological support should be available throughout treatment and afterwards. For some people, the emotional impact of cancer can become more apparent once treatment has finished, when there are fewer appointments and less regular contact with their clinical team. Finishing treatment can be a huge milestone while also bringing uncertainty about what comes next. People should know that support is still available if and when they need it.

For women affected by gynaecological cancers, there can also be very personal consequences of cancer and its treatment that we need to be better at talking about. Fertility, early or surgical menopause, sex and intimacy, body image and changes in relationships can all have a significant impact on a woman's life. Furthermore, these impacts may also occur earlier in a woman's life than conventional sources of information and support have been built around. There may be difficult or sensitive conversations to be had but avoiding them does not make their impact any less real. Women's Health Hubs, and other developments arising from the Women's Health Plan, need to better reflect and meet the needs of women with gynaecological cancer.

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Where possible, women should understand these potential effects before treatment and be offered appropriate information and support afterwards. It should not depend on a woman feeling confident enough to raise concerns about sex, fertility, menopause or changes to her body herself, nor should she be left assuming that nothing can be done to help. Successfully treating someone's cancer is of course the priority, but we should also care about the life they are returning to afterwards.

That principle should extend to support after treatment more broadly. People should know what follow-up they will receive, what changes or symptoms to look out for and who they can contact if they become worried. They may still be living with physical effects of treatment, fear of their cancer returning, changes to their relationships or the challenge of returning to work and everyday life. Finishing treatment should not mean feeling that support has suddenly disappeared with it.

Families and unpaid carers need support too. Cancer can have an enormous impact on the people around the person diagnosed. Partners, parents, children and friends may take on caring responsibilities, attend appointments, provide emotional support and help manage everyday life, often alongside work and responsibilities of their own. Where appropriate and with the patient's consent, they should receive the information they need and know where they can go for emotional, practical or financial support themselves.

We also need to recognise that people will need different things at different points in their cancer journey. Age, financial circumstances, disability, caring responsibilities, where someone lives and the cancer and treatment they experience can all shape the support they need. People should be asked what matters to them rather than assumptions being made on their behalf. Where support is offered, this might involve referral to services within the third sector, which tend to be flexible enough to respond to individual needs.

Finally, we need to keep listening to people who have been through cancer care. Women have already shared deeply personal experiences of gynaecological cancer in Wales in the hope that things will be better for those who come after them. Asking people to share those experiences matters, but so does showing them what changed because they did. Patient experience must be systematically collected, analysed and acted upon.

For Claire's Campaign, good cancer care should mean that people feel cared for as people, not just treated as patients. They should feel listened to, understand what is happening to them and know where to turn for help during treatment and afterwards. Cancer care should not end at treating the disease; it should also help people live as well as possible with what cancer and its treatment have changed.

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

Research has a huge role to play in improving cancer outcomes in Wales, but it is important that we think about research in its broadest sense. Developing new treatments and technologies matters, but so does research that helps us understand why people are diagnosed later, why experiences and outcomes differ, and what could work better within the services people already use.

For Claire's Campaign, there is a particular need to better understand the experiences and outcomes of women affected by different gynaecological cancers. Ovarian, womb, cervical, vulval and vaginal cancers are different diseases with different pathways, treatments and outcomes. Considering them individually would give us a clearer picture of where progress is being made, where gaps remain and where further research could make the greatest difference.

We also need to make sure that women with rarer gynaecological cancers are not overlooked. Smaller patient populations can make some types of research more difficult, but they can also result in less evidence being available to improve diagnosis, treatment and support. Collaboration across Wales, and with research taking place elsewhere in the UK where appropriate, could help widen opportunities for participation and make sure women affected by less common cancers are still represented in research. Implementation of the Rare Cancers Act 2026 will go some way to improve access to research and clinical trials opportunities, but Wales must be proactive in this endeavour.

There is also more we need to understand about how women reach a cancer diagnosis. Research into routes to diagnosis, including the experiences of women diagnosed following repeated presentations or through emergency routes, could help identify where opportunities for earlier investigation may be being missed. It will also be important to understand whether these experiences differ between different groups of women and different parts of Wales.

People across Wales should have a fair opportunity to take part in clinical trials and other cancer research. Finding out about a relevant opportunity should not depend on where somebody happens to receive treatment or whether their clinician or health board is involved in a particular study. Where appropriate, patients should be made aware of relevant research opportunities and given clear information about what taking part would involve so that they can make an informed choice.

We would also like to see patients involved earlier in deciding what cancer research looks at and how it is carried out. Institutions such as the James Lind Alliance bring patients, clinicians and researchers into priority setting partnerships. Women who have been through diagnosis and treatment can identify questions that matter to them, gaps that may not otherwise be recognised and outcomes that would make a

meaningful difference to their lives. Involvement should be meaningful and ongoing, rather than asking people to share their experiences after the important decisions have already been made.

Just as importantly, people should be able to see what happens as a result of their involvement. Women have already given their time and shared deeply personal experiences of gynaecological cancer in Wales because they want things to improve for those who come after them. If we continue asking people to contribute their experiences and expertise to research, we should also get better at communicating what was learned and what changed as a result.

The same principle applies to research findings. A successful study or promising innovation is only valuable to patients if what we learn can be translated into better care. When research identifies an approach that improves diagnosis, treatment, support or patient experience, there should be a clear route for considering how it can be adopted and, where appropriate, made available more widely across Wales. Good practice should not remain within an individual project or health board when patients elsewhere could benefit from it.

For Claire's Campaign, strengthening cancer research means asking questions that matter to people affected by cancer, making sure people across Wales have opportunities to contribute, addressing gaps in what we know about different gynaecological cancers, and using what we learn to improve care. Research should not end with a publication or a completed study; patients should ultimately be able to see its value in the care they receive.

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

For Claire's Campaign, future planning needs to look at the whole cancer pathway. Having the latest treatments and equipment matters, but they can only make a difference if there are enough people to deliver them and enough capacity for patients to move through diagnosis, treatment and follow-up without unnecessary delays.

We know there are already significant pressures. In March 2026, NHS Wales had an estimated 5,335 full-time equivalent vacancies, including an 8.8% vacancy rate among medical and dental staff, excluding trainees. In May 2026, patients were waiting on more than 115,000 diagnostic pathways in Wales, with over 35,800 waiting longer than the eight-week target.

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We know that the greatest delays in the gynaecological cancer pathway are during the diagnostic interval and these contribute to the overall poor waiting times for women with gynaecological cancers.

For someone waiting to find out whether they have cancer, those pressures are not abstract workforce or performance figures. They can mean more time waiting for a scan, a test, an appointment or an answer.

Workforce planning therefore needs to look beyond oncology alone. Cancer pathways depend on GPs, radiology, diagnostics, pathology, surgery, oncology, specialist nurses and many other professionals. A shortage or delay in one part of the pathway can quickly have a knock-on effect elsewhere.

For gynaecological cancers, we want GPs and other primary care professionals to have the training and support to recognise potential symptoms and know when further investigation is needed. Claire's Campaign recently shared findings (these were picked up by the BBC) of a GP survey it conducted that found around half of GPs saying that the lack of consultation time was a major concern.

The diagnostic and specialist capacity beyond primary care also needs to be able to respond. Training people to recognise cancer earlier and seeing more patients, without ensuring the next part of the pathway has the capacity to cope, simply risks moving the wait from one place to another.

Cancer specialist nurses are another part of the workforce we would like to see protected and strengthened. Having someone who knows your case, can explain what is happening and is there when you have questions can make an enormous difference during cancer treatment. These roles need sufficient capacity for that relationship to be meaningful, rather than specialist nurses becoming increasingly stretched across growing caseloads.

The workforce also needs to reflect the consequences of cancer and its treatment. For women affected by gynaecological cancers, this can include fertility, early or surgical menopause, sexual wellbeing and psychological health. Women should be able to access professionals with the right expertise to support them with these consequences, rather than having to find that support, which might lie outside the NHS, for themselves

Equipment and facilities need investment too, particularly diagnostic and imaging capacity, pathology and the technology needed to support modern cancer care. However, investment needs to be planned across the pathway. Increasing capacity in one area without considering what happens before and after it risks creating a new bottleneck somewhere else.

We also need to think carefully about where cancer care is delivered. Some specialist treatment will inevitably need to take place in larger centres, but where a woman lives should not determine the quality or timeliness of the care she receives. Where it is safe and appropriate, providing more care closer to home could reduce travel, time away from work and disruption for patients and their families. Where specialist care does require people to travel further, the practical and financial impact of doing so should be recognised and appropriate support made available.

Finally, workforce planning needs to look ahead rather than repeatedly responding once services are already under pressure. Wales needs to understand where gaps exist now, where demand is likely to grow and what skills and roles will be needed in the future. That should inform how people are trained, recruited and, importantly, retained across the cancer pathway.

For Claire's Campaign, the test is quite simple: when a woman is worried that she may have cancer, there should be someone with the knowledge to recognise when further investigation is needed, somewhere for her to be investigated without an unacceptable wait, and enough skilled people and capacity to care for her if cancer is found. Future workforce, equipment and facilities planning should be built around making that possible wherever a woman lives in Wales.

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

For Claire's Campaign, better cancer data is not simply about collecting more information. It is about answering basic questions regarding women's experiences of cancer care. Are women being diagnosed earlier? How are they reaching a diagnosis? Are some having to ask for help several times before referral? Are too many cancers still diagnosed following an emergency presentation? And does the answer depend on the type of gynaecological cancer a woman has or where in Wales she lives? Currently, the available data cannot always answer these questions.

The latest gynaecological cancer waiting-time figures show why this matters. In August 2026, just 35% of women with a gynaecological cancer started treatment within 62 days of cancer first being suspected. Performance has fluctuated dramatically over recent months, from 44.9% in March to 39.2% in April, 51.2% in May, 46.3% in June, and a little over half in July 2026, before falling to 35% in August 2026. This remains well below the national target. Furthermore, while attention and resources are focused on winter pressures, we do not see the same attention placed on the impact of summer pressures.

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Behind these figures are women waiting for answers and treatment, yet the data cannot tell us everything we need to know about why delays occur. The 62-day measure begins once cancer is suspected. It does not tell us how many times a woman sought help before reaching that point, what happened during those earlier contacts, or how long she had been experiencing symptoms. Nor can a single headline measure show where delays occur within the pathway. We need to understand the journey behind the figure.

One of the biggest opportunities is making better use of route-to-diagnosis data. Wales already collects information through the Patient Episode Database for Wales (PEDW) that could clarify how people reach a diagnosis, including via emergency presentations. We would like to see route-to-diagnosis and emergency-presentation data routinely published by health board and, where possible, by cancer type. This would allow Wales to contribute to cancer audits and identify patterns that are currently difficult to discern. If women with a particular gynaecological cancer, or in one part of Wales, are more likely to be diagnosed through an emergency route, we must identify that pattern, investigate what is driving it, and use that information to improve pathways.

We also strongly support better disaggregation of gynaecological cancer data. Ovarian, womb, cervical, vulval, and vaginal cancers are distinct diseases with different symptoms, pathways, treatments, and outcomes. Grouping them together hides significant differences. Looking at individual cancer types would provide a clearer understanding of where progress is being made and where targeted action is needed.

Alongside waiting times, Wales should look at measures such as stage at diagnosis, late-stage diagnosis rates, emergency presentations, survival, and inequalities to build a fuller picture. Waiting-time reporting could also be made more meaningful by reporting typical waits alongside the longest waits, involving patients in deciding which measures are most understandable to them.

Digital systems must also work better for individual patients. A woman moving between her GP, diagnostics, gynaecology, and oncology should not have to repeatedly tell her story because information does not follow her. Relevant referrals, test results, and clinical notes should be readily available to all professionals involved in her care.

Most importantly, better data must lead to better care. Claire's Campaign grew from women sharing experiences of where care had not worked as it should. Data offers the opportunity to understand whether these experiences are isolated or part of wider patterns. Where disparities exist, the response cannot simply be to publish another data point. For Claire's Campaign, the real value of better cancer data is helping us see where women are being missed, understanding why, and ensuring services change as a result.

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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?

For Claire's Campaign, reducing inequalities in cancer outcomes means being able to see clearly where differences exist, understanding why they exist, and then taking action to address them. At each stage, this is likely to involve non-NHS stakeholders.

For women affected by gynaecological cancers, the principle should be straightforward: a woman's chances of being diagnosed early, receiving timely treatment and having a good experience of cancer care should not depend on where she lives, her circumstances or which gynaecological cancer she develops.

Geographical variation is an important part of this. National figures can hide very different experiences across Wales, so we need enough transparency to understand how diagnosis, access to treatment and outcomes differ between health boards. Where one area is consistently achieving better outcomes, we should understand what is working and whether that learning can be applied elsewhere. Where women are experiencing poorer outcomes, there should be both support to improve and clear accountability for doing so.

We also need to understand whether some groups of women are being left behind. Wherever possible, cancer data should help us identify differences by deprivation and protected characteristics across the pathway, including diagnosis, treatment, survival and people's experiences of care. Identifying a disparity should then prompt a much more important question: why is it happening?

The answer will not necessarily be the same for every community. People may face different barriers to recognising symptoms, seeking help, screening, attending GP appointments or accessing specialist care. Financial pressures, caring responsibilities, communication needs, disability and the distance someone needs to travel for care can all affect their experience of the system. Services should work with communities experiencing poorer outcomes to understand the barriers they face rather than assuming what those barriers are.

We also need to recognise inequalities between different gynaecological cancers. Ovarian, womb, cervical, vulval and vaginal cancers have different symptoms, pathways, treatments and outcomes. As we set out elsewhere in our response, better breakdown of data by individual cancer type would help us identify whether women with particular gynaecological cancers are more likely to be diagnosed later, wait longer or experience poorer outcomes.

This is particularly important for rarer gynaecological cancers. Smaller patient numbers should not result in the experiences and outcomes of women with less

common cancers becoming invisible within national policy. Where numbers are small, Wales may need to think differently about how evidence is gathered and how services are planned, including working across health boards or with partners elsewhere in the UK where appropriate. Implementation of the Rare Cancers Act 2026 can help with determining what action is required in this space.

Practical access to cancer care also needs to be considered as part of reducing inequalities. Some specialist cancer services will need to be delivered in larger centres, but travelling further for appointments and treatment can bring additional costs, time away from work, disruption to caring responsibilities and practical difficulties for patients and families. Where specialist care requires people to travel, these impacts should be recognised, and support should be available so that distance does not become an additional barrier to receiving the best possible care.

Lived experience needs to sit alongside the numbers. Data can tell us that a difference exists, but the people experiencing that difference can often help us understand why. Communities experiencing poorer access, experiences or outcomes should therefore be involved in understanding the problem and shaping the response.

Importantly, reducing inequalities should be measured by whether gaps actually narrow over the lifetime of the strategy. It is not enough to identify year after year that outcomes are poorer in a particular health board, community or group of patients. We need to understand what action followed and whether that action made a difference.

For Claire's Campaign, equality should not mean simply offering everybody the same service and hoping for the same outcome. It means recognising that women can face different barriers, being willing to respond differently where needed, and making sure that where a woman lives, her circumstances or the gynaecological cancer she develops do not determine the quality or timeliness of the care she receives.

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

For Claire's Campaign, success should ultimately be measured by what changes for people affected by cancer, not simply by whether the actions in the strategy have been completed.

Publishing a strategy, delivering training or establishing a new service may all be important steps, but they are not outcomes in themselves. We need to know whether

people are being diagnosed sooner, receiving treatment more quickly, living longer and having a better experience of their care.

That means being clear from the beginning about what success looks like. The strategy should set measurable outcomes, establish clear baselines and timescales, and report progress against them regularly and publicly. Just as importantly, there should be clear accountability for what happens when progress is not being made or when some parts of Wales are falling behind.

For Claire's Campaign, this is particularly important because women affected by gynaecological cancers are waiting for change. The Health and Social Care Committee's follow-up to *Unheard: Women's journey through gynaecological cancer* found that, despite the Welsh Government accepting the need for clear and measurable objectives and targets for improving gynaecological cancer outcomes, almost two years later these had still not been published. The new cancer strategy is an opportunity to make sure we do not repeat that.

No single measure will tell us whether cancer care is improving. Success needs to be assessed across the cancer pathway, as well as outside and adjacent to it (for example, ensuring women feel heard and reducing repeat visits to primary care before cancer is suspected). Cancer pathway metrics need to measure earlier diagnosis, stage at diagnosis, routes to diagnosis, emergency presentations, waiting times, survival, inequalities and patient experience. Together, these paint a picture in which we understand whether national performance is improving, and whether that improvement is being experienced equally across Wales.

For gynaecological cancers, we also need to be able to see what is happening for women affected by different cancer types. As set out elsewhere in our response, ovarian, womb, cervical, vulval and vaginal cancers should be looked at individually wherever the data allows. An improvement in an overall gynaecological cancer measure should not be allowed to mask a lack of progress for women with a particular cancer.

The same principle applies to inequalities. National improvement cannot be considered a complete success if women in particular health boards, communities or groups continue to experience significantly poorer outcomes. The strategy should therefore measure not only whether overall outcomes are improving, but whether the gaps between different parts of Wales and different groups of people are narrowing.

Patient experience should also be treated as a meaningful measure of success alongside clinical outcomes. We should know whether people felt listened to and taken seriously, whether they understood what was happening to them, whether they knew who to contact when they needed help and whether they felt supported during and after treatment. These things matter in their own right and can tell us things about the quality of cancer care that clinical measures cannot.

Most importantly, measurement needs to lead to action. Where progress is off track, the response should not simply be to record that fact in the next report. There should be a clear process for understanding why, identifying what needs to change, assigning responsibility and then showing whether that action has worked. Reporting the same inequality or poor outcome year after year is not success.

Women have already shared deeply personal experiences of gynaecological cancer in Wales because they wanted things to be better for those who came after them. They should be able to see whether that change happened.

For Claire's Campaign, the test of the strategy should ultimately be whether we can answer some straightforward questions: Are women being diagnosed sooner? Are fewer reaching diagnosis through emergency routes? Are they receiving treatment more quickly? Are inequalities narrowing? Are more women surviving? And are women telling us that their experience of cancer care is getting better?

If, over the lifetime of the strategy, we cannot clearly answer those questions, it will be difficult to say with confidence that it has succeeded.

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

Claire's Campaign welcomes the opportunity to contribute to the National Cancer Strategy for Wales. Much of our response has focused on the experiences of women affected by gynaecological cancers, but there are several wider points about how the strategy is implemented that we would like to emphasise.

Firstly, there needs to be clear join-up between the National Cancer Strategy and the Women's Health Plan. For women affected by gynaecological cancers, these are not separate areas of healthcare. A woman may first present to her GP with abnormal bleeding, persistent bloating, pelvic pain or another symptom before moving through diagnostics and gynaecology and, where cancer is suspected or diagnosed, into specialist cancer services. Post-treatment, a woman may transition back into routine NHS care while having to manage and live with the long-term impacts of cancer treatment, such as infertility or medical menopause.

The policies and services around her should reflect that journey. There should be clear ownership of gynaecological cancers across the cancer and women's health agendas, so that responsibility does not become fragmented between different plans, programmes or parts of the NHS.

The development of women's health hubs is particularly relevant. These have the potential to improve how women access support and care, but there need to be clear

links into diagnostics, gynaecology and cancer pathways. Where a woman presents with symptoms that could indicate cancer, she needs to be able to move quickly into appropriate investigation and referral.

Greater consistency across Wales is also important. We recognise that services cannot always be delivered in exactly the same way in every health board, and that some specialist cancer care will need to be provided regionally or nationally. However, where a woman lives should not determine the standard or timeliness of the care she receives.

NHS organisations need to work together around the patient rather than expecting patients to navigate organisational boundaries themselves. This is particularly important where diagnosis, treatment and follow-up involve different health boards or specialist centres. Patients should know who is responsible for their care, services should communicate effectively with one another and transitions between different parts of the pathway should feel coordinated.

The same principles should apply where highly specialist services are provided outside Wales. Patients should have equitable access to the most appropriate care regardless of whether it is available within Wales. Where treatment in England is needed, referrals, clinical information, treatment and follow-up should be coordinated, with clear responsibility for the patient throughout. Patients should not be left to bridge the gap between different organisations or healthcare systems themselves.

We also believe the new strategy should build on work that has already taken place rather than starting again. Women affected by gynaecological cancers have already contributed extensively to work aimed at improving services in Wales.

The Health and Social Care Committee's *Unheard: Women's journey through gynaecological cancer* report made 26 recommendations, 24 of which were accepted in full or in part by Welsh Government. Its subsequent follow-up showed that important gaps remained. The National Cancer Strategy provides an opportunity to build on those recommendations and commitments, bringing them into a clearer framework for delivery rather than allowing previous work to lose momentum as new plans are introduced.

Lived experience should continue to inform that work. Women should not be repeatedly asked to share difficult and deeply personal experiences without being able to see what has changed as a result. Where patients and the public contribute to consultations, reviews, research or service improvement, there should be clear feedback about how their evidence influenced decisions and what action followed.

Across our response, Claire's Campaign has highlighted the importance of earlier diagnosis, timely investigation and treatment, reducing emergency presentations and

variation across Wales, better use of cancer data, and care that supports women as people as well as patients. These priorities are closely connected. Improving one part of the pathway while leaving significant problems elsewhere will only take us so far.

The National Cancer Strategy is an opportunity to bring together work across cancer services, women's health, primary care, diagnostics and the wider NHS, while providing clearer ownership and accountability for delivering the improvements women have already been asking to see.

For Claire's Campaign, the ambition should be simple: wherever a woman lives in Wales, and whichever gynaecological cancer she is affected by, she should be able to expect timely, joined up and high-quality care, and to see that the experiences women have already shared are helping to make that care better for those who come after them.