



Cynulliad Cenedlaethol Cymru The National Assembly for Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol The Health and Social Care Committee

**Dydd Mercher, 19 Chwefror 2014
Wednesday, 19 February 2014**

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir
trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In

addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Leighton Andrews	Llafur Labour
Rebecca Evans	Llafur Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Geoffrey Carroll	Cyfarwyddwr Meddygol, Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru Medical Director, Welsh Health Specialised Services Committee
Fiona Jenkins	Cyfarwyddwr Gweithredol Therapiau a Gwyddorau Iechyd, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Executive Director of Therapies and Health Science, Cardiff and Vale University Local Health Board
Dr Pushpinder Mangat	Cyfarwyddwr Meddygol Interim, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Interim Medical Director, Abertawe Bro Morgannwg University Local Health Board
Pete Phillips	Cyfarwyddwr, Labordy Profi Deunyddiau Llawfeddygol Director, Surgical Materials Testing Laboratory
Mark Roscrow	Cyfarwyddwr, Gwasanaethau Caffael, Partneriaeth Cydwasaethau GIG Cymru Director, Procurement Services, NHS Wales Shared Services Partnership
Alun Tomkinson	Llawfeddyg Clust, Trwyn a Gwddf, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Ear, Nose and Throat Surgeon, Cardiff and Vale University Local Health Board
Dr Phil Webb	Cyfarwyddwr Cynorthwyol, Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru Assistant Director, Welsh Health Specialised Services Committee

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Llinos Madeley	Clerc Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:22.
The meeting began at 09:22.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome everyone to this morning's session of the Health and Social Care Committee, where we will be continuing our inquiry into access to medical technologies. I remind Members to please turn off mobile phones or any other electronic equipment as they may interfere with the broadcasting equipment. The meeting is bilingual, and headphones can be used for simultaneous translation on channel 1 or for amplification on channel 0. There is no scheduled fire alarm this morning, so, if you hear the fire alarm, please follow the directions of the ushers. We have not received apologies, but Mr Pushpinder Mangat might be late, and there are a couple of Members who have indicated that they might be late as well.

[2] Before we start, may I welcome Janet Finch-Saunders to the committee? Welcome, Janet. I understand that you actually started on this committee when you first came to the Assembly, so I welcome you back. May I put on record our thanks to William Graham, who has served on this committee for almost two and a half years, and who has been very constructive in the work that he has put into the committee. We put on record our thanks to him.

09:23

Ymchwiliad i'r Mynediad at Dechnolegau Meddygol yng Nghymru:
Sesiwn Dystiolaeth 6
Inquiry into Access to Medical Technologies in Wales: Evidence Session 6

[3] **David Rees:** As I said, this morning's session is to continue to look at the access to medical technologies. I welcome our witnesses this morning. We have Fiona Jenkins, who is the executive director of therapies and health science at Cardiff and Vale University Local Health Board. We also have Dr Geoffrey Carroll and Dr Phil Webb, who are both from the Welsh Health Specialised Services Committee. You are very welcome. May I thank you for your written submissions, which have given us an indication as to where we want to go with our questions? I will just give you an indication that what we are thinking of is looking at how the NHS in Wales is consistent across the decision-making process, and at where good practice is in place as well.

[4] I will ask Gwyn Price to ask the first question.

[5] **Gwyn R. Price:** Thank you, Chair. Good morning, everyone. I just want to explore

the relationship between the Welsh Health Specialised Services Committee and the All Wales Medicines Strategy Group. Is there a duplication of appraisals between the two? This is in response to the suggestion by some witnesses that, perhaps, an integrated service between the two would benefit patients and would be the way forward in this area. I was wondering what your views on that would be. That would also be true of the National Institute for Health and Care Excellence, with which you work.

[6] **Dr Carroll:** Good morning. I will start, and my colleagues will add to that.

[7] As it happens, I am the medical director for the Welsh Health Specialised Services Committee; I will say WHSSC after now, it that is okay. I am on the All Wales Medicines Strategy Group, and have been for about six years. My colleague, Dr Webb, will explain what he does in relation to AWMSG. Therefore, the first point is that we have a connection and participation and, also, our director of finance colleague, Stuart Davies, is the representative for directors of finance on the All Wales Medicines Strategy Group. So, there is a deliberate, calculated participation, if you like, by WHSSC as a commissioning body, but through the interest and experience of people like me and my colleagues in directly connecting with the decision making. That is the first point. The second is that AWMSG makes decisions about the appropriate use of a medicine in Wales in terms of clinical and cost effectiveness. Our responsibility as the organisation in Wales dealing with specialised services on behalf of the seven health boards is to then examine how that medicine is used. We have had some recent examples where the approval of a medicine then leads us to require a detailed clinical policy to be certain what patients would benefit, how it is used and how it is evaluated. So, there is a continuous connection in that sense. However, we have different primary objectives—the appraisal of medicines for AWMSG, and the commissioning of specialised health services for Wales for WHSSC.

[8] **David Rees:** Do you wish to add to that, Dr Webb?

[9] **Dr Webb:** Members would have received a report talking about the new medicines group, which is the group that does the technology appraisal and the nitty-gritty of the work. I sit on the new medicines group. It reinforces what Dr Carroll has said, which is that there is integration from an AWMSG perspective with WHSSC and AWMSG. In terms of our relationship with NICE, we—and you will probably ask us about some of the methods we use in our assessment process—have had liaison and discussion with NICE about methods and techniques. We liaise with the people who look at the devices therapies, which is the medical technologies evaluation programme process for NICE, as well as the overall NICE technology assessment process. Through the work that we have, and through AWMSG, we also understand and look at the methods that NICE uses in its own technology appraisals process. We look for consistencies, methods, what type of methods are being used, how they are being used and what some of the issues are with using particular approaches to the assessment of evidence.

[10] **Gwyn R. Price:** Some of the witnesses have said that they think there is duplication in some areas where there could be delays. Would you agree with that or would you say what you have just said, actually, which is that you all work together?

[11] **Dr Webb:** We will address the duplication issue because we have read some of the transcripts and it does come across very strongly. Factually, last year, WHSSC did 85 appraisals of a whole range of different things that NICE would not have appraised, including devices, packages of care and some medicines issues. This year, we are taking a further 40 through. If you are asking the question of whether this overlaps, we have had a look at how much overlap exists and, out of the 140 things we will be looking at over the two-year period, there is actually a relatively small percentage where NICE may have done a particular piece of work for a particular area. It is about 10%, so if you want to ask us what the differences

are, there is a whole range of things that we took through assessment that NICE has never taken through assessment, which—

[12] **David Rees:** Do you know why NICE has never taken them through assessment?

[13] **Dr Webb:** They are things that, given the particular methods that NICE uses to assess, become difficult to assess. They are things like stem cell transplantation or bone marrow transplantation. Those are difficult to assess with the NICE processes. They do not go through the NICE process. There are things such as ventricular assist devices in particular contexts, because they are quite rarely used and they are specialised services, that NICE tends to avoid, at the moment, appraising through its methods. The other issue—and you will be discussing some of the differences in approach—is that NICE usually undertakes an appraisal at the request of the manufacturer, so it is based on a manufacturer's submission. We take appraisals that are identified through a process from the service perspective—things that actually affect people delivering care from a front-line basis. So, the route of entry into the appraisals process is different between us and NICE.

[14] **Gwyn R. Price:** Thank you.

[15] **David Rees:** That is interesting. Janet, do you want to ask a question on service planning?

[16] **Janet Finch-Saunders:** Yes. How do you identify and prioritise new technologies?

09:30

[17] **David Rees:** You have already given an indication that it is not necessarily through the manufacturers—

[18] **Dr Webb:** That is correct.

[19] **David Rees:** Could you expand upon how you do it?

[20] **Dr Carroll:** All right. Let me commence, and I am quite sure that Fiona, Push and Phil will come in. The £600 million per annum that is spent on specialised services, which is a bit like the top 10% of the NHS budget in Wales, relates to a very large range of clinical programmes delivered within Wales. Around 10% of that is delivered in England for Welsh patients crossing the border. So, many of the questions that we have may relate to individual patients and the proposal that they should access particular clinical care. So, we find a situation perhaps where there is a newish clinical intervention that may have had an element of publicity or may have had a degree of assessment, but it is a new proposition to us in terms of directing resources to support that treatment. That could be a very complex blood and marrow transplant, for example, proposed for the care of a patient but delivered in England.

[21] When we get one or two of those, we begin to see a pattern immediately and look quickly for whether there is a structured basis for a clear policy. The first category is to say that we are often bumped into the need to assess technologies, for example, by virtue of requests concerning pipeline embolisation devices for patients with neurological and, potentially, neurosurgical problems or related cancer issues or cardiac issues. That is number one. Number two is that we also have, through the clinical programs that we connect with, proposals all of the time about advances in technology. You have had evidence and you will be aware of multiple sources for that. Sometimes they come in a structured manner and sometimes they do not. However, we will aggregate those, working with our clinical advisers and our programme team, to determine what is rising to the top as a potentially significant change that may require, predictably, resource allocations. In our prioritisation programme

and evidence appraisal, we, as it were, collect at the beginning of each phase, against a set of key questions, proposals for technologies, medicines and procedures that we should assess.

[22] **Dr Webb:** It might be useful for Members to have an outline description of some of the structures around how we process things. We have been doing this process of evidence evaluation, appraisal and prioritisation for two and a half years. A lot of it, initially, was discussed with health boards as part of a national project to look at how we would appraise different technologies—sometimes very different technologies—through a systematic and prospective way to make sure that we got timely answers to questions that influenced clinical care, in a very structured manner.

[23] We realised rapidly that selecting the correct topic that needed to be appraised, which was pertinent to clinicians working in particular areas, was critical. As a consequence of that, there are now three main structures that we work with. First is the actual evidence appraisal team that looks at the methods and the techniques of how we appraise things. Second is that we are establishing clinical evidence reference groups that reflect, in part, some of the work that is now being done in the NHS in England. It constitutes a faculty of clinicians and citizens of Wales to look at the areas that are particularly pertinent to them, to prioritise those areas and to flag them up as hot topics so that they have some kind of input into what comes through the process. The third part of the machinery is that we have an independent panel that looks at the assessment of the evidence that is used to make those recommendations.

[24] The key issue is that those recommendations then get presented back to the clinical evidence reference group to discuss some of the nuances. We are very keen, and have always been, that part of that dialogue needs to happen with the clinicians who, ultimately, have to implement some of these recommendations that are made. So it is invested in clinicians and patients and members of the public. So, that loop now works quite effectively in both determining things that really are of importance that require assessment, from a clinical perspective and a patient perspective, and there is an ongoing dialogue between the people who make the recommendations independently and the clinical groups and the patient groups, to say, ‘This is what we think of the evidence as it is being presented to us; can we now have a clinical and patient look to see whether this makes sense?’

[25] Going back to Dr Carroll’s perspective, who are the patient populations that should be given access to treatments, under what circumstances and, very importantly, how do we measure the outcomes for those patients to make sure that they are receiving the benefits that are purported in the evidence assessment to begin with? We would also look at service specifications—what standards should be applied in delivering that service and under what circumstances. Then—we will probably come back to this—the measurement of the outcome becomes critically important. The clinical outcome, patient experience measures that we are using and quality of life are all driven and written by the clinical evidence reference groups.

[26] **Ms Jenkins:** Shall I answer from a health board’s perspective?

[27] **David Rees:** Yes, please.

[28] **Ms Jenkins:** I am Fiona Jenkins, executive director for therapies and health science in Cardiff and Vale University Local Health Board, but I also hold the executive lead role for technology and medical equipment. So, from a health board perspective, with any technologies that we are looking at, the driver is the optimum output and benefit for patient care. I guess that our perspective is more organically driven from the clinical interface with what will make patient care better, but at the same time keeping an eye out on the wider horizons of what technologies are evolving and how they could benefit our population. I guess that we are still learning how to do this—I would not say that we have it completely cracked—but one of the elements that we look towards is the health technology fund. We see

this as a resource that we can access to help drive forward the use of technology. If the health technology fund was not there, I think that we would struggle to find capital to develop some of the emerging technologies. However, some of the constraints with the health technology fund are that it is just capital and we are still constrained with the resource implications of getting some new technologies in, because it is not just capital. We have a process within the organisation, and I am sure that this is pretty much the same with other health boards too, in that we will be looking to keep an eye on what new technologies are out there. We will be looking at National Institute for Health and Clinical Excellence evidence and guidance. Our clinicians will be looking, within their specialty, at which emerging technologies can help improve their care.

[29] We have a process that we go through that is not dissimilar to the WHSSC process. We have a prioritisation panel, which would ask, 'Does the evidence back up?', 'Does this suit?' If we tick 'yes' that it does, we then get into a more serious consideration with a group of people that will include our commissioning people, our planning people, our finance people and our public health team, to look at this in terms of population benefit. In terms of the organisation, we will consider whether this is something that we are secure about in terms of revenue streams and that it fits in with our IT infrastructure. If we are bringing new technologies into an organisation, there is a whole raft of things that we have to cross check. It is complex, because it involves so many different people. A lot of the emerging technologies are for the benefit of more than one health board, which then becomes more complex because you have to look at the business case across organisations. We are funded on a one-health-board basis and some of it is for wider populations. We need to look at how we can do this for the benefit of a wider Welsh population rather than just for the benefit of one health board. So, we are learning and, perhaps, the message is that we very much welcome a health technology fund but it is the revenue that goes with the health technology fund that is causing us some constraints in our ability to embrace technology at the pace that we would like.

[30] **David Rees:** Mr Mangat, I welcome you to the meeting.

[31] **Dr Mangat:** Apologies for being late, Chairman.

[32] **David Rees:** Do you have a view on this?

[33] **Dr Mangat:** I am not going to repeat what has just been said, because that covers a lot of what happens in our health board. I thought that what I would do is give you an example of how something would work in our health board. We have a close relationship with our university, which comes up with many ideas through its research process. We have a clinical research forum that is now under the auspices of the university. It is not always from there, but an example is that one of our clinicians did some pilot research as part of a world-wide study into genetic testing for breast cancer. That is now progressing through our health board processes to see what the effects and benefits are and what the cost-effectiveness is. So, that goes through a specific committee that we have to look at innovations and technologies—it is called the effective practice approval committee. It is a multi-disciplinary team, which includes people from finance. If it is approved there, particularly a new technology that is not widely accepted or known, we then set up a similar type of commissioning group to look at it in a wider sense and engage with the company that does this test to look at how we can utilise the test in the most effective way and to see whether it is of benefit to patients and to us as a whole because it is more cost-effective. That is the sort of process that we go through; that is an example of it. We are in the process of doing that at this moment in time with that particular test. I echo everything that has been said by the other panel members, and I will just give that as an example of how we do it.

[34] **David Rees:** You have raised a lot of questions. Did you want to add anything, Janet?

[35] **Janet Finch-Saunders:** No.

[36] **David Rees:** I assume that these are supplementary questions, so I will call Kirsty, Lindsay, Rebecca and Darren.

[37] **Kirsty Williams:** Dr Carroll, you talked about the tip of the pyramid and people looking for approval to seek treatment across the border. One of the motivations behind the committee's doing this work is that Wales has, perhaps anecdotally, been seen as slow to adopt technologies. I think that the evidence that we have had to date backs that up. I am wondering whether, if we got better at doing this, the number of people that you would have to look at seeking treatment across the border would fall. Otherwise, are we talking about the procedures that you are approving being so specialist that we would never be in a position, clinically, to be able to deliver them in Wales? If that is not the case, do you think that there would be cost savings if we were able to have those technologies adopted here, as well as patient benefit from not having to travel so far for treatment and, potentially, the ability to recruit and retain very good doctors and more clinical staff if we could hold Wales up as a beacon of having those technologies here or adopting them more quickly?

[38] **Dr Carroll:** That was 12 questions.

[39] **Kirsty Williams:** I am sorry.

[40] **David Rees:** She does tend to ask a lot of questions in one go.

[41] **Dr Carroll:** I just about got hold of them.

[42] **Kirsty Williams:** I am sorry; I will be quiet for the rest of the meeting.

[43] **Dr Carroll:** No, that is fine. The first question was about speed—

[44] **Kirsty Williams:** Be careful what you wish for.

[45] **Dr Carroll:** When there are clinical referrals, typically they are because of services not being available in Wales. At our larger university hospitals, in Swansea and Cardiff, the clinicians often filter referrals from other parts of Wales, like Powys Teaching Local Health Board or Hywel Dda Local Health Board; so, you get a sequence of referrals. It is a reasonable situation, but quite frequently children get referred to Bristol for very complex treatment of bone marrow disorders. The tumour can be addressed, for example, in the University Hospital of Wales, Cardiff, but if there is a question of moving on to a more complex transplant, there is a real clarity in understanding that that will not be delivered in Wales, because the complexity of that requires a very large clinical team, full resource et cetera. When you multiply that by many examples, we do not propose in Wales that everything can be done in Wales. For a population of our size it would not be economic; you could not sustain the competent clinical team and all of the technologies that go with it. So, that is one element where there will always be a proportionate flow advisedly.

[46] However, there are component elements where, if you take some of the neurovascular interventions to do with aneurysms, quite rightly the combination of the neurosurgeons and neuro-radiologists will say, 'We believe that we could do this technique'. It may be relatively novel, and it may be early in the evidence approval stage, but its adoption could be possible in Wales. Therefore, there is a tricky calculation in terms of whether the calculated need in terms of the annual numbers would justify that. So, we quite often go through a phase that is a little bit confrontational with clinical teams. They get a bit troubled about whether we appear to be forcing them to refer to London, for example, when they think that they could do it in Wales.

Therefore, there needs to be a partnership, as there always is, with the wider clinical planning teams in the health boards to say, ‘This is at an early stage, not yet ready for movement and adoption into Wales’.

09:45

[47] So you have, with those two examples—one to do with haemato-oncology for children and the other to do with neurosurgery—always that tricky question about whether it would help to sustain and attract clinical staff. Epilepsy surgery in Cardiff, which you might want to come on to, is an example where, currently, a very small volume is done with complex techniques and technologies, but with the expectation that we would not any longer have to send people over to England because the clinical staff have the capability and the right imaging and surgical equipment. That is a starter in answer to your question.

[48] **Dr Webb:** This is slightly a note of caution. Particularly with specialised services, and particularly with device technologies, eminent Members around the table will have had expert witnesses saying that there is an issue about the level and quality of the evidence associated with devices in particular. That being said, from our perspective—and Geoffrey mentioned a slight conflict about proceeding too quickly with clinical groups—our issue is that the safety file on these devices is very small. Therefore, we have to go through a process of due diligence to make sure that, when we do the evidence appraisal, we actually identify both known and potential harm that is associated with interventions that would be accessible to wider populations than the cohorts that have already been studied if the data are available.

[49] A lot of the interventions we do with specialised services have quite severe clinical consequences and harms associated with them, and this goes back to the issue about monitoring outcomes. If we do not have a systematic way, which we are all trying to work on, to address the issue of measuring and systematically collecting the outcomes associated with these interventions, it becomes difficult to clinically regulate access appropriately, irrespective of whether that is in England or NHS Wales. So, the key issue related to this is that we need a good, systematic way of collecting the outcomes experienced with patients in order for us to make the decision on whether it is right to go to NHS England or whether there are equivalent outcomes that could be delivered with the available expertise and capacity and resources in NHS Wales. That is the only issue of caution, because there have been a number of circumstances in the NHS where the haste of implementing new technologies has actually led to significant major withdrawals and patient harms.

[50] We can go back to Thalidomide in 1963, which is why the Committee on the Safety of Medicines was set up. There was an acknowledgement by the UK that they did not want to recreate an inappropriate process that speeded up access to technologies that, potentially, were harmful as well as being beneficial.

[51] **David Rees:** Fiona, do you want to add to that?

[52] **Ms Jenkins:** Yes. I will bring it back to a more basic level. It is very easy to think of technologies as being very rare things for a few people that will always be provided on a UK-wide basis because we will never have critical mass, but actually the greatest benefit for the population of Wales is using technology for the masses.

[53] I will just give an example of one of the programmes that I am involved with at the moment, which is looking at how we can develop a genomic strategy for Wales. I am involved in this because it needed some executive leadership from the health board, linking with our partners, to work out what is a great idea for Wales—how on earth can we make this happen? There are 100 reasons why we cannot make it happen, but our trick is to try to get the partners together so that we can move forward with this.

[54] If we do develop a genomic service for Wales, we will prevent patients—not necessarily themselves, but their samples—being sent to other parts of the UK and internationally, which is something that we fund at the moment. More importantly, it will develop the skills, expertise, reputation and the sideline of business—and when I say ‘reputation’ I mean both our academic reputation and our clinical reputation—and it will enable us to use Wales as a good population to provide something that England cannot. Actually, we can do this better than across the border because of the nature of our population and the unique set-up our health service has compared to the English health service, providing everything from primary to tertiary care. So, actually, we are well placed to do this, but it is extremely difficult for us to negotiate with each other how on earth we are going to get a commissioned model that works correctly across the health boards, across the universities and across Swansea University with its secure anonymised information linkage database, and across our colleagues from Public Health Wales and WHSSC, as our commissioners. This is something about which I would say that, unless we actually grasp this and move forward with it, Wales will not stay still, we will actually lose the expertise that we have.

[55] So, there are some really big things that can affect a huge population. We could have much more personalised medicine and you would not need to have so many interventions and tests. We would be able to look at your genes and work out what your life chances of getting this or that are, and actually be able to target treatment at you appropriately. That is in simplistic terms. However, this is something that is really big for me on technology; it is an adaptation of technology, but is also an illustration of why it is not easy to do, so we need to get better processes to enable us to respond more quickly, to get key players together and work with the Welsh Government and health services to enable this to happen.

[56] **David Rees:** Pushpinder, do you want to add anything to that?

[57] **Dr Mangat:** I am not sure that I can.

[58] **David Rees:** That is fine. Kirsty, did it answer your twelve questions?

[59] **Kirsty Williams:** My concern is—I take your point about very specialist things—*[Interruption.]* No, I am a Liberal Democrat.

[60] I can understand that, but how can you justify clinicians from Velindre coming to the committee and saying that radiotherapy techniques that have been used for years at the Marsden are not available for them to use here? I take your point, but how do we overcome things that have been used routinely across the border that have not been adopted here? How can you justify that? It is not about patient harm and patient safety then; it is about slow adoption.

[61] **Dr Webb:** Potentially. The issue is: what is the prospective systematic approach to being able to rapidly assess a particular technology, in a particular proportion of patients, to come to the correct decision, to implement the commissioning strategy around it, and to make it happen? The difficulty is that without that framework being in place, it becomes very difficult for clinicians to engage with a very amorphous process. The rigour that is required from a clinical regulation perspective is that if you have a system in place that is well-articulated, and the process is communicated to clinicians and to patients, that entire dynamic becomes much easier to handle and you will get fewer clinicians saying, ‘Well, actually, at the Marsden they can do this and we can’t do it locally’, because there would be a prescribed process for actually assessing it. There is an issue about what that process may look like, which Members may want to explore further down the line, but the issue is having a process.

[62] **David Rees:** That is the issue that we are focusing upon: is there a process and what

process should there be and who should administer that process? It is critical that we come to that point. Lindsay is next.

[63] **Lindsay Whittle:** Good morning. We have had a lot of evidence from you and there is a consistent message that you want cost-effectiveness and an all-Wales approach, which I think is what we like to hear. We have heard evidence from previous witnesses—Professor Ceri Phillips from Swansea—

[64] **David Rees:** Ceri Phillips.

[65] **Lindsay Whittle:** I did say Ceri Phillips.

[66] **David Rees:** I thought you said Ken, sorry.

[67] **Elin Jones:** No, Ceri.

[68] **Lindsay Whittle:** Yes, Ceri. He told us that we needed a consistent approach to the individual patient funding requests. I understand that there are a number of panels across Wales. Of course, if different panels are making different decisions about how they affect patients, then that cannot be right. What are your views on the possible strengths and weaknesses? We want to see an all-Wales approach, so that wherever you live in Wales, you get access to the technology or the new medicines.

[69] **Dr Carroll:** Let me just give you, for information, some facts. The health boards have their own individual panels where they are responsible for their population. We then have an all-Wales individual patient panel for specialised services, where they cross the health board boundaries—that 10%. So, we would never consider issues about a patient where it was the responsibility, specifically, of Cardiff for example. There is sometimes a bit of difficulty in dividing it up and we toss it forward and back, much to the annoyance of patients and others, but once we get that feel, then the next question comes into play, which is: is it a difficult process to make a decision about an individual, and when you have done it and you reach a conclusion of ‘yes’ or ‘no’, does that set a precedent, does that create a policy and does that lead to confirmation for clinicians and others that they now know what will happen with the next patient? The answer is that, often, they do not. It is a very difficult process, and one quick reason for that is that it is framed around whether the patient is exceptional, which is perhaps the wrong way around. It should be, ‘Does the patient fit the criteria that matched the evidence?’ I know that the Minister has asked for a review of the IPFR process. I think that that is absolutely vital. It links to the use of drugs and technologies, but we need that urgent calculation, so that it moves from just individual patient considerations to construction of evidence-based policies.

[70] **Ms Jenkins:** On that question, I sit on the Cardiff and Vale IPFR committee, so that is lucky. I was also present at the recent meeting that we had of all the Wales IPFR panels, regarding this review that Geoffrey has mentioned around the process that we are all adopting. I think that it is fair to say that there is a difference in adoption across different health boards. There is probably more consistency with the majority, but not complete consistency across all of them. However, patients are not consistent in themselves either, so because a drug is being supported in one health board and not another, it might be that the patient’s circumstances were different and that that led to the decision. It is very much on an individual patient basis that we are looking at the moment. I have to say that if we had all the money in the world, we could give everybody everything. We have to make some decisions as to how we best use our funds on the basis of the budget that we have and the remit that we have for the health of the total population. However, at the moment, the IPFR committees do not consider the cost of this. As Geoffrey mentioned, it is the exceptionality clause that leads our discussions and decisions. We do have robust processes in place, but I would welcome

some more consistency about how this is done.

[71] **David Rees:** May I ask one question? Obviously, many of the technologies come under the specialised services, and we understand that, but since you are on a board panel, are there many cases in which technology is involved that are dealt with at a local health board level?

[72] **Ms Jenkins:** I would say that more than 90% of the requests that come to our panels are for cancer drugs.

[73] **David Rees:** So, it is medication.

[74] **Ms Jenkins:** It is largely medication.

[75] **David Rees:** I am grateful for that clarification.

[76] **Dr Carroll:** Briefly, this is not the case in terms of specialised services; it is probably the other way around, for example, technologies to do with deep brain stimulation or applications of radiotherapy. This comes back exactly to the point that you were making about, 'Is it available in Wales, if not, where do you get it and how quickly?'

[77] **Dr Webb:** There is an interrelationship between an individual patient funding request and having a systematic process that deals with the assessment of evidence for cohorts of patients not individual patients. It goes back to the point that if there were a systematic approach that dealt with things on a timely basis, you would probably find that the IPFR numbers came down to those very specific instances where individual consideration of that particular patient's circumstances would need to be taken into account, rather than the larger wider cohort of patients who may benefit from a particular intervention. So, I think the two are inter-connected.

[78] **Leighton Andrews:** I have spent a lot of my working life in a field where the ability to waste money on technologies was a very significant element of the process of development. I am reassured by what you say in terms of the processes that you have in place, and in particular what Fiona Jenkins just said about operating within an environment that is conscious of cost. To what extent do you feel that the current speed of change in a variety of technologies, whether they are diagnostic or therapies or whatever, is less under the control of professionals with the system and more under the control of those working in the companies that produce the technologies? Sorry, I realise that it is a bit philosophical, but I wonder if someone has some feedback on it.

[79] **Dr Webb:** We made the comment about some of the differences between NICE and AWMSG in their structural appraisal, which is that they take manufacturers' submissions, which obviously are led by the manufacturer wanting to have something submitted to gain access to the resources that are related to it. I think that there is a role for a wider collaborative debate with a whole range of stakeholders, including the manufacturing industry, patients, providers of service, commissioners and political members, about what we are trying to achieve for the population of Wales, which is an entirely different dialogue that we might want to explore and is different to the way that it is handled in NHS England. There is plenty of opportunity to devise something that is much more integrated and involving a whole range of different stakeholders, compared to the processes that have been developing historically or to the future development in NHS England, which runs through a different dynamic from Wales. We have an opportunity to do things better and have a much more integrated process as a consequence.

10:00

[80] **Leighton Andrews:** What might that look like?

[81] **Dr Webb:** That would be the \$64 million question. Having had clinicians in clinical evidence reference groups, which include patients, processes of assessment and health boards as partners, I think it looks like what we have just described. You are starting to get an emerging feeling about how an integrated approach involving all those very important stakeholders could work and could do something different for Wales.

[82] **Dr Carroll:** NICE has introduced a highly specialised technologies appraisal programme. It has taken it over from what was the English advisory group for national specialised services. I have represented Wales on that and its predecessors for the last 10 years. I attended as the Welsh observer on behalf of the All Wales Medicines Strategy Group at the meeting in December. The reason I am giving you this example is because the commercial company was very much a participant at the table. It was fully involved, in perhaps a little bit of a different way from the All Wales Medicines Strategy Group, in that, typically, we have a written submission, we have consideration of the evidence, as Phil has described, and then, at an AWMSG session, the company comes in and answers some questions. However, NICE took it one step further, and the company was more heavily participant for a very long session, going back over the medical evidence, the research evidence, and the basis on which patients might be treated. There were patients present too. That, in a way, gives life to what Phil has given you as an example. There are, if you like, methods that do not particularly favour the commercial companies, but are just treating them as a source of evidence and information.

[83] **Ms Jenkins:** To add to that, from my perspective, I would say that the development and greater use of technologies has to be driven by the needs of the patient and from the clinical base, but we would be foolish to think that industry is not a partner in this. If, by working with industry, we could collaborate better, we would be able to advance the implementation of technologies better. However, it has to be driven by the needs of the patient, with industry as a partner, but not necessarily an equal partner in that respect.

[84] **Dr Mangat:** I would agree with that. The sense I have is that, whereas industry drove a lot of things in the past, there has been a brake on that, certainly by the systems that we have in our own organisation. So, I do think that that has changed.

[85] **David Rees:** Darren is next.

[86] **Darren Millar:** I will just pick up on that, before I ask my own questions, if that is okay. We were told the week before last by the All Wales Medicines Strategy Group that it is now going to develop Welsh patient access schemes, which are, effectively, going to be initiated by manufacturers in terms of them coming up with a price that might be more acceptable to the Welsh NHS for drugs that may have already been appraised by NICE as not being cost-effective. So, there has been a hint that we are drawing back from manufacturer-initiated appraisals, and yet the evidence from AWMSG a couple of weeks ago was quite different. Can you just explain those different perspectives that you seem to have, compared to the AWMSG?

[87] **Dr Carroll:** I think, if I may say so, you are perhaps misunderstanding. When there is an examination of the evidence and a decision that there is clinical effectiveness but not relative cost-effectiveness, or that it is at a level that really challenges the ability of the NHS in Wales to fund that set of patients, then there may well be a dialogue with the company. There is a lot of publicity, for example, about cancer drugs and drugs for cystic fibrosis. What is always commercial in confidence—the price at which that company will agree to fund the drug—is, really, a secondary component. Whether that is a kind of manipulation to say, ‘If

you drop the price, it might look more cost-effective', that is quite a difficult component, which, I guess, is driven by the All Wales Medicines Strategy Group, as the national body for us, but it also has a commissioning relevance, because, ultimately, the health boards and WHSSC—even if it is a lower price—still have to work out whether that fits with the service plan and can be absorbed and has good outcomes. So, it is a two-step process. I do not think that it is circumventing manufacturers requesting appraisals.

[88] **Darren Millar:** These are actually NICE appraisals—

[89] **David Rees:** Do not stop Dr Webb from coming in.

[90] **Dr Webb:** I used to work for the industry for 10 years before working for the NHS. There are a number of issues associated with patient access schemes. In effect, it is as Geoffrey indicated: you go through an evidence appraisal and it is not because you are not clinically effective, it is because the price that you are charging, basically, is too high. So, it is a commercial negotiation between a manufacturer sponsor and the body that is looking at the appraisal to come down to a price that is more affordable. That is no different from international jurisdictions of other bodies such as IQWiG in Germany, which are much more interested in the clinical effect of a treatment and what the price is. They are not so sold on the idea of cost-effectiveness thresholds, for example. So, the issue about price negotiation happens not just in AWMSG for patient access schemes, or the NHS schemes that go through NICE, they happen internationally, because it does end up as a negotiation of the price.

[91] The issue that we have is that we are all very keen to make sure that patients get appropriate medications and technologies, but there has to be some kind of transparency with the industry, as an equal partner in this, about what price it is charging the Welsh population. That should be an open and transparent discussion, with very specific and pre-specified rules about how you engage with that particular process, because our ultimate aim is to get better value for the population of Wales.

[92] **David Rees:** May I ask, then, obviously, that example is of the medication aspects of it, but is it a similar process in relation to technologies?

[93] **Dr Webb:** Having read some of the submissions around procurement, this is where some of the procurement strategy comes in, because, actually, manufacturers do engage in regional and supra-regional procurement hubs to offer the ability to reduce their overall net price based on volume. I am sure that Fiona could talk about that, as well.

[94] **Ms Jenkins:** Procurement, for sure. The better the price that we can procure at, the more technologies we can adopt. So, anything that supports strengthening procurement is good. That, again, comes back to the fact that you are better off doing this on a bigger scale, rather than on a smaller one, and that could be across a whole raft of different technologies.

[95] **Darren Millar:** I am just trying to clarify in my mind the role of WHSSC. What you appear to be saying is that you are both a commissioning body and an appraisal body in many respects. Is that a fair comment?

[96] **Dr Carroll:** Appraisal is an essential method. Instead of just responding to disorganised prioritisation, we are trying to evaluate on a strong evidence base what is justified in terms of resource allocation, clinical need and appropriate care with good outcomes. So, what I would say is that what we have tried to do over the last couple of years is get better at that. I take the point that, sometimes, we might look like we are second guessing NICE; we are not actually doing that, but we are trying to use a lens to be really clear on which patients would benefit and then to be able to monitor that.

[97] **Darren Millar:** It sounds very much, however, as though you are part appraising and part commissioning, and that the commissioning role that you have is informed by a bit of a toe-in-the-water approach, as far as your appraisal work is concerned.

[98] **Dr Webb:** The issue is about how we define the term ‘commissioning’, because our use of the term is such that it is a much more holistic approach. We use a range of different partners and seek their views, whether that is industry, clinicians, patients, or our partner health boards—actually, as WHSSC, we act as agents of health boards; we are not a separate statutory organisation, we act on behalf of the seven chief executives of health boards—to actually come up with what the correct thing is to do for patients under what circumstances, whether we can be explicit about that, and whether, and I will continue to reemphasise this, we have the ability to monitor the outcomes that are expected. It is in everyone’s interest to produce good outcomes for patients, and that needs fundamentally to link to a process of appraisal and a process of monitoring.

[99] **Darren Millar:** So, I am just thinking through in my mind—

[100] **David Rees:** Make this your last question, because I want to Leighton to come in.

[101] **Darren Millar:** Yes. So, what we have is a situation where clinicians can initiate some sort of appraisal, and patients, in terms of individual patient funding requests, can initiate some sort of request for access to technology, manufacturers can, in some respects, also initiate a request for an appraisal of a technology, and then we have the All Wales Medicines Strategy Group, the WHSSC, and local health boards through the individual patient funding request processes as well, all doing a little bit of the jigsaw in terms of the appraisal work. However, the only real experts on appraisal that we have, as such, in terms of a body that is specifically set up to appraise, are in AWMSG. That is specifically set up and established to appraise.

[102] **Dr Webb:** For drugs, yes.

[103] **Darren Millar:** Yes, but only for drugs.

[104] **David Rees:** Let me point out that we are on technologies at this point. It does not do technologies.

[105] **Darren Millar:** The point that I making, however, is that it is the specialist body and it has the ability, potentially, to be able to expand the scope of its work to undertake technology appraisal in addition to the drugs work that it does. If it took away that element, if you like, of your responsibilities, would that be helpful? You are shaking your head.

[106] **Dr Carroll:** It would be profoundly inappropriate, because technology appraisal in the way that you characterise it is a component of the machinery. It answers one set of questions, but it does not answer the comparative prioritisation. Let me give you a quick example: a drug that goes through trials and is approved for use by AWMSG is, quite often, early in its publicity in clinical terms, with a very narrow group of patients who have qualified for that trial. When it is approved for use there is then a fundamental question as to whether it is only for that narrow group or for younger or older people. So, we have a duty to take on that wider area.

[107] **Darren Millar:** I understand the point that you are making, but I am suggesting to you that AWMSG, with a wider remit, might be at the top of the pyramid, if you like, before you are then able to make informed decisions about commissioning. That has the expertise, as we understand it, to undertake these detailed appraisals and could quite easily, according to some of the evidence that we have had from individuals, such as Ceri Phillips, take on the

responsibility for technology appraisals.

[108] **Dr Webb:** We would not be hostile to that.

[109] **Darren Millar:** Okay.

[110] **Dr Webb:** I think that the issue is the acknowledgement that that is part of a much broader and wider process, because you will have another group that has a wider remit to look at technologies. It will apply a particular method. We have already discussed some of the limitations of the method, because, currently, that is manufacturer-sponsored submission only. It appraises the evidence that is submitted by manufacturers, so, there is no independence or independent review of the evidence—you just take what the company has submitted to appraise. That might be a very narrow focus on the best evidence that you can possibly have from the manufacturer, because it is the one who is submitting it. So, I agree with you, but it is about the terms of reference, the scope, the methods, the integration with partners—because what we do not want to happen is that a recommendation comes out and then we, as agents of health boards, and the health boards themselves, suddenly have to worry about what is the true impact assessment of this technology, how we implement it, what things are we not going to do as a consequence—

[111] **Darren Millar:** Sorry, I am a little bit confused. We were told a couple of weeks ago—

[112] **David Rees:** One second, Darren; clearly, you are saying that the situation is that that there is a role for AWMSG to take on at a high level, but then a second role, at a lower level, at which you believe WHSSC could be involved.

[113] **Darren Millar:** May I just clarify? It is a very important point to clarify.

[114] **David Rees:** Let Fiona come in first.

[115] **Ms Jenkins:** I suppose one thing that I would like to add is that we could spend all of our health board money on drugs. If the all-Wales monitoring group were to say, 'Yes, this passes', that leaves us, as health boards, with a problem, because I know that we have other technologies that we just cannot afford to give to patients that perhaps have not had the rigour of pharmaceutical money behind them to do testing, and so the evidence base is not in the same double-blind-trial gold standard, and, actually, it compromises our ability to help some other people who might have lifelong conditions. For example, we have an issue around functional electrical stimulation. It is an electrical bit of kit that you put on the end of your foot, so that, if you are a multiple sclerosis sufferer, or a person who has had a stroke, it enables you to walk independently. There is no consistency about the adaptation of this across health boards. We would like to do it if we had more funds, but the more that we spend on drugs, the less that we have to look at other technologies that might help a wider group of patients for longer.

[116] **Darren Millar:** I completely understand that. I am just—

[117] **David Rees:** This is your last question, because we have to move on.

10:15

[118] **Darren Millar:** The information that we received from AWMSG did not suggest that everything it does is initiated by manufacturers. It was quite clear that it undertook significant horizon scanning, that it planned its work and that a lot of the work that it did was led by clinicians coming forward with suggestions for technologies—well, for drugs, in this case—

that might be adopted, and it certainly does not only accept manufacturers' evidence. Quite clearly, it takes some evidence from clinical trials that may have been conducted independently. You are shaking your head, Dr Carroll—

[119] **Dr Webb:** My experience from sitting on the new medicines group is that the evidence file is a manufacturers' submitted evidence file. There is no *de novo* attempt at analysis or independent review of the data that are submitted outside of the manufacturers' submission and, to be quite frank, sometimes, we have big discussions about the data that are presented on cost effectiveness.

[120] **David Rees:** Okay, I think that you have clarified your position. Thank you very much for that.

[121] **Darren Millar:** We need to clarify that with the head of AWMSG.

[122] **David Rees:** Elin, this is the last question because time is catching up with us.

[123] **Elin Jones:** I have a question on a completely different area, and that is the take-up of medical technologies and your views and roles with regard to the take-up of medical technologies. I am probably thinking of those technologies for the masses rather than the very specialised technologies. I am talking about ones that have been appraised that have gone through all of your systems, which you have already discussed. We have had evidence on this. The take-up is by clinicians, of course, whether in a hospital setting or a GP setting. Some of them will be very stuck in their ways and may not want to embrace new ways of working or new technologies. Different health boards will have different views as well on the ability to promote particular technologies. I was going to ask, possibly WHSSC, whether you are frustrated at times that technologies are not taken up or not taken up in every part of Wales. I was also going to ask the health board whether, in terms of your roles, particularly with GP technologies delivered in a GP setting, you think you have the capacity to train GPs and to promote particular technologies so that the patients actually get to use them and so that there is not a clinician sitting in the middle somewhere saying, 'I don't want to do it this way'.

[124] **David Rees:** Shall we start with the health boards, Fiona?

[125] **Ms Jenkins:** I will just give you an example. I was with our medical illustration service in the past few weeks. It was just about to take out a new camera to a GP practice for tele dermatology. The individual went out to educate the GP in how to use this camera so that the patient can have a photograph taken of their skin lesion, which can then be beamed into our dermatology department without requiring the patient to make a journey, and the GP gets an answer much more quickly. The medical illustration department is going out to educate GPs. They have some quality assurance around the granularity of the photos that come back in and they do some training and education and follow-up should the pictures not be good enough. As a service, we would keep an eye on which GP practices are using the camera, whether there are areas where we need to go out to provide some education and have some discussion. That is something that is still growing, but we have considerable evidence of spread. It is popular with GPs, it is popular with patients and it is popular with the dermatology service, so it is a win all round. So, if you have something like that that is a no-brainer it will spread by default.

[126] However, I was also in a discussion yesterday with colleagues from our IT service who were having discussions with our gastroenterology department. They were wanting to introduce what one could only describe as Skype at home, so that you could take a picture of your stoma wound and beam it to the consultant to advise on management, dressings and coping with it, wherever you are in Wales—it does not have to be on our patch. Some of these

are tertiary services. You think, 'Actually, this is a much better deal for patients. It is a much better deal for rural patients and, actually, it makes better use of our consultants' time because they do not have to go travelling to do clinics, so why don't we do that?'. In discussion with the IT service, it said, 'Actually, there is another health board doing this, but it is not spread across Wales and it is still seen as quite innovative'. I think that, in fact, this is fairly standard technology that we all use to communicate. Why are we not using this more? For me, it is technologies like that, which we should really be investing in, that would make a huge difference.

[127] **Elin Jones:** Just quickly, teledermatology has been around for about 10 years in Ceredigion, to a certain extent. Why is it not widespread? It is very specific. What you just described should not be novel.

[128] **David Rees:** That is a question for another group. Do you want to talk about your health board?

[129] **Dr Mangat:** We are on the same journey. We have actually bid into the health technology fund for exactly the sort of things that Fiona has just mentioned. However, there are much simpler things to do before you go down the line of Skype, teledermatology and that sort of technology. We have several helplines where people simply call a specialist nurse, and they have been very successful with rheumatology and chronic pain. People can actually call and say, 'Look, rather than wait for my next appointment, this is what my current problem is', and you can actually prioritise when you see people. Some people may not need regimented times, and that actually gives the power more to the patient as to when they feel they need to be seen, and how they need to be maintained. It is no different to how GPs work. They have patients coming back to them on a regular basis, and that is not always necessary either. I was at a conference recently where we had a description of what has happened in Alaska, which has a huge, widespread area. They use simple technology like texts and the internet for repeat prescriptions, for telling somebody that they have a problem and to ask, 'Can I come and see you sooner?'. This has increased their efficiency by big steps. They were visiting Wales recently, and there are some real lessons to learn on technologies. One of the guys, in the middle of a lecture, prescribed two patients repeat prescriptions and authorised them back in Alaska on his smartphone. So, we have a long way to go, but it is not beyond us to do that.

[130] **David Rees:** Elin also asked a question of WHSSC. Do you want to answer that, Dr Carroll?

[131] **Elin Jones:** It is just whether you are frustrated at times about the take-up of technologies.

[132] **Dr Carroll:** I cannot immediately think of examples in the context of what we do where the clinicians are slow to adopt. It is typically the converse—it is where the clinicians are anxious to get on board, and we discussed earlier the difficult calculation about whether Wales is too small to take on more complex treatment, or sometimes the reverse, where we could actually do it and repatriate work. I gave the example of epilepsy surgery, where we definitely want to do that and are encouraging that in Cardiff.

[133] **Dr Webb:** In answer to your question about why, as this is an evidence committee, there is a wealth of international literature to describe why things are not taken up by clinicians. There is a whole range of multidimensional reasons why individual clinicians or groups of clinicians do not take up technologies that are offered to them. Robert G. Evans wrote *Strained Mercy: The Economics of Canadian Health Care* in 1996, which is an assessment of the Canadian system. Some of the issues that he wrote about in 1996 are still predominant today. Part of this is trying to take the clinical faculty with you, and not doing something that people think is being imposed on them, which is why I would suggest that we

need to take a different approach to how we go about doing this, and involve all our major partners in the discussion about what should be done. Nobody likes somebody saying to them, 'You must do this, and only this, under these circumstances'—that has to be a negotiated position with each of our partners, whether they be commissioners, providers, clinicians and patients. Part of the reason why things do not get taken up is that that federated approach about how we go about doing the right thing is not integrated enough or invested in the people who really need to take it on board.

[134] **David Rees:** Fiona, do you want to come in there?

[135] **Ms Jenkins:** I was just reflecting on what frustrates clinicians most about technology. It is the most basic thing—it is our IT infrastructure. That is the thing that most frustrates our clinicians. There is always a reason why not—it is old, it is creaking, it does not interface, we have too many different servers that do not speak to each other, and the whole system is creaking. It is our basic IT infrastructure that frustrates clinicians most. I was in a discussion last week with our occupational therapy colleagues from health, social care and housing, trying to see how they could work better together. What frustrates them? They have to put a referral in the post to one another. They are not allowed to e-mail a referral to each other. Faxes have gone. They used to use updated faxes, but now those are not allowed. We are not enabled to communicate patients' information freely between organisations. That is what really frustrates clinicians.

[136] **Leighton Andrews:** In relation to points made by Elin, you answered in respect of use of lower level, low-end technologies but which are now everyday technologies, such as Skype, and you were talking about the use of smartphones, and so on. One of the most frustrating things for patients, whether it is recall or repeat prescriptions or simple diagnostics at a distance, is that those technologies are particularly not used by GPs to any great extent. So, to what extent are we able to incentivise or drive GPs to make wider use of all of these technologies? Most of my constituents have smartphones and are capable of using them. Why cannot GP practices respond to those?

[137] **David Rees:** In response to the question, you represent health boards, and Elin was trying to capture the picture across Wales, in a sense. If you are able to give a view of your health board, that would be very helpful. If you are also able to give a view across all health boards in Wales, that would also be very helpful, as to why we see a slower take-up among GP practices and primary care.

[138] **Dr Mangat:** It was commented by Dr Webb that the key to implementing something like this is getting buy-in right at the start. GPs and hospital consultants are a generally intelligent bunch with their own views and opinions, and changing some of them is quite difficult. I would say that clinical engagement is the biggest challenge in the health service, because it is a large body of people and changing its practice can be difficult—there is no question about that. It is really important to lead by example, and if you can find small areas or small groups who benefit their patients by introducing technologies, that will spread. In our health board, we are going to go down the network line, where, instead of having locality-based practice groups, we are having 11 networks developed. We hope to introduce some of the technologies that we are talking about into those who are most energetic and innovative. I think that that will set examples for other networks.

[139] So, I think that it is a question of starting in the simple ways in the areas where they are most amenable to creating examples for others to follow. That is the method and that is the difficulty that you will always have with general practice. They are working very hard as it stands, and change on top of working hard is difficult to press on people. So, if it is a top-down approach, it will be difficult, but we have to encourage them to do it because, in my mind, it is what is right for patients.

[140] **Ms Jenkins:** I have a couple of points on this. Actually, GPs have better IT systems than hospitals, so GPs are very often better at using technology for doing e-prescribing and such. They have far fewer paper records and much easier access to information. Sometimes, they are frustrated by the interface with the hospital services. So, I do not think that the GPs are behind the curve, and, in many respects, they are ahead of the curve. They are thirsty to use technology to make them more efficient.

[141] One of the discussions that we are having in Cardiff and Vale University Local Health Board at the moment is about a big bang approach with telemedicine and telecare, which will very much engage primary care within this as well as social care partners, and which will require different ways of working. This has been discussed with primary care and very much supported by it, and it is part of our health technology fund bid at the moment. It is one that we would like to do, but we do not have the resource to support primary care to do this without some pump-priming.

[142] Within the NWIS programme that GPs also have, you can, as a patient, request a repeat prescription online. You can e-mail your GP. My understanding is that the functionality for a two-way e-mail between patient and GP has not yet been switched on, but the functionality is there. So, if you are a patient and you want to contact your GP, I would think that this is something that we could commend, because, within hospitals, our system is not encrypted with a patient's home e-mail address, so we cannot contact them, but GPs can. So, GPs could use technology at a faster rate than some of the hospital-based services.

[143] Those that I know are keen to use technology, but perhaps we do not give them enough money to enable them to do it as much as they could.

10:30

[144] **David Rees:** Thank you for your evidence this morning. You have given us clarity on some points and identified some areas where we need clarity. Thank you very much for that. You will receive a copy of the transcript.

[145] Before you go, I have asked each of my groups and I now ask you—perhaps we will take one from the health boards and one from WHSSC—as to whether there is a single recommendation that you would like this committee to consider, what it would be and how it could be achieved. Dr Webb, you have identified very clearly this morning the systematic approach that you think needs to be adopted, but the second part of the question is: how do we get there? If you think that you cannot answer it now, we would be happy to receive a written response if you would prefer to do that.

[146] **Dr Webb:** We would be happy to provide a written response. This might avoid the question slightly, but I think that there is an opportunity not to be fettered by the current thinking in other jurisdictions and in NHS England, and to do something that is radically different about how we integrate partnership working into the process of the assessment of new technologies, its implementation and its use to better patient care. As has already been alluded to, that might in part be about setting up a group that allows consistency in the approach to be adopted, but it must be much more organic than that, because the issue is not about the technical process—which can always be achieved—it is about the integration with partners, patients, clinicians and the public to ensure that we implement what we all agree, and what we all believe to be, a good idea that is in the best interests of patients.

[147] **David Rees:** Okay, thank you. Fiona.

[148] **Ms Jenkins:** My reflective response might be better, but I will give you my quick

one. From where I sit, I would say that drugs are a part of it, but not all of it. My interest is in looking at the broader adoption of technologies. It cannot be done on a health board by health board basis and it cannot just be done within the NHS on its own. We need to get a partnership together on an all-Wales basis to look at how we can drive forward technologies. I am mindful that we have the health technology fund, but that is capital only and that has been causing us some problems. We cannot adopt technologies without looking at the revenue consequences, so that needs to be linked in with it. Our basic IT infrastructure is the place where I would start, because we have to build a platform from there that we can link technologies into, and our basic infrastructure is creaking.

[149] **David Rees:** Okay, thank you. Dr Carroll, you have the final word.

[150] **Dr Carroll:** I would just like to add that conditional approval and further evaluation is a very practical way of examining costs and benefits for patients. It is not a simple case of making a decision, 'yes' or 'no'. It may well be conditional with application through clarity about clinical criteria, which patients, under what circumstances, good policies, good service specifications and clear measurement of quality and outcomes.

[151] **David Rees:** Thank you. Pushpinder.

[152] **Dr Mangat:** I think that the most important thing from my perspective is that our clinicians have clarity on how they access health technologies. That needs to be streamlined, I believe, throughout Wales and down to the health boards. That is the system that I think would be welcome.

[153] **David Rees:** Thank you very much and thank you again for your time this morning.

[154] We will be going straight into the next session. We have extended our time by 20 minutes, so we will have a later break. May I remind Members that we are still in public session?

[155] May I remind Members that the next witnesses come from different areas, but that they have submitted a joint paper?

10:35

Ymchwiliad i'r Mynediad at Dechnolegau Meddygol yng Ngymru: Sesiwn Dystiolaeth 7

Inquiry into Access to Medical Technologies in Wales: Evidence Session 7

[156] **David Rees:** Good morning. I apologise for the delay; the previous session kept on going a little bit longer than we had scheduled. I welcome to this session Mark Roscrow, director of procurement services at NHS Wales Shared Services Partnership, Peter Phillips, director of the Surgical Materials Testing Laboratory, based at the Princess of Wales Hospital, Bridgend, and Alun Tomkinson, who is an ear, nose and throat surgeon at Cardiff and Vale University Local Health Board. Good morning and welcome. I thank you for the written evidence that you have provided to the committee for this morning's session. Again, I remind Members that we will be focusing particularly on the consistency of approaches across Wales and good practice and how that is shared, and considering the processes involved in accessing medical technologies. I will start the session as our colleagues will come back in; they have obviously had a quick comfort break. Gwyn, would you like to start the process?

[157] **Gwyn R. Price:** Thank you, Chair, and good morning, everybody. On the need for an all-Wales approach, could you give me your views on the response to the suggestion that a new technology group be established within AWMSG, and what would be the benefits and

limitations if that happened?

[158] **Mr Phillips:** To start with, we do not think that it should be just new technology. We think that there is merit in having a mechanism, such as the medicines strategy group, looking at all medical technologies and medical devices because the problems that we see with medical devices are not just with new technology.

[159] **Gwyn R. Price:** Right.

[160] **David Rees:** Do you agree that AWMSG should have that responsibility?

[161] **Mr Phillips:** Yes, absolutely—either that or a body similar to it.

[162] **Mr Roscrow:** Our view is that the All Wales Medicines Strategy Group has had a very clear focus around predominantly the pharmaceutical side and I think that there is a very strong argument from our perspective for something similar, but on the technology and devices side. So, it would be mirroring, but with a different focus. The product set and the people who are potentially involved in that are different, so I think that the arguments to create something are quite strong, but with a particular focus on technology, and as Pete said, not just bringing new and innovative product along, but also the renewal of the existing product set, which is also a problem for us.

[163] **Mr Tomkinson:** I would certainly support that as a clinician. Clinicians feel, in many ways, isolated from some of the decision making. I would support having a body like this with strong clinical engagement, and I do not just mean doctors, but all kinds of allied health professionals, and nurses and anybody who works within the NHS. The point that Pete is making about product within the NHS at the moment is a really valid one, because a lot of products are renewed, and every time the procurement process has to be implemented, there is an opportunity to look at the products that you are using and to ask the question, ‘Is there something better or more cost-effective out there or is this something that we actually don’t need to use?’

[164] **Gwyn R. Price:** But, your leaning really is towards the AWMSG umbrella.

[165] **Mr Tomkinson:** Yes.

[166] **David Rees:** You have identified that existing technologies need to be included in there and I understand that. If you are looking at the procurement situation, is there any assessment of a replacement or a more modern version of the technology that you are currently using?

[167] **Mr Roscrow:** There will be. It will depend on the market and on various issues. So, we have examples of things like cannulas, which are changing through new technologies, and which manufacturers will predominantly argue are delivering something better than the previous version did. Sometimes, that is what we call the Apple phenomenon—trying to get you to buy something that you did not know that you needed—and sometimes it is because that product set may offer a clinical improvement. So, as Alun said, part of what we are trying to ensure is that we have clinical involvement and engagement, and part of what Pete’s organisation does is the testing of that product, because it might be surprising, but sometimes these things do not do what they say that they are going to do. The clinical effectiveness or the safety, sometimes, of some of these products is not what you would expect it to be. We have lots of evidence of that from the work that Pete does.

[168] **Mr Phillips:** You ask whether we consider new technologies when we are re-procuring. An example of that is in tonsillectomy. Alun is an ENT surgeon. We have used

cold steel tonsillectomy equipment for 50, 60 or whatever years. There is a new technology called coblation, which was brought on to the market about 10 years ago. Through Public Health Wales's surveillance mechanism, Alun and people in Public Health Wales have shown that this new technology, which was the new bright hope in the firmament, has not been as safe as the traditional cold steel methods of tonsillectomy. In fact, it has caused more patient problems or safety issues.

[169] **Mr Tomkinson:** That is a complex issue. I would not want to get into the detail of that now, but with regard to the example that Pete has given, sometimes you think that something is going to be the answer to a prayer, but it is either no better than what you already had or has other issues associated with it that you were not expecting. It is worth, when you are introducing a new technology, being aware that those possibilities are there and to have a system in place that is going to spot them, so that, having introduced something, you do not find later that you have a problem that you did not have to start with.

[170] **David Rees:** Several Members want to come in, so I will hold my question back. Kirsty, would you like to go first?

[171] **Kirsty Williams:** The evidence that you submitted weighs, quite rightly, very heavily on patient safety and the unforeseen consequences of adopting technology too quickly without a proper review process. Could you give us some ideas about how, in evaluating technology, issues around monitoring could be included in that? Are they included at present and how could they be better included? Also, in your paper you talk about usability. We have spent a lot of time talking about why sometimes things do not get taken up by clinicians. How could you put usability into that process of evaluation as well?

[172] **Mr Phillips:** With regard to the monitoring, first of all, the NHS is trying to get bang for its buck. That tends to mean that we are buying a lot more stuff from the far east than we used to, from China in particular. Most of the medical gloves used to be made in Europe; we import most of them now from abroad. As we know that we can have problems with the suppliers occasionally, we have a programme where members of our lab go to the procurement stores and pull products out during the contract to make sure that we are buying or getting what we are supposed to be getting on the contract. We have, over the years, found medical gloves, for example, that are either very weak or full of holes. Clinicians wear gloves to protect themselves and the patients and it turns out that we have prevented a lot of gloves coming in that are substandard in the end. We are already doing some monitoring. We believe that there are opportunities to do more in this arena because I suspect that we are fairly unique in the amount of monitoring that takes place at the moment of medical equipment.

[173] **Mr Roscrow:** There are also examples where a new procurement process that involves an element of testing has identified areas where products or systems that have been used are not doing what they were expected to do. We had an example around the blood-warming devices that were being used. When we ran through a new procurement process, we identified that they were nowhere near as effective as people would have you believe that they were. So, part of the new contract and the recommendation was, obviously, not to use those and to change to something else.

10:45

[174] One of the problems that we have is that the adoption of that is a challenge sometimes. Understandably, when clinicians who have been using something for a long time think that it is doing what they think that it is, and then find out that it is not, it is not a terribly grand thing that they want to hear.

[175] **Kirsty Williams:** They are a stubborn bunch. *[Laughter.]*

[176] **Mr Tomkinson:** It is funny that you say that. Some of us are stubborn and sometimes the stubbornness is there for good reason, because we are suspicious of change. What we are talking about here today is creating an opportunity for clinicians—I use that term in its broadest sense—to engage in a process around getting the best for their patients. I can promise you that most clinicians want the best for their patients. If they believe that what they are presently using is the best and they have not seen any evidence to the contrary, they will defend that position. However, if you have a better system—the same works for medicines—that will show them evidence, they will be the first people to say, ‘Thank you for pointing that out, I think I will take the other option that you are offering me, because it also saves money for the NHS and it is going to be better for my patient and for me’. So, I get what you are saying about stubbornness, but I do not—

[177] **Mr Phillips:** It is about confidence with clinicians in many cases. If they have confidence in the process, they are much more likely to adopt the change or the technologies that are being proposed. If it is being imposed on them, it is much more difficult.

[178] **Mr Tomkinson:** My experience of dealing with issues over the last 10 years with these guys is that we are quite unique in Wales; we are in a relatively small geographical area and we pretty much know each other. Clinicians in various disciplines know each other and they understand each other’s problems. What happened around the tonsillectomy issue, which I was involved with, was pretty amazing, and it happened because of the advantages that we have in terms of how Wales is structured and how Wales is. We kind of made it up on the hoof, but if we were able to systematise that somehow, you would have something very strong and very powerful that the other regions in the UK would not have.

[179] **David Rees:** What about the question of usability?

[180] **Mr Phillips:** This is a big problem. Usability studies are, in theory, used by manufacturers when they are developing their new devices, but they are not used to assess devices when they are being brought into the NHS. So, there is very little usability that goes on. It is used in training in the NHS, so most clinicians will go through some sort of simulation suite, but very rarely do people say, ‘Here is an intravenous pump, now show me how you would use that having not read the instructions’. However, that is quite common—a clinician turns up on a ward and has to use the kit that is there to use without training, perhaps. Also, very rarely would they say, ‘Here is the instruction booklet, now run it’.

[181] One of the co-authors of our submission, Harold Thimbleby from Swansea University, has done a huge amount of work that shows that, in fact, some of these devices are sort of designed to fail. That is, if you knew what you were doing when you designed them, you would not have designed them that way. There are intravenous pumps that do not have the right sort of safeguards from the human factor perspective. At the moment, we are not using the human factor assessment in many respects to assess devices before we buy them. We think that there is a huge opportunity there. We have clinicians who are at the moment, across Wales—. The National Patient Safety Agency—which no longer exists, as NHS England has taken over its role—issued an alert to replace luer devices, which are ubiquitous in the NHS, with non-luer devices. This will affect all spinal root injections. We have had clinicians throughout Wales doing user assessments at the University Hospital of Wales, with some obstetric anaesthetists, and we found out that the devices currently on the UK market are pretty poor. In fact, Wales has made the decision to postpone the implementation of this alert, because we suspect that the perceived safety benefits of implementing them would be outweighed by the problems with the devices that the human factors assessments have come up with. So, we have dipped our toe into the water, but we think that there is a lot that can be done to develop that aspect of our work.

[182] **David Rees:** I have a question on safety, because your paper highlights safety and risk analysis a great deal. You have also highlighted, as other witnesses have, the difficulties in technologies and the number of people who are able to be part of an evaluation process. How do you see us getting around that to ensure that any new technologies or technologies used in the health service are safe, and that the process of evaluation has the ability to take that into consideration?

[183] **Mr Phillips:** It is a tricky one. I do not think that there is a magic or silver bullet answer to that. It is multifactorial, and I think that how you approach it will depend on individual devices or technologies. Certainly, from our experience, there is currently a European directive to prevent needlestick injuries, so, across Wales, health boards have been buying cannula that will self-blunt. It turns out that health boards have made some decisions off their own backs and cannulae have been uplifted from wards now, although those devices are CE marked, and, in theory, are perfectly safe and comply with all of the legislation, because they have caused clinical problems that were unforeseen. So, for those particular devices, we suspect that human factors or usability assessments would have pulled out some of those safety issues beforehand.

[184] However, I do not think that that is the same with everything. In terms of lymphedema stockings, for example, the Welsh Government has a lymphedema advocate, I suppose, who is working with procurement to unify the procurement of lymphedema garments across Wales. The assessment of those garments is done perfectly adequately in a laboratory. We found in our lab that some of them, which should provide, for example, 21mm of mercury, are providing 30mm to 40mm of mercury and some are providing 15mm. Neither of those situations is a good place to be in when you are expecting a certain amount of pressure to deal with patients' symptoms. So, I suppose that the answer is that it is horses for courses.

[185] **Mr Roscrow:** I think that the range of technologies and products that we are buying means that, in trying to take this forward, different approaches have to be applied to those different areas. So, what you might do—. We have recently bought a da Vinci robot—that is different to Pete's stockings example. So, it is about how you evaluate the clinical effectiveness and the safety of those things. That is one of the reasons why we are saying that it is different to pharmacy.

[186] **David Rees:** Darren, do you want to come in now?

[187] **Darren Millar:** I am sorry about earlier; I had to have a big cough.

[188] I just wanted to ask you about your role in a bit more detail. It seems that you are responsible for testing the quality of products, rather than assisting in the appraisal of products. Is that a fair comment to make?

[189] **Mr Phillips:** We also get involved in appraising products to a degree, as well. So—

[190] **Darren Millar:** Could you tell me a bit more about that, because you have noted that WHSSC sometimes asks you to undertake certain bits of work. Is that right?

[191] **Mr Phillips:** It is not WHSSC. WHSSC funds our laboratory, yes, but it tends not to ask us to—. Our programme tends to be driven pretty much by what is on the procurement horizon. I can give you the example of silver catheters, for example. They are catheters that are designed to reduce urinary tract infections, which are very common. Silver catheters came on to the market 10 years or so ago and they were about five to 10 times the price of the standard urinary catheter that was used. There were concerns by some clinicians that this might not be good value for money, so our research and development officer did a technology

appraisal, as it were—a literature search, pretty much. That is the sort of thing that Cedar in the University Hospital of Wales does on medical technologies. We came to the view that there was no convincing evidence that the catheters were of any clinical benefit. In fact, procurement then decided not to let the contract for silver catheters. As it happens, a multicentre study was published about two or three years ago, which supported the view that we ought not to use silver catheters, and that they did not provide any clinical benefit. So, we do get involved in some respects, although our focus is mainly on testing.

[192] **Mr Roscrow:** However, that testing does support the procurement process. So, if we are evaluating products—your stocking, for example—and looking at the tenders that we receive, as you will appreciate, it will be about how we evaluate and the various weightings that we will apply to price, quality and other aspects. So, the quality aspect will have a fairly high weighting, and Pete’s involvement will reflect that aspect of the evaluation process.

[193] **Mr Phillips:** May I just come back on that as well? I should probably explain that, in the procurement process, it will not just be our laboratory and procurement that are involved; there will also be a group of clinicians involved in evaluations. With the lymphoedema contract, for example, we have a group of lymphoedema nurses throughout Wales who meet with procurement and us, and we had a meeting in Builth Wells—in the Welsh pavilion, I believe—a few months ago, where lymphoedema patients came along. The lymphoedema nurses then had a look at some of the stockings and how to fit them on the patients. It tends to be different groups of people dealing with different areas. I would say that clinicians are at the front and centre of the procurement process.

[194] **Mr Tomkinson:** Just to add to that, from a clinical point of view, whether you have an old instrument, a new instrument, or a new product that has come on the market, you need an appraisal. From the clinicians’ point of view, it is a matter of finding somewhere where you can go to get valuable independent evidence. Often, there will be only two or three people perhaps in that particular marketplace. They will lobby you heavily; they will invite you out for lunch and try to sell their product. With any new company, that is their job; that is what they do. There is a huge value in this type of situation to be able to turn to someone like Pete’s laboratory and ask for evidence that is independent. That is hugely valuable. It is about trusting what has been said. You will never please everyone all of the time, but if you can show that you have been through a proper process in arriving at a conclusion to go in a particular direction, that is hugely powerful.

[195] **Darren Millar:** So, you are testing the efficacy of the products that can come in, and if there is a switch in supplier, as it were, you test the quality of the products that might come as a result of the supplier switch.

[196] **Mr Phillips:** Yes. One of the things that we do a lot is making sure that, if we find a product that is potentially cheaper, we get the same performance characteristics from it.

[197] **Darren Millar:** However, it does not appear, generally speaking, to be the very high-tech end that requires clinical trials et cetera—it is more about supporting the procurement process and the clinicians who might want to have the benefits explained to them.

[198] **Mr Phillips:** They tend not to be for the very high end things. Trials tend to take place for the sorts of things that you would expect. In fact, most of the silver catheter stuff that I referred to earlier was clinical trial-based; that is, it was based on the literature search.

[199] **Darren Millar:** That is a smaller part of the work.

[200] **Mr Phillips:** Yes.

[201] **David Rees:** I wish to just clarify something. Clearly, you have your procurement process involved in access to medical technologies. It is identified that you do some evaluation, and you have involved the Surgical Materials Testing Laboratory to do that. Where does NICE play a part? Obviously, NICE has its recommendations, which are not mandatory. What consideration of the NICE recommendations do you take when you make the decisions in your procurement process?

[202] **Mr Roscrow:** The recommendations that will come from NICE—and, again, there is a predominant but not exclusive focus around pharmaceuticals from NICE—are almost a precondition of us considering that product or item. So, it does need to have ticked that NICE box before we will actually take it further.

[203] **David Rees:** Whereas in terms of medication NICE is statutory or mandatory case, it is actually more of a recommendation and a guide—

[204] **Mr Roscrow:** Yes, it is more of a recommendation.

[205] **David Rees:** I was just trying to ask how, other than just ticking the box, you have used the NICE recommendations in your process.

[206] **Mr Phillips:** I do not want to spend the whole morning talking about stockings. *[Laughter.]* However, in terms of the anti-embolism stockings, which are designed to prevent deep-vein thrombosis, NICE issued a document that made a recommendation for the compression profile for these stockings, based on sound literature research—certain pressure at the ankle, and then lower at the calf and lower up the thigh. We take that evidence into the procurement process and then we test the products to make sure that those that have been submitted for the Welsh contract meet that requirement. Where NICE makes recommendations, we will use those recommendations. Unfortunately, for most of the products that we are involved with, there are no NICE recommendations. Even the—I cannot remember the name of the programme—medical device assessment programme that NICE runs tends to be for big-ticket items usually. It is not the sort of thing that I get involved in particularly. NICE has only really scratched the surface in medical technologies so far.

11:00

[207] **David Rees:** Okay. WHSSC mentioned to us this morning that, I think that it was last year, it undertook 85 evaluations that NICE did not do, for example. Are its recommendations considered in the same way as NICE in that situation?

[208] **Mr Phillips:** Sorry—

[209] **David Rees:** WHSSC undertakes some evaluations that NICE does not do. It identified 85, I think, that it did last year. Do you consider those recommendations in the same way as those of NICE?

[210] **Mr Phillips:** I have not been involved in any of the WHSSC recommendations, I am afraid, so I cannot talk about that.

[211] **David Rees:** How would you view, as we mentioned at the start, a new body to look at this? How would you view its position relating to your role and the evaluation of the technologies and recommendations? How would you use its recommendations as a consequence?

[212] **Mr Roscrow:** I think that, in terms of the role that WHSSC has, if this technology group was created, WHSSC would be a part of that and the membership of that would need to

be a broad parish. That is critical. Clinical, Pete, procurement—there needs to be a broad parish of people involved. The danger is that we would be creating different systems and that people would then get confused about whether it is going through this group or WHSSC.

[213] **David Rees:** Okay. Thank you. Cost-effectiveness is clearly something that you consider. Your paper mentioned value for money. We have had training on value for money and there are various different interpretations as to what it means, in a sense. How do you assess value for money and what would you consider as part of looking at value for money in your cost-benefit and cost-effectiveness analyses?

[214] **Mr Roscrow:** It is always a thorny subject. Perhaps I should use the example, rather than stockings again, of orthopaedics, where we have a national joint registry so we have some evidence of the clinical effectiveness of various products. A colleague of mine happened to be in a health board this morning talking to it about the mix of knees and hips that it uses, and different orthopaedic surgeons will have their own preferences around some of those things. So, the situation that we have is a group of orthopods and a range of products, and what we are doing is looking at the evidence, which is the national joint registry, which has been running for a number of years. What we are doing there is rocking up today and asking, ‘Did you know that you are using this particular knee, which is several hundred pounds more expensive than others your colleagues are using and, actually, the clinical effectiveness of that is no greater than other cheaper products?’ Now, orthopaedic surgeons are in the camp, sometimes, of being a little difficult—

[215] **Kirsty Williams:** Oh yes. That is my experience in this committee. [*Laughter.*]

[216] **Mr Roscrow:** However, we have been quite successful in getting some traction with quite a lot of them because sometimes it is the case that they do not know. They do not realise that that one is £1,000 more expensive than that one. Sometimes, there are training issues. There are broader considerations, I accept that. Part of the value-for-money evaluation is that simple position and then, working with the clinicians, which is obviously important, we are able, hopefully, to influence them on different decisions, because we are looking at a value-for-money judgment around that product: first, it is safe; secondly, it is clinically effective. So, if it is safe, clinically effective and cheaper, there is a line of thought that says, ‘Well, why wouldn’t we use it then?’

[217] **Mr Tomkinson:** There is another little bit of that equation as well. There is the industry itself. Sometimes, if you have the evidence, you can persuade a company that what it is selling a particular product for is more than it should be. I have been party to examples where companies have been willing, in order to keep the contract, to change a price because there is not actually any difference in clinical benefit between product A and product B—it is just that product B is more expensive. With that evidence, you can sometimes use that to your advantage in making purchases. Again, it is back to engagement and perhaps the right evidence.

[218] **Mr Roscrow:** One of the other things that we have mentioned in our paper is that sometimes we suffer from silo financial planning as well. There are sometimes areas where a more expensive product in Alun’s area might be justified and might offer better value for money, but the benefit may come further downstream in terms of where the patient is post operatively, or in rehabilitation. The challenge is to spend more here and save further downstream, but the way that we sometimes do our financial budgeting does not support that kind of thinking. In our paper, we have referenced some of these financial silos as being a challenge. It is almost a disincentive to use something, because, if Alun’s budget is then overspent, he is in trouble with the finance director.

[219] **David Rees:** How do you think that could be addressed, then?

[220] **Mr Roscrow:** I am actually meeting with the directors of finance on Friday, and we are talking about this very issue, coincidentally. One of the issues that we have raised with Welsh Government and with finance directors is this very approach about how we challenge and take a different approach to financial planning. I think that the change to three-year budgets will help that, but we also have to look at financial incentives, almost, to get some of these products in.

[221] **Mr Tomkinson:** I fully agree with what Mark has just said. In some ways, particularly when you are bringing something new in, you almost need a sand-box environment, whereby you can introduce a product that will not financially damage that particular area, which says, 'We are happy to be your guinea pig to trial this new innovation', and if, subsequently, it becomes apparent that that particular innovation is not what we thought it was going to be, there is no damage done to the organisation that decided to be the guinea pig. At the moment, people are really disincentivised, because you have such a tightly constrained budget within a small department—speaking for myself now—that you are taking a big risk if you decide to try to be innovative. That is the way that evolution works, is it not? We get better by trying and failing sometimes, and every now and then we hit on something that we do we really well. That is evolution.

[222] **Darren Millar:** This is just a follow-up question on the previous point that you raised, Mr Roscrow. You mentioned the three-year budgeting process. Does that give an opportunity for more significant bulk purchasing within the NHS in order to drive costs down? I appreciate that some products will have a shelf life, and that storage may be an issue, but, in terms of improving access to medical technologies, do you see the three-year budgeting process as an opportunity to improve your bulk-purchasing power within NHS Wales in order to drive costs down and therefore make more technologies available for clinicians and patients to use?

[223] **Mr Roscrow:** I am not sure per se that it would help hugely in that area, because, as you say, if we had the financial clout to buy a lot of stuff that carried us through a two-year period, that may or may not be a good decision, depending on a whole bunch of other factors, to be honest. The flexibility that the three-year financial budgeting process gives us is the greater ability to do some of this financial movement that would support the point that Alun is making, rather than per se the value for money around what we are buying.

[224] **David Rees:** May I ask a question? Obviously, we talk about silo budgeting, and these questions are about the departmental issues within organisations, but is there also a problem across organisations, in different boards? Do financial barriers exist between different boards, with perhaps one having the technology and another not having the technology, and in how they work that way?

[225] **Mr Roscrow:** One of the things from our point of view is that we are trying to get all-Wales arrangements, and we are trying to be consistent in terms of those products being utilised across Wales, and therefore a patient, irrespective of where they happen to be, is getting the same product. We are back to the issue of adoption of some of those in some areas—whether it is difficult clinicians or just inertia within the system, it sometimes means that that is slower to happen.

[226] **Mr Tomkinson:** That is particularly applicable to the big expensive items, if you are talking PET scanners and items such as that, where the economies of scale would mean that you would have to have it in one place, and people would have to travel to that location, particularly when that particular technology was being introduced. Somehow, when you introduce that system, you can damage the organisation into which you are putting it, because it then becomes a huge drain for the organisation, or it does not have the necessary co-

dependencies that would go with it, which is often a mistake that is made. So, better cross-working in those kinds of environment with the big items is easier to see, but it is also happens with smaller things as well.

[227] **David Rees:** If no other Members have any other questions, I have one final question for you. Horizon scanning has been mentioned by several witnesses, and it seems that we are lacking a little bit sometimes on horizon scanning. Should we have a more systematic approach to horizon scanning, other than allowing clinicians to do the work for us?

[228] **Mr Phillips:** I think that there is no doubt about that. We see the role of this centralised group as being able to co-ordinate horizon-scanning efforts. At the moment, horizon scanning, in theory, rests with each individual health board in Wales, but, in reality, it is difficult to do horizon scanning for new technology across each individual health board. It makes sense to have this in a single place, co-ordinated on behalf of the Welsh NHS. At the moment, we rely on organisations such as NICE, but we may have different problems that we want addressed in Wales from those that NICE is focusing on. I suppose that it is up to us to boot the right problems or the right itches that we want scratched up to NICE, or to do it ourselves.

[229] **Mr Roscrow:** One of the other things that we have talked about from an innovation perspective is that sometimes we are relying on companies to knock on our doors. One of the things that we have pondered doing, using people such as Alun, is asking what are the clinical challenges that he or other clinicians face day in, day out that we could do with innovative products or systems change around. We have lots of university capacity—it is in the title of health boards—so where are we in terms of joining these things up and potentially creating solutions to problems that we have? You can take that a step further and, if we can make and shape that in Wales and trial and test it in Wales, there is a potential double bonus for us. So, we are not terribly good at using our clinical expertise to look at what our problems and challenges are that we could invent solutions for.

[230] **Mr Phillips:** Alongside that, there is the issue of, once we have done that front part of the exercise, how that makes its way from horizon scanning and identifying a new technology through to delivery. If we are not careful, we will be in danger of having groups doing an assessment and a report that sits on the shelf, and we will be just passing good ideas around and not doing anything with them. The opportunity is to make sure that the research that has been done is not wasted and that it is going through something like a procurement exercise that delivers those products into the Welsh NHS.

[231] **David Rees:** Thank you for that. Before I let you go, I always ask witnesses in evidence sessions, if they had one key recommendation that we should be considering, what it would be.

[232] **Mr Phillips:** We had prior knowledge that we would be asked this question. *[Laughter.]*

[233] **Mr Roscrow:** Plus we looked at last week's transcript—we did our homework.

[234] **Mr Phillips:** It is not very different—you will not be surprised—from what is in our paper. We think that there is mileage in having a centralised co-ordinating body, either the medicines strategy group or a parallel body for medical devices, to co-ordinate all of these various things—horizon scanning, assessment and health economics. We have only touched on health economics, but there is a huge role for health economics, which we do not really do very well in the Welsh NHS. We need something that draws all of these threads together, and which, in many cases, does not require massive resource either. We have things in place, but we are probably not making the best use of them. We need something at the top that says,

‘Okay, let’s join the dots with this’.

[235] **David Rees:** Okay, thank you.

[236] **Mr Roscrow:** That should focus on replacing what we have, as well as the innovation part, so there are two key parts to it, not just innovation. It must also address the regular routine stuff.

[237] **David Rees:** I understand that. Thank you very much. You will receive a copy of the transcript to make any factual corrections. May I thank you once again for your evidence this morning?

11:15

Papurau i’w Nodi Papers to Note

[238] **David Rees:** There are some papers for Members to note. The first is the minutes of our meeting on 5 February. Are Members happy to note those? I see that you are. We also have a letter from the Business Committee regarding effective scrutiny of the budget by the committee. We did cover this last week in our private session, but I would like to hear any views from Members on the letter and any points that you may wish to make in response to the Business Committee. I do believe that we should write back to support a review of the budget process by the Business Committee, as we previously had some concerns as to the clarity of some of the budget lines, as well as the timeliness of the information. Darren, did you want to comment on this?

[239] **Darren Millar:** The Public Accounts Committee has also had some interesting exchanges with the Permanent Secretary about the presentation of the budget, which may be of interest to the committee. Perhaps we could also raise that in the letter to the Finance Committee.

[240] **David Rees:** The letter is going to the Business Committee.

[241] **Darren Millar:** Yes, the Business Committee.

[242] **David Rees:** Do any other Members have any comments? I see that Members are happy with that approach. Thank you.

11:16

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd ar gyfer Gweddill y Cyfarfod Motion under Standing Order 17.42 to Resolve to Exclude the Public for the Remainder of the Meeting

[243] **David Rees:** I move that

the committee resolves to exclude the public from the remainder of the committee meeting in accordance with Standing Order 17.42(vi).

[244] Are Members content with that? I see that you are. Thank you.

Derbyniwyd y cynnig.

Motion agreed.

*Daeth rhan gyhoeddus y cyfarfod i ben am 11:17.
The public part of the meeting ended at 11:17.*