Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
Thursday, 20 March 2014

Meeting time:
09.20

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:
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Agenda

1 Introductions, apologies and substitutions

2 Consideration of the Minister for Health and Social Services' response to the Committee's letter regarding the follow-up inquiry into stroke risk reduction (09:20 - 09:30) (Pages 1 - 5)

3 Inquiry into access to medical technologies in Wales: Evidence session 12 (09:30 - 10:20) (Pages 6 - 28)

Velindre NHS Trust
Professor Peter Barrett-Lee, Consultant Clinical Oncologist and Medical Director.

Royal College of Radiologists Standing Welsh Committee
Dr Richard Clements, Chair of the Standing Welsh Committee, Consultant Radiologist, Aneurin Bevan University Health Board;
Dr Martin Rolles, Secretary of the Standing Welsh Committee, Consultant Clinical Oncologist, Abertawe Bro Morgannwg University Health Board.

4 Inquiry into access to medical technologies in Wales: Evidence session 13 (10:20 - 11:10) (Pages 29 - 41)

Royal College of Physicians

Dr Alan Rees, Vice President for Wales.

Welsh Association for Gastroenterology and Endoscopy

Dr Miles Allison, Consultant Physician and Clinical Director of Gastroenterology, Vice President, Aneurin Bevan University Health Board.

Royal College of Surgeons

Jared Torkington, Consultant Laparoscopic Colorectal Surgeon, Cardiff and Vale University Health Board.

Break (11:10 - 11:20)

5 Inquiry into access to medical technologies in Wales: Evidence session 14 (11:20 - 12:30) (Pages 42 - 43)

Royal College of General Practitioners

Dr Nazia Hussain, Royal College of General Practitioners Wales

6 Papers to note (Pages 44 - 46)

7 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for items 1 and 2 of the meeting on 26 March

Mark Drakeford AC / AM
Y Gweinidog lechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/0537/14

David Rees AM
Chair
Health and Social Care Committee
National Assembly for Wales
Ty Hywel
Cardiff Bay
Cardiff
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19 February 2014

Dear David,

Thank you for your letter of 9 January 2014 in which you outline the follow up work of the Committee.

Annex 1 sets out my response to the Committee's recommendations and views on progress in relation to stroke risk reduction.

Best wishes

Mark.

Mark Drakeford AC/AM
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Stroke risk reduction – follow up inquiry – Welsh Government Response

Recommendation	Response
Welsh Government publish a timetable within 6 weeks of receipt of this letter clearly setting out when it expects to fully deliver the Committee's recommendations, all of which it accepted – at least in principle – in December 2011	**Reject** We agree with the sentiment of the recommendation however we so not feel it is necessary to publish a timetable as suggested in light of the fact that the Welsh Government published the Stroke National Delivery Plan in December 2012 which set out Welsh Government expectations and a timetable for stroke improvement. The first Annual Report on progress against that plan was published in October 2013, and will continue to be published on an annual basis. The Government therefore has a clear set of actions for which it is accountable and we wish to avoid the duplication and compilation of different timetables. The recommendations are covered within the Delivery Plan as set out below: Recommendation 1 of the original Committee Report refers to undertaking an evaluation of the Stroke Risk Reduction Action plan and utilising this to inform the Delivery Plan. Public Health Wales undertook the evaluation and it was used to inform the actions within Delivery theme 1 of the plan on the prevention of stroke. Recommendation 2 refers to the prevention of secondary strokes and the diagnosis of TIA. Running through the plan is an emphasis on stroke prevention and appropriate discharge arrangements which would include providing advice on secondary stroke prevention. Delivery theme 2 detecting stroke quickly has an action specifically on providing fully functional 7 day a week TIA services. Recommendation 3 refers to access to TIA services and carotid endarterectomies. As mentioned above this is covered within delivery theme 2 and also in delivery theme 3 delivering fast and effective care which has an action specifically on providing access to vascular surgery for carotid intervention within the timescales set out in national guidance. Recommendations 4 and 5 related to the identification and treatment of Atrial Fibrillation this is covered within delivery theme 1 and highlighted as a specific risk factor which must be managed in line with NICE guidelines.

Views	**Response**
1. There is clearly strong support for a national clinical network for stroke to be established, and a consensus amongst witnesses that the Welsh Stroke Alliance could form such a network if resourced appropriately. Whilst welcoming the Minister's intention to consider a stroke network in the context of work underway to examine the pattern and effectiveness of networks more generally, the Committee would urge the Government to undertake this examination with pace so that concerns regarding a lack of leadership and accountability in this area are addressed quickly. The Committee asks that the Minister includes a timetable for the completion of the work on clinical networks within the wider timetable requested in our letter above.	I agree that we need to ensure that the wider network review is completed rapidly in order to provide certainty and national coordination of vital services, such as stroke care, and to ensure coherence with the ongoing review of professional advisory structures. Officials are holding discussions with the NHS lead for the network review, Chief Executive Adam Cairns, over detailed time scales. I expect recommendations from this review to be presented by May 31st 2014.
2. It is clear from our inquiry and the follow-up work undertaken that data on stroke patients and their care is inadequate. This data is needed to inform service developments. Participation in clinical audits is too low to provide an accurate picture of performance and, although some data may be held locally (e.g. about transient ischaemic attack and atrial fibrillation), it appears that it is not routinely reported or shared. The issues of inadequate data collection/sharing – and lower than desirable participation in clinical audit – are not unique to this inquiry. The Committee recommends that work is undertaken with pace to improve data collection, facilitate the sharing of data, and increase participation in clinical audits as part of the roll out of the Stroke Delivery Plan. Furthermore, we recommend that consideration is given to the development of a stroke register for Wales.	The National Clinical Audit & Outcome Review Advisory (NCA&OR) Committee was established in April 2011. It is working to achieve the aims of this set of views. Its objective is to provide advice on Welsh participation and performance in the National Clinical Audit and Patient Outcomes Programme and, to maximise the benefit from audits and reviews by encouraging widespread learning to improve the quality and safety of patient treatment and care. Since its establishment in April 2011, the Committee has: Encouraged LHBs and Trusts to improve their performance in National Clinical Audits and Outcome Reviews. Encouraged LHBs and Trusts to appoint a clinical lead for each of the NCAs and Outcome Reviews Published two National Clinical Audit and Outcome Review Annual Plans Held two all Wales Annual Workshops (in collaboration with 1000 Lives Plus) Issued five NCA&OR eBulletin's Placed information on the Governance eManual website http://www.wales.nhs.uk/governance-emanual/ Are currently in the process of finalising a standard "Assurance" proforma to be used by all LHBs and Trusts. Provided support and information from audits

	to be published on the Welsh Government "My Local Health Service" website http://mylocalhealthservice.wales.gov.uk/#/en During the last year the Committee Chair and members have visited most LHBs and Trusts to meet with MDs and Clinical Audit / Quality Improvement leads to discuss their NCA&OR activities. Over the next year the Committee will focus on ensuring audit is an essential part of the quality improvement cycle, driving up participation in audit and transparently publishing the results of audit. I have asked the Stroke Implementation Group to consider the merits of establishing a stroke register for Wales.
3. The Committee notes that one of the key themes of the Greenaway review of medical training is a shift in balance away from specialism towards a more generalist approach. The Committee would welcome further information from the Minister on how he intends to consider the stroke workforce within this context, and what specific action he is taking to ensure there are sufficient numbers of adequately-trained clinicians to deliver quality stroke services in the short, medium and long-term.	While focussing on the need to move to a greater degree of generalist medical training, the Greenaway review also acknowledges the need for specialties. A UK wide group has been established to consider the review in more detail and to identify timescales for action. The first meeting of this group was held on 4th February. There was a range of issues discussed which will need to be addressed as part of any future plans and it is likely that it will be some months before the way forward is agreed. I expect the Local Health Boards to consider the workforce issues across all professions as part of their routine planning and delivery of services.
4. It is a matter of concern to the Committee that, nearly 18 months after the Government's published expectation, access to TIA services is not uniform across Wales. We would welcome further detail about what corrective action is being taken in North Wales to address the delays in the Betsi Cadwaladr area, and seek detail from the Minister – as part of the timetable requested in our letter above – about when services will be available across the whole of Wales within target timescales. Furthermore, we seek an indication of what action the Minister will take if Health Boards fail to meet these targets by the deadlines outlined in his forthcoming response to this letter.	All Health Boards, with the exception of Betsi Cadwaladr have confirmed that they complied with the requirement from the original set of recommendations to have a TIA service in place from April 2012. This service would give them the ability to provide access to high risk TIA assessment within 24 hrs. A review of stroke services has been undertaken in Betsi Cadwaladr University Health Board covering the first week of care including TIA. There are recommendations for improvements including access to assessment 7 days a week. Significant improvements in stroke care are expected by the end of April 2014 and a full TIA service by October 2014.
5. The Committee concludes that insufficient progress has been made in improving adherence to clinical guidance relating to carotid endarterectomies since the	A paper on the results of the Carotid Endarterectomies Audit (CEA) Round 5 has been presented and shared within Wales. This report highlights the poor progress made in this area. In response to a letter from the DCMO issued in

Committee reported two years ago. The Committee would welcome clarification from the Minister of the target timescales within which he expects patients to receive carotid intervention, and confirmation of the deadline by which he expects Health Boards to meet these targets. The Committee seeks an indication of what action the Minister will take if Health Boards do not meet the expectations he outlines in this regard.	October 2013, we have received confirmation from the five Welsh LHBs who treat CEA patients that action is being taken to ensure they meet the 7 and 14 day timescales for providing surgery. We have also received assurance of full participation in the audit in the future. The Welsh Government will be monitoring compliance with these requirements as part of the routine performance management arrangements. The need to review and improve the whole pathway from symptom onset to surgery needs is recognised. This issue will be discussed at the Welsh Stroke Alliance meeting at the end of February, and a half day session on carotid intervention will be included in the Welsh Stroke Conference in June.
6. It is not clear what progress has been made in the identification, treatment and management of AF. Furthermore, it appears that a consistent approach to providing manual pulse checks in primary care is lacking. A more strategic and coordinated development of methods to identify and treat AF in line with published NICE guidance, across primary and secondary care, is needed - this should include consideration of those who cannot be identified by a simple pulse check alone. The Committee awaits the outcome of the UK National Screening Committee's review of screening for AF.	Local Stroke delivery plans of Health Boards in Wales will address the treatment and management of AF. A strategic and co-ordinated approach across Wales for AF will be in place by October 2014. Health boards will then implement this strategic approach from October 2014. UK NSC's review of screening for AF is currently being reviewed and it is anticipated that the review will be completed by May 2014. I have recently considered a proposal from the Stroke Association relating to a pilot with communities pharmacies to detect AF in the community and agreed to assist.
7. There remains a need to increase public awareness of stroke risk factors, including AF and TIA. The value of community pharmacy campaigns in raising awareness and identifying people at risk of stroke is something the Committee has previously highlighted and the need for successful campaigns (such as FAST) to be sustained is clear. The Committee would welcome an indication from the Minister as to what plans there are for further action to increase public awareness of stroke risk and prevention (as well as the symptoms of stroke), and whether any specific work is underway to target young people as well as older generations.	I recognise the need to sustain messages about stroke risk factors in the public domain. As part of the Welsh Government's commitment to national health campaigns, in 2014/15 a priority will be given to stroke awareness. My officials in the coming months will work closely with Public Health Wales and third sector organisations in delivering a targeted campaign.

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Professor Peter Barrett-Lee, Velindre

- A more clear, efficient and professional approach to commissioning medical technology in Wales will have the following benefits:
- “Early adoption” and improved and timely access to “state of the art” care for our patients and public
- Better recruitment and retention of high calibre staff and researchers in NHS Wales
- Greater breadth and quality of NHS research, which improves outcomes and generates wealth
- Better industry collaboration leading to greater access to technology and access to resources.
- The new approach must be part of a strategic planning process across NHS Wales leading to:
- A clearer commitment to the evaluation and procurement of new technology within timescales comparable to other developed nations.
- Avoidance of mixed models of commissioning, and therefore an understandable and more timely process and with less uncertainty about the future.
- An All Wales approach avoiding variations in access to technologies for patients in different Health Boards and Trusts.
- New technologies, once implemented, must be evaluated by clinical studies and audits to ensure that the benefits of earlier adoption are realized for the benefit of patients and public.

The Royal College of Radiologists

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National Assembly for Wales

Health and Social Care Committee

Access to medical technologies in Wales

Evidence from The Royal College of Radiologists Standing Welsh Committee – MT 13

17 October 2013

Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay CF99 1NA

Dear Sir

Response of The Royal College of Radiologists Standing Welsh Committee to the National Assembly for Wales' Health and Social Care Committee Inquiry into Access to Medical Technologies in Wales

The Standing Welsh Committee (SWC) of The Royal College of Radiologists represents the specialties of Clinical Radiology and Clinical Oncology within Wales and would make specific observations as follows, based on our consultation with colleagues in Wales.

CLINICAL RADIOLOGY

1. Clinical Radiology uses many different imaging modalities for diagnosis and treatment – conventional X-Rays, ultrasound, CT, & MRI scanning, as well as nuclear medicine studies, such as isotope scans and PET-CT. Radiology is also a major user of digital technology for the handling of patient data and images. Digital image and data storage and transfer are central to contemporary radiological practice. Radiology departments have been at the centre of major technological developments in healthcare, and rapid changes in such technology used in patient management presents a challenge to healthcare purchasers and commissioners.

2. A few specific examples will highlight the complex commissioning issues that NHS Wales faces currently from recent technological advances in Clinical Radiology.

2.1. PET CT scanning. This is now an established technique in the diagnostic assessment of many cancers. In Wales this service is commissioned centrally, subject to the PET commissioning policy of WHSSC. Fewer numbers of scans are commissioned than in England. Wales currently performs about 700 scans per million population per year, while England has reached 1000 scans per million per year and are moving towards 1200. The number of funded indications is more restricted than in England e.g. gynaecologic cancer is poorly covered. New intercollegiate PET-CT guidelines were introduced in 2012 and are under discussion with WHSCC. Evidence-based indications for PET scanning are almost certain to increase, yet there appears to be no clear plan as to how this will be achieved for

Wales. Access remains geographically restricted, with a single Welsh PET scanner based in Cardiff
There is increasing evidence for the use of PET-CT co-registration for radiotherapy planning: this is likely to become a standard technique, which will require close co-operation between a PET centre and the radiotherapy centres: it is difficult to see how this can be co-ordinated for radiotherapy in South West or North Wales.
2.2 CT colonography: The SIGGAR study published in Lancet 2013 (Halligan et al) clearly demonstrated that CT colonography is a more sensitive test than Barium enema and should be the preferred radiologic investigation for patients with symptoms suggestive of colonic cancer. This is a common clinical scenario and will require commissioning of considerably increased CT studies across Wales.
2.3 Neural tube screening for Down's syndrome
NICE guidelines on Antenatal care (2003) support the use of Nuchal translucency (NT) assessment in the antenatal screening for Down's syndrome. Welsh health boards have been required to provide this service, yet no additional funding has been provided for this to be achieved.
2.5 Prostate cancer diagnosis: Recent advances in multi-parametric prostate MRI have the potential to radically change the investigation pathways for the diagnosis of patient with prostate cancer - the most common cancer in men. This would diminish the number of ultrasound guided biopsies with their associated morbidity but wide adoption of this new approach would have very significant cost and resource implications as
1. Prostate is the commonest cancer in men,
2. MRI capacity is limited in Wales,
3. the multi-parametric approach is a very lengthy procedure requiring very long MRI scanning times and needs very highly specialist interpretation of the scan images.
2.6 CR: PACS, Image transfer, IT issues IT is central to modern radiology and our specialty has been at the forefront of promoting digital solutions for image acquisition and storage, image transfer and the requesting and reporting of imaging studies. Efficient transfer of digital information between hospitals is essential in the management of many patients, yet has often been hampered by variable interpretation of data security by the Caldicott guardians in different health boards.
All Welsh hospitals have PACS systems for radiology; cardiology departments may have different PACS requirements that prevent them using a common PACS solution.
An all Wales approach to digital data and image storage, and new radiological IT developments is essential.

3. In her Annual Report for 2012-2013, the Chief Medical Officer stated that NHS Wales and the Welsh Government should ensure that the approach to healthcare constantly adapts to meet the needs of the 21st century, for example, through effective use of technology and rebalancing the role of specialised services and care delivered in communities.

4. The adoption of new technology in Clinical Radiology is not just about buying a machine. Staffing, training, servicing costs, record keeping are all part of the package, and there may be issues of radiation safety. The introduction of new imaging technologies should be encouraged but there should be an All Wales strategic approach to commissioning, which seeks to ensure that the running costs as well as capital costs are met. There is likely to be ongoing service reconfiguration in Wales and the National Imaging Programme Board (NIPB) within NHS Wales is well placed to advise commissioning on all Wales basis. The commissioning process should identify the mechanism for future service developments, that will allow access to this technology for patients living in other areas within Wales. There should be joined up thinking between directorates within a LHB to prevent similar (and sometimes incompatible) equipment being duplicated - e.g. overlaps between Cardiology and Radiology in PACS provision, cardiac catheter labs and CT equipment. The patient's perspective must also be considered in this commissioning process, which should also consider what is available for Welsh patients outside Wales, bearing in mind the relatively small population of Wales.

Clinical Oncology

5. Wales lags behind England and the rest of the EU with regards to commissioning new technology for radiotherapy. Cancer patients do not have equitable access to treatments that are available in England, and there is a marked disparity in provision within Wales itself. Commissioning in Wales is cumbersome, often requiring duplication of work already done in England. The commissioning process needs to be critically reviewed to see how it might be made faster, easier, and more proactive. At present the onus is on individual clinical groups in each of the 3 Welsh radiotherapy centres: this is slow, inefficient and parochial. When new services are commissioned it is important that the views of patients and carers are sought. To ensure equity, any potential barriers to accessing the service, such as travelling long distances for treatment and follow up, need to be addressed and funded.

6. For new techniques where the evidence-based, accepted indications are limited and patient numbers are likely to be small, it makes sense to have all-Wales commissioning and funding to establish the technique at a single centre initially. A good example of this is SABR for non-small cell lung cancer. This has been set up in Velindre at considerable expense, but with no funding provision to actually manage routine patients : IPFRs will be required for NHS patients, and there is significant concern for those patients from South West Wales.

7. Some technologies, such as Proton therapy are unlikely ever to be commissioned in Wales, but there will be a requirement for Welsh patients to access these specialised treatments on the same terms as patients from the other 3 UK nations. For Protons, where at present there is no UK facility, all UK patients are considered by a single panel, and suitable cases are sent abroad for proton therapy. This process does not discriminate with respect to where in the UK the patient comes from. The Proton Panel is likely to be dissolved when 2 British Proton units become operational in the next few years. It is vital that Welsh patients continue to have equitable access to Proton therapy. How this will be achieved is not clear.

8. Unlike new drugs, technological advances in Oncology do not have a pharmaceutical company backing to push through a NICE review. Advances in radiotherapy such as IMRT or IGRT are processes and techniques, rather than individual pieces of machinery. As such, appraisal with regards to efficacy and QALY does not work in the same way as for a NICE-style drug appraisal. A better and faster way of assessing these techniques for Wales is required. New techniques require training, MDT coordination, as well as hardware and software installation: this takes time to establish, and the revenue costs need to be recognised. A pro-active approach is required. There needs to be a greater willingness to accept major appraisals from England or elsewhere.

9. New interventions are sometimes considered through NICE under a technology appraisal guidance which may find that the procedure is safe but cannot make recommendations for routine use as there is insufficient data. As an example rectal brachytherapy for rectal cancer was the subject of a technology appraisal in 2006 and found to be reasonably safe but there was insufficient data at the time to recommend its use and the case has never been re-reviewed.

10. In some circumstances clinicians have been advised not to submit IPFRs as they will not be considered (SIRSPHERES is an example where the Hepatobiliary MDT would recommend this therapy but WHSSC would be reluctant to accept an IPFR). Patients have a right to request funding so clinicians need to support them. In many cases the expertise is available in Wales (i.e. SIRSPHERES) and could be performed at a lower cost than in England without the need for the patient to travel.

11. The inability of PACS systems to talk between LHBs and sometimes within an LHB is a major impediment to effective, efficient, and safe MDT function. Welsh MDTs commonly aggregate patients from a wide geographical area, and to try to make expert decisions when radiological information is lacking is a major clinical governance issue. Sometime this is due to incompatibility, but more often it is the result of data protection issues. This also applies to

specialist regional clinics. Clarification and simplification of data-sharing is potentially a big gain for relatively little cost.

12. Availability of cutting-edge technology is necessary to attract and retain good staff in clinical oncology, physics, and radiography. This is important for the development and sustainability of Clinical Oncology in Wales: trainees and consultants want to be able to practice their craft to the highest standard possible. There is a competitive market nationally for the best staff, and Wales is at a disadvantage compared to England.

With kind regards,

Yours faithfully

Dr Richard Clements
Chair, Standing Welsh Committee
The Royal College of Radiologists

Royal College of Physicians
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From the RCP vice president for Wales
O'r is-lywydd yr RCP dros Gymru

Dr Alan Rees FRCP
Wales@rcplondon.ac.uk

10 October 2013

ACCESS TO MEDICAL TECHNOLOGIES IN WALES

Response from the Royal College of Physicians in Wales to the National Assembly for Wales' Health and Social Care Committee inquiry into access to medical technologies in Wales

The Royal College of Physicians (Wales) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in Wales and across the world with education, training and support throughout their careers. As an independent body representing more than 28,000 fellows and members worldwide, including 1,000 in Wales, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Mae Coleg Brenhinol y Meddygon (Cymru) yn arwain y ffordd o ran darparu gofal o ansawdd uchel i gleifion drwy osod safonau ar gyfer arferion meddygol a hybu rhagoriaeth glinigol. Rydym yn darparu addysg, hyfforddiant a chefnogaeth i feddygon yng Nghymru a ledled y byd drwy gydol eu gyrfa. Fel corff annibynnol sy'n cynrychioli mwy na 28,000 o gymrodorion ac aelodau ym mhedwar ban byd, gan gynnwys 1,000 yng Nghymru, rydym yn cynghori ac yn gweithio gyda'r llywodraeth, y cyhoedd, cleifion, a gweithwyr proffesiynol eraill i wella iechyd a gofal iechyd.

The RCP welcomes this opportunity to respond to your inquiry into access to medical technologies in Wales. We are happy to give oral evidence, if invited. All quotations, unless otherwise stated, are taken from evidence submissions we received from fellows and members.

If you would like more information, please contact Lowri Jackson, RCP senior policy adviser for Wales, at Lowri.Jackson@rcplondon.ac.uk or on 029 2050 4540.

Our response

Our response is informed by our fellows and members in Wales.

1. **The RCP calls for an all-Wales strategic approach to the commissioning of new medical technologies to ensure better access. We recommend that clear guidance be produced, with the focus on a more joined up and clinically led approach. The approach should look at both the cost and the clinical effectiveness of a new technology and be applicable across Wales.**

2. A number of factors affect the access and availability of existing medical technologies. Among them is the impact of waiting times, conflicting clinical commitments, the impact of geography and regional availability and the impact of a lack of equipment, theatre space or trained teams.

   'In Wales, there is very poor access to existing technologies eg revascularisation (coronary artery bypass graft [CABG] or percutaneous coronary intervention [PCI]) for people with stable angina. There is also very poor uptake of emerging evidence based technologies for the treatment of heart attacks eg primary angioplasty.'

3. Our fellows and members felt strongly that as the treatment of disease becomes increasingly scientific and technological, it will become even more important that the Welsh Government develops clear policy and guidance on the commissioning and adoption of new medical technologies.

   'Some … investigations are only cost-effective on a regional or sub-regional basis, but the lack of strategic coordination means that commissioning of such services is ad hoc and unsatisfactory … A strategic, all-Wales approach is needed to the commissioning of such technologies so that all-Wales access is ensured, and services are refreshed as technology advances.'

4. We know that if a new technology exists only in one or two hospitals in Wales, to ensure access, patients will need to move between hospitals. Access to medical technology is quite clearly linked to patient access, medical training, and the organisation of the medical workforce, all of which need a strategic approach. We therefore recommend an all-Wales decision making approach for new medical technologies.

5. Our fellows and members also told us that some health boards do not prioritise new technologies against more traditional priorities, which is frustrating and has an impact on waiting lists for more routine procedures. There was some frustration that because of the financial situation in the NHS, health boards were not necessarily investing in new technologies which could improve patient outcomes. Respondents pointed out that while health boards have an obligation to prescribe approved drugs, guidance on new technology is only advisory.

   'We are not good in Wales at bringing in new technology. I have had experience in trying to get gamma probes in for sentinel node biopsy in breast cancer, which is now accepted as standard, but there was initial resistance from health boards in agreeing to purchase the machine. Also, we have tried (and failed) to

introduce intraoperative testing of the sentinel node using molecular pathology, although it has been introduced in many hospitals in England.

There does not seem to be a recognised pathway to get new technology. The usual problem is that unless it can be self-financing by saving money elsewhere, the [decision makers] will not consider the [proposal] even if it brings benefits to patients in terms of quality of life.'

6. The impact of these conflicting funding priorities and the shortage of national strategic planning in service development means that access to new medical technologies can be patchy. The decision making process lacks clarity, and isn't always evidence based. Many technologies do not have a formal assessment process and our fellows and members told us that some technologies have been introduced in an unplanned way.

7. We would like to draw the committee's attention to the RCP Clinical Commissioning Hub, an online resource for service planners and clinicians designing secondary care services across the UK. While the advice is primarily aimed at the new clinical commissioning groups in England, the information will be of interest to anyone planning and designing secondary care services in any health service.

'[Adoption] of new technologies is often organic, rather than planned … There is a lack of central planning. However, central control is usually very slow, often won't make a decision and tries to include everything … so it never happens. I favour organic growth, but it does have two main disadvantages: cost creep and patchy postcode services, as only the motivated consultants develop things.'

8. Ironically, some respondents pointed out that that their inability to access new, more advanced equipment (in part because of the lack of clear adoption processes) meant that they were still using older, more expensive technologies, which was actually costing the NHS more money in the long term. It is clear to us that more long term thinking is needed. Our fellows and members told us that the upfront cost of new technologies should be offset against the long term savings.

'[Phototherapy] technology has been embraced in continental Europe… [We don't have it in Wales which] is costing us dear as the alternative treatments are so expensive.'

9. It was suggested by some of our fellows that health boards should be required to use NICE recommendations to inform their decisions about new medical technologies:

'NICE often specifies the use of certain technologies within its clinical guidelines. In doing so, NICE recommends the use of these technologies. I would recommend that the [committee] makes all efforts to avoid wasteful "reinventions of the wheel" and accepts the value of existing technologies assessed by NICE, both directly and implicitly in its guidance.'

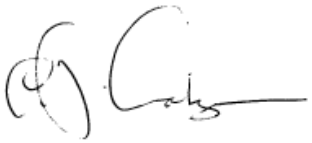
10. We heard that more work should be done to ensure that NICE guidelines are being met; that we need more effective dissemination of this information about new technologies and techniques, and that health boards should adopt proactive strategies for implementing these guidelines.

11. In conclusion, the RCP in Wales calls for a new process to approve new technologies on an all-Wales basis. This new process will need a transparent methodology for evaluating the technology, as well as an appropriate funding stream.

12. We also recommend that the committee consider whether a national body, either a new group or an existing group (eg the All Wales Medicines Strategy Group) should appraise equipment and technology to ensure a strategic national approach.

If you have any questions, or would like any further information, please contact my colleague, Lowri Jackson, RCP senior policy adviser for Wales, at Lowri.Jackson@rcplondon.ac.uk or on 029 2050 4540.

With very best wishes,



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National Assembly for Wales

Health and Social Care Committee

Access to medical technologies in Wales

Evidence from Welsh Association for Gastroenterology and Endoscopy – MT 15

October 2013

CONSULTATION ON ACCCESS TO MEDICAL TECHNOLOGIES IN NHS WALES
Response from Welsh Association for Gastroenterology and Endoscopy (WAGE)

1. Introduction:

1.1 WAGE represents healthcare professionals who contribute to the management of gastrointestinal and hepatobiliary disease in Wales. The Association is recognised by Welsh Government as the National Specialty Advisory group representing physicians, surgeons, paediatricians, radiologists and pathologists as well as clinical nurse specialists, many of whom are involved in the delivery of endoscopy. WAGE would welcome the opportunity to give oral evidence if invited.

1.2 Gastrointestinal and hepatobiliary endoscopy play a crucial role in the diagnosis, staging and treatment of a wide range of disorders including many pre-cancerous and cancerous conditions. The full potential of endoscopic therapy as an alternative to surgery is increasingly evident in managing early cancer of the gastrointestinal tract. Advances in endoscopic technology and technique can sometimes deliver minimally invasive as well as cost effective therapy for the patient.

1.3 Lower gastrointestinal endoscopy has achieved the most attention during the last 7 years due to the introduction of a national bowel screening programme aimed at early detection of polyps and cancers. The reduction in bowel cancer mortality arises not only from earlier detection of cancer, but also from its prevention through removal of adenomatous polyps during

screening colonoscopy. The introduction of bowel screening poses its own challenges in the field of new technologies, because more complex and time-consuming therapeutic techniques such as endoscopic submucosal dissection, trans-anal endoscopic microsurgery and laparoscopic approaches are increasingly needed for management of screening-detected pathology as minimally invasive alternatives to traditional open surgery.

1.4 WAGE welcomes the Welsh Government's consultation in the field of access to new (non-drug) technologies. Herein we set out some specific examples of NICE-approved and other new technologies relevant to the diagnosis and treatment of gastrointestinal and hepatobiliary diseases. We then describe examples of barriers that members have encountered in trying to introduce new technologies.

2. NICE-approved technologies

Some specific examples of those relevant to gastrointestinal endoscopy and their mapping to the issues requested by the Committee include:

2.1 Endoscopic submucosal dissection (ESD) of oesophageal (IPG355), gastric, duodenal and ampullary lesions (IPG 359 and 360) and lower gastrointestinal lesions (IPG 335). There is a substantial evidence base favouring ESD in removal of pre-malignant lesions and early cancer of the GI tract.

2.2 Radiofrequency ablation (RFA) of pre-malignant change occurring within Barrett's oesophagus (IPG 344). It is approved for treatment of pre-cancer and early oesophageal cancer in Barrett's oesophagus. There are over 30 centres offering this treatment in England, Scotland and Northern Ireland. Wales is the only area with no access to RFA. Currently patients have to be referred to England by individual clinicians and Health Boards on the basis of Individual patient funding requests (IPFR). The capital cost of RFA is around £50k, and the cost per patient treated is around £1,500. Individual Health Boards do not see it as a priority despite this treatment being much less costly and much safer than open surgical treatment. It is for these reasons that RFA is often recommended as the preferred treatment modality by regional upper GI cancer multidisciplinary team meetings.

2.3 Double Balloon Enteroscopy – or deep endoscopic examination for diseases of the small bowel. This form of endoscopy iis included within the investigation pathway for iron deficiency anaemia in guidelines from the British Society of Gastroenterology (BSG), and can sometimes be used in therapy such as cauterizing bleeding points or dilating strictures. Patients in Wales are currently being sent to Bristol for this form of endoscopy.

2.4 Impact of differing criteria for procedures compared to other regions of UK. (e.g. bariatric surgery is underprovided in Wales, and the criteria for acceptance of patients are much more stringent than elsewhere in the UK.) It is accepted that WHSSC is in the process of seeking agreement to increase the number of such procedures from 80 to 300 per year. Nonetheless if NICE guidance were to be followed we'd need a much larger capacity for provision of this service).

2.5 Miscellaneous: oesophageal function tests (manometry and 24 hour pH testing) where the underlying technology is rapidly advancing. A forward investment plan, therefore, needs to be identified; ano-rectal physiology, for which the same constraints apply; and capsule endoscopy, which incurs significant capital and revenue costs but is an important diagnostic test for a relatively small number of patients.

2.6 Common theme - Health Boards (LHBs) may flag up NICE-approved new technologies to Clinical Directors, asking them to appoint a Lead Clinician to develop business cases. Within a context of capacity constraints and shortage of funds, LHBs don't tend to prioritise these developments against the delivery of existing treatment priorities despite evidence of clinical and cost effectiveness. It is not surprising that clinicians find it frustrating writing business cases to support bids for such interventions when so few are approved.

2.7 For each of the above examples, Welsh consultants have the expertise and training to deliver the technology within Wales but lack support from their individual Health Boards. WAGE perceives that such interventions are best delivered on a supra-regional (tertiary) basis, given the lower volumes and specialist nature of these interventions in comparison with standard endoscopic procedures, and that a national joined-up approach is required.

3. Approval and adoption of other newer technologies (Early Adoption) – Illustrated example

Wales lags behind the rest of the UK in the provision of many relatively new endoscopic technologies. One example is “Spyglass” – a type of miniature endoscope that can be guided up the bile duct at ERCP to enhance diagnosis and delivery of therapy in some forms of biliary disease. Spyglass has not been the subject of a NICE technology approval but is available in many centres in England. It is a good example of a technology that should be available in just one centre in Wales.

4. Financial Barriers & Barriers to Timely Adoption

4.1 Financial Constraints & Commissioning- because money doesn't follow patients in Wales, there is often minimal incentive for LHBs to invest in the provision of new, approved technologies. There is a lack of national strategic planning in the development and delivery of tertiary services for new technologies.

4.2 Decision-making is often slow and patchy, and in most cases it is devolved to LHBs. One example in recent years was the consensus among experts in the delivery of endoscopic ultrasound (EUS) that there would be many advantages to centralizing the South Wales service as opposed to the current 3-4 smaller centres using expensive equipment just once per week. The proposal was discussed at one of the monthly meetings of the Health Board Chief Executives, and the conclusion was that it was up to each individual LHB to prioritise investment in this service as they saw fit. This was an unfortunate outcome, which has impeded development of a modern, cost effective EUS service in Wales, and an important opportunity for setting up a viable service with adequate volumes for training (meeting national standards) was missed.

4.3 Not all technologies are reviewed in the Welsh Health Specialised Services Committee. Decisions on selection criteria, definitions which technologies to adopt are often slow. Even when the intervention is included within the WHSSC portfolio decisions on funding can take months. Delays in the approval of funding for procedures delivered in England are also common.

5. Suggested Innovative solutions –

5.1 Annual bidding rounds within LHBs should be used for upgrading old equipment with newer devices, with more advanced technology (e.g. acquiring endoscopes that are capable of magnification and electronic chromo endoscopy; surgical video-choledochoscopies that allow dissemination of laparoscopic bile duct clearance; laparoscopic ultrasound probes that allow interrogation of the biliary ductal system without the need for radiation). Because of increased costs, and competition within a very limited budget, these bids usually fail.

5.2 A strategic, all-Wales approach is needed to the commissioning of such technologies so that all-Wales access is ensured, and services are refreshed as technology advances. Coordinated strategic planning and commissioning incorporating a list of technologies, available local expertise, options for coordinated service delivery (along with identified financial streams from each Health Board to contribute to these) should

be within the remit of an All Wales Strategic Gastroenterology and GI Surgical Group. Some gastroenterological investigations are only cost-effective when provided on a regional or sub-regional basis but the lack of strategic coordination means that commissioning of such services is ad hoc and unsatisfactory.

5.3 Partnership with Industry and Higher Education Institutions (HEI) – There is potential for collaboration with Industry in areas of Research & Development. In addition to the evaluation of new technologies, this approach lends itself to trials of comparative efficacy and cost effectiveness assessments in some of the areas where new technology is seen to be naturally aligned with areas of interest within University research departments. Collaboration between universities (e.g. the recent Health Technology ideas pilot by SARTRE (Severnside Alliance for Research – collaboration between Cardiff & Bristol) and similar themes for technology collaboration between Cardiff, Swansea & Bangor with Industry participation hold great potential for innovative solutions if supported conceptually as well as financially by the Welsh Government.

National Assembly for Wales Health and Social Care Committee
Inquiry into Access to Medical Technologies in Wales

Response from the Royal College of Surgeons Professional Affairs Board in Wales

Introduction

1. The Royal College of Surgeons is a professional body that sets the highest possible standards for surgical practice and training in order to deliver safe and high quality patient care.
2. The Royal College of Surgeons Professional Affairs Board in Wales provides a means by which surgeons at the front line can share information, bring concerns to local decision-makers and look for solutions which will lead to better patient outcomes.
3. Our submission considers the current process for the assessment of new or alternative medical technologies and the steps that we believe need to be taken in order to improve the current situation.

Summary of key recommendations to the Committee

- Currently, there is a lack of strategic coordination in commissioning new technologies in Wales. The Royal College of Surgeons would like to see better coordination among Health Boards, WHSSC and Welsh Government and a more joined-up approach for the commissioning of new technologies in Wales in order to contribute to improved outcomes for patients.
- There is a need to improve the transparency of Local Health Boards' level of compliance with NICE technology appraisals. We believe there is merit in Welsh Government taking steps to ensure that Local Health Boards publish their compliance levels.
- There are a number of shortcomings with the IPFR process which need to be addressed.
- Training and educating the current and future workforce is essential to the adoption and diffusion of new techniques and technologies. The Royal College of Surgeons believes that it is important to enable staff to take time for training and education to support the roll-out of new innovations and technologies.

The need for an all Wales strategic approach

4. Currently, there is a lack of strategic coordination in commissioning new technologies in Wales. There is also a lack of clarity and transparency about the formal assessment process under which new technologies are commissioned.
5. A number of different bodies contribute to whether a new medical technology is commissioned in Wales. These include: NICE through its technology appraisals and Interventional Procedural Guidance, the Welsh Health Specialised Services Committee, decisions made by individual Health Boards, and Individual Patient Funding Requests. This ad hoc approach is resulting in a great deal of regional variation in availability and access. Our view is that this current approach is not sustainable and needs to be addressed.
6. For example, sacral nerve stimulation can help control faecal and urinary incontinence by using a small system, surgically placed under the skin, to send mild electrical impulses to a specific nerve via a special medical wire. The therapy is widely available at selected sites in England but is only available on an individual basis in Wales.
7. The Royal College of Surgeons would like to see better coordination among Health Boards, WHSSC and Welsh Government and a more joined-up approach for the commissioning of new technologies in Wales in order to contribute to improved outcomes for patients. We believe there is merit in bringing forward a national all Wales strategic approach to commissioning all new technologies in Wales.

8. In England, the Royal College of Surgeons advocates all Trusts using clinical ethics committees to provide advice and make decisions around any ethical issues arising from the use of new innovations and technologies within hospitals. We believe consideration should be given to establishing similar mechanisms in Local Health Boards in Wales.
9. With expensive and highly technical equipment it is accepted that high patient volumes are needed to ensure expertise in surgeons, nurses, radiologists, pathologists and the dedicated unit overall. For example with the robotic-assisted laparoscopic prostatectomy, the evidence suggests that a minimum of 150 patients per annum are required to ensure the best outcomes for patients[1].
10. Some highly specialised and expensive technologies, such as psuedomyxoma surgery for pseudomyxoma peritonei cancer of the appendix and abdomen, are very rare. Therefore it may not be practicable to commission a service in Wales and consideration should be given to a collaborative approach to commissioning with England.
11. A strategic approach to commissioning new medical technologies would ensure that cost and budgetary constraints were balanced with the clinical effectiveness of any new medical technology, medical staff training and configuration of the medical workforce. It would also ensure that, from a patient perspective, consideration is given to the impact of accessing such services including travelling times and the waiting times for treatment.
12. Improving access to new more advanced equipment and technology in Wales would also facilitate the withdrawal of old and outdated technologies, which may actually be more expensive and less effective clinically.
13. It is worth noting that with budgets in NHS Wales under considerable pressure, a number of surgeons have raised specific concerns about a lack of funding for replacing basic equipment. We believe this is an area which needs to be addressed.

WHSSC

14. Currently the Welsh Health Specialised Services Committee (WHSSC) is responsible for ensuring that population of Wales has fair and equitable access to the full range of specialised services in Wales. We believe that WHSSC must ensure greater clarity and transparency around its processes in commissioning new medical technologies. This must include a review of the current use of the IPFR application process (see below).

NICE guidance

15. NICE develops 'Technology Appraisal Guidance' (TAG), recommendations on the use of new and existing medicines and treatments within the NHS in England and Wales, such as medical devices (such as hearing aids or inhalers), diagnostic techniques and surgical procedures[2]. Such appraisal recommendations are mandated in Wales and should therefore form the basis for commissioning and implementing new medical technologies in Wales.
16. NICE also publishes Intervention Procedural Guidance (IPG) which makes recommendations about whether interventional procedures used for diagnosis or treatment are safe enough and work well enough for routine use[3]. IPGs are not mandatory in Wales.

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[1] Comparative Cost-effectiveness of Robot-assisted and Standard Laparoscopic Prostatectomy as Alternatives to Open Radical Prostatectomy for Treatment of Men with Localised Prostate Cancer: A Health Technology Assessment from the Perspective of the UK National Health Service, European Urology, September 2013, further information available from: http://www.europeanurology.com/article/S0302-2838(13)00223-6/fulltext/comparative-cost-effectiveness-of-robot-assisted-and-standard-laparoscopic-prostatectomy-as-alternatives-to-open-radical-prostatectomy-for-treatment-of-men-with-localised-prostate-cancer-a-health-technology-assessment-from-the-perspective-of-the-uk-national-health-service

[2] NICE Technology Appraisal Guidance, further information available from: http://www.nice.org.uk/guidance/ta/index.jsp

[3] NICE Interventional procedures, further information available from : http://www.nice.org.uk/guidance/ip/index.jsp

17. There is a need to improve the transparency of Local Health Boards' level of compliance with NICE technology appraisals. We believe there is merit in Welsh Government taking steps to ensure that Local Health Boards publish their compliance levels.

IPFR

18. Independent Patient Funding Request (IPFR) applications can be made for any type of healthcare in Wales including a service, treatment, medicine, device, or piece of equipment that is not normally provided by the NHS in Wales[4]. Currently, applications to the IPFR are often made to enable patients to access NICE recommended new medical technologies.
19. There are however, a number of shortcomings with the IPFR process which limit its effectiveness in enabling access to new technologies in Wales. WHSCC describes the IPFR as constituting "*the lowest grade and quality of appraisal process currently in Wales. Each Health Board is required to run an IPFR Panel which considered individual cases on the basis of 'exceptionality'. The quality of appraisal varies considerably between Health Board and most Panels operate without robust methods of evidence appraisal.*[5]"
20. We believe that the shortcomings in the IPFR process is an area which needs to be addressed and that any consideration of new technologies under the IPFR should be closely linked to NICE technology appraisals and Interventional Procedural Guidance.

Health Technology Fund

21. The Royal College of Surgeons welcomes the Welsh Government's announcement regarding the establishment of a Health Technology Fund[6] as a positive step forward to improving investment in innovation and technology in Wales.
22. The award of around £2 million funding from the Fund to enable Wales to offer prostatectomy (the surgical removal of all or part of the prostate gland) by means of keyhole surgery with robotic assistance (the da Vinci® Prostatectomy) is an example of the benefits such a scheme can bring.
23. Although funding for the scheme has been ensured to 2015, we would welcome the Fund being put on a sustainable footing to ensure its longevity. We also understand that applications under the second phase of the scheme are limited to care supplied in a community setting which is disappointing as it limits the opportunity to bring forward new surgical developments which could benefit patients.
24. As awareness of the opportunity of the Fund among clinicians is low, we believe that steps need to be taken to improve the profile of the scheme.

Training and educating the future workforce

25. Training and educating the current and future workforce is essential to the adoption and diffusion of new techniques and technologies. Surgery differs from many other medical specialties in that the research and assessment of new innovations often requires the teaching of new manual skills.
26. Nationally commissioned training programmes such as the Welsh Colorectal Laparoscopic training scheme[7] have proved to be highly effective. The pioneering Colorectal Laparoscopic training scheme trains junior surgeons in keyhole bowel surgery. The programme was supported by the Welsh Government for five years and is run by the Welsh Institute for Minimal Access Therapy (WIMAT). As a result of the Welsh Government's funding for the scheme, access rates in Wales to laparoscopic colorectal surgery are among the highest in the world.

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[4] Further information available from: http://www.wales.nhs.uk/sitesplus/863/page/55331

[5] WHSSC submission to the NAfW Health and Social Care Committee, further information available from: http://www.senedd.assemblywales.org/documents/s500001650/MT%2036%20-%20Welsh%20Health%20Specialised%20Services%20Committee%20WHSSC.pdf

[6] Further information available from: http://wales.gov.uk/newsroom/healthandsocialcare/2013/130808htf/?lang=en

[7] Further information available from: http://www.walesdeanery.org/index.php/en/wimat-courses/welsh-laparoscopic-colorectal-training-scheme/1108-welsh-laparoscopic-colorectal-training-scheme-course.html

27. The Royal College of Surgeons believes that it is important to enable staff to take time for training and education to support the roll-out of new innovations and technologies. Furthermore, it is important that Local Health Boards ensure time for Supporting Professional Activities (SPAs) to enable consultants to undertake training and education. If the time available for SPAs in job plans declines, then there could be a negative impact on clinical outcomes.

College's role in medical innovation

28. In 2013, the Royal College of Surgeons established a network of surgical trials units[8] across the UK. Working with partners, including the National Institute for Health Research, Rosetrees Trust and Cancer Research UK, the aim of the centres is to revolutionise the delivery of surgical care for thousands of patients and ensure that surgical research can be pioneered and effectively developed. The units enable surgeons to learn more about how to deal with a range of conditions, assess new surgical techniques and discover surgical breakthroughs.
29. In partnership with our specialist surgical associations and affiliated charities, we have also appointed 11 national Surgical Specialty Leads with the specific remit to develop new trials, establish clinical networks and to work with their patients to develop and deliver new and innovative trials across the numerous surgical disciplines.
30. Lastly, the initiative facilitates the work of trainee research networks across the country. These networks encourage surgical trainees to collaborate by 'pooling' their patients and creating large-scale surgical trials, which help to gather evidence on existing procedures. The initiative helps to overcome one of the biggest obstacles to surgical trials: recruiting enough patients. It also encourages trainees to engage with research at an early stage of their career and has the potential to change the future research culture within surgery. The success of this in Wales has been shown by the recent £1million grant from the HTA awarded for surgical research into incisional hernias after colorectal cancer surgery.

[8] Further information available from: http://www.rcseng.ac.uk/surgeons/research/surgical-research/surgical-clinical-trials

Royal College of General Practitioners

National Assembly for Wales

Health and Social Care Committee

Access to medical technologies in Wales

Evidence from Royal College of General Practitioners – MT 6

Inquiry into access to medical technologies in Wales

The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the 'voice' of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 49,000 members, 1,932 in Wales, who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

RCGP Wales welcomes the opportunity to respond to this consultation, and would base its response around its response to the earlier consultation in the autumn of 2012, which is included with this correspondence.

RCGP Wales considers that the most important area at present to develop is integration of IT through secondary care, community and primary care systems. Currently, hospital systems are often bespoke and do not fit well with GP systems. Although there are increasing efforts to develop portals for results etc., there is no way to access actual imaging for example. There are a number of fixes in place to allow e-mail communication but so far no patient integration for things such as appointments.

RCGP Wales believes that the future for general practice is about near patient testing and would potentially give this the main priority.

The falling cost and increasing availability of new technologies is one of the most exciting developments in primary care.

Many practices have spirometry, sats measurement etc. (some even have a 24-hour ECG monitor which costs a few hundred pounds) but desktop testing for D-dimer and troponins for example, is now available at a modest cost. In the next few years more and more equipment will become available. Items

that cost thousands of pounds only a few years ago are now available for tens of pounds with no loss of reliability

Handheld diagnostic ultrasound and echocardiogram equipment is also now available and the cost is falling. Were these technologies and others to become routinely available, additional training for practitioners in their use would be necessary.

The primary care division at NWIS has been a key factor in the organised development of IT systems in general practice. It will be important to continue to ensure the systematic and integrated development of IM&T.

Given the likely effect of new technologies on the delivery of clinical care in general practice, Local Health Boards will need to be sensitive and flexible to funding priorities especially where low cost may introduce changes to extant clinical care pathways.

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 - Senedd**
Meeting date:	**Thursday, 6 March 2014**
Meeting time:	**09.18 - 14.06**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200000_06_03_2014&t=0&l=en
http://www.senedd.tv/archiveplayer.jsf?v=en_200001_06_03_2014&t=0&l=en

Concise Minutes:

Assembly Members:	**David Rees (Chair)** **Leighton Andrews** **Rebecca Evans** **Janet Finch-Saunders** **Elin Jones** **Lynne Neagle** **Lindsay Whittle**
Witnesses:	**Clare Bath, Cancer Research UK** **Dr Tom Crosby, Velindre Cancer Centre** **Emma Greenwood, Cancer Research UK** **Bernadette McCarthy, Velindre Cancer Centre** **Buddug Cope, Genetic Alliance UK** **Emma Hughes, Genetic Alliance UK** **Hayley Norris, Patient Representative** **Gwyn Tudor, MediWales** **Deborah Evans, West of England Academic Health Science Network** **Professor Carl Heneghan, Centre for Evidence-Based Medicine, Oxford University** **Dr Corinne Squire, South East Wales Academic Health Science Partnership**

	Lars Sundstrom, West of England Academic Health Science Network
Committee Staff:	Llinos Madeley (Clerk) Sarah Sargent (Deputy Clerk) Chloe Davies (Deputy Clerk) Philippa Watkins (Researcher)

TRANSCRIPT

View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 Apologies were received from Darren Millar, Gwyn Price and Kirsty Williams.

2 Inquiry into access to medical technologies in Wales: Evidence session 8

2.1. The witnesses responded to questions from Committee members.

2.2 Emma Greenwood informed the Committee of recent work undertaken in collaboration between Cancer Research UK and NHS England which asked relevant industry groups how they envisaged the field of radiography in 10 years. Ms Greenwood agreed to share information on this work with the Committee.

3 Inquiry into access to medical technologies in Wales: Evidence session 9

3.1 The witnesses responded to questions from Committee members.

3.2 Buddug Cope agreed to provide the Committee with information regarding the link between the NICE health technology programme and the UK Genetic Testing Network (UKGTN).

3.3 Ms Cope also agreed to provide the Committee with further clarification regarding the relationship between the approval of new tests by UKGTN and their subsequent commissioning by NHS Scotland.

4 Inquiry into access to medical technologies in Wales: Evidence session 10

4.1. The witnesses responded to questions from Committee members.

4.1 The Committee agreed to consider items 6, 7 and 8 before the consideration of item 5.

5 Inquiry into access to medical technologies in Wales: Evidence session 11

5.1. The witnesses responded to questions from Committee members.

5.2 Lars Sundstrom, West of England Academic Health Science Network, agreed to provide a note on the new system that has been introduced in England (that is available to Welsh organisations) which allows access to funds and provides a method of commissioning research and development through the healthcare system.

6 Papers to Note

6.1 The Committee noted the minutes of the previous meetings.

6.1 Letter from the Chief Nursing Officer in relation to action points arising from the Committee meeting of 30 January 2014

6a.1 The Committee noted the letter from the Chief Nursing Officer.

7 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

7.1 The Committee agreed the motion to consider item 8 in private.

8 Consideration of the Minister for Health and Social Services' response to the Committee's letter regarding the follow-up inquiry into stroke risk reduction

8.1 The Committee discussed the letter from the Minister for Health and Social Services regarding the follow-up inquiry into stroke risk reduction.

8.2 The Committee agreed that it would discuss actions in its public meeting on 20 March 2014.