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Written Response to the Rural Development Sub Committee Report "Inquiry into the Reorganisation of Schools in Rural Wales" by Jane Hutt AM, the Minister for Children, Education, Lifelong Learning and Skills

January 2009

Executive Summary

I welcome this inquiry which was wide ranging and the report which is well balanced.

I have set out below my response to the Report's individual recommendations.

Detailed Responses to the report's recommendations are set out below:

The Committee recommends that the Welsh Assembly Government:

1 (i) provides clearer guidance to local authorities on how surplus places are to be defined and addressed;

(ii) commissions further research on the actual cost of a surplus place.

Response: Accept part (i), Accept in principle part (ii)

I can accept the first part of this recommendation because action has already been taken to enable local authorities to consistently assess the capacity of their schools. Guidance Circular 09/2006 which was issued in July 2006 provides a consistent method of measuring the capacity of schools. Local authorities have gradually re-measured schools and are now in a better position to assess whether schools are of the right size for the number of pupils on roll. This important activity informs a local authority's need to plan school places. Revised draft guidance on school organisation will indicate that the identification of surplus capacity can assist local authorities in carrying out strategic reviews of school provision so as to assess whether the pattern of provision is appropriate. The removal of surplus capacity is not an end in itself. Improving efficiency in the provision of education should be for the purpose of improving educational outcomes.

I can accept part (ii) in principle but this will be subject to discussion with a range of stakeholders on the need for and scope of such research.

Financial Implications – None.

Recommendation 2: That the Welsh Assembly Government, in any new guidance on surplus places, states clearly that it is the responsibility of each individual local authority to deal with issues of resource use and surplus places within their overall budget and education policy.

It should be made clear that local authorities take these decisions and that the Welsh Assembly Government guidance is not designed and should not be taken to be pressure on individual authorities.

Response: Accept

I accept this recommendation. Revised guidance will make it clear that it is the role of the local authority to plan school provision in the light of local knowledge, in the interests of pupils, and with due regard for efficiency. The Welsh Assembly Government needs also to make it clear that resources available for education need to be used as cost effectively as possible, whilst protecting and where possible, improving standards of education.

Financial Implications – None. Costs of guidance issued by the Welsh Assembly Government will be met out of existing budgets (in 2008/09 or 2009/10).

Recommendation 3: The Welsh Assembly Government should publish a clear vision for Welsh primary schools:
• To include a definition of what "fit for purpose" means;
• To define and describe a "School Standard for Wales".

Response: Accept in principle
I can accept this recommendation in principle. The Welsh Assembly Government in line with its commitments set out in 'One Wales' has already begun work on creating and building a shared vision of 21st Century Schools, (both primary and secondary) by working in partnership with the Welsh local Government Association (WLGA) and all local authorities. Moving on from the concept of "fit for purpose" , a 21st Century School will be defined providing a consistent standard for local authorities to work towards. The WLGA and Local authorities will be involved in this process.

Financial Implications – None.

Recommendation 4: The Welsh Assembly Government should carry out a comprehensive audit of the school estate to establish how many school premises would comply with the standard and the amount of investment that will be needed in order to bring all Welsh schools up to this standard.

Response: Accept in principle

I can accept the principle of this recommendation, and local authorities are already taking action to meet that principle. Local authorities are required to have in place Asset Management Plans covering all their capital assets. A vital element of an Asset Management Plan is a comprehensive, structural audit of their physical assets; including school buildings. These audits are based on surveys of building condition, suitability and sufficiency and should be reviewed and updated.

In addition authorities are required to have Asset Management Plans for individual services. A robust Asset Management Plan for the education service should comprise a thorough analysis of condition and investment need. The Welsh Assembly Government accepts there is value in an aggregated and comprehensive knowledge base of the school educational estate in Wales; to enable national and local planning in relation to 21st Century Schools. The individual Asset Management plans will provide this.

Financial Implications – None.

Recommendation 5: That the Welsh Assembly Government establishes a clear strategy to ensure that all schools in Wales reach this standard within an agreed and published timescale.

Response: Accept in principle

I can accept this recommendation in principle. There is a need to recognise that not all Local Authorities are at the same position regarding the development of their school investment and re-organisation strategies. In line with Recommendation 3, the delivery of 21st century schools will implement a step change in the Welsh Assembly Government's capital investment programme. We will be taking a strategic approach to funding, design and procurement, including ICT integration, and we will be working in partnership with local authorities and assisting in the development of their capital investment programmes. 21st Century Schools will be a multi year, long term programme of investment recognising the differing stages that individual local authorities will be with regards to their school capital investment and re-organisation strategies.

Financial Implications – None.

Recommendation 6: That the Welsh Assembly Government does not need to define a small school in terms of enrolled pupil numbers at any one time – but does define a small school in terms of staff and the teaching load of its Head in order to provide and focus support on those schools where such support is most needed.

Response: Accept in principle

I accept that there is no need to define "small schools" for the purposes of planning school places. It is for a local authority to decide on the appropriate size of schools within the local context. It is however necessary to define such schools for specific practical purposes such as distributing targeted grants. The Welsh Assembly Government has provided additional grant funding for small and rural schools since 2002. In 2008/09, a total of £4.1 million is available. The Audit Commission identified a 90 (or fewer) pupil school as one which would cost proportionately more to run. Therefore when distributing funding targeted on small schools local authorities are instructed to prioritise schools with 90 or fewer pupils on roll. Part of the additional funding is also to

be targeted on schools which have head teachers with a significant timetabled teaching commitment.

Financial Implications – None. Existing budgets cover activity related to the distribution of grants.

Recommendation 7: The Committee recommends that the Welsh Assembly Government develops a code of practice for consultation and meaningful community engagement which should be followed by local authorities in managing this process.

Response: Accept in principle

I can broadly accept this recommendation. Future practical guidance on bringing forward statutory proposals will aspire to extend the good practice on undertaking consultation that already exists. It may not be appropriate to be overly prescriptive and issue a code of practice, but it will be made clear that interested parties need sufficient information and sufficient time to make their views known when they are asked to respond to proposals for change.

Financial Implications – None. Costs of guidance issued by the Welsh Assembly Government will be met out of existing budgets in the relevant year (2009/10)

Recommendation 8: The Committee recommends that the Welsh Assembly Government guidance includes the need for openness and transparency by LEAs when consulting on school reorganisation proposals. The Committee expects that active informed and meaningful consultation is at the heart of this process.

Response: Accept

I accept the need for consultation to be of the highest possible quality. The revised circular indicates that the sufficiency of consultation is a consideration when I need to determine whether statutory proposals which have resulted in objections should be approved. Officials in my department are also responsible for providing practical guidance to local authorities who are considering changes to schools. Revised guidance is currently under development. Consultation issues form part of that guidance.

Financial Implications – None. Costs of guidance issued by the Welsh Assembly Government will be met out of existing budgets in the relevant year (2009/10)

Recommendation 9: The Welsh Assembly Government in their revised guidance should clarify and formalise the roles of all stakeholders in the closure process. The revised guidance should be clear in expecting local authorities to proactively inform local communities and then to help those communities to participate in a debate on the future configuration of primary

education in any given area.

Response: Accept in principle
Guidance recently subject to consultation is the broad policy guidance which sets out the principles that are relevant to considerations about reorganising schools. Guidance on procedural matters such as consultation and engagement with interested parties is due to be revised within the next year. That guidance will include examples of good practice on consultation with interested parties and will aim to share that practice amongst authorities. I expect local authorities to engage thoroughly with the main stakeholders when consulting on proposals to change school provision. The key stakeholders will vary according to the nature of the proposal. Some changes might have relatively little impact beyond the parents, pupils and schools involved whilst in other cases, impacts will be far-reaching. The revised guidance will encourage authorities to carefully consider the question of who would be affected by change so as to ensure engagement with all relevant parties.

Financial Implications – None. Costs of guidance issued by the Welsh Assembly Government will be met out of existing budgets in the relevant year (2009/10)

Recommendation 10: The Committee recommends that the Welsh Assembly Government commissions research into the academic and social effects on children after they have moved to a larger school.

Response: Accept in principle

Whilst I accept in principle, this requires further consideration in conjunction with recommendation 11. Whilst I fully understand the Committee's purpose in making this recommendation this is a difficult area in which to conduct meaningful quantitative research. Whilst it is possible to identify a suitable, albeit very small sample and measure academic achievement, it would not be possible to identify the many influences on pupil outcomes amongst the sample, nor identify if attainment is better or worse than it would otherwise have been. It would be more appropriate to consider effects of transfer to a larger school alongside the type of social qualitative research suggested in recommendation 11.

Financial Implications – To be assessed once further consideration of scope for research is completed.

Recommendation 11: The Welsh Assembly Government should commission research to assess and to fully understand the impact of school closures on communities in rural Wales.

Response: Accept in principle

Whilst I accept this recommendation in principle, I need to consider this recommendation in conjunction with recommendation 10 further in order to ascertain the feasibility and scope of the recommended research. An initial step could be to undertake a review of any existing research and information on the impact of school closures, including the impact on communities and on the educational and other outcomes for pupils before deciding whether any new research is required. Since this recommendation cuts across other Ministerial portfolios, it is important that all those with an interest in such impacts are involved in discussions about the proposition. I am asking officials to provide me with further advice after discussions have been held.

Financial Implications – To be assessed once further consideration of scope for research is completed.

Recommendation 12: LEAs should carry out robust community impact assessments prior to the closure of any small school. The Welsh Assembly Government should provide guidance to LEAs on undertaking such community impact assessments based upon its research.

Response: Accept

I can broadly accept this recommendation. Current guidance already indicates that for school closure proposals, the overall effect on the community of closure and the extent to which the school is serving the whole community as a learning resource is a relevant consideration. Where a school is a focal point for community activity and its closure could have implications beyond the issue of education, it is expected that cases presented for Ministerial determination should show that options for maintaining community facilities in the area have been considered. The revised draft guidance suggests that that consideration by local authorities should be formalised as a community impact assessment. If research on impacts is commissioned then that could inform, in due course, a local authority's consideration of community issues. In the meantime authorities will continue to use their own judgement on how to assess the impact of a closure. Current guidance makes it clear that whilst the interests of the local community should be taken into account, educational interests should always be the prime concern. Revised guidance will continue to reflect this position.

Financial Implications – None. Costs of guidance issued by the Welsh Assembly Government will be met out of existing budgets in the relevant year (2008/09 or 2009/10)

Recommendation 13: That the impact on the Welsh language be considered as a major determinant when local authorities take decisions in school closures.

Response: Accept

I can broadly accept this recommendation. Revised draft guidance suggests that potential impact on the Welsh language should be assessed by local

authorities prior to bringing forward proposals. Impacts on the language within schools and on standards of pupils' learning are of the greatest importance. Local authorities that have brought forward proposals for the reorganisation of schools where pupils are taught mainly through the medium of Welsh have historically offered equivalent schools as alternatives. Local authorities have therefore already been addressing this issue.

Financial Implications – None. Costs of guidance issued by the Welsh Assembly Government will be met out of existing budgets in the relevant year (2008/09 or 2009/10)

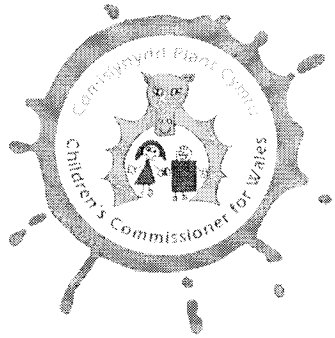
Recommendation 14: The Committee recommends that the Welsh Assembly Government reviews the process for reorganising schools to strengthen the role of local education authorities, supports them in their responsibilities in the reorganisation process and gives consideration to transferring the right to hear appeals against school reorganisation proposals to an independent arbitrator.

Response: Accept in principle

I can accept this recommendation in principle. Local authorities already have the power to make changes to schools as provided for by the School Standards and Framework Act 1998. My department assists authorities with guidance on the procedures that are necessary as a result of that legislation. I have the role of deciding contested proposals. The sub-committee report recognises the current division of responsibilities. Changes to the procedures and responsibilities in the manner suggested by the sub-committee would necessitate fresh legislation. I am willing to give consideration to the Sub committee's suggestions, contained in this recommendation, including that of transferring decision making to an independent arbiter, but this will require substantial investigation by my department. In the meantime I am content with the robustness of current legislation and the extent to which it permits authorities to engage with those affected by proposed change.

Financial Implications – none arising from the consideration of transferring powers.

Jane Hutt AM,
Minister for Children, Education, Lifelong Learning and Skills



21 January 2009

Your Ref: PET-03-109

Val Lloyd AM
Chair - Petitions Committee
National Assembly for Wales
Cardiff Bay
CARDIFF
CF99 1NA

Dear Val

Re: **Petition: Anti Bullying Schemes in Schools**

Thank you for your letter dated 10 December 2008.

My office monitors in-house the work of all National Assembly for Wales Committees and I have noticed some of the innovative practices being undertaken.

The fact that the Petitions Committee is open to children and young people under the voting age enables them to raise issues which affect their lives. This is very much in line with article 12 of the United Nations Convention on the Rights of the Child (UNCRC) which states:

> *State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.*

The Petitions Committee is an important access point for children and young people under 18 into the democratic and decision making process in Wales and its role cannot be underestimated.

This is why I welcome the questions from the Petitions Committee Members about how to improve practices. Whilst the questions may have arisen out of concern, I think it is worth reflecting that this process is still in its infancy and the

issues that have arisen could perhaps be seen as symptomatic of a relatively new process.

You ask my views about the following issues raised by the Committee:

The appropriateness of teachers acting as advocates for pupils when submitting petitions, particularly when the issues relate to schools.

I'm not familiar with the particular circumstances of the Pembroke School petition so it would be inappropriate for me to comment. I note, however, the potential hazards. Namely, conflicts of interest which could lead to:

- inappropriate influencing of the content of petitions by adults
- schools being concerned that a petition could reflect negatively on the school.

I believe these issues need to be taken into account as part of a wider review of the working practices of NAfW Committees.

One option would be to develop guidance or information leaflets for schools, aimed at children and young people and also at teachers. This could outline the role of the Committee and its processes as well as the status and responsibilities of the petitioners.

I believe the other points about the process of accepting petitions and how the views of young people are represented are interlinked. Though not wanting to provide you with a 'non answer', I believe that my office, along with others, needs to take time to think through all the issues around Committee engagement with children and young people before reaching any conclusions or suggestions. Some possible questions to consider include:

- How to make the wider Committee process accessible to children and young people? This raises questions around general promotion of the NAfW structures.
- As the committee environment may seem alien and intimidating for some children and young people, what procedures can be put in place to prepare them for Committee engagement?
- How can we ensure that the children and young people are fully aware and have an understanding of the level of very public scrutiny bearing in mind they may be more vulnerable than adults? If there are any matters

arising from evidence presented to the committee, how may the committees address these?

- Should the committees conform with the **The National Standards for Children and Young People's Participation** in order to ensure meaningful engagement?
- What of the Committees that don't currently engage with children and young people? There may be some who do not engage at the moment – but is this an issue about the way Committees work or is it rather due to the subjects they are debating?
- What are the good practices that could be replicated across Committees?
- Having established good practice on children's engagement some thought needs to be given to how this can be rolled out across all the Committees. Is it possible, for example, to consider the publication of Assembly wide standards, with a commitment to monitoring progress to ensure consistency?

This is by no means an exhaustive list of considerations.

It is worth noting that many of these questions are however being addressed, such as the imaginative use of alternative media to communicate with interested parties. I understand the Petitions Committee will use a DVD to interact with Portfield School. This is to be commended and I believe the practice should be shared. I also recall a member of the Committee advocating in a recent conference, the use of digital stories which could be presented as petitions.

I'd welcome the opportunity to progress this discussion and therefore propose the following:

- That representatives from my office meet with your clerking team to discuss the subjects in connection with the Petitions Committee.
- That my office opens a dialogue with the Assembly Commission to explore how we could contribute to discussions around the work of the Committees in improving accessibility for children and young people.

Cont/d..

My office will be in touch shortly to discuss the above. In the meantime, should your Committee secretariat or committee members wish to contact my office, please do so anytime. My Assembly Liaison Officer is Gwion Evans and he is available on 01792 765 600 or e-mail, gwion.evans@childcomwales.org.uk.

Yours Sincerely

Keith Towler
Children's Commissioner for Wales

Asiantaeth yr
Amgylchedd Cymru
Environment
Agency Wales

Ms Val Lloyd
Chair
Petitions Committee
Cardiff Bay
Cardiff
CF99 1NA

RECEIVED
28 JAN 2009

Ein cyf/Our ref: 09 01 Lloyd V 22

Eich cyf/Your ref: PET-03-122

Dyddiad/Date: 22 January 2009

Dear Ms Lloyd

Re. Petition on Hafod Quarry

Thank you for your letter dated 19 January 2009 asking for details of the comments Environment Agency Wales submitted in relation to designations of Hafod as a Special Area of Conservation (SAC) and a Site of Specific Scientific Interest (SSSI).

The initial designations (SSSI and cSAC) were made in 2000 and at this time we made no formal reply as no concerns over the designation existed.

In 2004, the site was granted full SAC status and we did not raise any objections to this.

The Countryside Council for Wales (CCW) are the lead authority for the designations and they make the final decisions. I suggest they may be able to advise further on the actual reasons regarding the designations.

With regard to your query regarding protection and integrity of conservation, our role with the Hafod site involved the determination of a PPC permit when the landfill was proposed. As you are aware, the decision to allow a landfill to be constructed lies with the Local Authority. Our role is to ensure that it is constructed to the appropriate standards and with adequate controls. In this case, I can assure you that the PPC application was determined and issued once the operators had provided sufficient evidence to show compliance with the current legislation.

As part of the determination, we consult with CCW to ensure that any conservation concerns are addressed. In this case, due to the proximity of the SSSI and SAC a Habitats Directive risk assessment was undertaken and the recommendations from this were implemented during the construction of the landfill to ensure adequate protection.

The full details of the permit application including the consultations and risk assessment are available for viewing on our public register in our office at Buckley.

If you would like to see these documents, I can certainly arrange for this for you. I am, however, happy that the process was followed correctly and, therefore, there is suitable legislative control and protection of the SAC and SSSI from the landfill operations.

Please do let me know if you require anything further.

Yours sincerely

Chris Mills

CHRIS MILLS
DIRECTOR WALES

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cc: David Edwell, Area Manager North

Cont/d..

To: Gareth Thomas, Committee Support Officer
National Assembly for Wales,
Petitions Committee, Cardiff Bay, Cardiff CF99 1NA

Cc Edwina Hart AM MBE, Minister for Health and Social Services, Welsh Assembly Government
Gwenda Thomas AM for Neath, National Assembly for Wales
Val Lloyd AM – Chair, Petitions Committee, National Assembly for Wales
Andrew R T Davies AM, Michael German AM, Bethan Jenkins AM,
Petitions Committee members, National Assembly for Wales

27th January 2009

Dear Gareth

Reference: PET – 03 –137 [HYPOTHYROIDISM IN WALES]

Thank you for your letter of the 4th of December 2008 in which you requested that I write to you in order to inform you of the specific steps that I would like to see the Minister take in order to improve the diagnosis and management of hypothyroidism in Wales.

Since this is such a complex issue, it would be useful as a starting point to refer to the petition wording in which an investigation was requested into both the non-diagnosis and mismanagement of hypothyroidism. The petition then goes on to state why the petitioners are unhappy with this state of affairs and of the serious concerns that the diagnosis and management of this profoundly debilitating condition, is too dependent on the interpretation of blood tests, whilst often ignoring the signs and symptoms of hypothyroidism. The petitioners believe that current methods are flawed and have led to un-diagnosed and untreated hypothyroidism for patients throughout Wales and beyond. This is a situation, which needs to be rectified, to prevent further suffering to the individuals concerned and prevent further drain on the state.

In support of the above assertions, there is already a great deal of scientific and medical evidence available and the committee has to date received much supporting information in relation to the petition including:-

The petition itself with a total of 1444 signatures
Supporting information from the Lead Petitioner, Dr Sarah Myhill
Supporting information from the Petition Co-ordinator
An extract from a report entitled, 'The Polemics Surrounding the Diagnosis and Management of Hypothyroidism' by Diana Holmes
Additional Information from Professor Grasbeck, [who was quoted in the "Polemics report"]
The book, 'Tears Behind Closed Doors' by Diana Holmes
The book, 'Hypothyroidism in Childhood and Adulthood' by C Phillips and D Roach
A letter of support and consensus statement etc. from Dr. Thierry Hertoghe, President of the International Hormone Society
A letter of support from Lyn Mynott, the Chair of the registered charity – ThyroidUK
A letter of support from Sheila Turner, founder of Thyroid Patient Advocacy - UK
A letter of support from Mary Shomon, USA, moderator of the Mary Shomon international thyroid forum and author of several books on this subject
A summary research proposal

All the above information and letters of support, are surely an indication of the seriousness and size of this issue. However, perhaps our concerns can best be summed up by a quote from a letter, dated 20th

October 2008, which you will have received from Dr. Myhill, the Lead Petitioner. In this, she says, under the heading "**Reasons why there appears to be massive under-prescribing of thyroid hormones"** that **" In the assessment of any patient, it is vital not to look at just the tests, but also assess the patient clinically. This is not being done by doctors. They are treating the blood test and not the patient.**

Why is this happening? Concerns were raised in my letter dated the 14th of November, which are repeated here for ease of reference. Within the Clinical Knowledge Summaries [CKS] relating to hypothyroidism, it states, ***"These recommendations are based on a consensus guideline produced by the Association for Clinical Biochemistry, the British Thyroid Association and the British Thyroid Foundation [BTA et al, 2006]. They are based on evidence from well conducted non-randomised clinical trials and expert opinion."*** However, this statement is disturbing, since in these same consensus guidelines produced by the Association for Clinical Biochemistry, the British Thyroid Association and the British Thyroid Foundation [BTA et al, 2006] on which the CKS are based, it states that, ***"Routine thyroid function testing has been available for more than thirty years. Therefore, it may be surprising that the quality of evidence to support the recommendations in these guidelines is generally poor…"*** and ***"There is real need to conduct new studies that conform to the rules of evidence based medicine in order to provide answers to some of the contentious issues in the use of thyroid function testing."***and ***"The document should be considered as guidelines only; it is not intended to serve as a standard of medical care. The doctors concerned must make the management plan for an individual patient".*** Therefore, it appears that the wording of the CKS regarding hypothyroidism has been given more certainty than is warranted on the basis of the source documentation used in its compilation and there is a clear contradiction here. One wonders why the above disclaimers have not been given prominence, if they had been, might doctors be dealing with the diagnosis and management of hypothyroidism differently?

Furthermore, Diana Holmes in an article in the Summer 2007 edition of the Thyroid UK magazine, reported that in relation to these same [BTA et al 2006 guidelines], the National Audit Office UK have stated ***"Whilst these guidelines offer advice on the use of the thyroid function tests, they do not introduce an NHS-wide standard of medical care"*** and ***" so far NICE has not issued any guidance on the diagnosis and treatment of hypothyroidism."*** Thus concerns revolve around the use by practitioners of these apparently 'non-commissioned' guidelines. In addition, the summary research proposal submitted via the Petitions Secretariat, also contained a reference to this concern as follows, in that here we have,*" an example of a proposition for which there is no evidence but has found its way into the corporate consciousness of the medical profession who teach that hypothyroidism can be excluded if one or both tests lie within the 95% reference intervals."*

The petition does raise one other main concern and that is, that many patients are being denied alternatives to thyroxine even when this is merited. So, the question raised here is, since individuals are different and can react in different ways to treatment, why is only one 'catch-all' treatment being promoted by the guidelines? These CKS guidelines [sourced from the BTA et al, 2006, guidelines], recommend one type of treatment only [i.e. levothyroxine] even though for some people levothyroxine does not suit and even though there are alternatives available [ie synthetic, eg T3 - tri-iodothyronine or natural treatments such as Armour Thyroid which is a porcine derived natural desiccated thyroid treatment].

Finally, one last point, which requires re-iteration, is that in the USA, in line with current research, the threshold for prescribing thyroid hormone has been changed so that more hypothyroid patients are being diagnosed and treated. This effectively means that there are now

many patients in Wales who are not being treated, who would be treated if they lived in the USA. This is clearly an anomaly, which needs to be considered as part of the review, especially as recent research indicates that such patients are being put at unnecessary risk of arterial disease and other chronic conditions. [See attached paper from Dr. Sarah Myhill the Lead Petitioner, which provides some more detail on this and for ease of understanding, cites the word 'normal,' currently in use by laboratories in this country, in relation to TSH and T4 reference ranges].

The petitioners therefore, as requested in the petition require an **urgent** investigation into this matter but of course acknowledge that this must happen within the remit of the National Assembly for Wales. In relation to the specifics, the question arises, how is this to be done?

It is thought that there is already sufficient information available [scientific, medical and potential testimony from patient support groups etc] to begin such an investigation. In addition, as stated in my many letters and e-mails to the Petitions Secretariat, it would be possible to organise presentations and/or discussions or a question and answer session in relation to this issue with a view to producing Terms of Reference for this investigation.

Furthermore, a summary research proposal has been provided to the Petition's Committee, should additional research be needed, in line with that called for by the BTA **[ie *"There is real need to conduct new studies that conform to the rules of evidence based medicine in order to provide answers to some of the contentious issues in the use of thyroid function testing."*].** The ideas and thoughts behind this proposal could again be explained to and discussed with the committee in detail with a view to setting parameters for endorsement by the National Assembly for the purposes of obtaining funding and ethical consent.

The above are just some ideas on how to move this issue forward, so that ultimately doctors can be provided with appropriate and helpful guidelines in place of those already in existence, which are known to be failing the patients in question, as the patients concerned will testify. It is hoped that the above information is helpful and that with the goodwill of all concerned, this problem can be resolved. Therefore, in summary, as a first step, we would very much welcome the opportunity to discuss the above with you in more detail with a view to ascertaining exactly what is possible and permissible under the NAfW remit. I look forward to hearing from you.

Yours sincerely

Julie Ann Cameron MBA
Petition Co-ordinator

Attachment from Dr. Sarah Myhill [Lead Petitioner]

Ref: Information/Thyroid correct prescribing … January 2009

Thyroid - the correct prescribing of thyroid hormones – and why this is not happening in the UK

There are three reasons why UK citizens are not subject to "best practice" with respect to prescribing thyroid hormones. Two of those reasons are biochemical, one reflects drug company influence. Both relate to the prescribing of thyroid hormone for underactive thyroid glands (hypothyroidism).

1. The threshold for thyroid stimulating hormone (TSH) is set too high.

When levels of thyroid hormone in the blood start to fall, the pituitary gland increases its output of thyroid stimulating hormone which kicks the thyroid into life and increases output of thyroid hormones. If the thyroid gland starts to fail, this is reflected by levels of TSH rising. The question is at what point should the prescription of thyroid hormones begin?

The normal range for TSH in this country varies enormously from one laboratory to another and ranges from 0.04 – 5.0mlU/L. This means in some locations in the UK a thyroid prescription would not be given until the TSH rose above 5.0mlU/l.

As a result of research, the normal range for TSH in America has now been reduced so that anybody with a TSH above 3.0 is now prescribed thyroid hormones. (See below Figure 1.) This research has shown that people with a TSH above 3.0 are at increased risk of arterial disease (a major cause of death in Western culture), insulin resistance (and therefore diabetes), inflammation and hypercoagulability (sticky blood) (see Figure 2). Indeed, there is a recommendation in America to further reduce the threshold to 2.5mlU/l.

What is completely illogical is that in UK the target TSH level for patients **on thyroid replacement therapy** is often stated as being less than 2 or even less than 1.5. This is a ridiculous anachronism and UK physicians should catch up with modern research.

We should reduce the threshold for prescribing thyroid hormones to <3.0mlU/L or better still 2.5mlU/l.

2. The population normal range for levels of thyroid hormone in the blood is not the same as the individual normal range.

We differ as individuals in our biochemistry as we differ in our looks, intelligence and morphology. This biochemical variation should be taken into account when it comes to prescribing thyroid hormones.

The population normal range of a Free T4 is 12 – 24pmol/L. A patient, therefore, with blood levels of 12.1 would be told they were normal because they are within the population normal range. But actually that person's personal normal range may be high. They may feel much better running a high T4 of say 22, i.e. nearly twice as much but still within the population normal range.

Research done originally in UK, and now repeated in America, clearly shows that the individual normal range of thyroid hormones is not the same as the population normal range. So, for example, as you can see in Figure 3 below, the participants on the right hand axis who normally run a high Free T4 (please note that the FT4 Index in Figure 3 is not the same as FT4 levels), in UK would not be prescribed thyroid hormones if they were found on blood tests to be running a low Free T4. The patient would be hypothyroid by their own standards and suffer all the symptoms and complications of hypothyroidism but they would not receive proper thyroid replacement therapy.

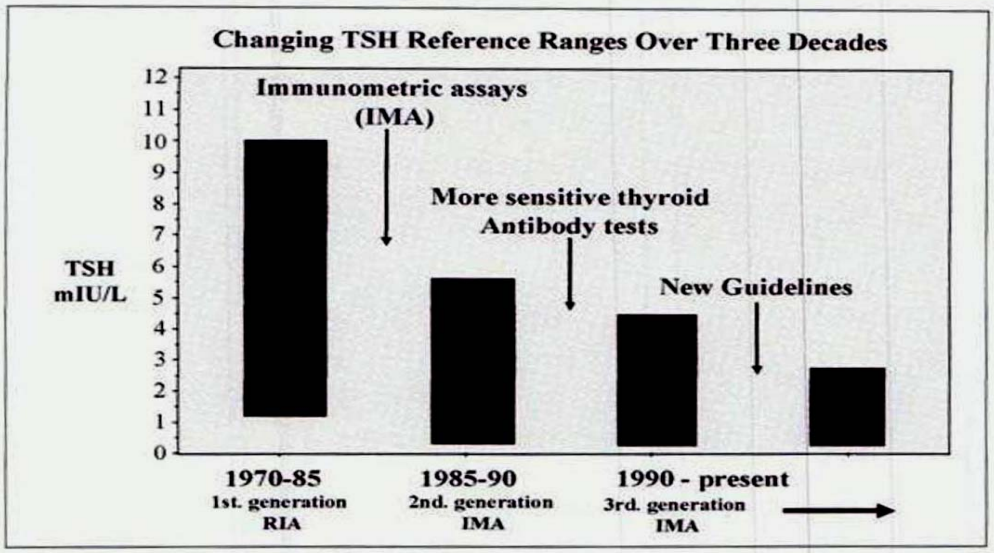
In order to find out who these individuals are, patients have to be assessed clinically as well as biochemically. In actual UK clinical practice this is rarely done except by a few physicians conversant with this issue.

3. Some people feel better on different preparations of thyroxine

In theory, if the patient has been shown to be hypothyroid then all their symptoms should be improved with synthetic sodium thyroxine. This is the only preparation readily available on NHS prescription. In practice, this is not always the case – there is no doubt that clinically some patients feel very much better taking biologically identical hormones such as natural thyroid (a dried extract of pig thyroid gland which is a mix of T4 and T3). Indeed before synthetic thyroid hormones became available, all patients were routinely treated with natural thyroid. The purity and stability of these preparations has been long established, indeed much longer than synthetic thyroxine.

Part of the reason why people fell better taking natural bio-identical hormones is that some people are not good at converting T4 (which is relatively inactive) to T3 (which is biologically active). However this does not explain the improvement in every case. It is difficult to explain why there should be an additional effect, but for many people it is the difference between drinking cheap French plonk and good quality Spanish Rioja. The alcohol content is the same, but the experience completely different!

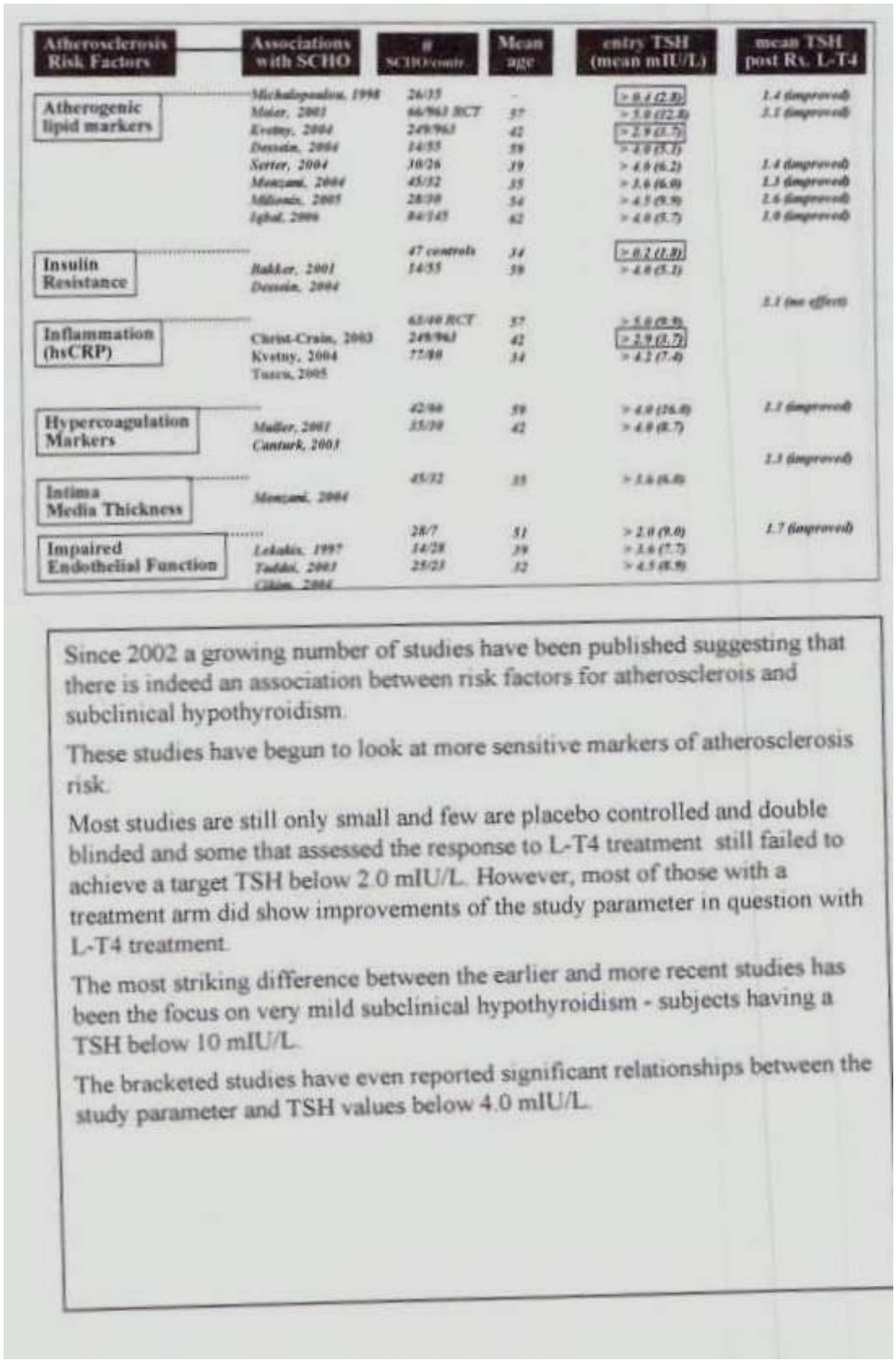
Figure 1



A review of TSH reference ranges across three decades shows that there has been a progressive contraction as a result of improvements in TSH sensitivity resulting from the development of immunuometric assays, coupled with improvements in thyroid antibody tests used to identify individuals with thyroid autoimmunity who have to be excluded from the reference cohort.

The contraction of the range has primarily affected the upper reference limit. New guidelines published in the last few years now recommend that the TSH upper limit be lowered still further down to 2.5 to 3.0 mIU/L.

Figure 2



Atherosclerosis Risk Factors	Associations with SCHO	# SCHO/contr.	Mean age	entry TSH (mean mIU/L)	mean TSH post Rx. L-T4
Atherogenic lipid markers	Michalopoulou, 1998	26/35	-	> 6.4 (2.8)	1.4 (improved)
	Meier, 2001	66/963 RCT	57	> 5.0 (72.8)	3.1 (improved)
	Kvetny, 2004	249/963	42	> 2.9 (3.7)	
	Dessein, 2004	14/55	59	> 4.0 (5.1)	
	Sutter, 2004	30/26	39	> 4.0 (6.2)	1.4 (improved)
	Monzani, 2004	45/32	35	> 3.6 (6.0)	1.3 (improved)
	Milionis, 2005	28/30	54	> 4.5 (9.9)	1.6 (improved)
	Iqbal, 2006	84/145	62	> 4.0 (5.7)	1.0 (improved)
Insulin Resistance	Bakker, 2001	47 controls 14/55	34 59	> 0.2 (1.8) > 4.0 (5.1)	
	Dessein, 2004				3.1 (no effect)
Inflammation (hsCRP)	Christ-Crain, 2003	65/40 RCT 249/963	57 42	> 5.0 (9.9) > 2.9 (3.7)	
	Kvetny, 2004	77/80	34	> 4.2 (7.4)	
	Tunes, 2005				
Hypercoagulation Markers	Muller, 2001	42/46 35/30	59 42	> 4.0 (26.0) > 4.0 (8.7)	1.1 (improved)
	Canturk, 2003				
Intima Media Thickness	Monzani, 2004	45/32	35	> 3.6 (6.0)	1.3 (improved)
Impaired Endothelial Function	Lekakis, 1997	28/7	51	> 2.0 (9.0)	1.7 (improved)
	Taddei, 2003	14/28 25/23	39 32	> 3.6 (7.7) > 4.5 (8.9)	
	Cikim, 2004				

Since 2002 a growing number of studies have been published suggesting that there is indeed an association between risk factors for atherosclerois and subclinical hypothyroidism.

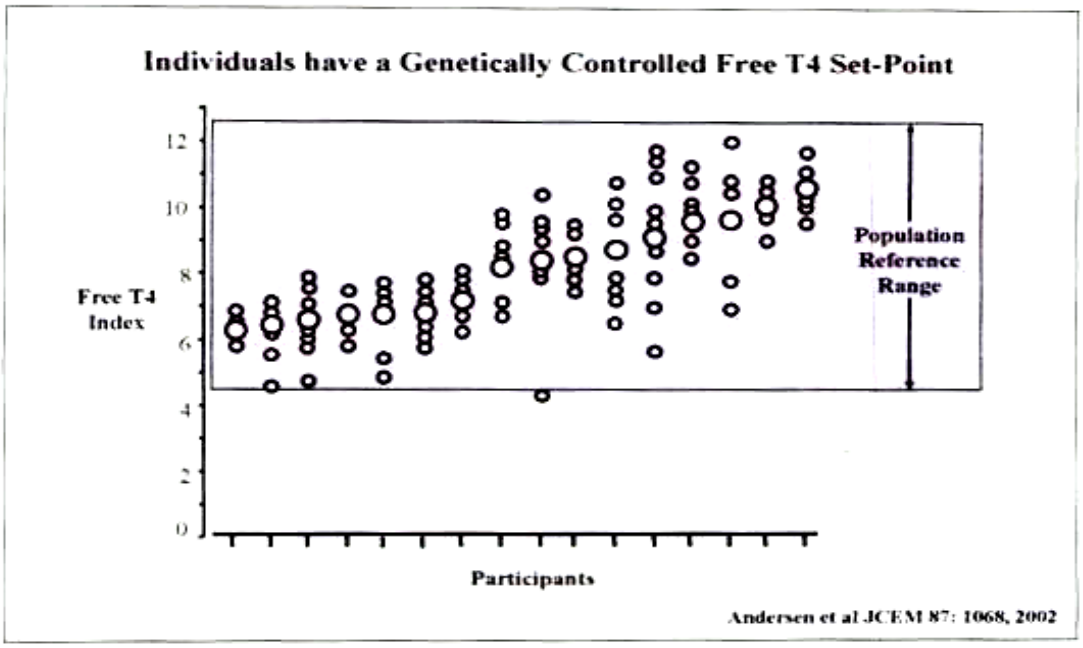
These studies have begun to look at more sensitive markers of atherosclerosis risk.

Most studies are still only small and few are placebo controlled and double blinded and some that assessed the response to L-T4 treatment still failed to achieve a target TSH below 2.0 mIU/L. However, most of those with a treatment arm did show improvements of the study parameter in question with L-T4 treatment.

The most striking difference between the earlier and more recent studies has been the focus on very mild subclinical hypothyroidism - subjects having a TSH below 10 mIU/L.

The bracketed studies have even reported significant relationships between the study parameter and TSH values below 4.0 mIU/L.

Figure 3



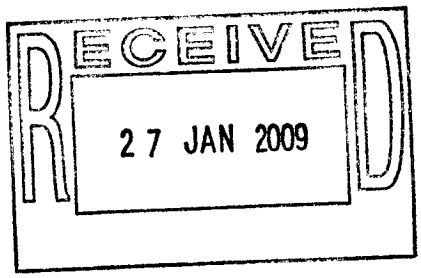
The reason is that TSH is so exquisitely sensitive to free T4 status is that individuals have a genetically determined free T4 setpoint, as illustrated by the study of Andersen in which free T4 was measured each month for a year period in 16 normal euthyroid individuals.

Although all the values fell within the population reference range, clearly the free T4 setpoint of some individuals was lower than for others.

Department for the Economy and Transport
Adran yr Economi a Thrafnidiaeth

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

23rd January 2009



Ms Val Lloyd, AM
Chair, Petitions Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

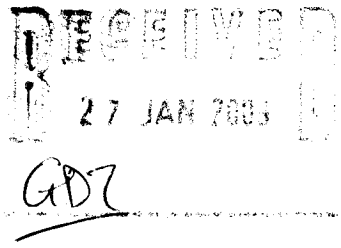
Dear Ms Lloyd

Llanbedr Airfield

With reference to the Deputy First Minister's letter of 5th December 2009 and your subsequent letter to him dated 20th January 2009, I have pleasure in enclosing the Statement of Information, Compliance Report and Press Release relating to his decision in respect of Llanbedr Airfield.

Yours sincerely

Adrian Leonard
Senior Property Manager



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Adran Yr Economi a Thrafnidiaeth
Dept for the Economy & Transport

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Newyddion News

Tuesday, 16 December 2008
W081257 DFM

Llanbedr plan will 'maximise local benefits'.

Following careful consideration of all environmental and legal implications relating to the development of Llanbedr airfield in Snowdonia National Park, the Deputy First Minister Ieuan Wyn Jones has approved the sale of the site to Kemble Air Services.

The sale of the airfield will secure the future of the site and the provision of employment opportunities for the benefit of the local economy.

The Minister said: "I'm satisfied that the disposal of the airfield in this way will maximise the economic benefits to the local community and bring jobs to an area which needs them.

" Llanbedr airfield lies within the Snowdonia National Park and has until very recently been a busy military facility. I am content that this new facility fully complies with our duty to have due regard for the purposes for which the National Park was designated, and that this less intensive use will not have an adverse effect on the conservation of the area."

The grant of a 125 year lease is conditional on Kemble Air Services first obtaining from the local planning authority all planning permissions, certificates and consents authorising the use permitted by the lease.

Kemble Air Services will form a new company, Llanbedr Airfield Estates, to operate the site to accommodate private flying and to let the many empty

Press Office, Welsh Assembly Government
Cardiff
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Shan.Ekin-Wood@wales.gsi.gov.uk
GTN:

buildings on the site for business uses which would create local jobs. A number of businesses have already expressed interest in occupying premises on the site.

Llanbedr Airfield was originally built in 1940 on low lying land between the mountains of Snowdonia and the sea. The main runway is aligned so that approach and landing paths are mainly over the sea.

Llanbedr was officially opened as an RAF camp in 1941 and was used during the war by both the RAF and US Air Force. After the war it was used for armament training and, latterly, for Hawk pilot training and for Eurofighter trials.

Between 1998 and the Airfield's closure by the Ministry of Defence in 2004 there were approximately 53,000 aircraft movements in and out of Llanbedr.

In 2002, when the Ministry of Defence announced its withdrawal from Llanbedr, the former Welsh Development Agency, in collaboration with Gwynedd Council, commissioned a report from KPMG on the impact of closure.

The KPMG report identified continued aerospace and avionic activity as the most viable future for the site having regard to local job creation and protection and environmental factors such as the presence of wildlife habitats and conserving the historic avionic heritage of the site.

In 2006, the WDA purchased the site to secure the future of the airfield - and in 2007, the Assembly Government began marketing the site.

A bid from Kemble Air Services, a very experienced and successful operator of a number of former military facilities, was ultimately selected as the best in terms of delivering sustainable economic benefits to the area.

The proposals for the airfield were opposed by the Snowdonia Society but backed by Gwynedd Council and Llanbedr Community Council. Petitions for and against the proposal were submitted to the National Assembly. An e-petition generated by the Snowdonia society attracted just 156 signatures - while a petition in favour of the proposal generated in the local community attracted 1,240 names.

Ends

For more information contact:
Shan Ekin-Wood
Press Office
Welsh Assembly Government
Tel 02920 898636

Notes to Editors:

- Section 5(1) of the National Parks and Access to the Countryside Act 1949 sets out the two statutory purposes of National Parks which are:

Conserving and enhancing the natural beauty, wildlife and cultural heritage of the Park; and
Promoting opportunities for the understanding and enjoyment of the special qualities of the Park by the public.

The duty also needs to be considered in the context of the duty placed on the Snowdonia National Park Authority under Section 11A(1) of the National Parks and Access to the Countryside Act 1949 which states that, in pursuit of their two statutory purposes, the National Park must seek to foster the economic and social well-being of local communities.

- The importance of the Airfield's role in the regeneration of Meirionnydd has been recognised in the 2008 'Sustainable Regeneration Framework for Central Wales' which identifies *'the development of Llanbedr Airfield to support the diversification of the Meirionnydd economy and the creation of value added employment opportunities'* as a strategic objective.

Skip to content

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Proposed Disposal of Llanbedr Airfield, Gwynedd

The Deputy First Minister has: noted actions taken to comply with the duty to have regard to the statutory purposes of the National Park under S11A of the National Parks and Access to the Countryside Act 1949; approved the disposal to Llanbedr Airfield Estates LL on a 125 year lease at a premium of £887,500 subject to planning permissions and certificates for the uses permitted by the lease being obtained; confirmed that the report evidencing compliance with the S11A duty be published.

Date of decision / Dyddiad y penderfyniad:

15 December 2008

Statement of information / Datganiad gwybodaeth:

The Deputy First Minister and Minister for the Economy and Transport has been asked to approve the disposal of Llanbedr Airfield to secure the future of the Airfield and the provision of employment opportunities for the benefit of the local economy.

The proposed disposal of Llanbedr Airfield to Kemble Air Services Limited ("Kemble") will b by way of an Agreement for Lease making the grant of the lease conditional upon Kemble first obtaining from the local planning authority all planning permissions, certificates and consents authorising the use permitted by the lease. The lease will be for a 125 year term at a lease premium of £887,500 plus VAT. It should be noted that Kemble will form a new company, Llanbedr Airfield Estates LLP which will be named as the leaseholder and will operate the Airfield.

In reaching his decision, the Deputy First Minister has considered all the relevant facts and issues, in particular, his duty under Section 11A of the National Parks and Access to the Countryside Act 1949 and has taken account of all the representations made to him.

Following the decision by the Ministry of Defence (MoD) to close Llanbedr Airfield in 2004 with the loss of 130 jobs, the WDA, in partnership with Gwynedd Council, commissioned from KPMG a study to identify options to reduce the economic impact of the closure. The KPMG study recommended a continuation of the existing aeronautical and employment-based use of the site.

The WDA purchased the site from the MoD in March 2006, and the Welsh Ministers becam freeholders of the site in April 2006. In 2007, Stuart Hogg Property Consultants, an independent commercial property agent, was appointed by the Assembly Government with a view to identifying an airfield operator that could secure the continuation of the aeronautical and employment-based use of the site.

The site was marketed on a long leasehold basis with a particular emphasis on enhancing the local economy. Among other requirements, the Airfield use was to be continued and

Unmanned Aerial Vehicles would be accommodated. The marketing was extensive and included advertisements in newspapers and journals. 170 enquiries were received and seven parties viewed the site.

Five bids/expressions of interest were received and, after evaluation, two were short-listed. The two short-listed bidders were invited to expand on their proposals and were visited at their existing operations by Officials of the Welsh Assembly Government. The result of this further evaluation was that Kemble Air Services Limited ("Kemble") was selected as the preferred bidder to acquire the Airfield on a 125 year lease. Kemble's proposals are to re-open the Airfield, initially as an unlicensed airfield to accommodate private flying and UAS, and to let the many buildings on the site for business use, thus providing local employment opportunities. A number of businesses have already expresse interest in occupying premises.

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

WELSH ASSEMBLY GOVERNMENT

Llanbedr Airfield, Gwynedd

Report on the Welsh Assembly Government's Compliance with Section 11A of the National Parks and Access to the Countryside Act 1949 in relation to the disposal of land at Llanbedr Airfield within the Snowdonia National Park

Report on the Welsh Assembly Government's Compliance with Section 11A of the National Parks and Access to the Countryside Act 1949 in relation to the disposal of land at Llanbedr Airfield within the Snowdonia National Park

Contents

1 Introduction

1.1 This report sets out how the Welsh Assembly Government (and the former Welsh Development Agency ("WDA")) has fulfilled its statutory duty (the "Duty") under Section 11A of the National Parks and Access to the Countryside Act 1949 (the "1949 Act") as regards the disposal of land at Llanbedr Airfield within the Snowdonia National Park.

1.2 There are a number of documents referred to in this report and these are available on request from the mid regional office.

2 The Duty

2.1 Section 11A of the 1949 Act places a duty on all relevant authorities to have regard to the purposes of National Parks when exercising or performing any functions in relation to, or affecting, land in a National Park. Relevant Authorities, including the Welsh Ministers, are expected to demonstrate that they have fulfilled this duty in disposing of any land situated within a National Park.

2.2 It is worth noting, at the outset, that the duty was incorporated into the 1949 Act by virtue of S62 of the Environment Act 1995. It is, therefore, often described as the "Section 62" duty, but in this document, it will be correctly described as arising under S11A of the 1949 Act.

2.3 Section 5(1) of the National Parks and Access to the Countryside Act 1949 sets out the two statutory purposes of National Parks which are:

a. Conserving and enhancing the natural beauty, wildlife and cultural heritage of the Park; and

b. Promoting opportunities for the understanding and enjoyment of the special qualities of the Park by the public.

2.4 Relevant Authorities are required to show that they have had regard to National Park purposes in their decision-making activities in dealing with land in a National Park.

2.5 The Duty also needs to be considered in the context of a duty placed on National Park authorities under Section 11A(1) of the National Parks and Access to the Countryside Act 1949 which states that, in pursuit of their two statutory purposes, they shall foster the economic and social well-being of local communities.

2.6 The Welsh Assembly Government has taken legal advice from its Legal Services Department and from First Counsel to the Welsh Assembly Government. The advice is summarised in the following three paragraphs.

2.7 So far as "purposes" are concerned, case-law dealing with similar legislation in the planning context [1] has established that "special attention" must be paid to "preserving or enhancing" the character of the area. In the relevant caselaw, an obligation to "preserve" was satisfied where the development in question did not have an adverse effect on the character of the area. In other words by leaving the area's character and appearance unharmed, it was preserved.

2.8 The Welsh Ministers, therefore, need to be satisfied that the disposal of the Airfield would not have an adverse effect on the conservation or enhancement of the natural beauty and cultural heritage of the area (in comparison with historical use) and would leave the site unharmed.

2.9 A disposal of the site which is consistent with previous usage is, therefore, likely to be consistent with the duty to have regard to the purposes of the National Park.

2.10 This document sets out actions taken by the Welsh Ministers, and officials on their behalf, in pursuance of the Duty.

3 Brief History of Llanbedr Airfield

3.1 Llanbedr Airfield was constructed in 1940 on low-lying land between the mountains of Snowdonia and Cardigan Bay. The land, at that time, was owned by the Ministry of Defence. The main runway is aligned so that approach and landing are mostly over the sea, avoiding the high inland mountain ranges. These approaches are unusual as they are situated over the sea and avoid built-up areas.

3.2 The Airfield was officially opened as an RAF camp on 15 June 1941. During World War Two, Llanbedr Airfield was used by British and Allied Forces to fly Spitfire, Mustang or Typhoon aircraft. It was also occupied by the elementary flying training school equipped with de Havilland Tiger Moths and was used on occasion by United States Air Force Thunderbolts P-51 Mustangs and P-38 Lightnings.

3.3 After the war, air-to-air training and armament training continued using Hawker Henley tugs, Spitfire, Hurricane, Vengeance, Martinet, Beaufighter and early Vampire aircraft. Other aircraft also used the Airfield including Firefly (manned and unmanned), Meteor (manned and unmanned), Sea

[1] South Lakeland District Council –v- Secretary of State for the Environment [1992] 1 All Er 573

Vixen, Vulcan, Dakota, Chieftain, Devon, Canberra, Gnat, Falcon and Airships.

3.4 More recently, the Airfield has been used for Hawk pilot training (5,668 Hawk movements were performed in 2001) for Eurofighter 2000 trials and has accommodated Alpha jets, Tornados, Sea Harriers, Harriers, Jaguars and helicopters including Sikorsky, Lynx, Apache, Chinooks, Sea Kings and the North Wales Police Helicopter. Jindivik unmanned aerial vehicles (drones) operated from the site between 1950 and 2004. The Airfield has been used as an emergency diversion airfield for RAF Valley with, on average, 12 diversions being made annually. Various privately-owned, company and air taxi aircraft used by VIPs, members of the Royal Family and Red Cross flights have also used the Airfield. Between 1998 and closure in 2004 there were approximately 53,000 aerodrome movements.

3.5 During the period of the Ministry of Defence's ownership, part of the site between the main runway and the dunes on the western boundary was designated as a Site of Special Scientific Interest and a protected species, the great crested newt, was identified as inhabiting emergency water storage ponds located adjacent to a number of the buildings.

3.6 In 2004, the Ministry of Defence ceased operations at Llanbedr Airfield and the former WDA acquired the site in March 2006 with the intention of re-opening it as an airfield. In the intervening period, the runways and associated infrastructure have been maintained and a number of aircraft have continued to use the Airfield. In 2007, the site was marketed with the specific intention of identifying an airfield operator.

4 Chronological Sequence of Events

4.1 2002 – Initial Consultation

4.1.1 When the planned closure was announced on 24 July 2002, the WDA met several times with the Ministry of Defence (and QinetiQ which operated the Airfield on behalf of the Ministry of Defence). The purpose of these consultations was to establish the relevant economic and environmental issues at the site in order to take initial stock of the factors which may affect the future of the Airfield and its potential marketing. Accordingly, officers of the then WDA considered factors (such as the existence of Sites of Special Scientific Interest ("SSSI's")) which would impact upon the purposes of the National Park in considering the future of the site.

4.2 Late 2002 – Commissioning of Report on Impact of Llanbedr Airfield Closure

4.2.1 The WDA, in partnership with Gwynedd Council, commissioned an economic impact study from KPMG with the aim of identifying options to reduce the economic impact of closure.

4.2.2 KPMG were commissioned to undertake the work and consulted with the WDA, Gwynedd Council, ELWA, the Snowdonia National Park Authority, QinetiQ, Llanbedr Community Council, Harlech Community Council, local businesses and local economic and community development groups including Antur Dwyryd Llyn, Deudraeth Cyf and Trawsnewid. An 'open' workshop with the task force was held at Plas Tan y Bwlch in late 2002.

4.2.3 The KPMG report reflects the input provided by such bodies. In particular, the Snowdonia National Park Authority ("SNPA") made the following comments:

- SNPA was most likely to accept a continuation of the existing use but would prefer that it was down-scaled.
- SNPA did not favour uses such as holiday static caravans, large scale adventure parks, speculative industrial sites/properties or housing.
- SNPA would challenge uses which did not coincide with the planning policies of the area, did not contribute directly to local development, and where the development was significant, and not of "national" importance.
- SNPA would oppose proposals for development on or close to any existing or proposed SSSI's, National Nature Reserves or other statutorily designated sites unless it could clearly be demonstrated that the development would not significantly harm the conservation value of the site and that the benefits arising from the development outweigh the nature conservation interests on the sites.
- Should development be permitted, SNPA would seek the imposition of conditions on the consent or the use of agreed planning obligations to ensure that its impact on the nature conservation interests on the site were minimised in both the short and long term.
- However, SNPA did not make any unfavourable comment about the existing planning use of the Airfield nor suggest that it conflicted with the purposes of the National Park.

4.2.4 The KPMG report, published in early 2003[2], concluded that the most viable and sustainable option for the site was a continuation of existing or similar activity. Both military and civil uses for the Airfield were listed as potential options.

4.3 2003 – Llanbedr Airfield Closure: Impact Assessment and Feasibility Report

4.3.1 The recommendation of the KPMG report, which involved consultation and discussion of the environmental impact, was that future options were largely limited to aerospace and/or avionic uses and SNPA did not dissent from this view.

4.4 2003 – Ministry of Defence Confirmation of Site Closure late 2004

4.4.1 Following publication of the KPMG report, the WDA worked closely with the Ministry of Defence and QinetiQ to review future options for the site. In 2004, the Ministry of Defence confirmed that the site would close. The WDA then undertook further consultations with the work force and management team affected by the closure to keep them appraised of progress in respect of the options being considered for the site. One of these meetings involved the local MP, Elfyn Llwyd. During these consultations, which consisted of open meetings with the work force and other meetings with the management team, the consensus of opinion was that the future of the site must be ensured given that the Ministry of Defence previously provided relatively well-paid employment in an area with lower than average GDP.

4.4.2 The Ministry of Defence ceased operations at Llanbedr Airfield in late 2004.

4.4.3 The WDA started work on seeking a future for Llanbedr Airfield as recommended by the KPMG report.

4.4.4 In summary, throughout this period, the WDA consulted with the local community and statutory bodies and commissioned the KPMG report to identify sustainable future options for the site which would be in-keeping with the purposes of the National Park.

[2] The final report is mistakenly marked "draft".

4.5 February 2005 – Purchase of Llanbedr Site in March 2006 by the WDA

4.5.1 The WDA negotiated with the Ministry of Defence with regard to purchasing the site.

4.5.2 Consideration of future uses for the site was based on minimum impact, that is, an assumption that no major planning changes would be needed, nor additional or improved road access. On this basis, the WDA requested an environmental report on the site from the Ministry of Defence Estates, to establish the details of the environmental assets, management issues and the constraints which could be placed on economic development.

4.5.3 Detailed negotiations commenced between the WDA and the Ministry of Defence in February 2005 regarding the potential WDA purchase of the site.

4.5.4 A meeting was held at SNPA's offices on 12 January 2006 between Adrian Leonard, Property Development Manager of the WDA and Richard Thomas and Aled Lloyd, Development Control Officers of SNPA to discuss uses for the site that would not require a change of use for planning purposes. Again, no suggestion was made by SNPA, at that meeting, or at any time since, that the existing use of the Airfield conflicted with the purposes of the National Park.

4.5.5 Several discussions took place between the WDA and the Countryside Council for Wales ("CCW") (Graham Williams, Senior Reserves Manager) about plans for the site and, in particular, environmental issues. CCW indicated that an operational airfield, similar to that operated under the Ministry of Defence, provided good opportunities for environmental management

4.5.6 The WDA's Project Approval report of 30 March 2006 (recommending to senior management that the site be purchased), addressed the environmental issues as follows:-

> *'The site is located in the Snowdonia National Park with an SSSI status over part of the estate. The site is one of environmental significance as a result of its dune habitat. Adjacent is Shell Island, an equally environmentally sensitive habitat, and itself hosting an SSSI. Management of the site will of course ensure management in accordance with the requirements of an SSSI.*
>
> *The planners have indicated that the scope for redevelopment is limited.'*

4.5.7 The report demonstrates that the WDA considered the purposes of the National Park: The report emphasises the environmental issues and indicates that future use must not have an adverse effect on the natural beauty of the area which should be preserved.

4.5.8 The site was subsequently acquired in March 2006 by the WDA. The purchase was publicised widely to SNPA, Gwynedd Council, the local MP, Mr Elfyn Llwyd and to other local stakeholders through a range of ongoing discussions with local third parties.

4.5.9 The following documents are relevant to the comments set out above:

(i) Phase 1 and 2 Land Quality Assessment (LQA) Reports on Llanbedr Site;
(ii) Letters from R Griffiths to Sioned Williams, and Geraint Davies 3 Dec 2005,
(iii) Llanbedr Permis Project Appraisal 30 March 2006
(iv) Note of meeting with SNPA 12 January 2006.

4.5.10 In the context of the Duty, during this period, the WDA acquired environmental information with a view to assessing future options for the Airfield, entered into discussion with CCW and considered the environmental implications of acquiring a site within a National Park.

4.6 18 July 2006 - Welsh Assembly Government Meeting with CCW

4.6.1 On 1 April 2006, the WDA was abolished and its assets transferred to the Welsh Assembly Government. The Welsh Ministers therefore became subject to the Duty.

4.6.2 Mark Stephens, Welsh Assembly Government Property Manager, met with Graham Williams, CCW's Senior Reserves Manager to discuss CCW's requirements in respect of the SSSI and the Great Crested Newts occupying the water storage ponds and discussed the issue of conserving and enhancing the natural beauty and wildlife of the Park.

4.7 14 August 2006 to 14 June 2007 – Email correspondence with the Countryside Council for Wales ("CCW")

4.7.1 Graham Williams, of CCW advised that he had discussed possible conservation management on the site with SNPA and suggested a number of conservation ideas to Mark Stephens, Welsh Assembly Government Property Manager.

4.8 Welsh Assembly Government – actions taken during the period April 2006 to July 2007

4.8.1 In the period of April 2006 to July 2007, work and consultation was undertaken to establish the optimum and most sustainable means by which the Llanbedr site could be operated for aerospace and/or avionic and related activities in line with Welsh Assembly Government policies and the KPMG report. The 'Outline Plan of Work' required dated May 2006, indicated the importance of sustainability issues, and a detailed study by Mott McDonald considered specific issues relating to the Airfield itself.

4.8.2 As part of this process, a site open-day and tour was held in June 2007 to discuss the Welsh Assembly Government's potential plans with the local community and with other local interested parties. The invitees were co-ordinated primarily through the local Community Council, but the Open Day was also widely disseminated through local newspapers (Cambrian News and Llais Ardudwy) and posters at key local sites (shops, pubs, restaurants, garages etc) and open invitations were issued. Key stakeholders, such as Elfyn Llwyd MP, Gwynedd Council and Snowdonia National Park Authority were also invited. The majority of the attendees were supportive of the venture, and felt that it would not detract from the National Park. In particular, it was clear that the historical and cultural heritage of the Llanbedr Airfield site was considered significant, adding to the potential for tourism within the National Park.

4.8.3 Following these consultations, further work was undertaken regarding the process by which a private operator for the Airfield could be identified. In order to achieve the desired outcome of economic and environmental sustainability, within the framework of KPMG recommendations and Welsh Assembly Government policy, officials considered various options including joint venture, outright sale, short lease and long lease. Officials concluded that a long lease (125 years) which would allow the use of the site to be controlled and provide sufficient security for investment in the site to be justified was the most effective means of meeting these combined aims. It was agreed to test the market in a proposal of this nature by issuing a widely disseminated request for Expressions of Interest in a proposal which incorporated references to both commercial and potential environmental issues (the latter incorporated primarily through the assessment criteria), combined with the focus on aerospace and avionic activity. The use would be similar to that of the previous owner, the Ministry of Defence.

4.8.4 The following documents are relevant to the comments set out above:-

Evidence & Refs:

(i) Outline Workplan, May 2006;
(ii) Mott McDonald Aviation Assessment Report;
(iii) Local open day and consultation presentation material, June 2007;
(iv) Assessment Criteria, Marketing & EoI request press release, August 2007

4.8.5 In summary, in the context of its Section 11A duty during this period, officials of the Welsh Assembly Government consulted with CCW and extensively with the local community. Assessment criteria were also devised for assessment of private sector expressions of interest.

4.9 August – November 2007: Market Survey of Interest in Operation of Llanbedr Site and Evaluation of Bids Received

4.9.1 Given that the operation and management of an airfield is a specialist activity, the Welsh Assembly Government did not wish to operate the site directly. Officials therefore sought to identify a private operator to operate a sustainable business which would enhance the benefit to the local economy, in order to foster the economic and social well-being of the local community in accordance with S11A(1) of the 1949 Act.

4.9.2 Stuart Hogg, Property Consultant, was appointed to market the Airfield and seek Expressions of Interest. The Airfield was marketed specifically for continued use as an airfield and associated uses and any enquiries that involved redeveloping the site for other purposes were rejected.

4.9.3 Expressions of Interest were received at the beginning of November 2007 and were evaluated in a two-stage process against the Assessment Criteria. Particular weight was given to the viability and sustainability of proposals. This included an assessment of the 'Recognition and Integration with the Rural Wales Economy/Constraints', such as planning and the 'Impact on the Local Economy'. The short-listed bidders were also visited at their existing businesses to assess their work practices, operational cultures and their environmental credentials.

4.9.4 The following documents are relevant to the comments set out above:-

(i) Stuart Hogg Sales Details and Covering Note,
(ii) Invitation to Bid Letter dated 29 September 2007,
(iii) Expressions of Interest requests.

4.9.5 In the context of the Section 11A duty, only proposals that fitted with the outcomes of the KPMG report and the established planning use were considered. Fostering the economic and social well being of local communities was also considered.

4.10 21 May 2008: Meeting between SNPA and WAG

4.10.1 Dr Geraint Davies, Regional Director and Adrian Leonard, Senior Property Manager of the Welsh Assembly Government met with Aneurin Phillips, and Aled Sturkey, respectively, Chief Executive and Director of Planning at the Snowdonia National Park Authority to discuss the Welsh Assembly Government's compliance with Section 11A of the 1949 Act. The meeting was also attended by representatives of the preferred bidders for the site, Kemble Air Services Limited who detailed their experience in operating former Ministry of Defence sites and the way in which they proposed operating Llanbedr Airfield as an airfield with the many buildings being let out to local businesses. The outcome of the meeting was that the Welsh Assembly Government would complete its Section 11A compliance report and that a copy would be forwarded to Snowdonia National Park Authority at the appropriate time.

5 Preferred Bidder's Proposals

5.1 As set out above, Llanbedr Airfield was acquired by the WDA in March 2006 with the objective of reopening the Airfield to maximise the economic impact to the local economy and in support of its aerospace strategy. The aim was to procure a private sector operator which would reopen the Airfield and provide employment opportunities.

5.2 Following a comprehensive marketing exercise, Expressions of Interest were received in November 2007. There followed a selection and due diligence process which involved assessing the proposals against predetermined criteria, short listing, visits to existing operations and interviews.

5.3 The result was that proposals submitted by Kemble Air Services Limited were considered to be the most sustainable for the following principal reasons:-

- Their particular expertise in the operation and management of former Ministry of Defence sites in the UK. Their group of companies owns seven former such sites at which more than 100 businesses are accommodated.

- By way of example, they own and operate a similar former Ministry of Defence airfield at Kemble, near Cirencester.

- Kemble Air Services Limited are additionally experienced airfield operators with full knowledge of Civil Aviation Authority requirements.

- At Llanbedr Airfield they proposed adapting the existing buildings to provide businesses with a range of diverse and adaptable quality premises which will allow for flexibility and expansion.

- They proposed encouraging start up businesses, innovation and entrepreneurship and would work with new businesses to enable them to operate effectively and efficiently without major overheads, commitment or obligations in order to allow them to concentrate on their businesses.

- They stated that they would provide direct and indirect employment opportunities (the latter through letting units on site).

- They proposed holding regular community liaison meetings to ensure that the flying activities would not cause a nuisance to the local community.

- They proposed promoting tourism and creating strong links with existing local businesses, i.e. integrating the Airfield within the community.

- Pilots would also be instructed to avoid villages and other settlements (as far as possible) as part of noise abatement procedures.

5.4 For the reasons set out in this report, having thoroughly considered the proposal to grant a lease of Llanbedr Airfield, officials recommend that the Deputy First Minister accepts Kemble Air Services Limited's proposal.

6 Impact of the Preferred Bidder's Proposals on the two statutory purposes of the National Park

6.1 'Conserving and enhancing the natural beauty, wildlife and cultural heritage of the park':

6.1.1 Continued use of the site as an airfield will not impact on the landscape. New development is not currently proposed but the existing buildings will be maintained and improved. (Otherwise, derelict buildings at the Airfield could have an adverse impact on the landscape.) In accordance with the

legal advice, the continuation of existing use is likely to conserve the natural beauty, wildlife and cultural heritage of the area.

6.1.2 The Ministry of Defence flew mainly Hawk fast jets from Llanbedr Airfield. The last available records indicate that this type of aircraft made 4,050 movements in the 12 months ending 1 June 2002 and that there were a total of 6,410 annual aircraft movements. As with most Ministry of Defence airfields there was also use by civilian aircraft of various types including aircraft of H M Coastguard, the Police and Air Ambulance – all providing a service to the community. The majority of Military aircraft movements, which also included unmanned aircraft operations, involved noisy jet aircraft. It is envisaged that less powerful, more economical and therefore less noisy aircraft will, in future, fly from the Airfield. As a result, the future operations at the Airfield are likely to have less of an environmental impact than the previous military use and the natural beauty, wildlife and cultural heritage of the area is therefore likely to be enhanced and improved rather than adversely affected.

6.1.3 Military aircraft currently undertake low flying exercises over Llanbedr Airfield. Reopening the Airfield would result in the reimposition of an Air Traffic Zone which would mean that military aircraft were no longer able to fly within a 2 nautical mile radius. This radius would include the village of Llanbedr and the settlements of Llandanwg, Coed Ystumgwern and Dyffryn Ardudwy. The result will be that the local communities are likely to experience lower aircraft noise levels than that from the current military low flying activities, in addition to the consequent positive effect on the natural beauty of the area.

6.1.4 Use of the site as an airfield has allowed wildlife to flourish. Part of the site is designated as a Site of Special Scientific Interest and colonies of Great Crested Newts, a protected species, are prolific in the water storage ponds on the site. The preferred bidder's proposals will not impact adversely on the wildlife qualities of the site. On the contrary those qualities will be conserved and enhanced in agreement with CCW. Specifically, Kemble Air Services Limited intends to propose to SNPA the relocation from the SSSI of a number of buildings presently sited within the SSSI to enhance further its special character and to preserve and encourage the existing wildlife on site.

6.1.5 The cultural heritage of Llanbedr Airfield should not be underestimated. Its role as a Spitfire base during World War Two and in later weapons testing and evaluation is of significant archaeological and historical interest. The continued use of the site as an airfield will ensure that this cultural heritage is preserved for future generations.

6.1.6 Snowdonia National Park has many **Special Qualities** and it is the blend of these qualities that produces the distinctive landscapes and

communities which merit National Park status. The Special Qualities are diverse but some of the special qualities that are applicable to the Airfield site and the preferred bidder's proposals are:

Diversity of Landscapes:

6.1.7 When the area was designated as a National Park in 1951 various landscapes including the slate waste areas in and around Blaenau Ffestiniog and the coastal towns of Barmouth and Tywyn were excluded. Llanbedr Airfield was included as it was considered to add to the diversity of the landscape of the National Park. The continued use of the Airfield for aeronautical purposes and use of the existing buildings for aeronautical and employment uses is not likely therefore to be detrimental to the diversity of the landscape as it will amount to the continuation of a use that has existed from prior to designation as a National Park. The extant Eryri Local Plan 1993 – 2003 (Adopted by Gwynedd Council in November 1999) under the heading of 'Disturbed Landscapes' on page 24 acknowledges that 'there are a number of areas in Snowdonia which have been permanently disfigured by quarrying, mining, *military use* or other activities'. It further states that 'some of these are of archaeological significance and that where large areas of land have been disturbed by human activity, they can constitute landscapes in their own right and have become acknowledged as an important part of the area's cultural heritage'. Retention of the runways and the Airfield use will be a condition of the lease thus ensuring that the existing diversity of landscape is retained and that it cannot be changed to a different use.

Range of Bio-diversity:

6.1.8 The range of bio-diversity at Llanbedr Airfield is extensive and is evidenced not only by the SSSI but also by the presence of great crested newts on other parts of the site. The continuation of the Airfield use as proposed will ensure that the high level of bio-diversity is maintained.

Tranquillity

6.1.9 At the time of the National Parks designation and until recently, the site was used by military aircraft which are predominantly noisier than the private aircraft. Military jets currently use the Airfield for target practice and other manoeuvres but the designation of an Air Traffic Zone will limit such activity and help to restore greater tranquillity to the area.

6.1.10 The selected bidder, Kemble Air Services Limited, has extensive experience of operating an airfield and currently operates stringent noise abatement procedures at Kemble Airfield near Cirencester. Officials are satisfied that the preferred bidder understands the implications of aircraft noise and works with the community to mitigate and minimise any

nuisance by recommending circuit paths and approach procedures etc. At Kemble they operate a Community Liaison Committee at which local issues including noise are raised and they seek, where possible, to address any concerns by adjusting procedures. They propose operating similar procedures at Llanbedr Airfield.

Vibrancy of the Welsh Language and Culture:

6.1.10 The proposal will promote the Welsh language and culture by ensuring that local residents, a substantial number of whom are Welsh speakers, are able to continue to work and live within the area.

The Area's Rich Archaeology, Historical and Cultural Heritage:

6.1.11 Llanbedr Airfield's history as an RAF base and its involvement in the Second World War is of significant archaeological and historical interest and the continuation of the Airfield will help to preserve and protect this heritage.

Community Spirit, Vibrancy and Sense of Identity:

6.1.12 Large sections of the local community have indicated their strong support for Kemble Air Services Limited's proposed future use of the Airfield. A petition with 1,240 signatures supporting the proposal has been lodged with the National Assembly for Wales. The proposal is also strongly supported by the local MP, Mr Elfyn Llwyd, by Gwynedd Council and by Llanbedr and Llanfair Community Councils. Members of the public have also written to support the project. Officials are content that Kemble Air Services Limited's proposal is to create a vibrant hub of economic activity which will enable people working at the site to identify with a location which is a significant local landmark.

6.1.13 For reasons of balance, it should be noted that a petition opposed to the proposal has also been lodged with the National Assembly and has attracted 156 signatures. The Snowdonia Society (a charity which states its aims as being to protect and enhance the Snowdonia National Park) has also claimed that the Duty has not been complied with. While the petition and the views of the Snowdonia Society have been noted, officials do not consider that their concerns are justified.

Ability to Offer a Place to Live, Work and Rest:

6.1.14 The loss of employment opportunities in rural areas of Wales is a continuing issue. Kemble Air Services Limited's proposals offer an opportunity to replace jobs previously lost.

6.2. Promoting opportunities for the understanding and enjoyment of the special qualities of the National Park by the public:

6.2.1 Kemble Air Services Limited's proposals will offer a number of opportunities for members of the public to understand and enjoy the special qualities of the National Park. These include:

6.2.2 Creating links with tourist information centres, tourist businesses and other facilities within the National Park for the benefit of members of the public flying to the Airfield.

6.2.3 Promoting events at the Airfield such as an annual air show and other one-day events which will attract the public to the area.

6.2.4 As at Carew Cheriton (a former Ministry of Defence airfield in the Pembrokeshire National Park) there is the scope for the war-time buildings to become visitor attractions, allowing the cultural heritage of the Airfield to continue to be enjoyed by the public.

7 Measures to Control the Use of the Premises

7.1 The proposed lease to the preferred bidder will restrict the use of the Airfield to aeronautical Use and to uses within Classes B1, B2 and B8 of the Schedule to the Town and Country Planning (Use Classes) Order 1987. Additionally, the lease will require the observance of environmental legislation. The Welsh Assembly Government will retain a right of access in the event of default. The granting of a lease will allow a measure of control, unlike a disposal on a freehold basis. These measures will conserve the natural beauty of the National Park. The proposed lease will set out provisions in respect of:

- Respecting the purposes of the National Park.
- Permitted Uses.
- Keeping the Premises in good repair.
- Maintaining the site in good order, acknowledging that the site includes a Site of Special Scientific Interest which will require special environmental management.
- Not to cause a nuisance.
- Rebuilding and reinstatement of damaged buildings.
- Landlord's power of entry to ensure compliance with lease terms.
- Landlord's right to undertake works in the event of tenant default.
- Observance of Planning legislation.
- Compliance with Environmental legislation.
- Provision for flying protocols to be agreed with the Welsh Ministers.

8 Summary

8.1 The Section 11A duty has been taken into account as follows:

8.1.1 There has been a long period of consultation, firstly by the WDA and subsequently by officials of the Welsh Ministers with the aim of seeking a sustainable future for the site.

8.1.2. Account has been taken of the views of SNPA, CCW, the local community (including the local business community and local politicians) and other interested bodies as to the future of the Airfield. Officials have endeavoured to take on board the views of all those who have been consulted in seeking a viable future of Llanbedr Airfield.

8.1.3 In particular, the following actions have been undertaken:-

8.1.4 The WDA commissioned KPMG to assess the economic impact of the Ministry of Defence's closure of the site and to suggest alternative, sustainable future uses for the site.

8.1.5 The study concluded that continued use as an airfield (that is aerospace and avionics activity) was the most appropriate future use of the site especially having regard to the SSSI and the habitat for great crested newts.

8.1.6 Continued use of the site as an airfield ensures that areas of the site (including the SSSI and wildlife habitats) remain undisturbed and can be managed for optimum biodiversity.

8.1.7 The heritage of Llanbedr Airfield is of historical significance and forms part of the culture and heritage of the National Park (especially as a tourist destination). There has, therefore, been a strong focus on maintaining the site's historic aviation heritage.

8.1.8 In seeking a bidder to operate the site as a commercial venture on a 125 year lease, substantial emphasis has been placed on ensuring that prospective operators of the site would be able to meet key criteria while maintaining a viable and sustainable business plan. The assessment criteria ensured that any business venture would operate successfully without requiring substantial additional infrastructure within the National Park.

8.1.9 The proposed lease to a commercial operator will restrict the use of the site to specified uses which will be in keeping with the statutory purposes of the National Park and will require strict observance of environmental legislation. The Welsh Ministers, as freeholder, will retain a significant element of control.

8.1.10 The preferred bidder's proposals are likely to enhance the natural beauty and cultural heritage of the site and it is envisaged that the proposals will have a positive impact on the two statutory purposes of the National Park, in comparison with historic use of the Airfield.

8.1.11 The process of reaching a decision as to the future of the site is on-going. Before the Welsh Ministers make a final decision as to the future of the site, all relevant issues, representations and documents will be put before them in the context of their Section 11A duty.

9 Conclusion

9.1 The proposed future use of the site is unlikely to have an adverse effect on the character, appearance or natural beauty and wildlife of the area which will be unharmed (or improved) in particular as a result of the reduced frequency of flights and the continued proliferation of resident species. The cultural heritage of the area will be improved as a result of the proposed bidder's emphasis on preserving features of historical importance. The cultivation of increased tourism to the site will further enhance the public's understanding and enjoyment of the Snowdonia National Park's special qualities.

9.2 Correspondingly, the proposal takes account of the need to improve the economic and social well-being of the area by creating a significant number of high-quality employment opportunities in an area traditionally lacking well-paid employment.

9.3 The evidence set out in this report demonstrates that, in considering proposals for the future of the Llanbedr Airfield, officials of the Welsh Assembly Government have, therefore, had regard to the purposes of the Snowdonia National Park as set out in Section 5 (1) of the National Parks and Access to the Countryside Act 1949.

9.4 The final decision as to the future of the Airfield will be made by the Welsh Ministers who will consider the purposes of the National Park in the context of their decision-making process.

31 October 2008

Prepared by Andrea Gordon
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Guide Dogs for the Blind Association
Welsh Assembly Briefing
Petitions Committee
February 10, 2009

P-03-144 Guide Dogs for the Blind:

'We the undersigned representatives, petition the National Assembly for Wales to lay specific responsibility on local authorities to be aware of their duties under the Disability Discrimination Act and Disability Equality Duty, and comply with them by not creating town centres, high streets and residential streets with shared surfaces that discriminate against blind and partially sighted and other disabled people, effectively excluding them from the street environment.

Introduction:

Guide Dogs notes that the Petitions committee has sought further clarification from the Welsh Assembly Government and the Department for Transport.

We note that paragraph 7 of the Department for Transport briefing states that "There is no conclusive evidence to suggest that shared surfaces are

inherently any less safe than conventionally kerbed surfaces." Guide Dogs research has demonstrated that shared surface streets affect the safety and independence of blind and partially sighted people. An alliance of over 20 disability organisations from across the UK representing people with physical, sensory and learning difficulties, have signed up to a joint statement expressing concern about shared surface streets.

Recently completed shared surface schemes in Brecon and Caernarfon and a proposed scheme in Cardiff illustrate the problems of shared surfaces, and their effect on the independent mobility of blind and partially sighted and other disabled people.

If you can't tell were the pavement ends and the road begins how can you possibly feel safe? Our position is therefore: unless an alternative delineator is demonstrated through research to be effective, footways with kerbs, along with pedestrian crossing points with dropped kerbs and tactile paving, must be retained.

We welcome the fact that the Department for Transport intends to make evidence based policy in this area; and that the Department is about to start a comprehensive two-year research project on shared space aimed at informing future policy and guidance.

Guide Dogs will be pleased to be involved in this research project. We hope that the Welsh Assembly Government will take the opportunity to participate in the research.

Call for a Moratorium:

Whilst the Department for Transport research is carried out, and until guidance is produced that sets out how the shared space concept can be applied without restricting the safe independent mobility of disabled people, Guide Dogs is calling for a moratorium on new shared surface schemes.

This is supported by the statement DPTAC (the Disabled Persons Transport Advisory Committee, statutory advisors on transport for disabled people) has recently released which calls on local authorities not to proceed with shared surface schemes pending the Department for Transport research and the issuing of guidance.

We would welcome the Welsh Assembly Government's position on this call for a moratorium pending the completion of the research and the issuing of guidance.

Prif Weithredwr/Chief Executive: Mr M S Evans
Cadeirydd/Chairman: Dr C D V Jones

Teaching | Addysgu
Bwrdd Iechyd Lleol
Local Health Board
Rhondda Cynon Taf
Rhondda Cynon Taff

Val Lloyd
Chair, Petitions Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Date 22nd January 2009

Our Ref : MSE/RR/VL

Your ref: PET-03-150

Dear Val,

Re: Petition – National Cancer Standards

Thank you for your letter dated 19th January 2009 regarding the petition from the charity 'Rhondda Breast Friends'. I acknowledge the concerns that are expressed in the letter of response from their Chairman, Mrs Diane Raybould, dated 2nd December 2008.

The recent merger between North Glamorgan NHS Trust and Pontypridd and Rhondda NHS Trusts has included the appointment of a new cancer services manager and trust lead clinician. As you will appreciate, the need to gain a full understanding of the current issues and the complexities of providing services across the newly formed Cwm Taf NHS Trust is of paramount importance.

As Local Health boards we are dependant on Cwm Taf trust to provide the operational detail required in the delivery plan. We have now received this document and it is scheduled for discussion at our next scrutiny committee at the end of January.

The Trust has established a cancer strategy group to oversee the delivery of the Cancer Standards. A cancer delivery plan has been developed. This includes as attachments to support its deliver: an action plan to deliver cancer site specific standards, the CANISC Implementation plan and a 2008-11 strategic framework action plan. Some actions identified in the cancer delivery plan are in many cases already being implemented as the target date approaches.

With response to the specific issues raised in the Petition:

The confusion in terminology between 'action plan' and 'delivery plan' in the Ministers letter may be due to the generic use of the term action plan in paragraph 2, whereas the delivery plan in paragraph 3 refers to the Local Cancer Service Delivery Plan in response to the Cancer Standards.

NHS WALES GIG CYMRU
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With regard to the issues raised as part of the consultation on the Health Social Care and Well Being Strategy, a formal response was made to Mrs Raybould. A copy letter is attached for your information.

The LHB is aware of good work undertaken by the Cancer Focus Group and continue to offer their support where ever possible. However, we are not able endorse individual groups and our formal engagement with the voluntary sector in Rhondda Cynon Taf is through Interlink.

Unfortunately, I am unable to comment on information provided by Velindre NHS Trust to their patients, as am I unable to comment on the 'All Wales Information Group'.

The Cancer Strategy Group is a quarterly group, attending by health care professionals and non health care professionals across Cwm Taf. In addition the LHB is invited. As stated in the petition, 2 seats have been allocated to Rhondda Breast Friends.

The last meeting of the Cancer Strategy Group took place 19th December. I understand that Mrs Raybould has been nominated as a representative to attend this group and as such attended. Following concerns in relation to the quality and availability of patient and carer information across Cwm Taf, Mrs Raybould has been asked to participate in a review of patient and carer information available across Cwm Taf.

A copy of the local Cwm Taf Cancer Standards Delivery Plan was emailed to Mrs Raybould 11th December 2008. This included details of our progress against the cancer site specific stands and compliance with CANISC and a summary of our position against the strategic framework

The role of the South East Wales Cancer Network is to provide strategic direction to service developments across south east Wales. Any issues relating to individual experiences should be addressed with the relevant organisation and lead. With regard to the patient forum of the Cancer Network in Cardiff, unfortunately I am not a member of this forum and therefore unable to comment. May I suggest that this issue and the concerns expressed regarding disseminating of patient information across the network, is discussed with Eleri Girt, Macmillan Patient Involvement Facilitator, South East Wales Cancer Network.

The Local Health Board hopes that the response in this letter has answered the petitioners concerns satisfactorily.

If we can be of any further assistance please do not hesitate to contact us.

Yours sincerely,

Mel Evans
Joint Chief Executive / Prif Weithredwr ar y cyd
Merthyr Tydfil LHB and Rhondda Cynon Taff Teaching LHB / BILI
Merthyr Tudful a BILI Addysgu Rhondda Cynon Taf

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Date / Dyddiad: 20th February 2008

Our ref / Ein cyf: NFD

Your Ref / Eich cyf:

Dear Diane,

Re: CONSULTATION ON HEALTH, SOCIAL CARE AND WELLBEING STRATEGY 2008-11

Thank you and Rhondda Breast Friends for taking time to respond to the consultation on the new Health, Social Care and Wellbeing Strategy. It is very helpful to have your comments on the individual themes of the Strategy as well as your general points and these have been taken into account in finalising the Strategy.

As you will be aware, the HSCWB Strategy is a very broad plan relating to the population as a whole. It is about tackling the wider issues which can have an impact on people's health and wellbeing including social, environmental and economic factors. This is reflected in the choice of the 7 themes of the Strategy and why they need to be continued from the first Strategy into the second. Although we have started to make progress and see improvements across all the themes of the Strategy, as highlighted in the consultation document, it will still take time for many of the issues we are trying to influence and change to really make an impact on people's lifestyle and behaviour.

Rhondda Breast Friends is rightly concerned with how the Strategy affects people with cancer. The points you have made showing how the 7 themes affect someone with cancer are well made. This is why the themes have been chosen, as, by tackling these, we will be improving health and wellbeing for all sections of the community, including people with cancer and their families or carers. As you indicate, people with cancer may also have very specific needs and issues which are different from other client groups and require particular responses from service providers. However, because the HSCWB Strategy is not a detailed action plan for specific conditions or groups, it is not appropriate to include within it the level of information that you are looking for. These issues will be addressed in other plans, for example as outlined below.

The commissioning and planning of Cancer Services is co-ordinated by the South East Wales Cancer Network. The network is made up of all the LHBs and NHS Trusts in South East Wales. The Network has been instrumental in developing a Cancer Services Commissioning Strategy which sets out local and regional actions which need to be taken if we are to improve Cancer Services and achieve the National Cancer Standards.

The Cancer Service Commissioning Strategy focuses on specific types of cancer and a broad range of supporting services, including Palliative care and Rehabilitation. Specific actions to improve rehabilitation services include:

- Undertaking a workforce mapping exercise to establish current access to Allied Health professionals and nurses to provide supportive care and rehabilitation .

- Developing a service model which ensures the psychological assessment of all patients and access to appropriate support as detailed in the National Cancer Standards.

- Developing quality standards for rehabilitation services

A wide range of actions have also been identified to improve Palliative Care services. Whilst not exhaustive these include:

- Ensuring that Specialist Palliative Care Teams (SPCT) develop in line with NICE requirements and National Cancer Standards

- Develop plans to ensure that SPCT can undertake face to face assessments at home or in hospital, seven days a week, and that there is 24 hour access to telephone advice.

- Ensuring that all patients have access to a SPCT.

- Ensuing that provision is made to enable patients to die at a place if their choice wherever possible.

These are only examples but illustrate how detailed plans in relation to cancer will be addressed through the Cancer Services Commissioning Strategy rather than the HSCWB Strategy. I know that you are already working with colleagues in the Network, for example through its Patients and Carers group. I have therefore forwarded a copy of your response on our draft HSCWB Strategy to the Network as your comments will also be of interest to them.

In relation to your two specific questions, there are not 7 separate departments for each theme. Each theme has identified priority areas for action which will need to involve a range of both statutory agencies and voluntary sector groups contributing to achieving them. Because of this, it will be very important to ensure that such responses are coordinated and that we make it easier for patients and their families to access the services and information they need when and where they need it.

You also query whether the Strategy fulfils the Disability Equality Duty. As part of the process of finalising the Strategy, we are required to undertake an Equality Impact Assessment. This assessment provides an integrated approach to all equality strands including for example, race, disability, gender and age and will therefore address the issues you raise.

I hope I have been able to address some of your concerns. Please do not hesitate to contact me if you want to discuss anything further.

Thank you again for your comments

Yours sincerely

Nicola Davies
Partnerships Manager / Rheolwr Partneriaethau
Health, Social Care and Wellbeing / Iechyd, Gofal Cymdeithasol a Llew

21 JAN 2009

Y Pwyllgor Deisebau

Petitions Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Chief Executive Officer
Rhondda Cynon Taf Teaching Local Health Board
Ynysmeurig House
Navigation Park
Abercynon
CF45 4SN

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff CF99 1NA

Our ref: PET-03-150

19 January 2009

Dear Chief Executive Officer

PETITION - NATIONAL CANCER STANDARDS

The National Assembly's Petitions Committee is considering a petition from the charity Rhondda Breast Friends that calls for the National Assembly for Wales to:

"investigate whether Local Health Boards have the necessary strategies and action plans in place to deliver the target to comply with the National Cancer Standards by March 2009 in Rhondda Cynon Taf and throughout Wales, as a matter of urgency."

The Minister for Health and Social Services wrote to the Petitions Committee on 21 October (copy attached), setting out the Assembly Government's position in relation to this petition. We have since received a response to that letter from the lead petitioner (copy also attached)

The Committee would like to know the Local Health Board's view on each of the petitioner's concerns. I am also copying in the Minister to this letter.

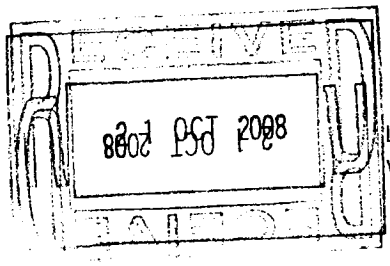
Yours sincerely

Val Lloyd

Val Lloyd
Chair, Petitions Committee

Tel: 029 2089 8728

Edwina Hart AM MBE
Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Cardiff Bay
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Our ref: EH/04772/08
Your ref:

Val Lloyd AM
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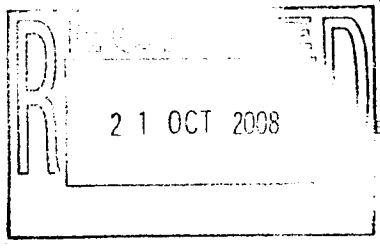

Dear Val

21st October 2008

Thank you for your letter of 6 October on behalf of the Petitions Committee asking for an update on the position of Local Health Boards (LHBs) in delivering the National Cancer Standards by March 2009 and; in particular, the position in relation to Rhondda Cynon Taff LHB. You also ask what sanctions and actions will follow in the light of any non-compliance with the Standards.

At the time the Standards were published in 2005, the Cancer Networks were required to map and assess current services against the Standards and develop formal action plans to map the journey to full compliance. All LHBs have action plans in place and the three regional Cancer Networks are working to support the LHBs to achieve the standards by March 2009. Progress against action plans is monitored carefully by the Regional Offices.

With regard to Rhondda Cynon Taf LHB, it is working with Cwm Taf NHS Trust on a delivery plan which details the remaining gaps and further work required towards compliance with the Standards. This plan should be finalised at the end of the month. The South East Wales Cancer Network is monitoring progress with compliance, providing quarterly progress reports to the South East Wales Regional Office.

The recent merger between the two Trusts will have made some issues more complex for the newly formed Cwm Taff NHS Trust but it is fair to say that the merger will have provided opportunities for some non-compliance issues to be overcome.

Rhondda breast friends

Registered Charity No: 1113717

2nd December, 2008

Dear Gareth,

Petition: National Cancer Standards

Thank you for your feedback from the Petitions Committee received 21st November, 2008.

I read the minister's letter attached but did not quite understand it.

Paragraph 2 states "All LHBs have action plans in place.....progress against action plans is monitored carefully by the Regional Offices"

Paragraph 3 gives details of RCT's "delivery plan.....should be finalised by the end of the month." (October)

Are these conflicting statements? Is the "action plan" which is apparently in place, the same as the "delivery plan" which is still to be completed?

We set up a Cancer Focus Group in RCT to raise the profile of cancer issues locally when it was felt that the new Health Social Care and Wellbeing Strategy did not address the needs of people with cancer in RCT. A meeting with the Local Health Board on 18th April reported that there was no specific implementation plan for Cancer Standards for RCT and no funding. We were congratulated on our Charter but told not to get our hopes up but that they (our health providers) wished us well!

The Cancer Focus Group adopted The Charter of Rights resulting from Rhondda Breast Friends (RBF) Community Cancer Conference as a local action plan in the absence of anything else. What really worries me and fills me with great sadness is that if an action plan exists, and they have not been able to provide us with one to date, then absolutely no involvement or participation has taken place. The LHB are well aware of the Cancer Focus Group and we now have 2 sub groups for cancer information and cancer carers.

The Information Sub Group, working with the Cabinet member in RCT,

- has succeeded in getting the local authority to agree to extend their chronic conditions library to include Cancer and the LHB have donated £1000 towards it.
- We are working with patient support officers in Velindre, Merthyr and Royal Glamorgan and we have seen many examples of good practice. The North Wales Cancer Network has developed a "Patient Information folder" containing general information for newly diagnosed patients which is supplemented according to individual need and this written information supports the advice given by the cancer patient's team. Well done North Wales.....so sad it is not available across all Wales.
- The Velindre Patient Involvement group provide basic packs which are sent out to feeder hospitals but we do not know of anyone who has ever received them. This is being investigated by the group.
- When asked about south Wales I am told the "All Wales Information Group" started but was discontinued when the lead left.....?

Cwm Taf

Ymddiriedolaeth GIG / NHS Trust

MEETING	
DATE	
RESPONSIBLE DIRECTOR	Director of Performance & Information
CORPORATE THEME	Sustainable Services

TITLE OF REPORT

Cancer Services Report

PURPOSE OF REPORT

The report notes the latest position and actions in respect of the achievement of Cancer standards at the end of November 2008.

INTRODUCTION

The health community is required to deliver cancer services in line with national cancer standards by 31st March 2009. The Trust has established a cancer strategy group to oversee the delivery of standards. The Trust has prepared a cancer delivery plan which outlines the areas currently not achieving the standards and the actions required. The detail contained within this report mirror those actions.

SUMMARY OF CURRENT POSITION AND KEY ACTIONS

The following section highlights key areas for action.

A) General Issues

Following detailed discussions with Trust cancer leads and wider across the Trust and South East Wales Cancer Network (SEWCN), a number of solutions have been developed to support compliance with the cancer standards by March 2009;

- Role profiles have been developed for lead clinicians which

specifically identify responsibility for delivery of some of the current gaps in standards achievement. These profiles empower the lead clinician to ensure all Multi Disciplinary Team (MDT) members undertake their role in full compliance with the cancer standards.

- A number of standards require policies, protocols to be in place, E.g. communication policies and ongoing support protocols. The Trust has identified responsibilities for these and sought 'Best Practice' evidence from wider afield.
- Certain standards require evidence from audit and patient/carer survey etc., to confirm that compliance with standards has been achieved. Discussions have been held to plan audits/surveys into Trust/LHB audit programmes, supplemented by MDT team activities.
- Some standards fail because data is less robust in some areas with full CANISC datasets not being captured. This is being addressed through increased support of Trust cancer team who will ensure all methods of data capture are robust. All cancer patients are managed through MDT arrangements and Radiology, Pathology and Haematology databases are used fully.
- Improved coverage and support for MDT meetings including outcome information, attendance records etc. has been identified as a weakness in some areas. The Trust has reviewed the constitution, support and attendance of all MDT meetings and actions are being addressed through the cancer team.
- A review of video conferencing capability and equipment has been undertaken. This has identified additional equipment requirements which the Trust is seeking funding from the SEWCN to support. This will allow for joint MDT meetings linked at both DGH sites and for links to wider network MDT meetings. It will also facilitate individual linking with Oncology and specialist or tertiary colleagues. A combination of these uses will result in MDT membership compliance with cancer standards.
- Access to specialist Psychological and Psychiatric services is not available in most areas. The Cancer Network is developing a proposal for provision of a specialist service in this area.

It is evident that CNS support, which is a core component of MDT's and cancer standards achievement, is a major issue and results in non compliance with MDT requirements.
Those CNS's in post are usually fully or part charitable funding. This is not acceptable as a long term strategy for a core service element of

cancer standards achievement. The Trust will continue to engage cancer charitable organisations to support the important work in these areas, however this should be seen as enhancing existing core services not replacing them.

B) Key MDT Standards summary by cancer tumour site.

To ensure that cancer care in provided by a specialist multidisciplinary team.

Gynaecology – There is monthly retrospective review currently at PCH and RGH with cases referred according to network guidelines to network MDT. There is no oncologist at MDT and no CNS in post in RGH and no pathology and radiology cover in PCH.

Actions:

- Establish fortnightly prospective MDTs on both sites with videoconferencing link to network MDT
- Seek additional resources for CNS
- Provide pathology and radiology support

Colorectal – There is no cover for oncologist and poor oncology attendance at RGH and no cover for Histopathologist or oncologist at PCH. Workload precludes a single MDT. Difference in access to laparoscopy surgery at both sites. Difference in follow-up protocols.

Actions:

- Continue separate MDT on both sites with separate MDT leads in short term
- Establish a Trust wide follow-up protocol based on best practice
- Improve oncology input to MDT and cover, through discussions with SEWCN and Velindre
- Histopathology cover to be provided from RGH

Lung – Separate MDTs established on both sites and workload precludes single MDT. No thoracic surgical input to either MDT but videoconferencing meeting established weekly between PCH, RGH and UHW. Poor oncology input at RGH and no consultant cover at both RGH and PCH. CNS available on both sites but limited contact with new

patients at PCH and no CNS cover on either site. CNS funding at RGH from charitable sources and limited radiology cover at RGH. Inadequate OP facilities at PCH.

Actions:

- Maintain separate MDTs and MDT leads in short term
- Trust to discuss improved oncology input to MDT and cover arrangements with SEWCN and Velindre
- Trust to review funding for RGH CNS and seek funding for CNS cover
- Trust to review CNS role at PCH
- Trust to address radiology cover at RGH
- Trust to review OP facilities at PCH

Haematology – Cancer leads attend network MDT at UHW and Velindre (for lymphoma) and have established a joint team meeting for myeloma and chronic leukaemia. Separate weekly radiology meeting established at RGH. A number of cancer patients managed outside of MDT meetings. No palliative care members or oncology cover. Outpatient facilities deemed inadequate at PCH. Chemotherapy provided at PCH not RGH, no MDT administrative support.

Actions:

- Trust to seek guidance from SEWCN to establish protocol for patient management to comply with standards
- Strengthen network MDT meeting with Velindre ensuring all cases discussed
- Continue Trust wide MDT for myeloma and chronic leukaemia's with patients discussed according to network standards
- Continue radiology meetings at RGH and establish radiology meeting at PCH
- Improve outpatient facilities at PCH
- Introduce processes to ensure all haematological cancers are recorded
- Trust to provide cancer services support and data capture for CANISC

Breast – Single handed consultant service at PCH with differences in clinical practice compared with RGH, eg. sentinel node biopsy,

mastectomy rates, primary reconstruction. No PCH radiologist reporting > 500 symptomatic mammograms.

Actions:

- Establish a single Trust wide MDT lead and link MDT at both sites via video conferencing
- Improve MDT support at PCH
- In the short to medium term, Trust to review provision of breast cancer services including breast imaging provided on both sites

Upper GI – A single Trust wide MDT lead has been appointed. On both sites cases are reviewed at colorectal MDT and subsequently managed through network MDT. Upper GI surgeons from both sites attend along with radiology lead from RGH. SEWCN due to announce clinical model reconfiguration which will impact on services provided currently at both DGH sites.

Action:

- Await network reconfiguration

Head and Neck – Single MDT lead appointed and single MDT established with input from Bridgend and Morriston. There is no CNS. Dietician and dental hygienist are not named core members of MDT with services accessed outside of MDT. Data capture on CANISC is patchy. SEWCN is commissioning an independent review on the future configuration of H&N cancer services.

Actions:

- Seek urgent funding for CNS
- Review core membership of MDT
- Trust to improve data capture from MDT for CANISC
- Await outcome of SEWCN review

Urology – The Trust has established a single Trust wide MDT lead and moved to a single weekly MDT. Plans made to link via video conferencing with Cardiff and Newport MDTs, subject to securing funding for equipment from SEWCN. CANISC data not captured. Currently data input into BAUS. Workload remains very high with in

excess of 30 cases discussed weekly. Additional urologist input at PCH being addressed.

Actions:

- Secure funding for videoconferencing equipment
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- Trust to provide improved MDT support and data capture for CANISC.

Skin – No existing MDT at RGH and newly established MDT in PCH. No skin cancer CNS in the Trust. Single Trust wide MDT lead appointed.

Actions:

- Review MDT meeting and establish protocol and process for inclusion of appropriate patients from both sites
- Review arrangements for pathway for melanoma patients
- Seek funding for CNS
- Improved MDT support and data capture for CANISC

Palliative Care – Separate MDTs in place. There is no administrative support to MDTs from central cancer team to either MDT. No access to specialist Psychological/Psychiatric care. Inadequate 7/7 cover and also 24/7 cover across network. Inadequate performance on seeing patients with uncontrolled symptoms.

Actions:

- Maintain separate MDTs and MDT leads in short term
- Increased admin support to be identified and resources sought
- Network to progress action on appropriate access to Psychological/Psychiatric services for all cancer sites
- SEWCN to address 7/7 and 24/7 cover issues across network.
- MDT's to review prioritisation processes for patients with u/controlled symptoms

CONCLUSION

A number of clear clinical service gaps, require significant investment from within the local health community or wider, e.g. Network, Velindre, charitable organisations.
The Trust will continue to engage in discussions in all of these areas.

The Trust will continue to play an active part in the SEWCN reconfiguration of services currently in progress across a number of the cancer sites. The outcome of these discussions will inevitably change service delivery within the Trust.

The actions identified in detail in the cancer delivery plan are being summarised by cancer site to be led by the MDT leads. This will result in individual implementation plans being developed and agreed between the Cancer lead team, the MDT leads and the relevant clinical division and directorate. They are further being summarised by clinical division and directorate for ensuring ownership of delivery throughout the Trust. Some actions identified in the cancer delivery plan have in many cases already being implemented as the target date approaches.

The Trust is confident it can deliver on the cancer standards that are linked to organisational change, e.g., MDT changes, data capture, admin support, survey and audit, clinical protocol development etc. The majority of standards failure is within these areas.

With the exception of Urology, there is no funding identified for permanently addressing clinical service gaps in MDT's within the Trust. This will be an issue for the SEWCN to address.

RECOMMENDATION

The performance against these targets is to be noted and the actions being taken to improve performance where required.

Cwm Taf

Ymddiriedolaeth GIG / NHS Trust

MEETING	
DATE	
RESPONSIBLE DIRECTOR	Director of Performance & Information
CORPORATE THEME	Sustainable Services

TITLE OF REPORT

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RECOMMENDATION

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CWM TAF NHS TRUST

CANCER STANDARDS DELIVERY PLAN

NOVEMBER 2008

Authors : Dr Richard Winter, Trust Cancer Lead Clinician
Mr Wayne Jenkins, Trust Cancer Lead Manager
Ms Kim Preece, Trust Cancer Lead Coordinator

CWM TAF NHS TRUST

Cancer Standards Delivery Plan

Contents

Appendices

1. INTRODUCTION

This document highlights the key actions that the Trust needs to take to ensure that the Designed for Life target that all cancer services comply with the National Cancer Standards by March 2009 is achieved.

It also identifies the actions needed to deliver the requirement to provide core clinical data onto the all Wales cancer information system CANISC by March 2009.

This delivery plan is set within the context of National Guidance, i.e. the National Cancer Standards and the evidence-based NICE Guidance, together with the current status of services.

It is primarily based on the trusts 2007/08 self assessment of their compliance with the National Cancer Standards and has taken account of the strategic direction for cancer services within the health community and the discussions and recommendations of the South East Wales Cancer Network's structure of cancer site-specific clinical advisory groups.

A CANISC status report was also provided by the SEWCN which identified the current compliance with core data requirement across the two DGH sites.

One of the key aims of the delivery plan is to ensure that equity, in terms of timeliness of access, patient pathway, access to appropriate cancer specialists and clinical outcomes, is achieved.

This can only be achieved by bringing together the best practice currently in place within the health Community supplemented by other clinical practice and supporting processes and service models in the wider NHS.

To deliver this will mean a number of current models of service delivery will change in the short term, others, where equitable delivery of service exists currently, will need to enhance existing arrangements and will look to develop medium term solutions.

The development of Cancer Services has traditionally been singular across both former Trusts with the exception of Head and Neck Cancer which has evolved as one MDT.

The Trust has appointed a new Cancer Lead Clinician, supported by Lead Cancer Manager, Cancer Coordinator and 7 MDT Cancer administrators.

Initial focus has been on addressing where non compliance against cancer standards and CANISC status was identified.

Each specific cancer tumour site across both former trusts has had in place a lead cancer clinician who was responsible for delivering services in line with the cancer standards. On merger, the existing management arrangements regarding the Cancer Lead Clinicians were reviewed and proposals developed. Cancer site teams have been reviewed and merged where appropriate.

The Trust has put in place an overarching Cancer Strategy Group to oversee the development of Cancer Services across the Health Community. The constitution has been agreed and membership includes LHB and voluntary sector and patient representation.

2. STRATEGIC CONTEXT

In 1995, the publication of "A policy framework for commissioning cancer services: A report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales" (known as the Calman-Hine Report) sought to restructure services to "create a network of care in England and Wales which will enable a patient, wherever he or she lives to be sure that the treatment and care received is of a uniformly high standard."
Fundamental to this was the development of a structure of cancer centres in a hub and spoke arrangement with cancer units.
The application of these principles in Wales was set out in the Cameron Report, 'Cancer Services in Wales' which laid down the foundation for the development of cancer services in Wales, with services based on three cancer centres. The report also stressed the pivotal role of specialist Multidisciplinary Teams (MDTs) in cancer care. The development of the All Wales Minimum Cancer Standards (2000) provided a framework for the continuing development of services. These were subsequently replaced by the National Cancer Standards (2005) which defined the core aspects of the service that should be provided for cancer patients in Wales. These National Cancer Standards take account of the evidence-based Improving Outcomes Guidance series published by NICE.
Designed for Life (2005) stated that the all cancer services would comply with the 2005 National Cancer Standards by March 2009. "Designed to Tackle Cancer" (2006) set out the Government's policy aims for cancer services. It focuses on the themes of more prevention, early detection, improved access and better services. It re-iterated that the achievement of the National Cancer Standards by 31st March 2009 was "key to developing and delivering the provision of world class cancer services in Wales".
The Calman/Hine and the Cameron Report also recognised that the

treatment pathway for patients with cancer is a complex one, with system problems often resulting from difficulties resulting from a lack of robust information and its subsequent flow. In recognition of these problems, the Health Information Management Board approved the establishment of the Cancer Information Framework (CIF), set out in WHC (2000) 40.
The framework was developed to support the information requirements associated with the implementation of the Calman/Hine and the Cameron Reports. The CIF recommended the use of a single summary electronic cancer record, which would be accessible wherever the patient receives specialist care. Consequently, the Cancer Network Information System Cymru (CaNISC) has been developed to allow all providers to meet this requirement. This system provides a case record for cancer patients in Wales, based on data items included in the All Wales Core Cancer Dataset. These data will also be available for secondary uses which include reporting the AOF cancer waiting times, participation in clinical audit and a key data source for the cancer registry Welsh Cancer Intelligence and Surveillance Unit (WCISU).
WHC (2008) 054 outlines the timetable for ensuring the All Wales Core Cancer Dataset information is collected and entered onto CANISC by 31st March 2009.

3. SUMMARY OF CURRENT POSITION AND KEY ACTIONS

The full details of all areas of non compliance identified in the latest cancer monitoring returns are included at appendix 1.
This section summarises those key areas and actions identified.

3a General Issues

Following detailed discussions with Trust cancer leads and wider across the Trust and South East Wales Cancer Network (SEWCN), a number of solutions have been developed to support compliance with the cancer standards by March 2009;

- Role profiles have been developed for lead clinicians which specifically identify responsibility for delivery of some of the current gaps in standards achievement. These profiles empower the lead clinician to ensure all MDT members undertake their role in full compliance with the cancer standards.
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- Certain standards require evidence from audit and patient/carer survey etc., to confirm that compliance with standards has been achieved. Discussions have been held to plan audits/surveys into Trust/LHB audit programmes, supplemented by MDT team activities.
- Some standards fail because data is less robust in some areas with full CANISC datasets not being captured. This is being addressed through increased support of Trust cancer team who will ensure all methods of data capture are robust. All cancer patients are managed through MDT arrangements and Radiology, Pathology and Haematology databases are used fully.
- Improved coverage and support for MDT meetings including outcome information, attendance records etc. has been identified as a weakness in some areas. The Trust has reviewed the constitution, support and attendance of all MDT meetings and actions are being addressed through the cancer team.
- A review of video conferencing capability and equipment has been undertaken. This has identified additional equipment requirements which the Trust is seeking funding from the SEWCN to support. This will allow for joint MDT meetings linked at both DGH sites and for links to wider network MDT meetings. It will also facilitate individual linking with Oncology and specialist or tertiary colleagues. A combination of these uses will result in MDT membership compliance with cancer standards.
- Access to specialist Psychological and Psychiatric services is not available in most areas. The Cancer Network is developing a proposal for provision of a specialist service in this area.

It is evident that CNS support, which is a core component of MDT's and cancer standards achievement, is a major issue and results in non compliance with MDT requirements.
Those CNS's in post are usually fully or part charitable funding. This is not acceptable as a long term strategy for a core service element of cancer standards achievement. The Trust will continue to engage cancer charitable organisations to support the important work in these areas, however this should be seen as enhancing existing core services not replacing them.

3b Key MDT Standards summary by cancer tumour site.

To ensure that cancer care in provided by a specialist multidisciplinary team.

Gynaecology – There is a monthly retrospective review currently with cases referred according to network guidelines to network MDT. *Trust plans to*

establish fortnightly prospective linked MDT with additional videoconferencing link to network MDT.
There is no Oncologist at MDT and no CNS in post in RGH and no Pathology and Radiology cover in PCH. *Trust to seek additional resources for CNS. Provide cover Pathology and Radiology support from RGH.*

Colorectal –There is no cover for Oncologist and poor Oncology attendance in RGH and no cover for Histopathologist or Oncologist in PCH. *Trust to discuss improved Oncology input to MDT and cover arrangements with SEWCN and Velindre. Histopathology cover in PCH to be provided from RGH.*

Lung – No Thoracic surgeon present at weekly MDT in either DGH, although alternate meeting takes place. Weekly meeting with oncologist input occurs. Oncology attendance only 60% in RGH. SPR Oncology cover only in PCH. *Trust to discuss improved Oncology input to MDT and cover arrangements with SEWCN and Velindre.* Inadequate CNS support at PCH and no CNS cover on either site. *Trust to seek additional resources for CNS.* Limited Radiology cover at RGH. *Trust to identify improved Radiology cover arrangements.* Inadequate OP facilities at PCH. *Improved OP facilities to be identified by directorate.*

Haematology – Cancer leads attend network MDT and also have local team meetings, although it is unclear whether this approach complies with cancer standards. A number of cancer patients managed outside of MDT meetings. No Palliative care members or Oncology cover in RGH. *Trust to Review Oncology attendance and cover arrangements with Velindre and to seek guidance from SEWCN to confirm protocol for patient management is deemed compliant with standards.* Outpatient facilities inadequate at PCH. *Improved OP facilities to be identified by directorate.* Chemotherapy provided in PCH not RGH. No MDT administrative support provided. *Introduce processes to identify all Haematological cancers including Myeloma. Cancer leads to review MDT meetings with increased cancer services team support.*

Breast – Single handed consultant service in PCH with differences in clinical practice identified e.g., Sentinel Node, Mastectomy rates and variation in MDT management and compliance. No Breast Radiologist at PCH reporting on >500 symptomatic mammograms.
To facilitate a standardised approach to patient management in the short term the Trust is to appoint a single Breast lead clinician for Cwm Taf and to link MDT meetings via videoconferencing. Trust is also to improve MDT administrative support on both sites. In the short to medium term the Trust will review the provision of Breast Cancer services including Breast Imaging provided on both sites.

Upper GI – A single Trust Upper GI cancer lead has been appointed. All upper GI patients are managed through the MDT route and both Upper GI lead surgeons attend network MDT.

Head & Neck – A single Trust Head & Neck cancer lead has been appointed. The Trust has a single weekly MDT for this service with input from Bridgend and Morriston, however there are gaps with no CNS in post. There is no Dietician and no Dental Hygienist as core MDT members with services being accessed outside of MDT. *Trust is actively seeking funding for these clinical service gaps.* SEWCN is commissioning an independent review on the future configuration of Head and Neck cancer services.

Urology – The Trust has appointed a single Urology cancer lead. The Trust has moved to a single service with one weekly MDT covering both sites. Funding has been secured for additional clinical support for the MDT model. The MDT will link in Cardiff and Newport via videoconferencing in January 09 subject to additional videoconferencing equipment support from the SEWCN.

Skin – No existing MDT in RGH, with newly established MDT in PCH. No CNS in post in the Trust.
Trust plans to move to single Skin Cancer lead clinician for Cwm Taf with single MDT covering patients both sites. Trust to seek additional resources for CNS.

Palliative Care – While Palliative Care staff support other MDT's, this participation is not fully available. Both services manage patients in a multidisciplinary way but are organised differently. Commitment from both leads to move to standardised clinical practice model and to single lead in the medium term.

4 CONCLUSION

A number of clear clinical service gaps which have been identified in the cancer delivery plan, require significant investment from within the local health community or wider, e.g. Network, Velindre, charitable organisations. The Trust will continue to engage in discussions in all of these areas.

The Trust will continue to play an active part in the SEWCN reconfiguration of services currently in progress across a number of the cancer sites. The outcome of these discussions will inevitably change service delivery within the Trust.

Actions identified in this cancer delivery plan have in many cases already being implemented as the target date approaches.

The actions identified in detail in appendices 1 and 2 are being summarised by cancer site to be led by the MDT leads. This will result in individual action plans being developed and agreed between the Cancer lead team, the MDT leads and the relevant clinical division and directorate. They are further being summarised by clinical division and directorate for ensuring ownership of delivery throughout the Trust.

The Trust is confident it can deliver on the cancer standards that are linked to organisational change, e.g., MDT changes, data capture, admin support, survey and audit, clinical protocol development etc. The majority of standards failure is within these areas.

With the exception of Urology, there is no funding identified for permanently addressing clinical service gaps in MDT's within the Trust. This will be an issue for the SEWCN to address.

OBJECTIVE	STANDARD (Notes; Status and actions reflect non compliant areas only, N = PCH, S = RGH) APPENDIX 1
Objective 2: Care provided by teams should be well co-ordinated to provide an efficient, effective service to patients.	**2.4 The MDT Lead Clinician should be confirmed by the Cancer Network Board in consultation with their respective TCLC and Medical Director or Executive Lead.**
	2.4 There should be a lead gynaecologist for each local gynaecological team, which should be a formal appointment *(Gynaecology Only)*
	2.4 The SPCT Lead Clinician should be confirmed by the Cancer Network Board in consultation with their respective TCLC and Medical Director or Executive lead *(Palliative Care Only)*
	2.5 The MDT lead clinician should **1. Have overall responsibility for team working, the team meeting, and clinical audit.** **2. Provide clinical advice and co-ordinate any modernisation projects that are associated with working of the MDT.** **3. Have dedicated administrative and secretarial assistance to support the functioning of the MDT.** **4. Attend both Trust and Network cancer meetings as appropriate *(2.8 in Gynaecology & 2.6 in Palliative Care & 2.7 in Upper GI & Urological)***
	2.5 The gynaecological cancer MDT Lead Clinician of the local, Network or supra Network team should be confirmed by the Cancer Network Board in consultation with their respective TCLC and Medical Director or Executive Lead *(Gynaecology Only)*
	2.6 The local MDT Lead Clinician should ensure the team, a. Provides rapid diagnostic and assessment services with rapid referral on to a Network or Supra-Network MDT in accordance with national guidance b. Identifies and manage patients with gynaecological cancer c. Provides information, advice and support to patients d. Liaises with the primary care team *(Gynaecology & 2.5 in Upper GI & Urological)*
	2.7 The Network/supra Network MDT Lead Clinician should ensure the team a. Provides a protocol for patient referral b. Liaises with the local gynaecological cancer MDT and patient's GP *(Gynaecology & 2.6 in Upper GI & Urological)*
	2.7 Each Trust or voluntary sector organisation providing specialist palliative care services should adopt a process, involving representatives from the Cancer Network , by which the organisation or the Trust Cancer Management Team report to their Board at least annually on compliance with the Cancer Standards *(Palliative Care Only)*
CURRENT STATUS AND ACTIONS:	2.4 Full compliance 2.5 1,2 and 4 A number of sites reported no, however these responsibilities have now been detailed in recently developed role profile to be adopted on appointment of Lead Clinician. 2.5 3 Non compliance in Haematology N&S, Breast N, Gynae N&S, Urology N AND Palliative Care N. **Action Urology and Breast will have combined/linked Cwm Taf MDT's and have dedicated support. Additional administrative Resources required to support full compliance for MDT's in Haematology and Gynaecology on both sites and Palliative Care North.** 2.6 Upper GI, no protocol for liaising with primary care team. **Action protocol to be developed.** 2.7 Full Compliance.

Objective 3: To ensure that patients and or their carers have support and all the information they require regarding the diagnosis, treatment options and treatment care plan.	**3.1 The MDT should agree a communication policy regarding** **1. Communication between members of the team.** **2. Communication between the team members and the patient and their carers.** **3. Communication skills training for team members with direct patient contact, especially those involved in breaking bad news.** **4. Adequate time for patients to consider treatment options.**
	3.2 Written information in a language and format appropriate to the patient should be offered to each new cancer patient. This should cover **1. General background information about the specific cancer.** **2. Detail of treatment options, specific local arrangements including information about the MDT and support services, and whom the patient should contact if necessary.** **3. Details of local self-help/support groups and other appropriate organisations**
	3.3 The MDT should nominate a person to be responsible for ensuring written information is offered to all new patients.
	3.4 A designated person/s should be responsible for ensuring that written information is generally available in appropriate wards/outpatient areas and is checked and replenished when necessary.
	3.6 There should be access to a private room or area where patients and or their carers can discuss the diagnosis in conditions of adequate privacy with the appropriate member of the MDT.
	3.7 The MDT should ensure that patients are assessed for ongoing support following treatment for their cancer. ***(3.9 in Colorectal, Gynaecological, Head & Neck, Thyroid & Urological. Not Skin or Palliative Care Cancer)***
	3.7 Patients requiring temporary or permanent stomas should be offered counselling on the implications of having a stoma, before and after surgery, by a specialist nurse *(Colorectal Only)*
	3.7 The MDT should ensure that patients with gynaecological cancer and their partners have access to advice on psychosexual issues *(Gynaecological & Urological Only)*
	3.7 The MDT should ensure that patients are assessed for ongoing support following treatment for head and neck cancer *(Head & Neck Only)*
	3.7 Patients found to have significant levels of anxiety or depression should be offered prompt access to specialist psychological or psychiatric care capable of providing level 3 and 4 psychological interventions as recommended in the NICE Supportive and Palliative Care Guidance *(Skin & Palliative Care Only)*
	3.7 New Thyroid Cancer patients should be supported at the time of diagnosis and post diagnosis by a clinical nurse specialist [CNS] *(Thyroid Only)*

	3.8 Patients found to have significant levels of anxiety and or depression should be offered prompt access to specialist psychological or psychiatric care capable of providing level 3 and level 4 psychological interventions as defined in the NICE Supportive and Palliative Care Guidance. ***(3.9 in Colorectal, Gynaecological, Head & Neck, Thyroid & Urological. Not Skin or Palliative Care Cancer)***
CURRENT STATUS AND ACTIONS:	3.1 The majority of MDT's reported that there was no specific communication policy in place, most did not report appropriate, Communication skills training for MDT members and many had not undertaken surveys of patients/carers views of communication received. **Action Development of generic cancer communication policy for adoption by all MDT's (Network to provide information on best policies in place elsewhere.) MDT member's communication skills to be reviewed following surveys of patients/carers views and based on survey results. Survey program to be developed and included within the audit programme for Trust and LHB clinical audits.** 3.2 Compliant except for Haematology S, which does not provide written info on treatment options. **Action Review N info for adoption.** 3.3/4 Non compliance reported for Upper GI S, Skin N and Gynaecology S. **Action MDT's to nominate responsible team member.** 3.6 Rooms available for all sites although facilities deemed inadequate for Haematology N&S, Skin N, Lung N, Urology S. **Action Divisional teams to work with outpatient departments to develop compliance plan.** 3.7 Non compliance reported for Gynaecology S, Haematology N&S, upper GI S, Urology S, Lung N&S. **Action MDT's to nominate responsible team member, written protocol in line with NICE guidance to be developed for each MDT (Network to provide information on best protocol in place elsewhere.)** 3.8 Non compliance across all cancer sites, with individual informal arrangements in place in one or two areas, however access to general psychiatric services only is the reported route. **Action Network to progress action on appropriate access to Psychological/Psychiatric services for all cancer sites.**
Objective 4: To ensure that care is provided by a specialist multidisciplinary team.	**4.1 All clinicians treating cancer should be part of the multidisciplinary team and have designated time to attend the MDT meeting.**
	4.1 The colorectal cancer MDT should include the following specialists: a. 2 designated colorectal surgeons with an interest in colorectal cancer. b. Radiologist c. Colonoscopist d. Histopathologist e. Clinical oncologist f. Clinical nurse specialists g. Palliative care physician/nurse - member of a specialist palliative care team. h. MDT co-ordinator/data clerk. *(Colorectal Only)*
	4.1 All clinicians treating haematological cancers should be part of an MDT structure that ensures the diagnosis, treatment and patient management decisions are taken on a team basis. *(Haem Only)*
	4.1 The MDT should include the following specialists with designated time for lung cancer work and participation in the MDT meeting: a. Respiratory physician b. Thoracic surgeon

	c. Radiologist d. Pathologist e. Oncologist f. Palliative care physician/nure-member of a specialist palliative care team g. Lung Cancer Nurse Specialist h. MDT co-ordinator/data clerk *(Lung Only)*
	4.1 The SPCT should include the following: a. Palliative medicine consultant who is on the specialist register, with at least one other doctor with a postgraduate qualification in Palliative Care in support b. Palliative care nurse specialist c. Social worker or other staff member with specialist training in providing psychological and social support and advice on benefits, with designated time for working with palliative care patients d. SPCT coordinator/secretary *(Palliative Care Only)*
	4.1 The MDT should include the following thyroid cancer specialists with designated time for cancer work and participation in the MDT meeting. One or more members of the team should be trained and licensed to give radioiodine a. Endocrinologist b. Surgeon who specialises in thyroid/endocrine oncology c. Oncologist d. Radiologist e. Nuclear medicine physician f. Specialist pathologists [both histopathology and cytopathology] g. Clinical Nurse Specialist [head and neck cancer CNS or an endocrine CNS] h. MDT co-ordinator/data clerk
	4.2 The MDT should include the following breast cancer specialists who should have time allocated to prepare for and attend the MDT meeting 1. Surgeons with each seeing at least 50 new primary breast cancer cases per year (first table below). Breast imaging specialist (second table below). 2. Pathologist with designated time for breast work (third table below). 3. Oncologists with designated time for breast work (third table below). 4. Clinical nurse specialists in breast cancer (third table below). 5. MDT co-ordinator/data clerk (third table below).
	4.2 The MDT should have a named contact and appropriate access to the following support staff/services, a. Gastroenterologist b. Liver surgeon who is a member of a hepatobiliary MDT c. Thoracic surgeon d. Interventional radiologist e. Plastic surgeon f. Urologist g. Gynaecologist

	h. Cancer Genetics i. Clinical Psychologist/psychiatry j. Allied Health Professionals [dietician/nutritionist, Occupational therapist k. Primary care team l. Social work m. Lymphoedema Services *(Colorectal Only)*
	4.2 The local gynaecological cancer MDT should include the following specialists with an interest in and designated time for gynaecological cancer work and participation in the local MDT meeting a. Lead gynaecologist b. Lead pathologist c. Oncologist d. Radiologist e. Nurse specialist in gynaecological cancer f. Palliative care physician/nurse – member of the specialist palliative care team g. MDT co-ordinator/data clerk *(Gynaecology Only)*
	4.2 The MDT should specify the level of care provided and include the following specialists: a. At least two haematologists who specialise in leukaemia and/or lymphoma and at least one haematologist from each hospital site covered by the MDT. b. At least one clinical nurse specialist and the ward sister from hospitals which provide services at BCSH level 2 or above. c. Radiologists d. Histopathologists e. Oncologists f. Microbiologists g. Palliative care physician/nurse - member of the specialist palliative care team h. MDT co-ordinator/data clerk *(Haem Only)*
	4.2 The core MDT should include the following specialists all with expertise in head and neck cancer: a. Surgeons, with the majority of their work involving head and neck cancer b. Clinical Oncologists c. Restorative dentist d. Radiologist/s e. Pathologist/s f. Palliative care physician/nurse – member of the specialist palliative care team g. Speech and language therapist/s h. Dental hygienist i. Dietician/s j. Specialist nurse/s k. An MDT/data co-ordinator *(Head & Neck Only)*
	4.2 The MDT should have contact and appropriate access to the following support staff/services, a. Primary care team

	b. Clinical Psychologist/psychiatry c. Social work *(Lung Only)*
	4.2 The MDT should include the following specialists with expertise in the management of skin cancer: a. Surgeons with adequate expertise and training, particularly in the requisite techniques of excision and repair, as appropriate to the local Trust b. Dermatologists c. Radiologists d. Pathologists e. Oncologists f. Clinical nurse specialists [CNS] g. MDT co-ordinator/data clerk *(Skin Only)*
	4.2 The SPCT should be sufficiently staffed to allow direct assessment of patients with life-threatening illness in all care settings during normal working hours, as agreed with the Network, seven days a week *(Palliative Care Only)*
	4.2 The local and specialist Network Thyroid cancer MDTs should have contact and appropriate access to the following support staff/services, a. Fine needle aspiration cytology service b. Clinical Geneticist c. Clinical Biochemist d. Nuclear Medicine Physicist e. Clinical Psychologist/psychiatry f. Primary Care Team g. Social Worker *(Thyroid Only)*
	4.2 The local upper GI team should include the following specialists: a. A designated Lead Clinician [normally a physician or surgeon] b. One or more designated physicians or surgeons specialising in gastroenterology c. Endoscopist d. Oncologist e. Palliative physician/nurse – member of the specialist palliative care team f. Histopathologist g. Radiologist with expertise in cross-sectional imaging [US, CT, MR] h. A clinical nurse specialist with knowledge of endoscopy i. MDT co-ordinator/data clerk *(Upper GI Only)*
	4.2 The local and specialist Network or supra Network urological cancer MDTs should include the following specialists with an interest in urological cancers who should have time allocated to prepare for and attend the MDT meeting: a. A minimum of two urologists who are registered on the Specialist Register b. Radiologists c. Pathologist d. Oncologists e. Palliative care physician/nurse: member of a specialist palliative care team

	f. Clinical nurse specialists in urological cancer g. MDT co-ordinator/data clerk *(Urological Only)*
	4.3 The MDT should have a named contact and appropriate access to the following support staff/services. 1. Plastic surgery 2. Orthopaedic surgery 3. Neurosurgery 4. Cancer genetics 5. Palliative care physician/nurse - members of a specialist palliative care team. 6. Clinical Psychologist/psychiatry. 7. Lymphoedema services. 8. Physiotherapy. 9. Allied Health Professionals. 10. Primary care team. 11. Social work.
	4.3 Patients requiring emergency care and not initially managed by the colorectal MDT should be referred to the MDT following diagnosis and emergency treatment. *(Colorectal Only)*
	4.3 The gynaecological Cancer Network MDT should include the following specialists with an interest in and designated time for gynaecological cancer work and participation in the Network MDT meeting: a. Two gynaecological oncologists [subspecialists who specialise in surgery for gynaecological cancer] b. Clinical oncologist c. Cytopathologist d. Radiologist e. Nurse specialist in gynaecological cancer f. Palliative care physician/nurse – member of the specialist palliative care team g. MDT co-ordinator/data clerk *(Gynaecology Only)*
	4.3 The Head and Neck Cancer MDT should manage at least 80 new cases of Head and Neck Cancer a year. This should be reviewed on the publication of the NICE service guidance *(Head & Neck Only)*
	4.3 The local and specialist Network skin cancer MDTs should have contact and appropriate access to the following support staff/services, a. Lymphoedema services b. Physiotherapy c. Clinical Psychologist/psychiatry d. Primary Care Team e. Social work f. Plastic surgery g. Allied health professionals *(Skin Only)*
	4.3 The SPCT should make arrangements for direct patient assessment by core team members in exceptional circumstances outside normal working hours *(Palliative Care Only)*
	4.3 The specialist Network/supra Network MDTs should include the following specialists with a major interest in oesophago-gastric, pancreatic and liver tumours a. Surgeons b. Cross sectional imaging radiologist c. Interventional radiologist d. Pathologist

	e. Gastroenterologist f. Anaesthetist g. Radiation oncologist *(Upper GI Only)*
	4.3 The local and specialist Network urological cancer MDTs should have contact and appropriate access to the following support staff/services, a. Primary care team b. Clinical psychologist/psychiatry c. Clinical genetics/genetics counselling d. Lymphoedema services e. Social work f. Allied Health Professionals g. Stoma nurse h. Advisor/counsellor in cancer and psychosexual problems *(Urological Only)*
	4.4 A regular team meeting should form the basis of clinical management and inter-team communication. *(4.3 in Lung)*
	4.4 Patients considered to have resectable liver metastases should be referred to a specialist hepato-biliary MDT *(Colorectal Only)*
	4.4 The Gynaecological Cancer Network MDT should have contact and appropriate access to the following support staff/services, 1. Psychosexual advise/specialist counselling 2. All Wales Cancer Genetics Services *(Gynaecology Only)*
	4.4 The MDT meeting should be held at least every two weeks and should review the management of all patients currently undergoing treatment or supportive care regardless of the setting. Where inpatient treatment and care is being delivered daily team assessment of patients should be in evidence. *(Haem Only)*
	4.4 The MDT should have contact and appropriate access to the following support staff/services: a. Surgical Specialist experienced in microvascular and microneural *(Head & Neck Only)*
	4.4 Treatment recommendations should be drawn up as a formal plan by the MDT and recorded in the notes *(Lung Only)*
	4.4 Patients with advanced and metastatic malignant melanoma falling into the category of stage IIa [primary melanoma greater than 1.5 mm in depth] to stage IV [widespread metastatic malignant melanoma] should be managed by a member of the skin cancer MDT *(Skin Only)*
	4.4 The SPCT should, in agreement with the Network, ensure access to specialist palliative care telephone advice 24 hours a day 7 days a week *(Palliative Care Only)*
	4.4 Patients diagnosed on fine-needle cytology or biopsy should be referred to the MDT thyroid surgeon pre-thyroidectomy *(Thyroid Only)*
	4.4 The Local and specialist Network MDTs should have contact and appropriate access to the following support staff/services, a. Primary care team b. Clinical psychologist/psychiatry c. Social work d. Allied Health Professionals *(Upper GI Only)*
	4.4 The specialist MDT managing complex and uncommon urological cancers at the Network or supra Network level should have rapid access to the following specialists should their services be required for the management of:

	○ renal cancer [Network level] ▪ Cardiothoracic surgeon ▪ Nephrologist ▪ Access to dialysis facilities ○ prostate and bladder cancer [Network level] ▪ Colorectal surgeon ▪ Plastic surgeon ▪ Continence CNS ○ testicular cancer [supra-Network level] ▪ Vascular surgeon ▪ Access to sperm bank facilities ○ penile Cancer [supra-Network level] ▪ Plastic surgeon *(Urological Only)*
	4.5 All new breast cancer cases from whatever source should be discussed at the MDT meeting. *(Breast Only)*
	4.5 The Cancer Network should designate one colorectal cancer MDT to manage patients diagnosed with anal cancer. Membership in addition to that required for the colorectal MDT should be reviewed to take account of the NICE Service guidance *(Colorectal Only)*
	4.5 A regular team meeting should form the basis of clinical management and inter-team communication. *(Gynaecology, Thyroid & Upper GI Only)*
	4.5 Trusts either treating acute leukaemia at BCSH level 1 and/ or regularly treating less than 5 acute haematological malignancies per annum must demonstrate that they have adequate facilities and satisfy the Network that there is a need for them to continue such treatment. *(Haem Only)*
	4.5 The MDT should be supported by a well equipped maxillofacial laboratory *(Head & Neck Only)*
	4.5 Clinicians who are not members of the MDT have an obligation to discuss and refer on if appropriate patients presenting to them are subsequently found to have lung cancer *(Lung Only)*
	4.5 Patients with non-melanoma that should be reviewed by a member of the MDT are those with, a. Multiple skin lesions. b. Recurrent skin lesions. c. Large lesions near important anatomical structures *(Skin Only)*
	4.5 If not already core team members, the SPCT should have access to: a. An occupational therapist and physiotherapist, with specialist training as defined by the NICE guidance on Supportive and Palliative Care and designated time to assess and provide palliative rehabilitation b. Appropriate mental health specialist to provide specialist psychological and/or psychiatric intervention at level 3 and level 4 as defined by the NICE Guidance on Supportive and Palliative Care c. A suitably qualified spiritual care provider, such as an authorized healthcare chaplain, to provide support and liaise with local faith leaders d. Input from site-specific cancer MDTs e. A named pharmacist with a special interest in Palliative Care f. Other appropriate Allied Health Professionals: Dietician and Speech and Language therapist *(Palliative Care Only)*
	4.6 The MDT should agree a means of rapid communication to facilitate clinical management of selected cases should they present after the regular team meeting. *(Gynaecology Only)*
	4.6 The MDT should ensure that all relevant sections of the all Wales Cancer Data Set are completed for each new

	patient diagnosed with cancer. (4.7 in Gynaecology)
	4.6 Cancer Network/s should ensure that adequate cover between local colorectal MDTs and the Network colorectal/anal cancer MDT *(Colorectal Only)*
	4.6 High dose therapy with progenitor cell transplantation should be carried out only in centres that meet The Joint Accreditation Committee ISCT-EBMT [JACIE] accreditation standards and carry out a minimum of 10 autologous and/or 10 allogenic stem cell transplant procedures per year. MDTs undertaking less transplant procedures should only do so in agreement with their Network and must be able to demonstrate adequate staffing, facilities, management according to clinical protocols. In addition the unit should demonstrate a clinical and managerial relationship with a larger accredited transplantation centre *(Haem Only)*
	4.6 CT, MRI, ultrasound, ultrasound guided fine-needle aspiration, videofluoroscopy and nuclear medicine facilities should be readily available *(Head & Neck Only)*
	4.6 The responsible clinician will communicate the treatment plan to the patient *(Lung Only)*
	4.6 When a diagnosis of a rare skin cancer or a cutaneous lymphoma is made, the details of the patient should be sent to appropriate members of the MDT and advice on further management given if necessary *(Skin Only)*
	4.6 The Cancer Network/s and their SPCTs should work together to ensure adequate sharing of specialist resources between SPCTs to meet patient need *(Palliative Care Only)*
	4.7 The MDT should participate in all Wales clinical audits as specified by the CSCG All Wales Breast Cancer Steering Group. *(Breast Only)*
	4.7 A regular team meeting should form the basis of clinical management and inter-team communication. This should be reviewed on publication of the NICE service guidance *(Colorectal & Skin)*
	4.7 Facilities for the assessment of speech and swallowing function, including videofluoroscopy should be available *(Head & Neck Only)*
	4.7 Nurses and Allied Health and social care Professionals working as part of the specialist team should have a post registration qualification in palliative care appropriate to their professional role *(Palliative Care Only)*
	4.8 The MDT should participate in Network-wide clinical audit as specified by the Network Breast Cancer Advisory Group. *(Breast Only)*
	4.8 The MDT should agree a means of rapid communication to facilitate clinical management of selected cases should they present after the regular team meeting. *(4.6 in Gynaecology, 4.7 in Haem, 4.6 in Upper GI)*
	4.8 There should be an active programme of surgical voice rehabilitation for laryngectomy patients *(Head & Neck Only)*
	4.8 Each SPCT within a Cancer Network should have access to specialist palliative care inpatient facilities capable of addressing complex symptom or other needs not readily met in other settings *(Palliative Care Only)*
	4.9 The MDT should ensure that all relevant sections of the all Wales Cancer Data Set are completed for each new patient diagnosed with cancer. *(4.7 in Gynaecology & Lung, 4.13 in Head & Neck, 4.7 in Upper GI)*
	4.9 Cancer Networks should work collaboratively to ensure adequate specialist cover for Network MDTs *(Head & Neck Only)*
	4.9 Specialist inpatient units should have sufficient core staff to provide 24 hour medical cover *(Palliative Care Only)*
	4.10 The MDT should participate in all Wales clinical audits as specified by the CSCG all Wales Steering Group. *(4.8 in Gynaecology & Lung, 4.8 in Haem, 4.14 in Head & Neck, 4.12 in Palliative Care, 4.7 in Thyroid, 4.8 in Upper GI)*
	4.10 A regular team meeting should form the basis of clinical management and inter-team communication *(Head & Neck Only)*
	4.10 All cancer patients referred to the SPCT should be discussed by the team at the first available meeting *(Palliative Care Only)*

	4.11 The MDT should participate in Network-wide clinical audit as specified by the Network Advisory Group. ***(4.9 in Gynaecology, 4.9 in Haem & Lung, 4.15 in Head & Neck, 4.13 in Palliative Care, 4.8 in Thyroid, 4.9 in Upper GI)***
	4.11 The MDT should agree a means of rapid communication to facilitate clinical management of selected cases should they present after the regular team meeting *(Head & Neck Only)*
	4.11 The SPCT should agree mechanisms for collection of the Welsh Palliative Care Minimum Dataset on each of its patients *(Palliative Care Only)*
	4.12 The MDT should hold a regular team meeting in addition to joint clinics for the purposes of clinical audit and inter team communication *(Head & Neck Only)*
CURRENT STATUS AND ACTIONS:	**Gynaecology** 4.2 No Oncologist at MDT and no CNS in post in S, No radiology cover in N. 4.5 Only 6 MDT meetings reported in year in N. 4.7 Number of new cases referred to MDT recorded but no core dataset collected or entered on CANISC. **Action Seek additional resources for CNS. Network to discuss with Velindre Oncology input to MDT. Medium term – link MDT's via videoconferencing. Provide cover radiology support from S. Cancer team to support MDT in CANISC proforma completion.** **Lung** 4.2 No Thoracic surgeon present at MDT in S although input via videoconferencing in place. Oncology attendance 60% in S.SPR Oncology cover only in N. Incomplete returns both N & S, missing attendance data of MDT members. 4.5 No confirmation of policy for referral by non MDT members in S. 4.6 No audit demonstrated communication of treatment plan to patient by responsible clinician N or S. 4.7 No numbers of patients referred for surgical opinion or re-section captured N or S. **Action Network to review Oncology attendance and cover arrangements with Velindre. Improved recording of attendance by MDT coordinators. Reconfirm referral policy for non MDT members. Patient survey planned with Trust and LHB Clinical Audit teams. Information on resection to be routinely collected by cancer team.** **Colorectal** 4.2 No cover for oncologist and poor oncology attendance in S. No cover for Histopathologist or Oncologist in N. 4.3 97% of patients referred to MDT following emergency care in S. Audit due in N therefore no % known. 4.5 Documented referral pathway between MDT and Network Sp Anal cancer MDT in S, Not answered in N. 4.9 Number of resections with curative intent not known N or S. 4.10 No participation in network audit N. **Action Review Oncology attendance and cover arrangements with Velindre. Histopathology cover in N to be provided from S. Audit plan to be developed by MDT, referral pathway S to be adopted in N, information on resection to be routinely collected by cancer team. Participation in National Audits to be mandated and supported through cancer team.** **Haematology** 4.2 to 4.5 Cancer leads attend network MDT and also have local team meetings. No Palliative Care members or

MDT admin support or oncology covering. No policy detailing daily assessment of patients receiving Inpatient care and treatment.
4.6 No information ob patient numbers in the South.
ACTION Confirm with SEWCN that protocol for patient management with network MDT and local team members is acceptable. Network to review oncology cover arrangements. Introduce process to capture all Haematological Cancers including Myeloma.

Breast
4.1 Single handed consultant in the North. No Radiologist reported > 500 symptomatic mammograms. No audit of appropriateness of referrals. No mechanism for monitoring referral policy for non MDT members.
ACTION Trust to appoint a single breast cancer lead over both sites. Link MDT via video conferencing to ensure clinical management of patients is consistent. Enhance MDT admin support in the North. Ensure audit programme developed by MDT.

Skin
4.1 No mechanism for monitoring referral policy for non MDT members. GP's treating Skin Cancer do not follow MDT clinical protocol in the North & South.
4.2 No functioning MDT in the South. The North does not have CNS or Oncologist.
4.4 – 4.6 No referral guidelines or audit of compliance for patients with advanced disease, lesions or rare cancer treated by MDT member
4.7 No agreed written protocols between specialist skin and local MDT.
4.10 Patients not being recorded on core dataset in the South.
4.11 No participation in audits.
ACTION Trust to appoint single skin cancer lead clinician. Single MDT to be held covering patients from both sites. Trust to seek additional resources for CNS. Clinical protocols and referral guidelines to be developed by MDT. Dataset information to be captured at MDT meeting by cancer team. Audit programme to be developed by MDT.

Palliative Care
4.1 No MDT admin support in the South. No MDT attendance numbers reported in the South.
4.3 7/7 assessment not available in the South. Both consultants part of SEWCN rota 24/7 medical advice.
4.5 No OT or SP therapist in the South. No OT or SP therapist except Inpatient in the North.
4.9 Inadequate 24hr cover in Inpatient units in the North & South.
4.11 Clinical data not recorded in the North & South.
4.12 No audit submitted to All Wales/UK Clinical Trials in the North.
ACTION Increased admin support to be identified and resources sought. SEWCN to address 7/7 and 24/7 cover issues across network. Audit programme to be devolved. OT & SP therapy input to be agreed within Trust.

Upper GI
4.1 No mechanism for monitoring referral policy for non MDT members.
4.2 Cover surgeon not MDT member plus poor oncology attendances and no cover and no cover for CNS in the

	South. **ACTION A single Trust Upper GI Cancer lead has been appointed. Cross cover arrangements to be agreed. Network to review oncology issues with Velindre Trust.** **Urology** 4.1 No mechanism for monitoring referral policy for non MDT members. 4.2 New arrangements in place for simple MDT Meeting. 4.7 Patient data entered onto BAUS not CANISC in the South. **ACTION The Trust has appointed a single Urology Cancer lead and is providing a single service across tow sites with a weekly MDT. MDT clinical support provided through network resources. Audit programme to be developed by MDT. The South is migrating to CANISC following agreed BAUS audit extract.** **Head & Neck** 4.1 1 No mechanism for monitoring referral policy for non MDT members. GP's treating Skin Cancer do not follow MDT clinical protocol in the North & South. 4.2 No CNS, Dietician or Dental Hygienist in MDT. 4.3 No numbers of patients managed by MDT provided. 4.13 Core dataset not complete in the North. 4.13 No information on resection numbers provided. 4.13 No participation in audits. **ACTION A single Trust Head & Neck cancer lead has been appointed. Single MDT weekly now covering both sites. Funding sought for CNS, Dietician and Dental Hygienist. Dataset compliance following new MDT arrangements. Clinical protocols and referral guidelines to be developed by MDT. Audit programme to be agreed by MDT.**
Objective 5: Patients with Breast cancer should be referred, diagnosed and treated promptly.	**5.1 The Cancer Network breast cancer advisory group should agree referral guidelines for use by the MDTs and GPs, which should be revised on publication of the NICE referral guidelines.**
	5.1 SPCTs within each Cancer Network and their referring clinicians should agree referral criteria, and where appropriate discharge criteria, for core palliative care services [inpatient care, outpatient clinics, day care facilities and community-based care] in line with the recommendations of the NICE guidance. There should be, within each Network, a service directory clarifying the contact points for, and types of service provided by, NHS and voluntary palliative care services. *(Palliative Care Only)*
	5.2 Written referral pathways should be drawn up by the MDTs in collaboration with primary care which detail the patient journey from whichever point patients access the system.
	5.2 The agreed referral pathway must provide explicit information on how to access services not directly provided by the SPCT including psychological support services, spiritual care, family and carer support services and complimentary therapy services. *(Palliative Care Only)*
	5.3 There should be explicit arrangements for referral to the specialist hepato-biliary and pancreatic MDTs *(Colorectal Only)*
	5.3 The Network should ensure that referral pathways are adhered to particularly where pathways cross Trust or Network boundaries. *(5.4 in Colorectal)*
	5.3 There should be explicit arrangements for referral to designated centres for radiotherapy, bone marrow/stem cell harvesting and transplantation.

	Referral Pathways should be identified for a. Stem cell Transplantation b. Allogenic Transplantation c. Matched unrelated donor transplantation *(Haem Only)*
	5.4 Patients presenting to their GP with symptoms within the criteria for suspected cancer should be referred as 'urgent suspected cancer' to the MDT. *(5.5 in Colorectal & Haem)*
	5.4 The Network should ensure that referral pathways are adhered to particularly where pathways cross Trust or Network Boundaries *(Haem Only)*
	5.4 Patients referred to the SPCT for urgent review of uncontrolled symptoms should be assessed within 2 days of referral. *(Palliative Care Only)*
	5.5 Patients referred as urgent suspected cancer by the GP and confirmed as urgent by a member of the MDT or their representative should, if diagnosed with breast cancer, start definitive treatment within 2 months of the receipt of the referral at the hospital. *(5.6 in Colorectal & Haem)*
	5.5 The Network should agree with its SPCTs time limits for initial and follow up assessment, treatment and care of patients and carers referred for non-urgent evaluation. *(Palliative Care Only)*
	5.6 The GP should be informed if the specialist downgrades an urgent suspected cancer referral to non-urgent. *(5.7 in Colorectal & Skin, 5.8 in Haem)*
	5.6 Patients referred as urgent suspected cancer by their GP and confirmed as urgent by a member of the MDT or their representative should, if diagnosed with SCC, start definitive treatment within 2 months of receipt of the referral at the hospital. *(Skin Only)*
	5.7 Results of diagnostic tests should be communicated to patients within 1 week of the last diagnostic procedure. *(Breast Only)*
	5.7 Patients with acute leukaemia, if considered suitable for treatment, should start definitive treatment as soon as possible and always within one month of receipt of the referral at the hospital. *(Haem Only)*
	5.7 Confirmation of the diagnoses of cancer should reach the GP within 24 hours of the patient being informed. *(5.9 in Heam & 5.10 in Skin)*
	5.8 When diagnosed with cancer, patients not already included as an urgent suspected cancer referral should start definitive treatment within 1 month from diagnosis regardless of referral route. *(5.10 in Breast 5.9 in Colorectal)*
	5.9 Patients should be seen by the breast cancer Clinical Nurse Specialist [CNS] when informed of a diagnosis of cancer. *(Breast & 5.8 in Lung)*
	5.9 Patients diagnosed with Head and Neck cancer should be offered a consultation with the head and neck specialist nurse within 1 week of diagnosis *(Head & Neck Only)*
	5.9 Patients with BCC should be seen by the relevant specialist, normally a dermatologist, within 2 months of receipt of the referral by the GP. Following assessment, times to definitive treatment for patients with basal cell carcinoma will depend on clinical necessity but should not exceed an additional 3 months from the date first seen by a specialist. *(Skin Only)*
	5.9 Patients undergoing orchidectomy for testicular cancer should have their operation within 2 weeks from clinical diagnosis . *(Urological Only)*
	5.10 Patients, regardless of referral categorisation, diagnosed with Small Cell Lung Cancer [SCLC] and referred for first-line chemotherapy should start treatment within 2 weeks of date of diagnosis *(Lung Only)*
	5.11 Patients undergoing radiotherapy should be treated within the maximum waiting times as recommended by The Joint Council for Clinical Oncology [JCCO]. *(Breast Only)*

CURRENT STATUS AND ACTIONS:	**Colorectal** 5.5 No audit of appropriateness of urgent referrals in N, in S audit commenced results not yet available. 5.7 No information reported on number of GP's receiving cancer diagnosis within 24 hrs. **Action Ensure audit plan devised by MDT. Ensure cancer confirmation proforma system adopted by MDT members.** **Gynaecology** 5.4 No audit of appropriateness of urgent referrals in N, in S audit commenced results not yet available. 5.6 No information on whether GP informed if referral downgraded to non urgent in N or S. 5.7 No information reported on number of GP's receiving cancer diagnosis within 24 hrs in N, in S audit commenced results, not yet available. **Action Ensure audit plan devised by MDT. Ensure cancer confirmation proforma system adopted by MDT members.** **Lung** 5.4 No audit of compliance with referral criteria in the South. 5.7 No audit yet reported of 24hr GP notification. 5.8 90% of patients in the South seen by CNS on diagnosis. No data shown for the North. 5.10 Patients with SCLC having first line Chemotherapy within 2 weeks. No data in the South, 50% compliance in the North. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Haematology** 5.1 No audit in the North or South of appropriateness of Urgent Suspected Cancer referrals. 5.3 & 5.4 No shared care protocols in place in the North or South. 5.7 No audit in the North or South of patients with acute leukaemia started treatment within 31 days. 5.9 No audit yet reported of 24hr GP notification. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Breast** 5.7 92% of the South patients told of results of diagnostic tests within 1 week. The North is not audited. 5.8 No audit yet reported of 24hr GP notification. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Skin** 5.4 audit in the North or South of appropriateness of Urgent Suspected Cancer referrals. 5.5 No audit completed on start of treatment within 6 weeks for malignant melanoma. 5.7 No audit where patients were downgraded to Non Urgent Suspected Cancer. 5.9 No audit of BCC patient's treatment times.

	5.10 No audit yet reported of 24hr GP notification. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Palliative Care** 5.1 No network agreed referral proforma in the North or South. 5.2 Network director does not have copy of the agreed care pathways for North or South. 5.3 No audit of adherence to referral pathways in the North or South. 5.4 Numbers of patients seen within 2 days with u/controlled symptoms = 30% in the North & 40% in the South. **ACTION Referral proforma to be approved by MDT's. Audit Programme to be agreed by MDT's. MDT's to review prioritisation processes for patients with u/controlled symptoms. Network address access issues 7/7 & 24/7.** **Upper GI** 5.4 No audit in the North or South of appropriateness of Urgent Suspected Cancer referrals. 5.6 No audit where patients were downgraded to Non Urgent Suspected Cancer. 5.7 No audit yet reported of 24hr GP notification. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Urology** 5.3 No audit of compliance with referral criteria in the South. 5.4 No audit in the North or South of appropriateness of Urgent Suspected Cancer referrals. 5.6 No audit where patients were downgraded to Non Urgent Suspected Cancer. 5.7 No audit yet reported of 24hr GP notification. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Head & Neck** 5.1 No network agreed referral proforma in the North or South. 5.2 Network director does not have copy of the agreed care pathways for North or South. 5.3 No audit of adherence to referral pathways in the North or South. 5.4 No audit of compliance with referral criteria in the South. 5.6 No audit where patients were downgraded to Non Urgent Suspected Cancer. 5.7 No audit yet reported of 24hr GP notification. **ACTION Referral proforma to be approved by MDT's. Audit Programme to be agreed by MDT's. MDT's to review prioritisation processes for patients with u/controlled symptoms. Network address access issues 7/7 & 24/7. Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.**
Objective 6:	**6.1 Clinical management of patients including follow-up should follow written locally agreed, clinical policies, in-line**

Patients with Breast cancer should be diagnosed, staged and treated promptly and in-line with best practice guidelines.	**with the NICE service guidance and clinical guidelines when published. These clinical polices should be developed by the Network cancer site advisory group for use by MDTs within the Network.**
	6.1 Written, locally agreed, clinical and service guidelines should be provided by the Network palliative care advisory group for use by Network SPCTs. These should incorporate the NICE guidance on Supportive and Palliative Care and be consistent with the clinical guidelines recommended by the All Wales Palliative Medicine Consultants Group. These clinical and service guidelines will need to take account of new NICE and other national guidance publications when issued. *(Palliative Care Only)*
	6.2 Each MDT should provide a written programme of audit to assess adherence to clinical policies.
	6.2 The SPCT should work to guidelines, agreed with the Network, for patient assessment in relation to the following potential needs: a. Symptom control b. Functional c. Psychological d. Social e. Those of the carer *(Palliative Care Only)*
	6.3 New breast cancer patients should be offered pre-, peri- and post-operative nursing care by the breast cancer CNS. *(Breast only)*
	6.3 Patients should be given the opportunity to enter approved clinical trails for which they fulfil the entry criteria. *(Standard 6.4 in Breast)*
	The SPCT should work to guidelines, agreed with the Network, for management of palliative care needs in at least the following situations: o Control of specific symptoms o Common palliative emergencies o End of life care , to include families and carers *(Palliative Care Only)*
	6.3 Patients being treated in hospitals providing a service level >1 [BCSH Guidelines] must have emergency access to the MDT *(Haem only)*
	6.3 More than 60% of patients with small cell lung cancer and more than 10% of patients with non small cell lung cancer should receive chemotherapy *(Lung only)*
	6.3 Patients should be seen by the skin cancer CNS when informed of a diagnosis of cancer *(Skin only)*
	6.4 The SPCT should support research into models or types of intervention and measurement of outcomes important to patients and carers *(Palliative Care Only)*
CURRENT STATUS AND ACTIONS:	**Gynaecology** 6.2 Local policies in place but no audit of adherence in the North and South. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Lung** 6.2 policies in place but no audit of adherence in the North. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.**

	Colorectal 6.1 Locally agreed policies only in N not endorsed by network. 6.2 No audit of clinical policy adherence in N. **Action Ensure audit programme devised by MDT. N to review policies in S and adopt by MDT members.** **Haematology** 6.2 Local policies in place but no audit of adherence in the North and South. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Breast** Nothing to report. **Skin** 6.2 Local policies in place but no audit of adherence in the North and South. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members. Funding sought for CNS.** **Palliative Care** 6.1 Local policies in place but no audit of adherence in the North and South. 6.4 No patients referred for research studies in the North and South **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members. MDT to review criteria for patients for research.** **Upper GI** 6.1 Local policies in place but no audit of adherence in the North and South. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Urology** 6.1 Local policies in place but no audit of adherence in the North and South. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.** **Head & Neck** 6.1 Local policies in place but no audit of adherence in the North and South. **ACTION Audit programme to be agreed with Trust/LHB clinical audit teams and supported by MDT and Cancer team. Improved data capture by MDT members.**

Objective 7: The MDT should have access to high quality imaging services.	7.1 Imaging departments should provide clear, written information to MDTs on the range of investigations provided, and their availability. Where availability is limited or intermittent, particularly for complex investigations, there should be written alternative referral pathways agreed with the Cancer Network. *(Breast only)*
	7.2 All Departments of Clinical Radiology should have written policies on the referral and imaging investigation of patients with caner or suspected cancer by cancer site. These should reflect the latest advice from the Royal College of Radiologists [RCR]. *(Breast only)*
	7.3 Standardised imaging protocols for staging should be agreed within teach Cancer Network. *(Breast only)*
	7.4 Staging should be reported in standardised format agreed within each Cancer Network. *(Breast only)*
	7.4 New Patients diagnosed with colorectal cancer should have their liver imaged by either CT or MRI unless this information would have no influence on management *(Colorectal only)*
	7.5 Each MDT should have access to specialist opinion for radiological diagnosis and staging where appropriate. *(Breast only)*
	7.5 There should be access to appropriate pre-operative CT or MRI facilities *(Gynaecological Only)*
	7.5 Each MDT should have access to specialist opinion for radiological diagnosis and staging where appropriate.
	7.6 Specialist radiologists should have regular sessions in their area of expertise identified in their job plan.
CURRENT STATUS AND ACTIONS:	**Gynaecology** 7.5 Percentage of cervical cancer patients who had pre treatment MRI not know in the North and South. **ACTION Implement appropriate data capture process with MDT and audit team.** **Colorectal** 7.4 No audit of CT or MRI of liver in N. Audit shows 94% in S. 7.5 No access to specialist radiological opinion outside of MDT in N. **ACTION Ensure audit plan devised by MDT, clinical information capture to be automatic. Specialist Radiological opinion from South to be provided.** **Palliative Care** – 7.1 No audit of percentage of patients where notes were available at first assessment in the North. **ACTION Improve record keeping to actively record numbers during the assessment.**
Objective 8: The MDT should have access to high quality Pathology services.	8.1 Please complete the following to signoff this standard *(Palliative Care only)*
	8.1 All pathology laboratories should participate in Technical External Quality Assessment [EQA] and Clinical Pathology Accreditation [CPA]. *(Breast only)*
	8.2 Reports on resection specimens should comply with all items of the pathology component of the all Wales Cancer Data Set. *(Breast Cancer only)*
	8.2 All histopathologists reporting haematological malignancies should participate in a diagnostic EQA scheme *(Haem only)*
	8.3 Each Cancer Network or group of Networks has designated specialist haematopathologist/s such as provided by the all Wales

	Lymphoma Review Panel *(Haem only)*
	8.3 Pathologists reporting breast cancer specimens should participate in the appropriate Breast Histological EQA Scheme. . *(Breast only)*
	8.3 Each MDT has a mechanism for access to specialist opinion for histopathological diagnosis and classification where appropriate.
	8.3 Pathologists throughout the Network should ensure that diagnostic biopsy samples that show thyroid cancer are reviewed by a pathologist with a particular interest in thyroid disease who attends the MDT meeting *(Thyroid only)*
	8.4 Each MDT has a mechanism for access to specialist opinion for histopathological diagnosis and classification to difficult lesions where appropriate. *(Breast only)*
	8.4 Specialised techniques in molecular diagnostics and cytogenetics should be integrated with morphological diagnosis where appropriate*(Haem only)*
	8.4 Each Cancer Network or group of Networks has designated specialist histopathologists.
CURRENT STATUS AND ACTIONS:	**Heamatology** 8.4 Access to specialised techniques in Molecular diagnostics and Cytogenetics not specified in the North and South ACTION MDT to review and document process for access in specialised techniques.
Objective 9: Surgical management of Gynaecological cancer patients requires appropriately designated, staffed and resources facilities	9.1 The local Gynaecological cancer MDT should carry out initial assessment and diagnostic procedures for women referred with possible or suspected gynaecological cancer. The lead gynaecologist should normally carry out surgery for endometrial cancer [stage1a or 1b, grade 1 or 2] and for pelvic masses where the risk of malignancy is low *(Gynaecology Only)*
	9.1 Patients undergoing surgery should be cared for on wards specialising in surgery of the head and neck *(Head & Neck Only)*
	9.1 Upper GI cancer patients should be managed by a specialist upper GI MDT with care provided by the local and specialist Network MDT as agreed by the Network *(Upper GI Only)*
	9.1 Surgery for urological cancer should only be performed by or under the supervision of designated urologists who are registered on the Specialist Register *(Urological Only)*
	9.2 Management of women with ovarian cancer, later stage endometrial cancers [stage 1c to iv] and all cancers of the cervix, vulva or vagina should be by the gynaecological Cancer Network or Supra-Network MDT *(Gynaecology Only)*
	9.2 Nursing care should be co-ordinated by specialist nurses with post-registration training in cancer or palliative care or head and neck counselling skills *(Head & Neck Only)*
	9.2 The local Upper GI MDT and specialist upper GI MDTs should agree referral guidelines in-line with IOG guidance and as agreed by the Network *(Upper GI Only)*
	9.2 The management of complex and uncommon urological cancers should be undertaken by the Specialist urological MDT at Network or supra Network level a. Renal cancer. The Network specialist MDT should manage tumours involving the inferior vena cava, bilateral tumours or tumours in a solitary kidney requiring nephron-sparing surgery and patients with von Hippel-Lindau disease b. Prostate and bladder cancer. The Network specialist MDT should perform radical surgery working in a single site. Surgeons carrying out 5 or less radical procedures for either prostate or bladder cancer per year should refer to designated surgeons who are members of the specialist MDT c. Testicular cancer. A supra Network specialist MDT should manage all new cases of testicular cancer

	d. Penile cancer. A supra Network specialist MDT should manage all new cases of penile cancer *(Urological Only)*
	9.3 Specialist teams performing complex gynaecological operations at Network and/or supra-Network level should be backed up by dedicated anaesthetic and theatre staff, specialist nurses, appropriate intensive care facilities and emergency radiological support and by colleagues with experience to provide cover during periods of absence *(Gynaecology Only)*
	9.3 There should be specialist expertise in airway management and the management of the tracheostomy site *(Head & Neck Only)*
	9.3 Curative resectional surgery should be carried out by a specialist gastro-oesophageal, pancreatic or hepatobiliary MDT. Surgical procedures should be carried out in appropriate centres and include, a. Partial and total gastrectomy including, in selected cases, extended lymphadenectomy b. Subtotal oesophagectomy c. Laryngo/pharyngo oesophagectomy in association with specialist ENT surgeons d. Pancreatectomy e. Liver resection f. Bile Duct resection *(Upper GI Only)*
	9.3 Specialist teams performing complex urological operations at Network and/or supra-Network level should be backed up by dedicated anaesthetic and theatre staff, specialist nurses, appropriate intensive care facilities and emergency radiological support and by colleagues with experience to provide cover during periods of absence *(Urological Only)*
	9.5 Surgeons should be backed up by dedicated anaesthetic and theatre staff, specialist nurses, appropriate intensive care and high dependency facilities and emergency radiological support by colleagues with experience to provide cover during absence or illness *(Upper GI Only)*
	9.6 Anaesthetists should be experienced in thoracic epidural and one-lung ventilation techniques and anaesthesia for liver resection *(Upper GI Only)*
CURRENT STATUS AND ACTIONS:	**Gynaecology** 9.1 No audit reported of percentage of surgery for early stage endometrial cancer in the South. 9.2 No data on number of patient managed through MDT in the South. **ACTION** Audit under way in the South for early stage endometrial cancer. Cancer team to work with MDT lead to ensure data set requirements are met in the South. **Upper GI** 9.1 Network service model with teams undertaking local and network level services is not in line with NICE guidance and standards in North and South. 9.3 No data provided on number of re-sectional surgeries with curative intent in the year for North and South. 9.5 No dedicated Upper GI theatre with senior staff in the North. **ACTION** The network is developing a service model which complies with NICE, Trust will support this model. Network re-configuration will address re-sectional surgery issue. MDT lead to review theatre provision. **Urology**

	9.2 No data provided on number of complex renal, radical bladder, prostate surgery and testicular and penile cancers managed by MDT for North and South. **ACTION** Single MDT lead to ensure that cases are referred on for management at the appropriate level. **Head & Neck** 9.1 No dedicated Head & Neck ward. **ACTION** Await outcome of network discussions. Following network decisions on service provision MDT lead to review appropriateness of Head & Neck beds/ward.
Objective 11: To ensure that all patients receive adequate assessment of, and provision for, their Palliative care needs at all times and in every setting. This includes care of dying patients, their families and carers.	11.1 All health professionals engaged in care should receive training to allow adequate assessment and delivery of general palliative care *(Breast Only)*
	11.2 There should be clear arrangements to access specialist palliative care services
	11.3 Palliative care needs should be rapidly addressed, and specialist palliative care advice available, in all settings 24 hours a day
	11.4 An integrated system should be in place in all care settings to ensure best practice in the multi professional care of dying patients. The All Wales Care Pathway for the Last Days of Life represents an appropriate model
	11.5 All profession-specific teams engaged in palliative care provision such as nursing, physiotherapy, occupational therapy, should have at least one member who has undergone post-registration education and training in palliative care *(Breast Only)*
	No Objective 11 in Gynaecology, Head & Neck, Palliative Care, Upper GI & Urological.
CURRENT STATUS AND ACTIONS:	**Compliance reported with standards in this area.**
Objective 12: Signoff *No Objective 12 in Palliative Care*	**12.1 Please complete the following to signoff this standard**

	12.2 There should be clear arrangements to access specialist palliative care services *(Gynaecological & Head & Neck & Upper GI & Urological)*
	12.3 Palliative care needs should be rapidly addressed, and specialist palliative care advice available, in all settings 24 hours a day *(Gynaecological & Head & Neck & Upper GI & Urological)*
	12.4 An integrated system should be in place in all care settings to ensure best practice in the multi professional care of dying patients. The All Wales Care Pathway for the Last Days of Life represents an appropriate model *(Gynaecological & Head & Neck & Upper GI & Urological)*
CURRENT STATUS AND ACTIONS:	**Compliance reported with standards in this area.**

Canisc Implementation Plan

Background

Following merger of the former North Glamorgan and Pontypridd and Rhondda NHS Trusts there is still outstanding organisational issues affecting the integration of services, which has adversely affected progress against the delivery of a number of targets, including the implementation of CANISC.
The Trust has put in place an overarching Cancer Strategy Group to oversee the development of Cancer Services across the Health Community. The constitution has been agreed and membership includes LHB and voluntary sector and patient representation.
The Trust has appointed a new Cancer Lead Clinician, supported by Lead Cancer Manager, Cancer Coordinator and 7 MDT Cancer administrators. Initial focus has been on addressing where non compliance against cancer standards and CANISC status was identified.
Each specific cancer tumour site across both former trusts has had in place a lead cancer clinician who was responsible for delivering services in line with the cancer standards. On merger, the existing management arrangements regarding the Cancer Lead Clinicians were reviewed and proposals developed.
Cancer site teams have been reviewed and merged where appropriate, and others remain separate but will work more closely and with enhanced support from the cancer teams.
Role profiles have been developed for lead clinicians which specifically identify responsibility for delivery of some of the current gaps in standards and CANISC achievement. These profiles empower the lead clinician to ensure all MDT members undertake their role in full compliance with the cancer standards and CANISC requirements.
This is being addressed through increased support of Trust cancer MDT officers who will ensure all methods of data capture are robust.

Brian Gibbons AC/AM
Y Gweinidog dros Gyfiawnder Cymdeithasol a Llywodraeth Leol
Minister for Social Justice and Local Government

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Eich cyf/Your ref P-03-170
Ein cyf/Our ref BG/00042/09

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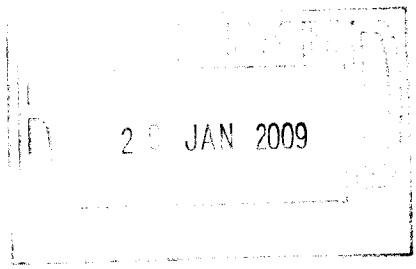

28 January 2009

Dear Val,

Petition from Mencap Cymru – more employment opportunities for people with a learning disability

Thank you for your letter of 19 January, about the employment of people with a learning disability within the Welsh Assembly Government, Assembly Commission and across the Welsh public sector. I understand that you have also written to the Permanent Secretary who I believe will respond to you separately about the employment practices of the Welsh Assembly Government.

In terms of policy development, the Welsh Assembly Government is working to promote equality of opportunity for disabled people in Wales. This is reflected in the Welsh Minister's report on the implementation of the Disability Equality Duty published on 1st December. This first report provided an overview of how public authorities in Wales are embedding disability equality into their work.

Our report sets out recommendations for how the Welsh Assembly Government will take forward and co-ordinate action by public authorities to further improve on equality of opportunity for disabled people. A copy of the report can be found on the Welsh Assembly Government website: http://wales.gov.uk/topics/equality/?lang=en

The Welsh Assembly Government is committed to promoting equality of opportunity for all people in society. Our aim is to develop policies and deliver services that are exemplar to meeting and responding to the needs of the people of Wales. In working towards this goal, we will publish our first Single Equality Scheme shortly. It will allow us to look at and tackle key equality, diversity and human rights issues across all equality strands. It will help to identify where people might face multiple barriers in their everyday lives, including access to training and employment.

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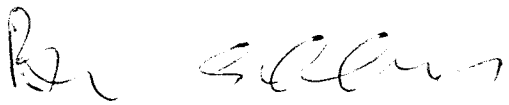
Correspondence.Brian.Gibbons@Wales.gsi.gov.uk

This will be supported by the Welsh Assembly Government's method for equality impact assessment, known as Inclusive Policy Making (IPM). The guidance also adopts a multi-strand approach and aims to reflect the principals of human rights. When used effectively, Inclusive Policy Making can remind people who develop policy and deliver services that the needs of the individual are central to what we do as a government.

Yours sincerely



Brian Gibbons AM

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Val Lloyd AM
Chair, Petitions Committee
National Assembly for Wales

Your ref: P-03-170

29 January 2009

Dear Val,

Petition from Mencap Cymru – more employment opportunities for people with a learning disability

Thank you very much for your letter of 16 January regarding the Petitions Committee's consideration of Mencap Cymru's petition to:

"urge the Assembly Commission and the Welsh Assembly Government to take a lead in employing more people with a learning disability, and to encourage other public sector employers such as the NHS and local authorities to employ more people with a learning disability."

The Assembly Commission Recruitment Policy states that all appointments must be made on merit following open and fair competition, therefore certain groups cannot be targeted for employment. However the Assembly Commission has developed initiatives to increase the amount of staff from underrepresented groups. Officials have met with Mencap caseworkers sometime ago to discuss how we might encourage more people with learning disabilities to apply for work with the Assembly Commission. At the time, no suitable opportunities were identified but it was agreed that Mencap would be alerted by our HR team as to when suitable vacancies become available. As I understand, the HR and Equality and Access Team welcome the opportunity to work with MENCAP and re-examine how we might assist MENCAP in their objective.

We are currently exploring the option of working with organisations such as MENCAP, the Job Centre and Remploy to offer 'train the trainer' sessions with the purpose of the organisations being able to provide information to their clients on our recruitment system etc. We will look at the feasibility of extending this across the other equality strands.

Also, the Assembly Commission operates the ‘Positive About Disability – Two Ticks’ Scheme which guarantees interviews to disabled candidates who meet the minimum criteria specified for the job specification. The Scheme also extends to people with learning disabilities. Furthermore, candidates that are invited to interview are encouraged to inform the HR Recruitment Team whether they have any special requirements so they can be assisted by whichever means possible. I hope that this offers reassurance to people with learning disabilities who might consider applying for a post in our organisation.

It might be helpful if, when our HR and Equality and Access Teams have re-convened with colleagues from MENCAP and the other relevant organisations, I report back to you on the outcome of those meetings.

Yours sincerely

Lorraine Barrett AM,
Commissioner for the Sustainable Assembly

Brian Gibbons AC/AM
Y Gweinidog dros Gyfiawnder Cymdeithasol a Llywodraeth Leol
Minister for Social Justice and Local Government

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Eich cyf/Your ref
Ein cyf/Our ref BG/00035/09

Val Lloyd AM
Chair
Petitions Committee
National Assembly for Wales
Cardiff Bay
Cardiff
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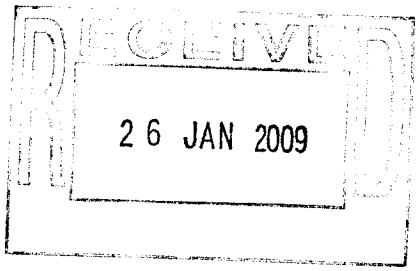

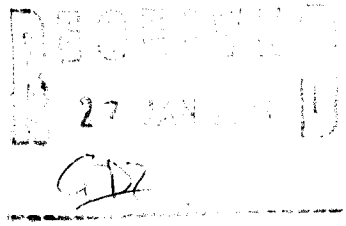

26 January 2009

Dear Val

Thank you for your letter of 19 January informing me that the Petitions Committee has received a petition about the proposed siting of a new prison in Wales and the implications if it is located in Cwmbran. I have seen a copy of the transcript.

You have asked a number of specific questions and I will answer them in turn. There has been regular correspondence and contact between myself and the Prisons Minister, David Hanson MP. In particular I wrote to David Hanson MP following the consultation last year. Our position, should the decision be to locate a prison in South Wales, was that we would prefer the Merthyr Tydfil option.

Prison matters are not devolved to Wales. They are the responsibility of the Ministry of Justice. Under the devolution settlement devolved administrations are committed to the principle of good communication especially where one administration's work may have some bearing on the responsibilities of other administrations. Where necessary the administrations should seek to give appropriate consideration to the views of other administrations. The First Minister and the Counsel General may make appropriate representations about any matter affecting Wales, so in this case Welsh Ministers were able to make representations to the Ministry of Justice concerning any consultation on the location of the proposed new prison in Wales.

Since the announcement of proposals for additional prison spaces in England and Wales, the Ministry of Justice have kept us updated on progress and we have kept them informed of Welsh opinion including the representations made from the MPs, AMs and the local population in the Cwmbran area.

We have not yet been informed of any decisions following the consultation in Wales and it will be for them to decide if they need further consultation.

Yours sincerely

Brian Gibbons AM

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Pwyllgor Menter a Dysgu
Enterprise and Learning Committee
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Val Lloyd AM
Chair of the Petitions' Committee
National Assembly for Wales
Cardiff Bay
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28 January 2009

Dear Val

Petition – Post 19 Students with Additional Learning Needs

Thank you for your letter of 22 January 2009 requesting that the Enterprise and Learning Committee consider the petition on post 19 students with additional learning needs.

I am happy to confirm that the Committee is content to undertake a short inquiry into the issues raised by this petition. We hope to scrutinise the Minister for Children, Education, Lifelong Learning and Skills and other key stakeholders toward the end of this term.

I undertake to keep you informed of the progress of our inquiry and provide you with a copy of our report on its completion.

Yours sincerely,

Gareth Jones AM
Committee Chair

Dr Kathryn Jenkins
Clerc y Pwyllgor/Committee Clerk
Kathryn.jenkins2@wales.gsi.gov.uk
Tel: 029 20 89 8501
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Dear Ms Lloyd

I refer to your letter dated 20 January 2009, on the subject of neo natal intensive care provision at Royal Glamorgan Hospital.

I can offer the following comments on the issues you have raised.

It has been difficult to recruit middle grade doctors to cover the rota for neo-natal services due to the national shortage of middle grade doctors, i.e. doctors with 2 to 3 years in the relevant specialty.

There seems to be a consequence in the changes of work permit arrangements for non E. U. doctors, which has meant that many doctors who used to come to the UK to work for a period, from India and the Indian sub continent, are now unable to gain work permits. The numbers of doctors in specialty training in England and Wales has decreased, and without the contribution of the non E U doctors it has proved impossible to cover the rotas for this service.

Similar problems exist in other areas, i.e. anaesthetics, paediatrics, and accident and emergency.

These problems are common across Wales, and indeed across the UK.

With the introduction of the EWTD in full on the 1 August 2009, the shortage of relevantly trained medical staff is likely to be a severe problem as all medical staff will be required to reduce their hours to a 48 hour working week.

I hope this information is helpful.

Yours sincerely

Margaret Foster
Chief Executive
Cwm Taf NHS Trust

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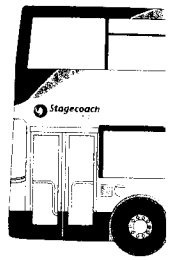


Ms Val Lloyd
Chair
Petitions Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Your Ref: PET-03-194
Our Ref: JLG/arw WAG/VL-PC
22nd January 2009

Dear Ms Lloyd,

PETITION: X38 SERVICE, RHYMMNEY VALLEY TO CARDIFF

I write in response to your letter of January 19th 2009 on the above matter.

May I firstly and respectfully point out that the X38 is and was not a contracted service. It is operated by Stagecoach on a commercial basis without subsidy and as such is wholly reliant upon the revenue provided by fare-paying and concessionary passengers for its continued existence. This has been the case from at least the mid 1980's.

As with a small number of other services operated by Stagecoach in South Wales, usage of the X38 has been in steady decline, to the extent that it has been the case for the past ten years or so that patronage has not been sufficient to cover the service's operating costs. To put this into context, prior to last October, the service averaged around 0.7 passengers carried per mile operated. The average for all services operated by Stagecoach in South Wales is 1.6. For the then timetable to become commercially viable, the number of passenger journeys would have needed to double at current prices.

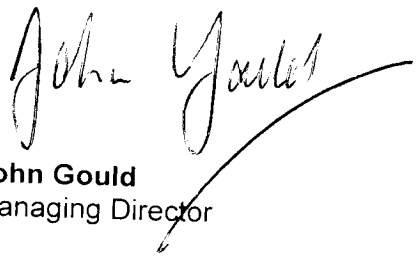
The decline in patronage has been exacerbated, it has to be said, by improvements to the train services from Bargoed, particularly since the introduction of the four trains per hour timetable in March 2006 and in the worsening economic environment and with passenger numbers continuing to fall, we found ourselves no longer able to support the erstwhile level of service from within the South Wales business.

At the time we were faced with several alternatives, namely to withdraw the service entirely, to reduce the frequency of the full service to two-hourly, or to introduce a consistent hourly timetable throughout the day between Bargoed and Pontypridd. We opted for the latter, mindful that there were nine departures per hour from Pontypridd to Cardiff. May I add that we first consulted the affected local authority (Caerphilly CBC) on this issue back in September 2007 and the statutory eight weeks notice was given to the Welsh Traffic Area Office for the changes to take effect from October 6th 2008.

Finally, I regret that, particularly in the prevailing economic climate, I am not in a position to reinstate the service to its previous level. To do so would require a subsidy in excess of £110k per annum at current prices and, for Caerphilly CBC to be able to meet this extra cost, I would hazard the guess that it would be at the expense of existing subsidy for bus services elsewhere in the county.

I am sorry that I am unable to be of further assistance on this occasion, but please do not hesitate to contact me directly in the event of further or future query.

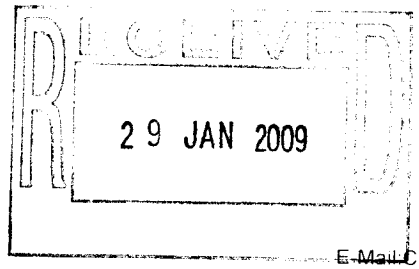
Yours sincerely,



John Gould
Managing Director

Edwina Hart AM MBE
Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Our ref: EH/00193/09
Your ref: PET/03-196



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Val Lloyd AM
National Assembly for Wales
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Dear Val

29th January 2009

Thank you for your letter dated 19 January about the Petitions Committee's consideration of the petition submitted on behalf of Mr Paul Popham, about the availability of Sutent for the treatment of renal carcinoma (P-03-196).

You will wish to be aware that, at my request, the Deputy Chief Medical Officer, Professor Mike Harmer, wrote to Local Health Boards (LHBs) on 22 January, instructing them to make the drugs bevacizumab (Avastin), sorafenib (Nexavar), sunitinib (Sutent) and temsirolimus (Torisel) available to suitable patients with immediate effect, providing that each request for funding for the life-prolonging drugs is supported by two cancer specialists.

This is a temporary arrangement that will be in place until NICE make their final decision on these drugs, and has been done to allay the anxiety felt by patients and their relatives during this interim period.

Professor Harmer is also carrying out the clinical audit that you refer to in your letter. This work is looking at the processes used by LHBs in the consideration of requests for Sutent, including the appropriateness of the request. I expect to receive his report in the next few weeks.