Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 1 - Y Senedd

Dyddiad:
Dydd Iau, 8 Mai 2014

Amser:
09.15

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:
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Agenda

1 Cyflwyniad, ymddiheuriadau a dirprwyon

2 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y canlynol: (09.15)

Eitem 3.

3 Ystyried blaenraglen waith y Pwyllgor ar gyfer tymor yr hydref 2014 (09.20 - 09.45) (Tudalennau 1 - 13)

4 Ymchwiliad i fynediad at dechnolegau meddygol yng Nghymru: Sesiwn dystiolaeth 15 (09.45 - 10.30) (Tudalennau 14 - 33)

Pwyllgor Cynghorol Gwyddonol Cymru

- Yr Athro Huw Griffiths
- Yr Athro John Watkins

Egwyl (10.30 - 10.45)

5 Ymchwiliad i fynediad at dechnolegau meddygol yng Nghymru: Sesiwn dystiolaeth 16 (10.45 - 11.45) (Tudalennau 34 - 41)

Mark Drakeford AC, Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Ifan Evans, Dirprwy Gyfarwyddwr, Arloesi Gofal Iechyd
Christine Morrell, Prif Ymgynghorydd Gwyddonol (Iechyd) Dros Dro

(Cinio 11.45 - 13.15)

6 Ymchwiliad i wasanaethau orthodontig yng Nghymru: Sesiwn dystiolaeth 1 (13.15 - 14.15) (Tudalennau 42 - 71)

Cymdeithas Ddeintyddol Prydain yng Nghymru

- Stuart Geddes, Cyfarwyddwr Cymdeithas Ddeintyddol Prydain yng Nghymru

Cymdeithas Orthodontig Prydain

- Peter Nicholson, Orthodontydd Ymgynghorol, Ysbyty Brenhinol Morgannwg

7 Ymchwiliad i wasanaethau orthodontig yng Nghymru: Sesiwn dystiolaeth 2 (14.15 - 15.15) (Tudalennau 72 - 92)

Cynrychiolwyr Byrddau Iechyd Lleol

- Karl Bishop, Cyfarwyddwr Meddygol Cyswllt (Deintyddiaeth), Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg
- Yr Athro Stephen Richmond, Athro mewn Orthodonteg, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro
- Bryan Beardsworth, Arweinydd Gwasanaethau Deintyddol, Bwrdd Iechyd Lleol Hywel Dda
- Warren Tolley, Cynghorydd Deintyddol Gofal Sylfaenol, Bwrdd Iechyd Lleol Addysgu Powys

8 Papurau i'w nodi (Tudalennau 93 - 129)

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon

Eitem 5

Cynulliad Cenedlaethol Cymru

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Mynediad at dechnolegau meddygol yng Nghymru

Tystiolaeth o Llywodraeth Cymru – MT 40

Ymchwiliad y Pwyllgor Iechyd a Gofal Cymdeithasol i fynediad at dechnolegau meddygol yng Nghymru – tystiolaeth gan Lywodraeth Cymru

Rhagfyr 2013

Diben

1. Mae'r papur hwn yn cyflwyno tystiolaeth ar gyfer ymchwiliad y Pwyllgor Iechyd a Gofal Cymdeithasol i fynediad at dechnolegau meddygol yng Nghymru yn cynnwys:

    a. cefndir ar faterion gwerthuso a rheoli newid yn gysylltiedig â mabwysiadu technoleg;
    b. polisi a strategaeth berthnasol Llywodraeth Cymru;
    c. y gwaith o gyflawni i hyrwyddo'r defnydd o dechnolegau ar sail tystiolaeth.

Cefndir

2. Bu hanes hir o gynnydd mewn meddygaeth wrth gyflwyno technolegau newydd. Dros y degawdau diweddar bu newid mawr yn y gwasanaethau'r GIG yng Nghymru gyda symud mawr tuag at driniaethau wedi eu targedu'n well a llai o lawdriniaethau gyda gwell technolegau diagnostig yn sylfaen allweddol i hyn. Gall mabwysiadu technoleg arwain at fuddion effeithiolrwydd wrth i brosesau gael eu hawtomeiddio neu newidiadau eraill mewn llwybrau gofal cleifion. Gall datblygiadau technolegol alluogi darparu gwasanaethau yn agosach at gleifion yn eu cymuned leol.

3. Mae'r Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol yn cydnabod bod buddion technolegau'n anoddach ac yn fwy cymhleth i'w gwerthuso nag elfennau fferyllol (Canllaw Dulliau Rhaglen Werthuso Technolegau Meddygol NICE Ebrill 2011 pp.7-8):

    - *Gellir addasu technolegau dros gyfnod o amser mewn modd sy'n newid eu heffeithiolrwydd.*
    - *Mae'r canlyniadau clinigol yn deillio o ddefnyddio'r technolegau'n dibynnu'n aml ar hyfforddiant, cymhwysedd a phrofiad y defnyddiwr (y cyfeirir ato ar adegau fel y 'gromlin ddysgu').*

- *Mae tystiolaeth glinigol ar dechnolegau, yn enwedig technolegau newydd, yn aml yn gyfyngedig, yn enwedig astudiaethau cymharol, yn erbyn triniaethau amgen priodol neu ddulliau diagnosis.*
- *Mae buddion y system gofal iechyd a geir o fabwysiadu technolegau meddygol yn aml yn dibynnu ar ffactorau sefydliadol, megis y cyd-destun lle defnyddir y dechnoleg neu'r staff sy'n ei defnyddio, yn ogystal â'r buddion uniongyrchol o ddefnyddio'r dechnoleg.*
- *Pan fydd y dechnoleg yn brawf diagnostig, bydd canlyniadau clinigol gwell yn dibynnu ar y ddarpariaeth o ymyriadau gofal iechyd priodol yn dilyn hyn.*
- *Efallai na fydd effaith y profion diagnostig ar ganlyniadau clinigol ar gael oherwydd nad yw gwelliant mewn cywirdeb diagnostig wedi ei adlewyrchu mewn canlyniadau clinigol gwell neu ganlyniadau safon byw o reidrwydd.*
- *Nodir rhai technolegau wrth reoli neu ymchwilio nifer o gyflyrau meddygol gwahanol a gellir eu defnyddio gan weithwyr gofal iechyd proffesiynol gwahanol ac mewn amryw o sefyllfaoedd gofal iechyd.*
- *Mae costau technolegau meddygol yn cynnwys costau caffael (yn cynnwys seilwaith cysylltiedig) a chostau rhedeg (yn cynnwys cynnal a chadw a defnyddiau traul).*
- *Gall technoleg newydd effeithio ar gostau drwy ei heffaith ar wahanol agweddau ar y llwybr gofal, yn ogystal â chostau'n gysylltiedig yn uniongyrchol i'r defnydd o'r dechnoleg.*
- *Yn gyffredinol, mae prisio technoleg fodern yn fwy dynamig na'r rhai sy'n gysylltiedig â mathau eraill o ymyriadau meddygol.*

Mae'r ystyriaethau uchod yn golygu y bydd penderfyniadau ar fabwysiadu technoleg weithiau'n amrywio yn ddibynnol ar y cyd-destun lleol.

4. Gall cyflwyno technolegau sy'n neilltuol o newydd olygu'r angen am newidiadau yn y ffordd y mae gwasanaethau'n cael eu trefnu a'u cyflawni. Mewn adroddiad gan Gonsortiwm Economeg Iechyd Caer Efrog "Organisational and Behavioural Barriers to Medical Technology Adoption" a gyhoeddwyd yn 2009, cafwyd adolygiad systematig o'r dystiolaeth ryngwladol ar y testun hwn. Pwysleisiodd prif ganlyniadau'r adroddiad bwysigrwydd gweld mabwysiadu technoleg lwyddiannus fel rhan integredig o weddnewidiad gwasanaeth a datblygu sefydliadol. Ni ddylid ystyried y mater ar wahân i drosglwyddo gwybodaeth, gwelliant ac ymagwedd fwy cyffredinol o fabwysiadu'r arfer orau ym mhob agwedd ar iechyd a gofal cymdeithasol felly.

5. Er gwaethaf yr heriau hyn, mae Llywodraeth Cymru yn ystyried fod rhoi technoleg feddygol newydd ar waith yn elfen gritigol o gwrdd â nodau ac amcanion Llywodraeth Cymru, gyda'r gallu i: godi ansawdd a lleihau cost gofalu; darparu mynediad mwy cyfartal at ofal ym mhob rhan o Gymru; i ymgysylltu â'r cyhoedd a chleifion wrth ddarparu iechyd a gofal cymdeithasol ar y cyd; ac i leihau'r angen a'r galw, yn enwedig drwy ddiagnosis gwell ac atal salwch. Mae Llywodraeth Cymru'n croesawu ymchwiliad y Pwyllgor Iechyd a Gofal Cymdeithasol i'r testun hwn ac yn edrych ymlaen at dderbyn cynigion adeiladol ynglŷn â sut y gellid gwella'r trefniadau presennol.

Ymagwedd Strategol

Safonau Gofal Iechyd i Gymru

6. Mae Safon 7 o 'Gwneud yn Dda, Gwneud yn Well – Safonau ar gyfer Gwasanaethau Iechyd Cymru' yn gofyn i sefydliadau a gwasanaethau sicrhau bod cleifion a defnyddwyr gwasanaeth yn derbyn triniaeth a gofal diogel ac effeithiol yn seiliedig ar yr arfer orau a chanllawiau a gytunir arnynt gan gynnwys y rhai a ddiffinnir gan Fframweithiau Gwasanaeth Cenedlaethol, Y Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol (NICE), Asiantaeth Genedlaethol Diogelwch Cleifion (NPSA) a chyrff proffesiynol. Mae hyn yn cynnwys mabwysiadu technolegau iechyd yn seiliedig ar dystiolaeth ar gyfer triniaeth effeithiol.

7. Defnyddir y safonau gan holl sefydliadau'r GIG ar bob lefel ac ar draws pob gweithgaredd fel ffynhonnell allweddol o sicrwydd i'w galluogi i benderfynu pa feysydd o ofal iechyd sy'n gwneud yn dda a pha rai a allai fod angen gwella. Mae sefydliadau a gwasanaethau'n hunanasesu yn erbyn y safonau ac yn datblygu cynlluniau gwelliant i ddangos cynnydd. Defnyddir yr hunanasesiadau gan Arolygiaeth Gofal Iechyd Cymru i gwblhau gwaith profi a dilysu yn erbyn y safon bob blwyddyn fel rhan o'u swyddogaeth o roi sicrwydd cyhoeddus.

Cynllun Sicrhau Ansawdd

8. Yn y Cynllun Sicrhau Ansawdd 2012-2016 "Rhagori", disgrifiwyd y pwysigrwydd o wneud defnydd o dechnoleg newydd i wella mynediad at ac ansawdd gofal a thynnu sylw at y Rhaglen Werthuso Technolegau Meddygol a gyflwynwyd gan NICE fel ffynhonnell bwysig o gyngor, o gofio bod hyn yn canolbwyntio'n benodol ar ddewis a gwerthuso technoleg feddygol newydd neu arloesol. Gofynnwyd i Fyrddau Iechyd ac Ymddiriedolaethau gydweithio i roi prosesau effeithiol ar waith i sicrhau yr aethpwyd ati i ddefnyddio technoleg newydd yn seiliedig ar dystiolaeth sy'n gwneud y gorau o fudd a gwerth yn fuan.

Canllaw ar Systemau Mabwysiadu Technoleg

9. Sefydlwyd y Bwrdd Arferion Gorau ac Arloesi ym maes Iechyd a Lles ('Y Bwrdd Arloesi') gan y Gweinidog blaenorol ar gyfer Iechyd a Gwasanaethau Cymdeithasol. Ei ddiben oedd rhoi cymorth wrth sbarduno arloesedd yn berthnasol i iechyd a gofal cymdeithasol, gan ychwanegu gwerth wrth adnabod arloesedd ar draws y system a'i roi ar waith, a mabwysiadu a lledaenu arfer gorau, technolegau trawsffurfiol, modelau gwasanaeth a chyflawni.

10. Er mwyn cefnogi cyrff y GIG, cyhoeddodd y Bwrdd Arloesi ddogfen "Canllaw ar Systemau Mabwysiadu Technoleg" gan gynghori ar ymagwedd fwy systematig a chyson wrth adnabod, gwerthuso a mabwysiadu technoleg ar draws GIG Cymru, gan adeiladu ar Safon 7 y Safonau Gofal Iechyd i Gymru. Roedd rhanddeiliaid allweddol yn rhan o waith drafftio sicrwydd y ddogfen, a ddarparwyd i Gyfarwyddwyr Cynllunio ym mis Awst 2013 ac mae wedi ei thrafod â Phrif Weithredwyr. Mae pob sefydliad wedi enwebu uwch brif swyddog

i arwain gweithrediad y Canllaw, ac i ddatblygu ymagwedd rwydweithiol, gyda Phartneriaeth Cydwasanaethau GIG Cymru hefyd yn randdeiliad allweddol ohoni.

11. Mae'r Canllaw yn gosod nifer o argymhellion a disgwyliadau ar gyfer Byrddau Iechyd ac Ymddiriedolaethau, yn enwedig mabwysiadu proses 'Mini-HTA' (Asesiad o Dechnoleg Iechyd) i fod yn sail i gefnogi penderfyniadau yn ymwneud â chyflwyno technoleg newydd. Mae hyn yn offeryn cefnogi penderfyniadau strwythuredig i asesu defnyddioldeb, cost-effeithiolrwydd a phriodoldeb technoleg newydd. Bydd defnyddio mini-HTA o gymorth wrth ystyried a yw technoleg neilltuol yn dderbyniol, effeithiol, diogel ac a yw'n bosibl ei chyflwyno ar gost is neu debyg i'r ymarfer presennol. Mae'r canllaw yn argymell cyhoeddi asesiadau mini-HTA wedi eu cwblhau er mwyn sicrhau na ddyblygir y gwaith ac y rhennir gwybodaeth.

Fframwaith Cynllunio GIG Cymru

12. Mae Fframwaith Cynllunio GIG Cymru a gyhoeddwyd ym mis Tachwedd 2013 yn adlewyrchu'r angen i sicrhau bod mabwysiadu technoleg yn rhan ganolog o drawsffurfio gwasanaeth a datblygiad sefydliadol yn unol â chanfyddiadau adroddiad Consortiwm Economeg Iechyd Caer Efrog a ddisgrifir uchod. Dywed y Fframwaith bod ymagwedd systematig i nodi a chyflawni buddion technolegau newydd yn un o nodweddion system effeithiol o ofal iechyd sydd wedi ei chynllunio o ran mabwysiadu technoleg GIG Cymru. Mae'r canllaw yn sbarduno Byrddau Iechyd ac Ymddiriedolaethau i: ystyried goblygiadau adnoddau newid mewn technoleg; a darparu tystiolaeth o arloesi a swyddogaeth posibl technolegau newydd. Dyfynnir y Canllaw ar Systemau Mabwysiadu Technoleg fel dogfen gyfeiriol allweddol i gefnogi hyn.

Cyflawni

Cefnogaeth ar gyfer y Rhaglen Asesu Technoleg Iechyd

13. Mae Rhaglen Asesu Technoleg Iechyd (HTA) y Deyrnas Unedig yn cynhyrchu gwybodaeth ymchwil annibynnol ynglŷn ag effeithiolrwydd, costau ac effaith ehangach triniaethau gofal iechyd a phrofion i'r rhai sy'n cynllunio, darparu neu'n cael triniaeth yn y GIG. Ariennir y Rhaglen HTA gan yr NIHR yn Lloegr, gyda chyfraniadau gan Swyddfa'r Prif Wyddonydd yn yr Alban, Ymchwil a Datblygu Adran Iechyd a Chymdeithasol Gogledd Iwerddon a'r Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd (NISCHR) yng Nghymru. Mae cyfraniad yr NISCHR yn sicrhau mynediad at y rhaglen ar gyfer ymchwilwyr yng Nghymru.

14. Mae gan y rhaglen HTA ganghennau a arweinir gan Ymchwil ac a Gomisiynir. Trwy'r ffrwd gyllid ar gyfer ymchwil a gomisiynir, mae'r HTA yn nodi bylchau yn nealltwriaeth y GIG ac yn comisiynu'r ymchwil i'w llenwi. Mae'r rhaglen yn comisiynu ymchwil hefyd ar gyfer nifer o 'gwsmeriaid polisi' yn cynnwys Y Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol (NICE) a'r Pwyllgor Sgrinio Cenedlaethol.

15. Yn ogystal â dosbarthu drwy'r ffrydiau academaidd arferol, cyhoeddir canlyniadau'r rhaglen ymchwil HTA yn yr Health Technology Assessment Journal, sydd â ffactor effaith pum mlynedd o 5,804 ac wedi ei restru'n drydydd (allan o 82 o deitlau) yng nghategori 'Gwyddorau a Gwasanaethau Gofal Iechyd' Thomson Reuters 2012 Journal Citation Reports (Science Edition). Ceir rhagor o wybodaeth ar yr HTA, yn cynnwys gwybodaeth ar y prosiectau a ariennir ar hyn o bryd a chyhoeddiadau diweddar, ar www.nets.nihr.ac.uk/programmes/hta

Y Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol

16. Mae Llywodraeth Cymru wedi sefydlu Cytundeb Lefel Gwasanaeth gyda NICE sy'n cynnwys mynediad at werthusiad NICE o dechnolegau meddygol newydd ac arloesol (yn cynnwys dyfeisiau a diagnosteg). Mae Llywodraeth Cymru'n disgwyl i'r GIG i ystyried canllaw NICE o ddifrif wrth gynllunio a darparu gwasanaethau, gan eu bod yn seiliedig ar y dystiolaeth orau sydd ar gael.

17. Gall unrhyw un wneud cais i NICE ystyried canllaw ar dechnoleg feddygol drwy gyflwyno ffurflen hysbysiad. Bydd NICE yn asesu a yw technoleg hysbysedig yn gymwys o fewn swyddogaeth y rhaglen ac yn cwrdd â meini prawf y rhaglen. Ceir gwybodaeth bellach ynglŷn â sut mae NICE yn datblygu ei ganllaw ar dechnolegau meddygol, yn cynnwys manylion ei feini prawf yn: http://www.nice.org.uk/aboutnice/howwework/developing_medical_technologies_guidance/DevelopingMedicalTechnologiesGuidance.jsp

Pwyllgorau Cynghori Proffesiynol Llywodraeth Cymru

18. Mae gan Lywodraeth Cymru bwyllgorau cynghori proffesiynol sy'n darparu modd i'r galwedigaethau ddod â thechnolegau newydd i sylw Llywodraeth Cymru a'r GIG:

    a. Pwyllgor Deintyddol Cymru
    b. Pwyllgor Meddygol Cymru
    c. Pwyllgor Nyrsio a Bydwreigiaeth Cymru
    d. Pwyllgor Optometrig Cymru
    e. Pwyllgor Fferyllol Cymru
    f. Pwyllgor Cynghori Gwyddonol Cymru
    g. Pwyllgor Cynghorol Therapïau Cymru

19. Er enghraifft, mae Pwyllgor Cynghori Gwyddonol Cymru wedi darparu cyngor dylanwadol ar dechnolegau radiotherapi uwch sydd ar gael ar wefan y Pwyllgor. Yn ddiweddar cynhaliwyd Symposiwm llwyddiannus ar 2 Hydref 2013 ar Dechnolegau Newydd mewn Gofal Iechyd lle cafwyd anerchiadau gan y Gweinidog a phennaeth rhaglen gwerthuso technoleg NICE. Nod y Symposiwm oedd ymchwilio'r ffactorau sy'n effeithio ar fabwysiadau a lledaenu technolegau newydd, yn enwedig o safbwynt GIG Cymru

Hyrwyddo ymgysylltu gan GIG Cymru gyda'r rhai sydd yn rhan o ddatblygiad/gwneuthuriad technolegau meddygol newydd

20. Mae gan y GIG a gwasanaethau cymdeithasol ran bwysig i'w chwarae yn ecosystem arloesi yng Nghymru ac mae NISCHR yn gweithio er mwyn ysgogi a gwobrwyo gweithgareddau arloesol drwy ei raglen ymchwil a datblygu. Mae NISCHR yn cefnogi ymchwilwyr sy'n gweithio o Gymru ar gyfer rhaglen Dyfeisio i Arloesi (i4i) NISCHR a chynllun tystiolaeth o gysyniad INVENT ar gyfer y GIG a gofal cymdeithasol. Diben y ddau yw annog datrysiadau newydd, yn cynnwys technoleg feddygol, ar gyfer anghenion newydd clinigol a gofal cymdeithasol, a fydd, yn eu tro, o fudd i gleifion.

21. Dros y pum mlynedd diwethaf, ffurfiodd NISCHR gysylltiadau cryf gyda MediWales, y fforwm sy'n cynrychioli'r sector dechnoleg feddygol yng Nghymru, drwy gefnogi'r gwobrau arloesi blynyddol sy'n dathlu cydweithredu rhwng y GIG a'r diwydiant. Yn ychwanegol, mewn cydnabyddiaeth o'r gwahaniaethau sy'n bodoli rhwng sectorau technoleg feddygol a fferyllol o safbwynt datblygu cynnyrch a'r llwybr rheoliadol, comisiynodd NISCHR MediWales i gynnal adolygiad o'r rhwystrau i fynediad clinigol. Amlygodd yr adroddiad hwn nifer o heriau sy'n llesteirio datblygiad dyfeisiau meddygol arloesol megis diffyg arbenigedd clinigol yn ystod gwerthusiad cynnar o syniad am gynnyrch a diffyg mynediad at gyngor arbenigol a thystiolaeth o brofi cysyniad.

22. Mae argymhellion o'r adroddiad hwn a gan Grŵp Gorchwyl a Gorffen y Diwydiant Rhaglen Cydweithredu Academaidd ym maes Gwyddorau Iechyd (AHSC) NISCHR wedi ffurfio datblygiadau ynghylch gwell ymgysylltu â'r diwydiant. Sefydlwyd 'Ymchwil Iechyd Cymru' gan NISCHR i hwyluso'r datblygiad o gysylltiadau defnyddiol rhwng y diwydiant, y maes academaidd a'r GIG. Mae hyn yn golygu gwasanaeth partneru ar gyfer cwmnïau technoleg feddygol, sy'n galw am gyngor ar ymgymryd ymchwil clinigol yn y GIG yng Nghymru a, ble'n bosibl, mynediad at arbenigedd clinigol.

23. Fel cyllidwr ymchwil ar iechyd a gofal cymdeithasol, mae NISCHR yn cydnabod y swyddogaeth bwysig o drosglwyddo gwybodaeth yn effeithiol wrth wella gofal ac ymarfer. O ganlyniad, mae NISCHR wedi comisiynu rhannau o'i seilwaith a ariennir, Rhaglen Cydweithredu Academaidd ym maes Gwyddorau Iechyd NISCHR a Chydweithredu Academaidd Cymru Gyfan ar gyfer Ymchwil Gofal Cymdeithasol (ASCC), i sefydlu Grŵp Gorchwyl a Gorffen ar drosglwyddo gwybodaeth i helpu nodi'r elfennau sy'n galluogi ac yn rhwystro cynnydd mewn trosi gwybodaeth ymchwiliol mewn iechyd a gofal cymdeithasol. Bydd hyn yn cwmpasu tystiolaeth ymchwil masnachol ac anfasnachol ac argymhellion ar gyfer newid yn y system.

24. Ers 2010, cydnabu Llywodraeth Cymru Gwyddorau Bywyd ac Iechyd fel blaenoriaeth yn y sector datblygu economaidd. O ganlyniad cafwyd nifer o fuddsoddiadau ac ymrwymiadau allweddol i gefnogi'r sector yng Nghymru, yn cynnwys cefnogi ail gam y Sefydliad Gwyddorau Bywyd yn Abertawe, Cronfa Fuddsoddi Gwyddorau Bywyd gwerth £100 Miliwn, a chyhoeddi y bydd Canolfan Gwyddorau Bywyd newydd yn cael ei lleoli ym Mae Caerdydd. Ochr yn ochr â'r cyhoeddiadau blaenllaw hyn mae cefnogaeth barhaus i ymchwil a datblygu busnes, arloesi, twf a masnach ryngwladol. Mae Llywodraeth Cymru hefyd yn cefnogi rhwydweithio ac ymgysylltu â'r diwydiant, o brosiectau

cyfnewid gwybodaeth academaidd i ariannu MediWales, rhwydwaith sector gwyddorau bywyd Cymru. Er enghraifft, mae'r prosiect Gwyddorau Bywyd Cymru presennol sydd wedi ei leoli yn Sefydliad y Gwyddorau Bywyd yn cynnwys cynrychiolaeth gref gan bartneriaid o'r sectorau iechyd academaidd a diwydiannol ledled Cymru ac ar draws y llwybr datblygu technoleg cyfan.

25. Yn ddiweddar ffurfiodd Llywodraeth Cymru bartneriaeth â'r Bwrdd Strategaeth Technoleg i gefnogi nifer o heriau 'caffael datblygol' y Fenter Ymchwil Busnesau Bach (SBRI). Dyfarnwyd dwy o'r pedair her gyntaf i fyrddau iechyd, gan ddarparu bron i £2 Filiwn o gyllid ychwanegol i ddatblygu datrysiadau technoleg arloesol i anghenion gofal iechyd neilltuol.

Cronfa Technoleg Iechyd

26. Yn ystod 2013, cyhoeddodd Llywodraeth Cymru fuddsoddiad ychwanegol sylweddol i dechnoleg feddygol drwy'r Gronfa Technoleg Iechyd gwerth £25 Miliwn. Dyrannwyd cyfraniad cychwynnol o £5m i fuddsoddiadau technoleg o flaenoriaeth uchel gan gynnwys cyflymydd llinellol ar gyfer Ysbyty Glan Clwyd ym Mwrdd Iechyd Prifysgol Betsi Cadwaladr; sganwyr ac offer geneteg. Cefnogodd ail don 21 o brosiectau, gan ymrwymo £15 miliwn ar gyfer offer meddygol newydd ym meysydd mamolaeth, canser, y galon, iechyd meddwl, diagnosteg a gofal heb ei drefnu. Roedd y prif brosiectau'n cynnwys:

    a. system llawdriniaeth robotaidd gyntaf i Gymru ym Mwrdd Iechyd Prifysgol Caerdydd a'r Fro gyda'r gallu i fedru lleihau'r angen am driniaeth lawfeddygol o ganser prostad;
    b. offer o'r radd flaenaf mewn cynllunio radiotherapi a bracitherapi cyfradd dos uchel i gyflawni'r dulliau triniaeth canser diweddaraf yn Ymddiriedolaeth Felindre;
    c. offer awtomataidd ar gyfer adnabod bacteria gan bron i dreblu cynhyrchiant, gwella ansawdd a diagnosis cyflymach ar gyfer gwasanaeth meicrofioleg Iechyd Cyhoeddus Cymru yn Ysbyty Glan Clwyd;
    d. cyfnewid colonosgopi drutach a llawfeddygol gyda sganiwr CT neilltuol ar gyfer y gwasanaeth canser y colon ym Mwrdd Iechyd Prifysgol Betsi Cadwaladr;
    e. technolegau newydd i hyrwyddo iechyd meddwl a lles ym Mwrdd Iechyd Aneurin Bevan;
    f. dadansoddiad cyfrifiadurol o guriad y galon mewn babanod â phwysau geni isel i atal marwolaethau a niwed yn yr uned newydd-anedig ym Mwrdd Iechyd Prifysgol Abertawe Bro Morgannwg.

Cronfa Technoleg Iechyd a Theleiechyd

27. Yn 2014 bydd Llywodraeth Cymru'n buddsoddi o leiaf £9.5 Miliwn mewn technoleg mewn lleoliadau nad ydynt yn ysbytai, drwy Gronfa Technoleg Iechyd a Theleiechyd. Mae gan y Gronfa olynol hon bwyslais ychwanegol ar gefnogi'r defnydd o dechnolegau digidol a theleiechyd i ddarparu gwasanaethau yn nes

at gleifion, ac ar alluogi mwy o gwmpas ar gyfer arloesi ac arddangos technoleg newydd neu a weithredir mewn lleoliadau newydd.

28. Mae'r Gronfa hon yn adeiladu hefyd ar brosiectau peilot blaenorol a gefnogwyd gan Gronfa Arloesi Iechyd Gwledig rhwng 2010 a 2014. Dan gyngor Grŵp Gweithredu Iechyd Gwledig annibynnol, cefnogodd hyn ymchwil ac ymgysylltu a arweiniodd at 15 o brosiectau, gan gynnwys gwasanaeth cymorth yn y cartref, adsefydlu niwrolegol, gofal fferyllol gwledig, a rhoi technoleg telefeddygaeth ar waith ar draws rhan helaeth o Gymru.

Mae cyfyngiadau ar y ddogfen hon

National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from British Dental Association – OS 03

British Dental Association

Evidence to the H&SCC on Orthodontic Services in Wales 2014

March 2014

BDA

Cymru Wales

The British Dental Association (BDA) is the professional association for dentists in the UK. It represents 18,000 dentists working in general practice, in community and hospital settings, in academia and research, and in the armed forces, and includes dental students.

We welcome the opportunity to provide written evidence and comment on the Health and Social Care Committee's inquiry into the provision of orthodontic services in Wales.

Throughout our paper reference will be made to the work done by Professor Stephen Richmond who, in 2010, looked at the provision of orthodontic treatment in Wales in great detail and made a large number of recommendations.[i]

The terms of reference are to inquire into the provision of appropriate orthodontic care in Wales including:

- Access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales.

1. *There still appears to be long waiting lists in parts of Wales. We feel that this may be due in part to the number of inappropriate or early referrals.*

2. *The Index of orthodontic treatment need (IOTN)[ii] which is used as a guide to eligibility for NHS orthodontic care is not well understood by general practitioners. This results in children being referred for the correction of minor irregularities, sometimes as a result too, of parental pressure.*

3. *Consequences of long waiting lists:*

    - *Children who need to be seen and who will need treatment may wait so long that they will have passed to optimal time for treatment.*

    - *Long waiting lists reduce the 'enthusiasm' for treatment. There are more failed appointments and less patient co-operation.*

- *Minor irregularities may self correct and the patient/parent may no longer wish treatment but, in the meantime they have occupied a waiting list space.*

- **The effectiveness of working relationships between orthodontic practices and Local Health Boards in the management of local orthodontic provision, and the role of Managed Clinical Networks in helping to deliver more effective orthodontic services in Wales (e.g. effective planning and management, improvement in the appropriateness of referrals and performance management, workforce arrangements).**

4. *Where managed clinical networks are in place our members report that they work well.*

5. *One difficulty has been that the introduction of the 2006 contract put orthodontics into the Personal Dental Services (PDS) group of contracts. These are usually fixed term and because of their value, health boards have put them, on renewal, out to tender.*

6. *Orthodontic treatment takes some time so practices are never certain that they will be able to complete treatment. But, practices receive full payment for the course of treatment once it has started.*

- **Whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money.**

7. *This is difficult!*

- *Orthodontic treatment accounts for approximately 50% of spending on the oral/ dental care of children.*

- *Wales has the highest level of dental disease of all of the UK countries.*

- *More funding is being put into preventive dental care in Wales but it will be some time before we see vast improvements in levels of dental disease (all of which are preventable) although early trends are encouraging.*

- *There is little, if any evidence underpinning long term outcomes and the impact of orthodontic treatment.*

- *Can we argue for more funding, or even retaining existing funding for orthodontics when there is greater need in other areas of health care?*

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- **Whether orthodontic services is given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector**.

10. Whilst there are some groups of individuals who will need orthodontic corrections we have to accept that the vast majority of treatment is to correct cosmetic irregularities.

11. Children who are born with a cleft palate, other facial deformities and dental problems such as hypodontia, congenital abnormalities of tooth tissue etc will need the care of specialist orthodontists – usually in secondary care and they should receive that.

12. Gross dental irregularities should also be corrected as a decent smile is, these days, the accepted norm and children can be cruel to their contemporaries resulting in loss of confidence and subsequent educational issues.

- The impact of the dental contract on the provision of orthodontic care.

13. The 2006 contract change put most of the orthodontic contracts into the PDS group – fixed term - usually for three but sometimes five years and introduced the Unit of Orthodontic Activity (UOA). In England, the value of the UOA was fixed, not so in Wales.

14. We feel that mistakes were made:

- *The UOA value should have been fixed*
- *and that, subject to satisfactory completions of treatment - with appropriate peer review, contracts should have been 'rolling contracts'.*

15. There are other issues:

- *Payment for a course of treatment is made on commencement rather than staged through to completion. Professor Richmond highlighted this as being a reason why there is no reliable data on satisfactory completion of treatment.*
- *Waiting lists are a catalyst for early (and inappropriate) referral which heightens the problem.*
- *There were a few practitioners who had existing patients undergoing orthodontic care and they were able to incorporate into their practice contracts a number of UOAs. Many of these GDPs had an interest in providing some of the simple orthodontic treatments for children in their practices – this saved a referral to a specialist and in many cases the treatment would have been completed quite quickly. The pre-2006 contract included fees for treatment of these simple cases – usually paid on completion and after submission of models showing 'before' and 'after' treatment.*

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- *It is now almost impossible for a dentist who has not undergone post graduate training in orthodontics / orthognathics to take on and treat simple cases.*

[i] http://wales.gov.uk/docs/phhs/publications/101109reporten.pdf

[ii] http://www.learn-ortho.com/IOTN-1.html

National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from the British Orthodontic Society – OS 07

National Assembly for Wales
Health and Social Care Committee Inquiry

Orthodontic Services in Wales

Response on behalf of the British Orthodontic Society

1.1) The British Orthodontic Society is a charity that aims to promote the study and practice of orthodontics, maintain and improve professional standards in orthodontics, and encourage research and education in orthodontics.
It is also a representative body of all branches of general dentists and specialist orthodontists in the UK who provide orthodontic care. The Groups within the Society are the Specialist Practitioner Group and General Practitioner Group working in Primary Care and the Consultant Orthodontist Group working within the Secondary Care Hospital services, together with the University Teachers Group.

1.2) The BOS seeks to improve the quality of medical care for the benefit of patients. The immediate benefits of correcting a malocclusion include reducing the risk of trauma to teeth that protrude; treatment of impacted teeth that may become cystic or resorb (dissolve) the roots of adjacent teeth, creating space for replacement of teeth that are congenitally absent, improving the ability to clean areas where food packing increases risk of caries and improved long-term dental health with improvement in oral hygiene following orthodontic intervention.
In addition, the benefits of orthodontic treatment also include an improvement in appearance, self-esteem and psychological well being, especially important during the school years of the younger patients, with a reduction in bullying and teasing found following correction of malocclusion.

A reduced body image arising from the dissatisfaction with dental appearance persists into adulthood. There remains the possibility that career opportunities may be limited compared with individuals with a more aesthetically pleasing smile and dentofacial appearance in general, who are known to possess a better body image and greater self-confidence.

Orthodontic treatment as an intervention at an appropriate age decreases the burden of dental treatment for those patients who would otherwise have a great commitment to care throughout life. Much of this care would be the responsibility of the NHS and an orthodontic treatment intervention at an appropriate age therefore provides good value for money. A course of orthodontic treatment takes on average 2 years to complete with appointment intervals of 6 – 8 weeks during that time.

BOS members have responded to the requests of the enquiry and the BOS response is as follows:

Response to inquiry into the provision of appropriate orthodontic care in Wales:

2) *Access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales.*

2.1) Access to orthodontic services:
Access will depend upon the availability of services locally and also the waiting times for treatment.

2.1.1) Primary Care Services
Members of BOS report long waiting times in primary care and up to 2.5 years in some areas. Patients whose orthodontic treatment is appropriate in primary care will start their treatment immediately after assessment. However these long waiting times will delay the transfer of patients with more severe and complex problems to secondary care and may compromise their treatment.
In rural areas there are fewer patients requiring orthodontic treatment and most areas would not support a specialist practice. Salaried specialists working in the Community Dental Service could provide local access to care.

2.1.2) Secondary Care Services
Treatment within the secondary care service is usually restricted to the very complex and multidisciplinary cases and services are located within areas of greatest population.
The waiting times to see new patients in secondary care are within the Referral to Treatment Times of within 36 weeks. However the time to start the treatment after assessment is not within RTT and a recent survey of waiting times reported an average of 24 to 40 months in the majority of Hospitals.

2.2) It is the view of BOS that a commitment to proper funding and recruitment within Orthodontics is essential. Recommendation 9 from the Report on Orthodontic services in Wales February 2011 from the Health, Wellbeing and Local Government Committee was: “We recommend that the Welsh Government funds a one-off waiting list initiative to clear the backlog of patients waiting for orthodontic treatment.”
The implementation of this Recommendation would reduce the treatment waiting times and improve the accessibility of orthodontic treatment for the population of children in Wales that need orthodontic treatment.

3) *The effectiveness of working relationships between orthodontic practices and Local Health Boards in the management of local orthodontic provision, and the role of Managed Clinical Networks in helping to deliver more effective orthodontic services in Wales (e.g. effective planning and management, improvement in the appropriateness of referrals and performance management, workforce arrangements).*

3.1) A recent survey of the BOS membership relating engagement with local networks has shown that Managed Clinical Networks have been established in North Wales, South West Wales and South East Wales. There are also professional advisory bodies (LOCs) in South West and South East Wales as a forum for all providers to advise on standards of care, policies and protocols. The MCNs contribute to the Oral Health Advisory Group/Dental Services Planning Group in their area.
New referral protocols have been developed to allow GDPs to consider the appropriateness of the referral and to help them refer to the most appropriate provider in either primary or secondary care. Most referrals, particularly in primary care, are from GDPs which gives the best opportunity for the patients to be referred at the most appropriate time and with the appropriate level of dental health. These new referral forms and protocols seem to be working well and the number of inappropriate referrals is thought to be reducing and with more efficient referral of the patients to the most appropriate provider.

4) *Whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money.*

4.1) Provision of orthodontic treatment in Wales is determined by use of the Index of Treatment Need and not on demand, but in some areas the need still exceeds the present capacity, despite greater efficiency within the referral management process.

4.2) The provision of orthodontic care should be through a number of pathways: Hospital Consultants, primary care Orthodontists on the GDC Specialist List, salaried Community Dental Services, Dentists with enhanced skills in Orthodontics and Orthodontic Therapists. Those who are not registered Orthodontic Specialists must receive training and ongoing supervision by specialists to ensure they are working within their competence.

4.3) In September 2010, the Task and Finish Orthodontic Sub-group reported that 7.5% of funding should be reinvested to facilitate modernisation, detailed management and support. One of the Recommendations from the Report on Orthodontic services in Wales February 2011 was that the Welsh Government fund a waiting list initiative to reduce the number of patients waiting for orthodontic treatment.
In order to ensure that those patients with the highest treatment needs are not disadvantaged, consideration could be given to changing the Index of Orthodontic Treatment need (IOTN) level at which treatment is available on the National Health Service.

The threshold for treatment could be increased from IOTN 3 to IOTN 4 and 5 only. This would thus direct funding to those with the greatest treatment need.

5) *Whether orthodontic services is given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector.*

5.1) Unlike preventable dental caries, the development of malocclusion is related to a genetic inheritance independent of the patient's life-style and choices. Orthodontic treatment is supported by evidence-based interventions that deliver a quantifiable health gain and should be maintained as a priority with the Welsh Government's oral health plan.

5.2) Appropriate contract monitoring is required for quality assurance and protection of the public. Orthodontics as a profession has robust measures already in place to monitor outcomes of care by using the Peer Assessment Rating Index.

5.3) The MCNs have a role in facilitating close monitoring of treatment outcomes through PAR and should be monitored for all providers on an annual basis for **all** providers.
In primary care, the practitioners use the PAR Index to score the outcomes for their patients both for the Business Service Authority (BSA) and for the Local Health Boards. The BSA also monitors standards of care in the GDS/PDS using a traffic light system on selected cases and aspects including record keeping and clinical outcomes are investigated and scored. These systems already in place are robust and accepted.
Secondary care providers are actively engaged in local and national outcome based audit and has increasingly become a contractual requirement within the Appraisal process for Hospital Consultants.
However, BOS is concerned that monitoring within the independent sector is inadequate. In this sector, Practitioners have no obligation to assess the quality of their care for patients as required by the BSA or Local Health Boards.

6) *The impact of the dental contract on the provision of orthodontic care.*

6.1) There is a minimum UOA (Unit of Orthodontic Activity) value below which appropriate, safe, quality care is not achievable. The UOA must take in to account the costs of maintaining the practice premises, all staff salaries, consumables including appliances, laboratory costs, patient/practice records, environment and procedures compatible with HTM 01-05. This has not been determined in Wales.
6.2) The current contract system fixes the volume of activity for each practice without allowance for increased activity. With an increase in dental health awareness, there may be more of a demand from those with a need. Without an increase in the contracts, an inability to treat these patients will result. BOS members have reported that as Orthodontic contracts are fixed term, opportunities for financial investment and development are limited due to the uncertainty at the end of each contract period. Contracts renewals should be for a minimum of 5 years, or preferably rolling contracts for well-performing practices. BOS considers this to be essential for best patient care. Indeed it could be considered unethical to start treatment for patients when completion of that treatment cannot be guaranteed because of the contract time limit.
In addition there is considerable concern that the tendering process for contracts in primary care has on some occasions favoured corporate bodies with the award of multiple contracts in the same Health Board and/or neighbouring Health Boards to the same provider. This could lead to an unhealthy monopoly of orthodontic provision.

6.3) There are no contracts for orthodontic treatment for over 18 year olds in primary care in Wales and thus this will exclude some patients from receiving treatment when they may not have had the parental support to seek treatment earlier. Greater clarity is required for the management of those patients referred at the age of 18 or before as to whether the date of referral or the date of assessment determines eligibility for NHS treatment in primary care. The length of treatment waiting lists should not prevent this cohort of patients accessing appropriate care simply because of their age when seen to start such treatment.

7) Summary and Recommendations

- There are unacceptably long waiting lists for orthodontic treatment in both primary and secondary care in some areas of Wales.
    - Fund waiting list initiatives on a one time only basis to clear the numbers of patients waiting for orthodontic treatment.
    - Fund salaried specialists on a part-time basis in rural areas, where needed, to allow greater and easier access to treatment.
- MCNs have been established throughout Wales and there is efficient and effective communication between orthodontic providers in primary and secondary care with the LHBs.
    - MCNs and LOCs should to continue to advise on policies, protocols and standards of care.
- Orthodontic treatment has proven short and long-term dental health benefits and provides excellent value for money within the NHS financial framework both in primary and secondary care.
    - If funding is limited further, treatment is restricted to patients with IOTN 4 and 5, thereby concentrating funding on those with the highest need.
- Standard of care monitoring is quite robust within primary and secondary NHS services.
    - The monitoring of standards of care in the independent sector must be improved.
- Short term PDS contracts do not allow for any flexibility and limits potential investment by providers working within the primary care sector.
    - Consider contracts of a minimum of 5 years and rolling contracts in well-performing practices.

Eitem 7

National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from Abertawe Bro Morgannwg University Health Board – OS 16

Abertawe Bro Morgannwg University Health Board [ABMU HB]: Response to the National Assembly for Wales' Health and Social Care Committee [HSCC] Short Inquiry into Orthodontic Services in Wales.

April 2014

1. Background

ABMU Health Board provides orthodontic services from both within the hospital and community based specialist practices, the latter including three dentists with a specialist interest [DwSIs]. The specialist and DwSI services are delivered through Primary Dental Service [PDS] agreements. Details of the contracted activity within ABMU are set out in the table below:

Location	Provider	Contract Vol (UOAs)	Contract Value (£)
Swansea	Specialist practices	32,836	2,043,611
	DwSI	2064	124,522
Neath Port Talbot	DwSI	2045	127,620
Bridgend	Specialist practice	7,823	490,809

The total value of the PDS contracts is £2,786,563 and accounts for 10% of the total GDS budget allocation in ABMU HB. Nationally, it is understood that orthodontic expenditure accounts for around 40% of the spending on NHS dental services for children.

It is important to note that activity undertaken within specialist practices in ABMU HB will be inclusive of referrals for residents of Hywel Dda Health Board and that the secondary care service provision is wholly inclusive of Hywel Dda residents.

The South West Wales Orthodontic Managed Clinical Network which reports to Hywel Dda and ABMU Health Boards has submitted evidence directly to the HSCC. It is understood submission from the network represents the views of the majority but not all of the network members and has been submitted with the *caveat* that it is primarily a service provider's perspective.

This submission from ABMU Health Board reflects its broader role and responsibilities in respect to integrated planning of services based on the wider dental public health requirements of the population and in line with the Board's Local Oral Health Plan [LOHP]that was submitted to Welsh Government in December 2014.

2. Question

The impact of the dental contract on the provision of orthodontic care and whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money?

2.1. Response

In an environment of 'prudent healthcare' and care based on best evidence then the key factors to consider when attempting to respond to this question are (i) the health gain associated with orthodontic treatment, (ii) the true need of the population and (iii) the potential for service modernisation. Without this information it is impossible to assess whether orthodontic care is adequate, affordable or provides value for money.

i. Health Gain

The health gain associated with the majority of orthodontic treatment has become less clear in recent years. However, it is acknowledged within the Health Board that not all orthodontists support the emerging views.

The major dental public health issue affecting the population is tooth decay (caries) and gum disease (specifically periodontal disease i.e. gum disease which may risk tooth loss in some individuals). The major risk factors for these diseases are primarily poor oral hygiene and diet (the basis for the preventive 'Designed to Smile' programme) with chileredn from lower socio-economic groups particularly vulnerable. Evidence suggests that if these factors are improved then the risk of gum disease or tooth decay reduces significantly even in the presence of irregular teeth or an 'atypical' bite. Paradoxically, children who are at risk of gum disease and tooth decay are ,correctly,refused access to orthodontic treatment since placement of braces in such an environment increases the risk of further disease.

It is understood that evidence would also suggest that orthodontics may not have significant long-term beneficial effect on the majority of jaw or bite irregularities. However orthodontics may improve an individual's self esteem by improving the aesthetics of their teeth. However, it is unclear how best to identify which patient groups benefit from an intervention for aesthetic reasons. There are obvious exceptions where the benefits of orthodontic treatment is unquestionable, egb for patients with significant abnormalities such as cleft palate. These most severe discrepancies require an orthodontic intervention together with surgical correction of the facial bones or defects (orthognathic surgery). The number of patients with this degree of irregularity is however limited but require highly specialized multidisciplinary teams.

ii. Need

Historically, the orthodontic need has been based on the Index of Orthodontic Treatment Need [IOTN]. However, it is understood that the validity and robustness of this method of assessment has now been questioned. For example, as a consequence of the IOTN being applied, in ABMU HB there are 1,067 (as of December 2013) patients aged 11 years or younger awaiting orthodontic assessment in specialist practices (approximately 20% of patients waiting for assessment). The Health Board has found it difficult to understand this demand based on the evidence available especially considering the pressure it places on resources and at a time where the

Board strives to embrace and implement the concept of 'prudent health care' in all the services it provides and commissions.

iii. Service Modernisation

Welsh Government's 2010 review of orthodontics led by Professor Stephen Richmond recognised that the normative need of 12 year olds requiring orthodontic treatment should and could be met within the existing resource that was committed at that time by Health Boards across Wales through existing PDS agreements. Professor Richmond's report highlighted areas of the service delivery model which, if changed, would lead to efficiencies in the service without negatively affecting the quality of care. Although there have been developments, such as the establishment of MCNs, it is disappointing to report that, to date, there has been little change in the service model.

For example, in ABMU LHB there has been little expansion or development of DwSI or orthodontic therapists and no contracts put in place which reflect and encourage economies of scale. In fact, contrary to the conclusions of Welsh Government's Orthodontic Review (2010) some colleagues within the orthodontic specialty have advised since that orthodontic therapists will not provide any opportunity to improve the cost effectiveness of the service. This is in direct conflict to the information provided to justify the development of this group of individuals within the UK and evidence provided to HSCC in 2010-11. This advice would also appear to undermine the strategic basis for the expansion of dental care professionals (DCPs) more widely and their roles within the UK. Some orthodontic specialists have also expressed concern over the model for Dentists with Specialist Interests in orthodontics which, again, was seen as a development to aid the implementation of a more efficient service in Welsh Government's Review (2010) and HSCC's recommendations in 2011.

Without workforce modernisation and orthodontic specialists' active support and involvement in training and employment it is unlikely that DwSI in orthodontics or the wider use of orthodontic therapists in Wales will develop. In addition, as recommended in the 2010 Welsh Government review, there should be clear incentives through the contract process to facilitate service modernisation. This should allow more effective planning and management of orthodontic services and removal of potential perverse incentives. Regrettably there appears to have been little progress on this to date.

2.2. Question 1:Conclusion

Health Boards need to balance the demand for 'routine' dentistry for the population at large with the provision of more specialised dental services. In the current climate of 'prudent' healthcare, serious consideration needs to be undertaken to balance the demand currently anticipated by orthodontic service providers with the Health Boards' ability to deliver against actual patient need and health gain.

It is considered that until the actual health need of the population and the gain associated with the majority of orthodontic treatment is independently assessed, and robust criteria applied, it is impossible to state with certainty whether the current

spending on orthodontics is justified or sustainable. However, based on the current service models and criteria to assess need it is considered that additional investment in orthodontic services is not affordable or sustainable particularly as the there appears currently questionable evidence of value for money. Significant changes to improve the efficiency and effectiveness of the service would be required before further investment could be justified.

To resolve these issues it would probably be appropriate for the NHS to provide a definitive position on actual orthodontic need of the population, the health gain associated with active intervention and models for a modern service based on an independent evaluation of robust scientific information. In the meantime an increased allocation of resources to orthodontics from the GDS budget would divert monies from the most vulnerable, needy and at risk and would conflict with the broader needs of an ageing and more frail society. Perversely it would also redirect resources from the most at risk children to those of low risk of dental disease. This would be difficult to justify and would not be consistent with the key objectives set out in the Health Board's Local Oral Health Plan.

3. Question

Access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales

3.1. Response

It is understood that there is variation in access to orthodontic services across Wales as well as differing access criteria for secondary care. This is often attributed to local circumstances e.g. number of specialist practitioners in the locality and variation in 'need' of local populations. A number of orthodontists work in both specialist and hospital based practice.

A centralised referral management system based on clear objective nationally described and agreed criteria for referral and access into specialist and hospital services would aid consistency across Wales and support planning by Health Boards. This should involve clarity as to where services should be delivered to improve access rather than simply reflect historical practice. Furthermore, as discussed previously, true 'need' requires clear definition and differentiation from 'demand'.

There has been a suggestion that prioritisation of patients accepted for NHS care should be introduced to improve access. If this is considered then it should not result in overall longer waiting times since it potentially diverts those in low priority groups who can afford to pay into the private sector and disadvantages poorer socio-economic groups.

It is understood that there is significant variation in the number of orthognathic cases treated across Wales. However national databases have recently been established by the specialist societies and NHS England. The NHS in Wales may wish to look at how best these could be used to inform Health Boards in planning and managing these services in Wales.

4. Question

Whether orthodontic services is given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector?

4.1. Response

Welsh Government has historically given a high priority to orthodontic services which has been reflected in resource allocation. This may be a consequence of idiosyncrasies associated with the change to the new dental contract in 2006, the pressure that is often placed on Health Boards where there are large waiting lists associated with the provision of paediatric services and a failure to differentiate between 'demand' and true 'need'.

Arrangements for monitoring standards of delivery and outcomes of care are hampered by a number of factors. For example, orthodontic payment is not linked to completion of treatment or robust quality of outcome standards or data. This causes problems for Health Boards as they attempt to manage services and budgets as well as removing a key incentive to practitioners. It is strongly recommended that these issues are considered as part of any new contractual discussions to ensure that there is an incentive for contractors to complete treatments and better enable Health Boards to manage the quality and outcome of services.

It is also considered that there is also a strong case, to aid monitoring of access, delivery, expenditure and outcomes, to separate primary care orthodontic budgets from the wider GDS budget and ensure that orthodontic services are managed within this financial envelope.

With a population of approximately 3,000,000, Welsh Government may also wish to consider the benefits of developing national standards for planning, and monitoring orthodontic services.

5. Conclusion

In trying to achieve a balanced approach to dental service delivery ABMU Health Board is seeking within its LOHP to consider service developments that will benefit the population as a whole rather than considering specific patient groups, access to primary general dental services being a key consideration. To achieve the balance of service provision required there must be positive and balanced engagement from all stakeholders and planning based on the best evidence available true 'need' not 'demand' and consideration to the most effective and efficient use of dental resources, including workforce, for the population. This may be best achieved by developing national guidance based on robust and independent evaluation of the best scientific evidence available.

There is also a need for all stakeholders, including professionals, to recognise the wider health needs of the population, the concept of 'prudent care' particularly within the financial climate that now exists, along with the need to deliver more specialised dental services within the primary and community setting for the general population. The National and Local Oral Health Plans have laid excellent foundations in this regard and it is crucial that the broad dental health agenda reflected therein is pursued consistently.

National Assembly for Wales
Health and Social Care Committee
Inquiry into Orthodontic Services in Wales
Evidence from Cardiff and Vale University Health Board – OS 17

Cardiff and Vale University Health Board Response to the Short Inquiry Into Orthodontic Services In Wales (Health & Social Care Committee of the National Assembly for Wales) April 2014

The National Assembly for Wales' Health and Social Care Committee is undertaking a **short inquiry into orthodontic services in Wales**. The terms of reference are to inquire into the provision of appropriate orthodontic care in Wales including:

- Access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales.
- The effectiveness of working relationships between orthodontic practices and Local Health Boards in the management of local orthodontic provision, and the role of Managed Clinical Networks in helping to deliver more effective orthodontic services in Wales (e.g. effective planning and management, improvement in the appropriateness of referrals and performance management, workforce arrangements).
- Whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money.
- Whether orthodontic services is given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector.
- The impact of the dental contract on the provision of orthodontic care.

The following response has been collated from both Dental and Primary, Community & Intermediate Care (PCIC) Clinical Boards and relates to the 3 areas of provision: Primary care, Community Dental and Hospital Dental Services

Section 1 - Primary, Community & Intermediate Care (PCIC) Clinical Board

1. The PCIC Clinical Board of Cardiff & Vale UHB are responsible for commissioning Primary Care Dental Services, including Primary Care Specialist Orthodontic practices, which provide care for patients in Cardiff & Vale, Cwm Taf and some parts of Aneurin Bevan Health Boards. We work closely with the UHB's Clinical Board for Dentistry which provides Community & Hospital orthodontic services along with training of orthodontists and general dentists, and we are a core member of the South East Wales Managed Clinical Network for Orthodontics. The PCIC Clinical Board's views have been fed into the

response of the MCN but may not be distinct or in their fullest and so a separate response has been created to reflect our views.

2. The PCIC Clinical Board will respond to each of the five specific areas as outlined in the letter of 10th February 2014, from the Chair of the Committee (David Rees AM).

Access For Patients To Appropriate Orthodontic Treatment, Covering Both Primary And Secondary Care Orthodontic Services, And Whether There Is Regional Variation In Access To Orthodontic Services Across Wales.

3. Much of the access to primary care orthodontic services is based on historical location and practice resulting from the previous (pre-2006) contractual arrangements, whereby practices were allowed to set up and practice where they wished and where it was most economically advantageous to do so. Therefore, much of the NHS orthodontic treatment for South East Wales was centred on three very large specialist practices in Cardiff and this has continued with Cardiff & Vale UHB holding and managing the contracts for these three practices on behalf of all of the LHBs. There is no breakdown of 'allocations' per LHB as there is no geographical restriction on patients accessing the primary care specialist services.

4. The PCIC Clinical Board is closely involved in the work of the South East Wales Managed Clinical Network for Orthodontics to ensure that service provision and planning is appropriately managed and equitable across the area. The three MCNs communicate regularly as well as being part of the All-Wales Strategic Advisory Forum on Orthodontics to ensure we are not out of sync with the rest of Wales.

5. Cardiff & Vale UHB currently invests in excess of £4 million into primary care orthodontics which provides good access for all patients who fit the criteria for NHS treatment as outlined in the Index of Orthodontic Treatment Need (IOTN).

6. On the introduction of the new standardised Referral Form, the UHB worked with the Local Dental Committee in 2012 to train General Dental Practitioners on how to make a basic assessment of IOTN to help reduce inappropriate referrals into the specialist practices, the community dental service or the University Dental Hospital. This helps to give patients realistic expectations of what is and is not available.

The Effectiveness Of Working Relationships Between Orthodontic Practices And Local Health Boards In The Management Of Local Orthodontic Provision, And The Role Of Managed Clinical Networks In Helping To Deliver More Effective Orthodontic Services In Wales (e.g. Effective Planning And Management, Improvement In The Appropriateness Of Referrals And Performance Management, Workforce Arrangements).

7. Cardiff & Vale UHB have a strong and positive working relationship with all of the practices providing orthodontic treatment in our area. The three large specialist practices are supplemented by a smaller specialist contract attached to a General Dental Practice in the Vale of Glamorgan, intended to ensure more local provision in the central/western Vale area for those who may find it difficult to attend one of the Cardiff

practices. The UHB also makes use of some Dentists with Enhanced Skills (DwES) for a limited amount of less complex orthodontic work. The DwESs are General Dental Practitioners who have proven to senior clinicians that they are competent to carry out orthodontic treatment. DwES are particularly useful in much more rural areas, where it would be both impractical and undesirable to attempt to set up a specialist practice. This is not especially relevant for the Cardiff & Vale UHB area and so there are only four very small contracts for DwES in Orthodontics.

8. The provision of orthodontic treatment is via time-limited Personal Dental Services (PDS) agreements. At the outset of the new contractual arrangements in 2006, providers were awarded a three year PDS agreement (2006-2009). These were then renewed for a further three years (2009-2012). As there was agreement within the UHB that these contracts provided high quality specialist care and were good value for money within the current contracting model, it was agreed that the next renewal would be for five years (2012-2017), which brings Cardiff & Vale UHB in line with both NHS England and most other LHBs. These five year contracts allow practices to plan sensibly for income levels and treatment planning, as well as investment in technology and equipment. It also gives the UHB both stability for provision of services but also fixed term contracts to enable some ability to redesign services if necessary.

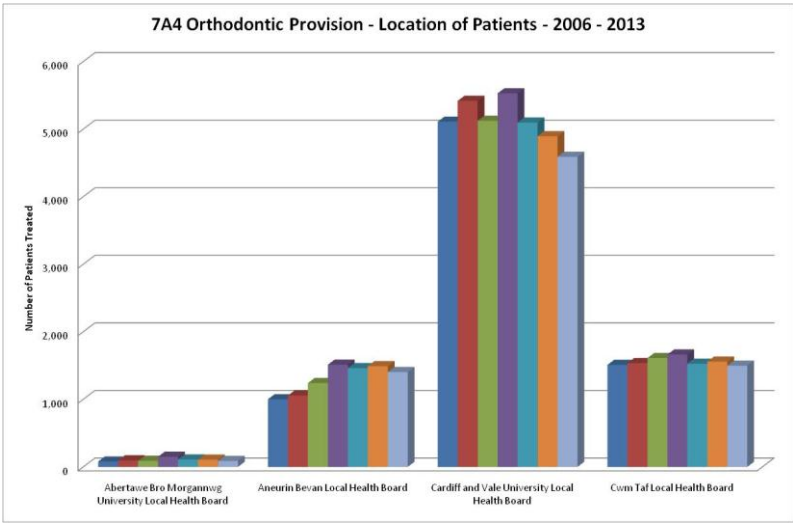
9. The contract model for orthodontics is not ideal for providing robust performance management and ensuring the best value for money for treatment provided. The concept of paying for a full two year's worth of treatment up-front to the provider makes it more difficult to ensure that the treatment is robustly provided and recorded through to completion. There are also issues with patients who move during their treatment. In these circumstances, the original provider is paid the full treatment fee (approx £1,500) and the new orthodontist who picks up the work is also paid a full treatment fee. The Welsh Government's Strategic Advisory Forum on Orthodontics is undertaking work to review the current contract model and suggest changes which could improve care and cost effectiveness.

10. In 2011 the Welsh Government issued guidance on improving the performance management of orthodontic contracts which looks at issues beyond simply the achievement of activity targets. This guidance now forms an appendix to all Cardiff & Vale UHB orthodontic agreements and is being used to start to performance manage the contracts in a much broader manner. Early signs are that they will help give a more nuanced approach to performance management of these contracts.

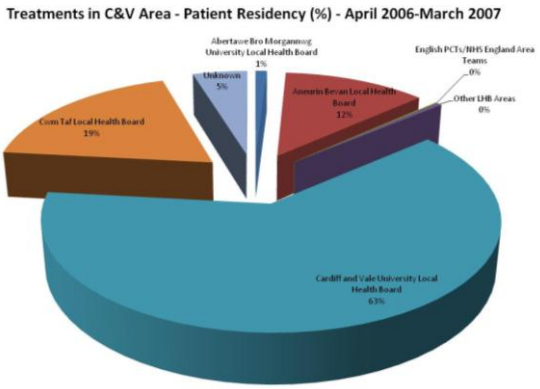
11. Since the creation of the SE Wales Managed Clinical Network for Orthodontics, much work has been achieved in terms of creating a standardised referral system (including criteria and paperwork), establishing an accreditation process for Dentists with Enhanced Skills (DwES), improvements in the ability to audit and monitor orthodontic treatment outcomes and discussions to bring recommendations on issues such as orthodontic appeal panels, and the transfer of orthodontic care.

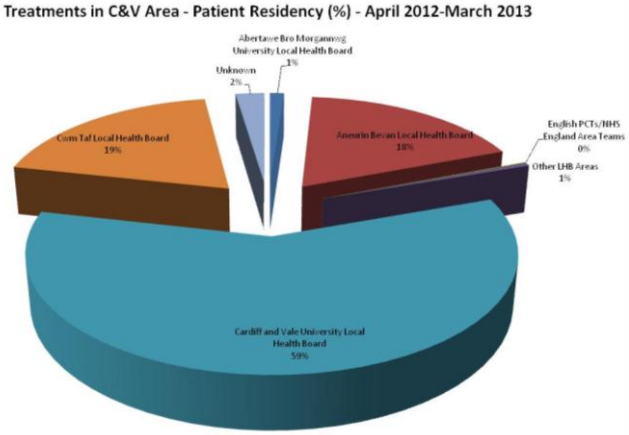
Whether The Current Level Of Funding For Orthodontic Services Is Sustainable With Spending Pressures Facing The NHS, Including Whether The Current Provision Of Orthodontic Care Is Adequate, Affordable And Provides Value For Money

12. With no specific intervention from any of the South East Wales LHBs, there has been little change in the proportion of patients seen at the three major orthodontic practices in Cardiff from each of the LHB areas. The three major practices in Cardiff are located with good access to road and public transport enabling patients within the surrounding LHB areas to access care.



13. Approximately five years ago, Cardiff & Vale UHB was requested by a neighbouring LHB to investigate the feasibility of relocating some of the finances to that LHB to provide orthodontic services more locally. It was decided that patients were better served by creating centres of excellence within primary care and that larger specialist practices were more appropriate than smaller, less competent mixed practices. Therefore, it was agreed to maintain the larger specialist practice contracts and to continue to monitor the percentage of patients per UHB area.

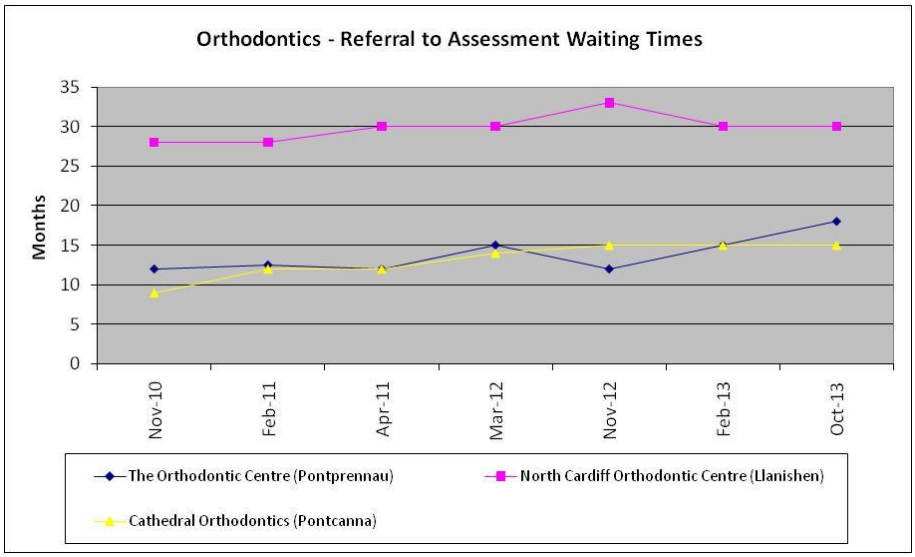




14. In terms of performance management, quality, effectiveness and referrals, the three large specialist practices in Cardiff are benchmarked against one another.

15. Waiting times for assessment at all orthodontic practices have been monitored since November 2010. The three main

practices have shown a slight overall increase in the waiting time for an NHS assessment but it suggests that the demand for NHS orthodontic treatment is not increasing significantly and this would suggest that the level of funding in orthodontics is appropriate to meet the current demand but would require a large 'one-off' investment to reduce this waiting time significantly. Cardiff, especially, has seen a significant population increase over the last 10 years and yet the waiting time increase suggests that the current funding level is absorbing any increase in demand caused by population increase.



Whether Orthodontic Services Is Given Sufficient Priority Within The Welsh Government's Broader National Oral Health Plan, Including Arrangements For Monitoring Standards Of Delivery And Outcomes Of Care Within The NHS And The Independent Sector.

16. The National Oral Health Plan outlines the need to improve the performance of orthodontic contracts to maximise the amount and quality of patient care available within the existing financial envelope. As outlined in paragraph 10, the guidance issued by Welsh Government has provided a starting point for the development of more robust performance management of the quality of the outcomes for primary care specialist practices.

17. Given the pressures on the funding of all parts of dentistry and the difficulties caused by this in developing new primary care services such as conscious sedation, minor oral surgery, domiciliary dental care, the committed investment in primary care orthodontics is quite substantial and the UHB both does not have the funds to invest additional sums into orthodontics and cannot justify the need, given that the supply of care seems to meet the demand for it.

18. The significant population increase in Cardiff especially (approx 3 times the average growth in Wales according to the 2011 census), means that providing access to general dental services and emergency/urgent dental care may well take priority on increasingly pressured budgets (the primary care dental allocation has seen no increase since the introduction of the new contract models in 2006).

The Impact Of The Dental Contract On The Provision Of Orthodontic Care.

19. The orthodontic contract introduced in 2006, use a very crude core performance management tool of measuring achievement against a target of Units of Orthodontic Activity (UOAs). This does not take into account the quality of care, complexity of treatment or any other quality indicators. This meant that for the early years of this contract, it was relatively easy to achieve the contract targets with minimal effort. The introduction of the Guidance by Welsh Government in 2011 has allowed LHBs to start to introduce other tools into the performance management of the contracts. It is still early days in using this guidance to understand the long term quality and performance impacts it could have.

20. The current orthodontic contract also does not allow flexibility in payment mechanisms. This includes being able to transfer part payment of the fee from one provider to another one in another part of the country when a patient relocates. This would save LHBs and Area Teams from paying twice for treatment on the same patient.

21. Also, the contract does not have the flexibility to look at different operational models for providing care. There is move towards the greater use of orthodontic therapists, who provide a more cost effective method of providing the ongoing care of patients whilst remaining under the supervision of an orthodontic specialist. However, the contract will still pay the practice the same amount whether they use an expensive orthodontic specialist or the less expensive orthodontic therapist. This does not encourage LHBs to seek to develop these skill mixes which may ultimately provide a more comprehensive service for more patients within the same financial envelope. There is a need for the orthodontic contract to be able to recognise this shift.

Section 2 – Community Dental Service

Background

The Community Dental Service covering both Cardiff and Vale and Cwm Taf LHBs, operates orthodontic sessions from 4 sites: Merthyr Tydfil, Aberdare and Pontypridd north of the M4, and Barry Hospital in the Vale of Glamorgan. Two orthodontists, equating to 1.4wte, operate the sessions with one of the posts being a joint collaboration with the Dental Hospital and the University. This partnership ensures that the individual is not isolated in their professional work, enriching their position with commitment to the undergraduate teaching programme.

The CDS is responsible for the dental care of a large cohort of paediatric patients throughout its geographical area of responsibility and having a CDS managed orthodontic service ensures seamless treatment for the patients. The immediate advice that is available for the dental officers and to the GA Assessment service is invaluable.

Both positions have recently experienced the retirement of the orthodontists and on each occasion the Dental Clinical Board, the University and Cwm Taf LHB have supported the continuation of the service.

Access for Patients

CDS receives referrals from GDS – Pontypridd 39.5% and Barry Hospital 58.6%.
Aberdare and Merthyr do not currently take referrals from GDS

Waiting Times

Clinic	New assessment		Treatment	
Pontypridd	6 months		24 months	
Barry Hospital	2 months		20 months	
Merthyr Tydfil	2 months		18 months	
Aberdare	3 months		18 months	

Working Relationships – Ortho practices, the LHBs and the role of the MCN

CDS ortho service is supported by the LHBs with good collaborative working and understanding. Recent MCN referral form has improved the way the service is accessed, minimising inappropriate referrals, and providing dentists with clearer understanding of the criteria for referral to assist their conversations with patients.

Funding

Despite the present financial difficulties, the CDS orthodontic service is key to its plans, regarding the delivery of a holistic dental service to the vulnerable patients that it is responsible for. Orthodontics is essential for the complete delivery of a 21st century dental service where debilitating malocclusions are treated based on need rather than demand and access.

National Oral Health Action Plan

Adequate emphasis placed in the plan – focuses on reducing inappropriate referrals and ensuring treatment is provided for those with the most need and therefore most health gain. However mention should be made of the long waiting times for initial assessment and treatment and an action plan to reduce this.
Action plan needs more focus on secondary care services such as Maxillofacial Surgery as patients who require surgical extractions or exposure have to wait up to 12 months, which then impacts on orthodontic care.

The impact of the dental contract

Only those patients with an IOTN (Index of Orthodontic Treatment Need) of 5, 4 or 3 with and aesthetic grade 6 receive treatment as agreed in the dental contract. This has ensured that only those cases with the greatest need receive orthodontic treatment

Section 3 - University Dental Hospital's (UDH)

1. *Access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales.*

Access to orthodontic services at the University Dental Hospital (UDH) is aligned with the Welsh Government's National Oral Health Plan (NOHP) (2013). This follows a regionally agreed referral pathway allowing the GDS, CDS and HDS to work together and ensures that residents can access specialist orthodontic services using an integrated approach through delivery of the aforesaid services.

Referrals to UDH for an orthodontic consultant opinion are requested for adults and children from across Wales. The number of orthodontic referrals to UDH over the last 4 years is shown in Table 1.

Table 1 Number of orthodontic referrals to UDH by Health Board of patient residence

		2010/11	2011/12	2012/13	2013/14
ABM ULHB	Adult	23	15	14	19
	Child	3	5	8	7
ANEURIN BEVAN LHB	Adult	103	98	91	62
	Child	73	56	67	84
BETSI CADWALADAR ULHB	Adult	-	-	1	1
	Child	-	-	-	-
CARDIFF AND VALE ULHB	Adult	329	261	255	284
	Child	276	235	267	454
CWM TAF LHB	Adult	86	65	66	57
	Child	63	61	60	113
HYWEL DDA LHB	Adult	2	1	2	1
	Child	-	1	1	-
POWYS TEACHING LHB	Adult	6	1	1	2
	Child	1	-	1	1
NO LHB INFO AVAILABLE	Adult	1	1	3	4
	Child	2	2	2	2
	TOTAL	**968**	**802**	**839**	**1091**

The UDH fulfils its role as the largest centre in Wales for specialist orthodontic consultations. The majority of patients (68%) seen for orthodontic consultations are from C&V UHB but significant numbers of patients are also seen from neighbouring Aneurin Bevan and Cwm Taf LHBs. Unfortunately the current data does not indicate whether referrals from outside of C&V UHB are from primary, secondary or tertiary sources. Overall there has been a 13% rise in orthodontic referrals to UDH over the last 4 years (22% decrease in adult referrals and a 58% increase in child referrals).

The UDH currently has 166 new referrals waiting for assessment. The longest wait from referral to assessment is currently 8 weeks (correct as of 11.03.2014). Table 2 shows the current demographics of new referrals.

Table 2 Number of new orthodontic referrals to UDH waiting for assessment (grouped by Health Board of patient residence)

	Total
ABM ULHB	2
ANEURIN BEVAN LHB	17
CARDIFF AND VALE ULHB	131
CWM TAF LHB	16
TOTAL	**166**

Acceptance for orthodontic treatment is based on the following criteria:

- Patients under 18 with a score on the Index of Orthodontic Treatment Need (IOTN) of 3.6 (DHC = 3, AC = 6), 4 or 5
- Patients over 18 requiring multidisciplinary care that specifically requires hospital management, e.g. those that require orthodontic treatment in combination with corrective jaw surgery or complex hypodontia cases requiring orthodontic and restorative input
- Requirement for student teaching

The UDH referral guidelines are freely available on the UHB website and can accessed using the link below:
http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/209978

There is a wide range of clinical skill mix providing orthodontic services in UDH. Our current staffing levels are outlined below:

- Year 3 and Year 4 undergraduate students (n=160) see new routine child orthodontic referrals, child orthodontic reviews and carry out simple removable treatments, e.g. interceptive orthodontics, under specialist orthodontist supervision
- Specialty Doctors (WTE n=0.4) treat all levels of patient care
- Training grades within the speciality (WTE: 1.6 StR's, 3.6 overseas postgraduate students and 0.6 Post-CCST) treat all levels of patient care
- Orthodontic Consultants (WTE n=3) conduct multidisciplinary clinics, manage orthodontic service within department and treat all levels of patient care

The longest wait for orthodontic treatment from assessment is 26 months. There are currently 903 patients on our waiting lists-496 on the Fixed Appliance waiting list and 402 on the Secondary waiting list for MDT consultations (correct as of 11.03.2014) which is an 11% increase compared to 2010 (n=816). The UDH treatment waiting list is cyclical and reduces considerably during the new intake of training grades in October each year. Further reasons for long treatment waiting times are discussed in Point 3.

UDH cannot comment on the regional variation in access to orthodontic services across Wales although a significant number of patients are being seen at the UDH who reside outside the C&V UHB.

2. The effectiveness of working relationships between orthodontic practices and Local Health Boards in the management of local orthodontic provision, and the role of Managed Clinical Networks in helping to deliver more effective orthodontic services in Wales (e.g. effective planning and management, improvement in the appropriateness of referrals and performance management, workforce arrangements).

The South East Wales Orthodontic Managed Clinical Network (MCN) was established in January 2009. UDH has representation on the MCN Executive Committee and MCN clinician meetings both held quarterly. The MCN has improved working relationships between orthodontic providers and LHBs and helped to deliver more effective orthodontic services. The benefits to UDH are outlined below:

- Referral management: early referrals and multiple referrals to different providers had previously been recognised by the MCN as challenges in this area. A common referral form for South East Wales has been established and in use since April 2012. The UDH only accepts referrals from primary care (GDS and CDS) on this form, which has simplified the process of vetting and ensures patients are allocated onto the most appropriate clinics for their consultation. An audit is currently being planned to assess the impact of the common referral form on the appropriateness of referrals to UDH
- Treatment outcome monitoring: all completed cases at UDH are independently scored to assess quality of treatment outcome using the Peer Assessment Rating (PAR). Annually, the treatment outcomes of 50 cases at UDH are submitted to the LHB via the MCN to compare outcome against regional providers.

3. Whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money.

- Current Funding level

The provision of specialist orthodontic services is funded as part of the Dental SIFT allocation which has not been uplifted for a number of years. Recent cost reduction schemes are impacting on the Hospital services as a whole including orthodontic provision. The long wait for complex multidisciplinary treatment partly outlined above reflects this. The overall situation is unlikely to improve given the increase in referral numbers to UDH.

- Adequacy of current provision of care:

Provision of orthodontic care for all patients is identified by objective orthodontic treatment need (IOTN), in addition acceptance of adults who require multi-disciplinary care only. As a number of patient referrals reside outside the C&V UHB it would be helpful that some formal SLA could be agreed with other LHB's.

- Value for money:

It has already been shown that clinicians working in the hospital service provide cost-effective orthodontic treatment (Richmond 2005).

UDH is a teaching institution and the service model is centred on the education of training grade groups. There are currently 3.6 WTE overseas postgraduate students - unpaid by the C&V UHB - who provide orthodontic treatment from the department's waiting lists. Each trainee will treat approximately 120 patients during their 3-year training period.

Measures have also been taken by the orthodontic department to make savings. Since 2011 UDH have been charging patients for lost appliances and retainers. Retainer boxes and oral health aids are now purchased by the patient rather than given 'free of charge'. Fluoride was routinely prescribed to prevent decalcification during orthodontic treatment. In line with Cardiff and Vale Health Board policy (2011), prescriptions for 'over the counter medicines' were stopped–since this change in policy, fluoride mouthwash can no longer be prescribed. It is now 'advised' rather than prescribed. This has had a detrimental effect on the decalcification rates for patients undergoing fixed appliance treatment at UDH as shown by a recent audit. This may have service provision implications for other specialties within UDH such as restorative dentistry.

The department has been involved in the Clinical Board Development sessions to encourage clinical engagement with financial planning. Clinicians have been encouraged in identifying 'blue sky' opportunities to make financial savings and income generation.

4. Whether orthodontic services is given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector.

- Priority within the Welsh National Oral Health Plan (NOHP):

The delivery of the NOHP (March '13) has a small section relating to orthodontic services. It appears to broadly accept the recommendations from the previous orthodontic review (Health, Wellbeing and Local Government Committee, Orthodontic services in Wales, February 2011)

Good practice recommendations from the above review included the development of an Orthodontic MCN-this has already been delivered.

- Monitoring standards of delivery and outcomes of care:

Orthodontics is one of the few dental specialties that routinely use objective measures of treatment outcome – the Peer Assessment Rating (PAR) and Index of Complexity Need and Outcome (ICON).

UDH current protocol includes:

- PAR scoring every completed orthodontic case.
- Registration with the European Federation of Orthodontic Specialists Association (EFOSA) and use of their database to record, maintain and update PAR scores.
- A rolling audit project undertaken by an orthodontic training grade to report PAR results locally and undertake root cause analysis for cases scoring 'worse/no different'.
- Submission of PAR scores of 50 consecutively completed cases to Cardiff and Vale LHB on an annual basis.

5. The impact of the dental contract on the provision of orthodontic care.

Since the introduction of the 'new' orthodontic contract in 2006 orthodontic care has been provided when the orthodontic threshold of IOTN has been reached (DHC 4&5 and DHC 3 and AC >5). This has helped to prioritise delivery of services based on a treatment need and a health gain.

There is a perception there may have been an increase in referrals for a second opinion following the introduction of the contract, but this has not been fully quantified.

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List of Abbreviations Used

ABM	Abertawe Bro Morgannwg
AC	Aesthetic Component
AM	Assembly Member
CCST	Completion of Certificate of Specialist Training
CDS	Community Dental Service
DHC	Dental Health Component
DwES	Dentists with Enhanced Skills
EFOSA	European Federation of Orthodontic Specialists Association
GA	General Anaesthesia
HDS	Hospital Dental Service
ICON	Index of Complexity Need and Outcome
IOTN	Index of Orthodontic Treatment Need
LHB	Local Health Board
MCN	Managed Clinical Network
MDT	Multi Disciplinary Team
NHS	National Health Service
NOHAP	National Oral Health Plan
PAR	Peer Assessment Raring
PCIC	Primary, Community & Intermediate Care
PDS	Personal Dental Service
SIFT	Service Increment for Teaching
SLA	Service Level Agreement
StR	Specialist Training Registrar
UDH	University Dental Hospital
UHB	University Health Board
UOA	Unit of Orthodontic Activity
WTE	Whole Time Equivalent

National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from Hywel Dda University Health Board – OS 11

Inquiry into orthodontic services in Wales

Hywel Dda University Health Board welcomes the opportunity to comment on this inquiry. We have made significant progress in improving access to assessment and treatment over the past twelve months and this focus has led to particular insights. At this time of significant austerity, and with a view to providing prudent healthcare, we would welcome a debate on access criteria for NHS funded treatment.

1. **Access & variation for patients to appropriate orthodontic treatment :**

    a. There is a single point of entry to all orthodontic services within Hywel Dda. Referrals are received by the Dental Services Team and then directed onto the appropriate provider whether primary or secondary care. There is a tracking system in place to have a clear understanding of the waiting times for patients.

    b. Variation is limited as there is one service provider for initial clinical assessment, one provider for primary care treatment and one provider for secondary care treatment.

2. **Working relationships between orthodontic practices and Local Health Boards :**

    a. The managed clinical networks are welcomed, although the Primary Care service is still contractually driven. They are particularly helpful for agreeing referral forms, protocols and pathways but it must be recognised that there is always the opportunity for commercial interests to be present within the discussions.

    b. Primary Care Orthodontic Practices have contracts of 3 to 5 years which end at different times depending on when commissioned, this means that regional and strategic planning is limited by these contractual timeframes. Effort is made on the part of the Local Health Board and the orthodontic practices to build positive and professional relationships.

3. **Current provision is adequate, affordable and provides value for money :**

    a. Currently levels of funding can be sustained however a far greater amount of routine care could be delivered instead. There is a broader debate to be had regarding clinical priorities in such times of austerity.

    b. Hywel Dda has historically had very long waiting times for routine orthodontic treatment. The backlog of 3 years 6 months when the current year started has now reduced to 2 years and 4 months. The new orthodontic assessment only service has a mean waiting time for routine assessment of 9 months. Reducing these

waiting times is therefore underway and this work will continue until a sustainable position is reached.

c. Consideration should be given to strengthening the acceptance criteria for routine NHS treatment. There is considerable social demand for orthodontic treatment.

d. Value for money is not assured as payment is made up front at the start of treatment. Where a contract expires the provider retains no responsibility for the patient resulting potentially in a double payment.

4. Priority within the national oral health plan :

a. We consider it appropriate to focus primarily on preventative and routine care in the oral health plan, orthodontics do not warrant a higher priority than currently given.

5. Impact of the dental contract :

a. This has a significant impact on the demand for the service and the payment tariff. Hywel Dda would welcome the ability to consider alternative, more flexible approaches to delivering orthodontic care to those patients most at need.

Health and Wellbeing
Best Practice and Innovation Board

Final Report

January 2014

Document Information

Title	Health and Wellbeing Best Practice and Innovation Board: Final Report
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Purpose	This document provides a summary of the work programme undertaken by the Health and Wellbeing Best Practice and Innovation Board since its establishment in 2012.
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Timing	January 2014
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Ministerial Foreword

Professor Mark Drakeford AM
Minister for Health and Social Services

I strongly believe that innovation is the key to improving the quality of health and social care services in Wales.

I want to see a planned national health system which delivers equitable access and outcomes for people wherever they live in Wales, which helps people to engage with and to take responsibility for their own wellbeing and health, and which routinely and relentlessly applies new learning and understanding into practice as a key principle of delivering prudent healthcare.

Given current budget challenges, applied innovation in health and social care is an imperative for the Welsh Government. But this is also a global challenge, so there are potential economic and reputational benefits from meeting the challenge of providing high quality services which are efficient and sustainable.

I welcome the Board's whole system view of health and wellbeing, covering all sectors and stakeholders, including business. I endorse its guidance on technology adoption and its recommendations on strengthening links between health and wealth - these point to the shared value that can be created in Wales from bringing clinical, academic, third sector and business communities together.

I wish to record my thanks to members of the Health and Wellbeing Best Practice & Innovation Board for their work, which will inform the continued improvement of health and social care services in Wales.

1: Background

The Board

The Health and Wellbeing Best Practice & Innovation Board ('the Board') was established in 2012 by Lesley Griffiths AM, the Welsh Government Minister for Health, Social Services and Children.

Its purpose was to add value to the identification and implementation of system-wide innovation and the rapid adoption and diffusion of best practice and transformative technologies, service models and models of delivery. The Board has focused on assisting in accelerating the pace of innovation relevant to health, social care and wellbeing, and supporting the systematic identification and spread of best practice.

The Board was established as a time limited mechanism, with the independent Chair and the Board members appointed by the Minister for two year tenure. A Programme Director and Programme Administrator were also appointed to support the Board in taking forward its programme of work. A list of Board members and support staff is provided at Annex 1.

Terms of Reference were developed and are set out in Annex 2. These reflect the Minister's requirement that the Board should focus on accelerating the uptake of evidence based best practice and innovation across the health and social care system, with an emphasis on partnership working with all key stakeholders to achieve agreed outcomes.

Health and Social Care Context

The health and social care system in Wales is experiencing significant challenges in meeting increasing demand for services at a time of financial constraint. Such pressures require broader thinking and consideration of alternative models of delivering services.

There is increasing recognition that working across organisational boundaries can help identify innovative models of service delivery and drive the adoption of evidence based best practice. Improving service delivery involves a wide range of partners and stakeholders and requires more rapid and effective application of research and learning into practice. There is scope to further develop partnership working with industry in Wales, where that offers shared value to health and social care providers and to the Welsh economy.

Innovation and improvement has often been driven by the provision of either a grant or other dedicated resources, leading to 'add on' approaches rather than the transformative change management that would embed such change into core delivery. Additionally, innovation initiatives are often small scale projects seeking to test new solutions in discrete contexts, leading to fragmentation and an inability to 'scale up' to wider application. In line with national policy, the Board has been mindful of the need to ensure that national direction is balanced with local flexibility, and has sought to protect principles of co-production and a citizen centred

perspective. This will ensure that the culture of health and social care provision in Wales encourages and sustains innovation and improvement, to support the delivery of health and social care services, and improve the health and wellbeing of people in Wales.

Policy Position

The 2011 *Programme for Government*[1] sets out the Welsh Government's vision - to improve the lives of people in Wales by ensuring healthy people are living productive lives in a more prosperous and innovative economy. It establishes the principles that guide the Government's approach - investing in infrastructure, skills, innovation and improving the public sector and business environments. Specific commitments include:

- Strengthening the conditions that will enable business to create jobs and sustainable economic growth;
- Supporting the delivery of effective and efficient public services that meet the needs of people in Wales;
- Better health for all with reduced health inequalities:
- High quality, integrated, sustainable, safe and effective people-centred services that build on people's strengths and promote their well-being.

Together for Health[2] (2011) describes the challenges and demands facing healthcare over the coming years and sets out the ambition that people in Wales should have access to health services that match the best in the world. *Sustainable Social Services*[3] (2011) reflects the same messages and sets a similar challenge for local government, recognising that doing more of the same will not provide sustainable, responsive social care services within the context of growing demand. It also recognises that both NHS and local government organisations need to work together in partnership to develop more sustainable and citizen centred services.

Welsh Government policy is clear that, if Wales is to address and reduce inequalities and ensure that health and wellbeing outcomes are amongst the best, the status quo is not an option. There is much in Wales to be proud of, but this should not lead to complacency – the continuous search for new and better ways of doing things is essential if Wales is to ensure a modern, sustainable range of services in the years ahead.

The Board was one of a number of strategic actions put in place to achieve that world class ambition by adding value to the identification and implementation of

[1] *The Programme for Government*, Welsh Government.
http://wales.gov.uk/about/programmeforgov/?lang=en

[2] *Together for Health: Five Year Vision for the NHS in Wales,* Welsh Government.
http://wales.gov.uk/topics/health/publications/health/reports/together/?lang=en

[3] *Sustainable Social Services for Wales: A Framework for Action,* Welsh Government.
http://wales.gov.uk/topics/health/publications/socialcare/guidance1/services/?lang=en

system wide innovation and the rapid adoption and diffusion of best practice and transformative technologies, service models and delivery.

Innovation Wales

The Welsh Government has recently completed an extensive consultation on the development of a new innovation strategy. Innovation Wales[4] has been produced as a result of this consultation and has led the Welsh Government to identify one overriding principle - that it should promote, encourage and enable innovation across the whole economy, but that key investments should be made on the basis of clear strategic priorities, built on Wales' strengths. The strategy identified five key themes for action on innovation:

- Improving collaboration
- Promoting a culture of innovation
- Providing flexible support for innovation
- Innovation in government
- Prioritising and creating critical mass

The health and social care system is a key part of this approach, which is closely linked to the support for research and development provided through the National Institute for Social Care and Health research (NISCHR).

[4] *Innovation Wales,* Welsh Government
http://wales.gov.uk/topics/businessandeconomy/publications/innovation/?lang=en

2: Programme of Work

Definition and Content

The Board was established by the Minister for Health and Social Services to add value to the identification of innovation, and the rapid adoption and diffusion of best practice. It has a systems wide remit, seeking to identify and progress opportunities relating to transformative technologies, service models and modes of delivery.

Within this broad context, the Board sought to:

- Identify and support the implementation of systems wide innovation;
- Identify best practice transformational technologies, service models and modes of delivery and create the context for spread and adoption.

In undertaking its work, the Board considered broader innovation and best practice, including particularly those originating from academic and business sectors. Given its very broad scope, the Board adopted a thematic approach, focusing on a small number of issues, and prioritising its work to optimise its impact.

All of the Board's actions were linked to the *Together for Health* and *Sustainable Social Services* direction and priorities, and reflected innovation both from a systems perspective and for individual interventions.

The Board's original terms of reference are attached at Annex 2.

Structure and Accountabilities

The structure adopted by the Board for delivery was the establishment of a Programme Board. This had responsibility for setting the overall work programme and related work streams, and oversaw progress and dissemination to ensure delivery of the agreed objectives and outcomes.

The Chair had a broad remit to ensure engagement with all appropriate representatives, to represent the Board at national level, and to ensure that relevant and appropriate policy and strategic development advice was offered to the Welsh Government.

The Board was accountable to the Minister for Health and Social Services, through the Director General of the Department for Health and Social Services, Welsh Government. Through the Chair, the annual work programme was agreed with the Director General, NHS Chairs and Chief Executives, local government Cabinet members and Chief Executives, and subsequently endorsed by the Minister for Health and Social Services.

The Board's membership is attached at Annex 1.

Workstreams

Workstreams were established to reflect the Board's systems wide approach to prioritisation. Each workstream was chaired by a Board member or a recognised expert who reported regularly to the Board on activity and progress. These workstreams were:

- Integrated Services;
- Incentives and Investment;
- Leadership, Culture and Employee Engagement;
- Access to Evidence;
- Knowledge Transfer;
- Health, Social Care and Business;
- Public and Patient Engagement.

The Programme of Work

The actions undertaken by the Board and its constituent workstreams included:

- Analysis of current systems and the broader policy and strategic context within which the Board operated;
- Wide scale horizon scanning relevant to the Board's remit, including business, enterprise, industry, academia, and UK wide/global developments;
- Commissioning literature reviews and research appropriate to the Board's activities and remit;
- The dissemination of relevant material arising out of other national processes, including the Public Services Leadership Group and the Welsh Government Good Practice Wales website;
- Completion of the *Call for Evidence* submissions process, with a final report providing analysis of the responses and a series of Recommendations for the Minister;
- A mapping process undertaken to identify organisations, sectors and funding streams relevant to health and social care innovation and best practice in Wales, UK and internationally*;*
- Collaboration with the Board of Community Health Councils (CHC) to explore their role in the innovation and best practice agenda, using Aneurin Bevan HB area as a test site;
- Extensive engagement across all sectors, by the Board and its Workstreams, including facilitated events and a national conference focusing on the opportunities provided by the better use of technology, including the potential opportunities and impact in rural settings;
- *Determinants of Effective Integration of Health and Social Care* - advice provided to Welsh Government to support policy development;
- *Technology Adoption Systems Guidance* - guidance to support the systematic adoption of technology through a consistent all Wales process;
- *The Essential Leadership Pre-requisites for Innovation and Best Practice* – advice to inform further work on leadership by Academi Wales and other improvement agencies;

- *Innovation and best practice criteria and prioritization* – a matrix to support the screening of Welsh Government Invest to Save bids;
- *Information Driven Improvement* – a report on the fundamental role of information in improvement and the development of measures that capture improvement;
- *The Characteristics of High Performing Organizations* – a report on the QUEST methodology;
- *Recommendations on Health and Wealth in Wales* – advice and recommendations on a systematic approach to innovation, linking health and wealth policy aims and objectives.

3: Evidence

The Process

The Board recognised at a very early stage the need to undertake a benchmarking process – seeking to identify contemporary issues impacting upon innovation and best practice – and also to capture views and opinions on the levers and barriers that can impact upon the ability to deliver environments within which best practice can be identified and adopted and innovation be nurtured.

The *Call for Evidence* process sought to gather views and information on the following key areas:

1. The approach to organisational learning and knowledge management;
2. The 'delivery systems' in place to ensure a systematic approach to innovation and best practice adoption and diffusion;
3. The systems in place to allow and encourage the seeking out of best practice from others;
4. Support systems in place to encourage staff to introduce new ideas and technologies;
5. The management of intellectual property;
6. The systems in place to monitor and continuously improve person-centred outcomes;
7. The arrangements in place to review best practice from others and compare it with current systems;
8. Actions taken to stop outdated and ineffective models of care;
9. The enablers to innovation and the diffusion of best practice;
10. The barriers to innovation and best practice adoption/diffusion;
11. The opportunities for the health and social care systems in Wales to learn from other national and international systems;
12. Views on the focus for the Best Practice and Innovation Board during 2013/14.

In addition to these questions, respondents were invited to share examples of innovation and the adoption and diffusion of best practice.

Methodology

The *Call for Evidence* data collection process commenced in December 2012 and concluded on 28 February 2013. The *Call for Evidence* was circulated widely across NHS Wales; local government; third sector; independent sector care providers; the regulatory and improvement agencies; academia; professional organisations and bodies; business and industry. Recognising the need to be able to support and encourage responses, and to be able to respond promptly to queries, a specific resource was identified with an academic and research background within health and social care to offer support, advice and guidance during the submission process.

A database was developed to record submissions and key information (such as sector, categories, evidence and outcomes) to ensure the responses could be interrogated appropriately in the future. In addition to the database, a log was also created to ensure every contact (irrespective of whether this contact resulted in a submission) was captured.

Given the approach adopted – of a template containing key questions and an invitation to submit evidence and share work underway – the responses were analysed and presented in three categories:

- Direct responses to the specific questions presented on the circulated template;
- Examples of innovation and best practice, provided in free text;
- Examples of publications and additional academic evidence referenced in the responses.

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Respondents were given the opportunity to submit information anonymously, or to request that their information was not published or shared with others. No respondent took up this option.

Responses and Summary Findings

A total of 101 submissions were received. Of these 34 completed the questions on the template; 48 provided examples of innovation and/or best practice; and 17 provided examples of literature and additional evidence. These responses were analysed and distilled into ten key conclusions:

1. Improvement and change is best progressed when there is support from across all levels of organizations and, where appropriate, across sectors. 'Top down' approaches that fail to recognize and facilitate pathways between senior leaders and frontline practitioners can lead to a cultural collision at middle management level, with the risk of a disconnect between those responsible for delivering high quality services and those at a senior level.

2. The need for local discretion in developing new models of care was recognized, within the context of national direction. Externally driven approaches that fail to allow local partners some control over the range of services provided is unhelpful – locally grown solutions allow responsibility for managing to be retained and owned at the point of care delivery resulting in a more participative organisational culture and sustainable improvement.

3. Accessing to real time data to support improvement is essential but still problematic. The reporting of data for performance purposes to monitor compliance against targets was viewed in a negative context. Respondents were clear that data collected for improvement should not then be used as a proxy for performance data and to measure comparative performance. The value of outcome based measures that operate across sectors was recognized but continue to be limited.

4. Systems do not exist to support primary care innovation and best practice being identified and shared across both other primary care practitioners and the whole health and social care system.

5. National policy tends to operate on a 4-5 year basis, related to the political cycle. This risks a focus on shorter term delivery, further compounded by the one year business delivery requirements. Models that require several years to implement and begin to provide results can get lost within the shorter term approach. Driving improvement requires sustained vision and determined leadership, supported by consensus and co-production.

6. In identifying innovation opportunities and the adoption of best practice there needs to also be a focus upon the decommissioning of outmoded services/models of care. This should be undertaken from a governance perspective and will release time and resources to support, invest, and implement alternative evidence based approaches.

7. Business/industry respondents viewed the public sector in general and NHS Wales in particular, to lack agility, making it difficult to respond appropriately through the flexible use of resources and services to changing need and to new and/or innovative opportunities.

8. Organisational behaviours are based upon risk averse/permission based cultures can stifle innovation and remove ownership and responsibility from those at practitioner level who are pivotal to driving change. Organisational cultures that create the environment within which innovation can flourish need to recognise that becoming more innovative will mean being prepared to fail.

9. There is growing evidence that silo finance models block innovation opportunities and can create cultural disconnect, especially if the benefit is experienced within a different part of the organisation to that expected to resource it. A move towards a more pathway based resource model will allow benefits to be identified by those with ownership of the service.

10. Whilst systems exist to identify evidence based good practice, there is limited opportunity to capture outcomes and share with others on a ‘once for Wales’ basis. The evidence base is also growing that small scale changes are very closely linked to the local pattern of services, and the potential to ‘scale up’ and embed more widely is limited. Instead the requirement needs to be the identification of key principles that should be applied more consistently, with the actual pattern of services developed to reflect these principles owned and implemented locally.

4: Recommendations

Based on the evidence gathered through the *Call for Evidence,* the Board's extensive engagement activity, and the expert knowledge of Board members, the Board concluded that there continues to be significant opportunity to use innovation as a driver for change and improvement across health and social care services in Wales. In particular, new technologies and approaches can help with the remodelling of services so that they are delivered as close to home as possible, avoiding disruption to usual living and care arrangements and protecting what can be fragile independent living.

The Board has delivered a number of advice and guidance documents. Some of these promote equitable access to health and social care throughout Wales. For example, by moving to a more consistent approach across Wales or reducing difference in service responses based upon where a person lives. Others aim to place the person at the centre of service planning and delivery. For example, by identifying system level issues that could be addressed to make better use of public resources and to deliver sustainable high quality services. Collectively, these reports provide a range of advice and recommendations on improving the identification and adoption of best practice and creating an environment within which innovation can flourish.

A key opportunity identified by the Board was the relationship between health and social care sectors and business/industry. A facilitated meeting early in 2013 with business leaders in Wales identified a willingness and enthusiasm from the private sector to working with public sector services in a more managed planning process, seeking to avoid ad hoc engagement that does not make the best use of the opportunities provided by industry innovation. *Recommendations on Health and Wealth in Wales* is a key document that will support the ongoing development of this relationship, with recommendations that will ensure more robust relationships will be in place to support future planning intentions.

The Board has submitted its recommendations to the Minister for Health and Social Services, who has committed to considering their application and impact across the full range of health and social care related policy development. These recommendations align to the ten key messages highlighted from the *Call for Evidence* process:

1. We recommend that organisations review whether current pathways facilitate a direct relationship between senior leaders and frontline workers and/or care providers - who are the experts in delivering care and support - to ensure a balanced approach is in place. The leadership paper issued by the BPIB in June 2013 includes recommendations that refer to the need for leaders across sectors to commit to a distributive form of leadership, and to creating organisational cultures that are participative and recognise and reflect the need for improvement to be driven by practitioners at the point of care delivery. The Welsh Government has a role to play in creating the climate within which such cultural change will thri

2. We recommend that Welsh Government, in setting its policy and performance requirements, reflects the need to delegate both accountability and responsibility to organisational and sectoral leaders for the modes by which national requirements are delivered – i.e. there should be an appropriate balance between national direction and local discretion. Success should be measured via outcomes rather than upon compliance with pre-determined requirements that can hinder improvement. Organisations across sectors should seek to reflect the characteristics of high performing organisations described within the evaluation of the QUEST model including rebalance measuring success away from a focus on process driven performance targets to one that reflects outcome based measures.

3. We recommend that all sectors recognise the need to move towards information based change, including the appropriate and safe sharing of data across organisational and sectoral boundaries. This requires the routine collection of comprehensive and consistent data, and urgent progress in the implementation of shared care records, to: improve data quality; provide a foundation for robust outcomes-based reporting and comparison; identify areas most in need of improvement; and to promote evidence-based evaluation of the impact of innovation. The specific recommendations within the 'Information Driven Improvement' report should be implemented to support whole system change.

4. In line with national policy commitments and service developments, we recommend that work be undertaken to focus upon and identify innovation within community settings, and that this work be used as the basis for consideration of the most appropriate model to ensure cross fertilisation across community care services. This work needs to recognise and manage risk and seek to ensure that independent living is protected and supported.

5. We recommend that Welsh Government recognises the limiting impact of policy developed over such a short timeframe, and commits to moving towards the development of policy over a longer time frame, recognising that policy impacts will not necessarily be seen within the lifespan of a single government. There should be a divide between government and those public sector organisations delivering services.

6. Welsh Government should expect organisations to have in place an ongoing programme of disinvestment in those services that no longer reflect a contemporary evidence base.

7. We recommend the Welsh Government develops a clear vision of a healthcare innovation system which systematically turns potential into outcomes, with a clear focus on addressing areas of need through research, harnessing innovation at the front line of healthcare delivery, and translating ideas, invention and discovery into applied benefits for patients and into more efficient healthcare services. A clear expression of how health and wealth outcomes are linked and a significant increase in industry collaboration are critical factors.

8. We recommend that organisations ensure that accountability arrangements are clear and robust, and that decision making is transparent and supported by data. The Welsh Government should ensure the forthcoming review of regulation considers how regulatory functions can contribute to creating a culture of learning from innovation rather than focusing simply on compliance and failure.

9. We recommend that Welsh Government considers the incentives that would explore the potential to implement pathway based resourcing across general NHS budgets, initially tested via a prototype model working with, and advised by, NHS Wales Shared Services Partnership. Incentives that operate across sectoral boundaries – such as formal pooled budget arrangements - also need to be reinforced and encouraged in order to ensure partners make the best use of resources and develop robust and sustainable models of care and support.

10. We recommend that senior leaders should ensure that evidence based improvement focuses at population level to achieve maximum impact. Pilots that are used to test out potential solutions should specifically consider and factor in the potential to scale up improvement. The Essential Leadership Pre-requisites for Innovation and Best Practice paper issued by the Best Practice and Innovation Board in June 2013 recognises this issue and the value of training staff in improvement methodologies as a key element of creating an adaptive organisational culture.

The Board commends this final report to the Minister. The Board's advice, guidance and recommendations should inform and support future policy development, contributing to the continuous improvement and transformation of health and social care services in Wales.

Finally, the Board wishes to extend its thanks to all those who: took the time and effort to respond to the *Call for Evidence* and/or provided advice and guidance to the Board during the development of its products; to workstream members who willingly assisted in the development of key aspects of the work programme on top of their busy working days; and to Welsh Government officials who contributed significantly to the overall outputs of the Board.

Annex 1

Health and Wellbeing Best Practice & Innovation Board Members

Chair(s)

Mrs Jan Williams	Chair to 31 July 2013
Professor Sir Mansel Aylward	Chair from 1 August 2013

Board Members

Constance Adams	Senior Policy Officer – Wales Council for Voluntary Action (WCVA)
Prof Helen Bevan	Chief of Service Transformation - NHS Institute for Innovation and Improvement
Helen Birtwhistle	Director - Welsh NHS Confederation
Alan Brace	Director of Finance - Aneurin Bevan Health Board
Jo Carruthers	Director of Academi Wales/Public Service Management Wales – Welsh Government (WG) (from February 2013)
Tina Donnelly	Director - RCN Wales
Ifan Evans	Deputy Director, Healthcare Innovation - Welsh Government
Sue Evans	Chief Officer Social Care and Housing, Torfaen County Borough Council (from June 2013)
Abigail Harris	Director, Strategy, Policy and Primary Care - Welsh Government, Department of Health, Social Services and Children (to August 2013)
Albert Heaney	Director of Social Services Wales, Welsh Government (from February 2013)
Bob Hudson	Chief Executive, Public Health Wales (to 30 November 2013)
Dr Phil Kloer	Director of Clinical Services - Hywel Dda Health Board
Prof Ronan Lyons	Professor of Public Health - College of Medicine, Swansea University

Paul Matthews	Chief Executive - Monmouthshire County Council
Dr Paul Myres	Chair of Royal College of GPs Wales
Martin Palfreman	Head of Social Services Directorate, WLGA (to 6 September 2013)
Carys Thomas	Head of NHS R & D Strategy and Funding - National Institute for Social Care and Health Research (NISCHR)
Dr Gwyn Thomas	Director of Informatics (Health and Social Services)/Chief Information Officer – WG (to August 2013)
Steve Thomas	Chief Executive – Welsh Local Government Association (WLGA)
Dr Alan Willson	Director, 1000 Lives Plus

Support Team

Gaynor Williams	Programme Director
Sheena Jones	Programme Administrator
Fatima Downing	Workstream Support Officer (from 11 March 2013 – 19 July 2013)

Annex 2

Health and Wellbeing Best Practice & Innovation Board

Terms of Reference

Purpose

The Health and Wellbeing Best Practice and Innovation Board is being established to add value to the identification and implementation of system-wide innovation and the rapid adoption and diffusion of best practice and transformative technologies, service models and models of delivery. It has a health and social care system-wide remit, with an emphasis on partnership working with all key stakeholders to achieve agreed outcomes.

It will achieve its purpose by:

- Mapping the existing landscape to confirm all existing organizations/functions whose purposes include innovation and the adoption and diffusion of best practice across health and social care. This will enable the Board to specify its unique contribution to the agenda
- Critically reviewing the research literature/relevant publications that have relevance in Wales, disseminating the learning from this review and utilizing the findings in the Board's work programme
- Developing the relationship with scientific, academic and business communities to determine future 'horizon scanning' capability requirements, agreement on key critical issues and any new partnership approaches
- Reviewing existing policies and strategies to assess current focus and incentives to underpin innovation and best practice adoption e.g. procurement strategy, and taking account of these accordingly
- Making recommendations on the integrated health and social care system architecture required to underpin systematic innovation and best practice adoption and diffusion. This will include locality modelling that places primary care at the heart of system delivery
- Reviewing the current arrangements for data collection and information transfer across the system and making recommendations for improvement
- Identifying priorities for future development, as informed by the above reviews and analysis, based on impact on health and wellbeing and value for money

Accountability

The Board will be accountable to the Minister, through the Director General for Health, Social Services and Children and will provide advice on any strategy or policy implications that arise from its work. Through the Chair, an annual work programme will be agreed with the Director General, NHS Chairs and Chief Executives and Local Government Cabinet members and Chief Executives, for approval by the Minister.

Key Deliverables

- Creation of a coherent system for best practice adoption and innovation, to overcome the perceived barriers to innovation across health and social care in Wales, and to promote rapid and effective best practice adoption and diffusion 'at scale'
- Advice on strengthening leadership, accountabilities, roles and responsibilities across the system
- Advice on incentives and investment in support of innovation and best practice adoption
- The design of a robust evaluation process, in partnership with the academic sector, to ensure that the outcome of investment in service change can be measured and adoption lessons shared
- The production of evidence of learning from health and social care systems world-wide, and from third and private sectors, to reflect Wales' ambition to compare with the best in the world

All deliverables will have clear outcomes, together with the means for measuring achievement.

Membership

A Chair will be appointed on a fixed term basis to lead the work of the Board with experience in both leadership in a large and complex organization, and innovation and knowledge transfer methodologies.
Membership of Board to include:

- Chair (time requirement – 1 day per week)
- WLGA Chief Executive
- NHS Confederation Director
- 1 NHS Chief Executive
- 1 Local Government Chief Executive
- 1 Director of Social Services
- 1 NHS Executive Director (Clinical)
- 1 NHS Executive Director (Resources)
- Director 1000 Lives Plus
- Director, Social Services Improvement Agency
- 1 RCGP member
- Innovation Expert
- Academic (health and social care research interest)
- NISCHR
- WCVA
- Professional body/Trades Union member
- Welsh Government
    - Director of Strategy - lead official
    - Director of Workforce/OD
- Informatics Expert

The Board needs to be compact and agile in its mode of working so it may be necessary to review this membership during the process to identify Board members.

It is recommended the Board members are invited to sit on the Board for an initial period of two years to allow for consideration to be given to reviewing the make-up and membership of the Board and allowing opportunities for refreshing membership if necessary.

Reference Groups/Expert Advisors

Because of the breadth of the work, reference groups/expert advisors from the following areas will support the Board:

- Academic expertise
- Regulatory machinery
- Patient/representative groups
- Digital/social media
- Life Sciences Industry
- Information sources/data collection
- Professional machinery

Role of the Chair

- To lead the Board in the delivery of the work programme, and ensure its fitness for purpose through appropriate development
- To report to the Minister, Director General and NHS on progress, and advise on any strategy and policy implications falling out of the Board's work
- To engage with stakeholders and build/sustain ownership of the Board's role
- To represent the work of the Board as appropriate at seminars/conferences
- To work effectively with system regulators on matters of mutual interest
- To establish the Reference Groups/Advisors referred to above

Mode of Working

The Board will:

- Deliver annual work programme, agreed by the Minister, aligned with the Welsh Government's priorities, and based on demonstrable improvements in outcomes. The Board will focus on a small number of themes each year linked to *Together for Health* priorities. The annual work programme will be informed by discussions with all key partners
- Adopt a formal programme management methodology, and utilize dedicated workstreams for the delivery of specific projects
- Meet bi-monthly to provide strategic direction and to provide assurance to the Minister on the delivery of the annual work programme, and its expected outcomes
- Engage and collaborate effectively with other key stakeholders, as exemplified through active fora and inclusion in the Board's work

- Collaborate effectively with the system regulators (WAO, HIW, CSSIW), with clear sharing of learning between the Board and the regulators
- Ownership of the Board's work across the health and social care system, and among the partners with whom the Board works
- Publish regular on-line newsletters, case studies, guides and directories of innovation, policy and good practice, together with the outcomes of any evaluation studies
- Invite organizations to act as adoption partners. The partnership agreement will include publication and dissemination of all learning from the programmes, to assist with evaluation and modelling for wider application
- Examine the most effective methods of dissemination, transfer, and adoption of innovative practice, and explore the drivers and barriers – these include, organizational leadership, culture, incentives, competence, capacity and structures

To assist its baselining work, the Board will issue a 'Call for Evidence' - a technique it may repeat as the work unfolds.

The Board's work will be delivered in partnership with existing mechanisms such as the 1000 Lives Programme, NLIAH (following re-structure), professional advisory machinery, Social Services Improvement Agency and other networks as appropriate. It will also link into other Government initiatives designed to support the dissemination of good practice, such as the Public Services Leadership Group workstreams and the Good Practice Wales website.

Resources

A Programme Director, accountable to the Chair, will support the Board to ensure delivery of the work programme. An administrator will ensure the effective running of the Board and delivery of its functions.

The small ring-fenced budget will be available to support the following:

- The remuneration of the Chair
- The Programme Director and Administrator
- Expenses related to Board members (where appropriate)
- Commissioned expertise to review evidence, undertake applied research on impact assessment and to provide evaluation support for adoption schemes

Service costs, including pump priming, to be met by service organizations; they will not be met from the Board's resources.

Measures of Success

The Board will produce an annual report, setting out evidence of system changes and dissemination/adoption of innovation and best practice in line with key deliverables. At each meeting, the Board will review progress against in-year milestones.

All deliverables will have specified outcomes, and means of measuring achievement.

Technology Adoption Systems Guidance

June 2013

Technology Adoption Systems Guidance

1. Background and Context

Advances in technology are fundamental to the provision of modern healthcare. There are many ways to categorise such technology, linked to the context within which it is used:

- Low cost/high volume technology in everyday use across NHS Wales;
- High cost/low volume technology used for specific clinical interventions and/or treatments;
- Specialist regional/national technology provided by specialist centres on behalf of NHS Wales organisations.

Despite the increasing use of technology, there is no consistent approach in place across NHS Wales to consider, adopt and monitor technology. NICE (the National Institute for Health and Care Excellence) produces guidance based on systematic evidence reviews through its medical technology, diagnostic technology and interventional procedure programmes. In addition NTAC (the NHS Technology Adoption Centre) has reviewed over 200 technologies and produced eight detailed technology adoption guides, following successful pilot site implementation. Evidence is also available through the outputs of the NIHR HTA (National Institute for Health Research Health Technology Assessment) Programme and the NIHR Centre for Reviews and Dissemination database of systematic reviews, economic evaluations and HTAs. In line with standard 7a of Healthcare Standards for Wales "Doing Well Doing Better", it is important that NHS bodies in Wales have systems in place to routinely consider the local opportunities for their organisations in implementing such guidance.

This Systems Guidance aims to address the expectation set out in standard 7a and proposes a framework to support the consistent consideration and adoption of technology across NHS Wales. It has been developed by a Task and Finish Group of the Health and Wellbeing Best Practice and Innovation Board ('the Board'), informed by clinical representation from NHS Wales. Its development has also been informed by technology related responses to the recent *Call for Evidence.*

The role of the Board has been to develop Systems Guidance for Welsh Government. NHS Wales organisations remain responsible for ensuring that effective systems are in place to provide safe, evidence based, high quality services that include the use of technology. This responsibility is reflected within the *Annual Quality Plan 2012 – 2016.*

2. Scope and Definitions

This Systems Guidance provides clarity around the definitions and scope. The NICE definition (provided below) is broad, and is linked to methods.

The NICE definition

Health technology: Any method used by those working in health services to promote health, prevent and treat disease, and improve rehabilitation and long-term care. Technology in this context is not confined to new drugs or items of sophisticated equipment.

For the purposes of this Systems Guidance the inclusions and exclusions are set out below:

Technology Adoption Guidance in Wales – Inclusions and Exclusions

In scope:

- Medical devices;
- Diagnostic tests;
- IT systems with direct application to patient care such as telemetry and telemedicine.

Out of scope:

- Pharmaceuticals
- The larger IT systems
- Models of care and care protocols

Consistency of approach across Wales

Within this guidance, the term 'Health Board' includes independent primary care contractors. Health boards should therefore ensure appropriate systems are in place to capture technology used in primary/community settings.

The following arrangements apply to those components considered out of the scope of this guidance:

- Advice on pharmaceuticals is provided by NICE and the All-Wales Medicines Strategy Group.
- Larger IT systems are considered and overseen by NWIS (NHS Wales Informatics Service).
- Advice on models of care and care protocols is produced by NICE.

3. The Policy Context

Achieving excellence - The Quality Delivery Plan for the NHS in Wales 2012 - 2016 includes reference to the use of technology. The specific requirements are set out below:

Achieving excellence - The Quality Delivery Plan 2012-2016
Technology Adoption Related Extracts

- *'Using research and innovation to improve care and accelerating the uptake of beneficial new technology'.*
- 'Using *new technology* to improve access and quality of care

The implementation of new and emerging technology, including information and communication technology, is a crucial element in delivering safe, sustainable services and in enabling patients/users to be treated as close to home as possible.

The NHS will collectively review how well they take up new technology.

One source of advice will be the new Medical Technology Evaluation Programme (MTEP) introduced by the National Institute for Health and Clinical Excellence (NICE) which focuses specifically on the selection and evaluation of new or innovative medical technology (including devices and diagnostics).'

Additionally, Action 8 of the Quality Delivery Plan states '*During 2012 Health Boards and Trusts will work together to put effective processes in place to ensure the prompt uptake of evidence-based new technology that maximise benefit and value'*

**Note: In April 2013 the National Institute for Health and Clinical Excellence became the National Institute for Health and Care Excellence. The text above refers to the organisation's title at the time the Quality Delivery Plan was issued.*

Standard 7a "Safe and Effective Clinical Care" from *Doing Well Doing Better* also includes relevant policy requirements as follows:

> ***Doing Well Doing Better* Standard 7:**
> **Safe and Clinically Effective Care**
>
> Organisations and services will ensure that patients and service users are provided with safe, effective treatment and care:
>
> a) based on agreed best practice and guidelines including those defined by National Service Frameworks, National Institute for Health and Clinical Excellence (NICE), National Patient Safety Agency (NPSA) and professional bodies;
>
> b) that complies with safety and clinical directives in a timely way; and
>
> c) which is demonstrated by procedures for recording and auditing

.

Reflecting these requirements, Welsh Government discussed the need to appraise new technology at the November 2012 Chief Executives meeting and, in a January 2013 letter to Chief Executives of health boards and trusts in Wales, reinforced the requirements of Action 8 in the *Quality Delivery Plan.* [1]

Welsh Government will monitor adherence to this systems guidance as part of the *Quality Delivery Plan* and *Doing Well Doing Better* reporting mechanisms.

4. Factors to be Considered in Delivering Effective Implementation

Technology adoption is often highly content specific and requires consideration of a number of wider factors:

- The evolutionary nature of technology development;
- The clinical need for the technology;
- The capacity and capability available to operate the technology. This includes both the workforce numbers and the required skills sets;
- The possibly limited evidence base, though there is an expectation that some evidence of effectiveness will exist to support implementation. Whilst rigorous RCT evidence may not be available, the best level of evidence available should inform decisions. This may result in a requirement for more evidence before implementation is considered appropriate;
- The lack of general NICE mandation of technology adoption, as opposed to pharmaceuticals;
- Efficiency savings may not occur within the service area that meets the cost of the technology, but in other parts of the organisation;
- The decommissioning of outmoded models of care;

[1] Letter dated 10 January 2013 from Dr Owen Crawley, Welsh Government Chief Scientific Advisor to Chief Executives of Local Health Boards and Trusts regarding update of evidence based new technologies.

- Adherence to Clinical Governance policy and standards requirements.

NHS bodies need to have effective systems in place to judge whether new technologies would deliver efficiency gains and benefit their populations when seen in the local context, and taking into account the potential local costs and benefits. A framework utilising the mini-HTA process is set out in this Guidance to support such consideration. A summary of the evidence for major new technologies, available from agencies such as NICE and NTAC, should be used to support the decision making process.

5. The Key Systems Requirements:

In making decisions about technology, NHS organisations need to take seven main factors into account:

a) Technology Uptake Policy Requirements

Welsh Government has set out expectations within the *Annual Quality Plan 2012-2016.*

NHS organisations should:

- Seek to comply with national policy;
- Provide assurance to Welsh Government that appropriate systems are in place to manage technology in a consistent manner within and across organisational boundaries;
- Provide assurance that Boards have systems in place to capture technology in use, and implement new technology via an evidence based approach.

Welsh Government will monitor compliance with these policy requirements as part of the *Quality Delivery Plan* and *Doing Well Doing Better* reporting mechanisms.

b) Levels of decision making for new technology

It is not proposed that the HB Boards need to specifically consider and approve all new technology being introduced into their organisations, but rather that they need to ensure that appropriate governance arrangements are in place to:

- Identify what technology is available, and what is right for their populations;
- The range of technology in use across its population, services and estate;
- Access and consider the evidence base;
- Ensure a formal and auditable system/process to record decisions around whether to implement a new technology or not or decommission a technology in current use, to ensure full assessment has been undertaken, and the added value determined;
- Ensure effective change management processes;
- Ensure that declared evidence/outcomes are substantiated;
- Identify the technology decisions reserved for the Board, and be clear about the level of delegation regarding those decided at department and also at /network/region/national level. A process should be put in place to ensure Board level assurance in line with the scheme of delegation, including a process in place to record such decisions.

c) Expected Governance arrangements

It is essential that any assessment of new technology identifies and considers risk, including those that may/can be mitigated. Such processes must have demonstrable links with Governance frameworks and requirements.

Each organisation should:

- Demonstrate Board level assurance that decisions about the use of health technology are taken in procedurally transparent and consistent ways;
- Identify a named Executive Director lead for technology. Given the need for a consistent approach across Wales, it may be appropriate for the same Director in each organisation to undertake this role. Co-ordination can then be undertaken using existing all Wales meetings rather than putting additional processes in place;
- Ensure that the use of technology by independent contractors is reflected within their governance arrangements;
- Ensure arrangements are in place to capture those services provided on a regional/national level that require the use of technology, enabling commissioner and provider organisations to demonstrate that the above requirements have been met;
- Put appropriate change management mechanisms in place to effectively manage the implementation of new technology.

- Put appropriate scrutiny processes in place, both internally and externally through regulators;
- Put systems in place to monitor and report performance.

d) Evaluation

Evaluation requirements can be divided into two main strands – the evaluation of new technology prior to adoption, and the evaluation of the new technology in use. The following requirements should therefore be considered from these two perspectives. Each organisation should:

- Recognise the limited capacity of NHS organisations to undertake evaluation and evidence reviews as individual organisations, and so ensure that arrangements are in place across organisational boundaries, using recommendations from professional organisations where these exist, to evaluate technology. A process is set out within this Guidance that will support health boards in reaching decisions on technology adoption;
- Undertake technology adoption consideration using the process provided in this guidance;
- Ensure new technology is introduced within the context of process measures that ensure benefits are continuously realised;
- Ensure that new technology is introduced only if there are continuous checks on the process or pathway to which the technology is intended to contribute.

e) Service and Capital Planning

Each organisation should:

- Adopt the mini-HTA process set out in this Guidance to ensure that new technologies are reflected and embedded in local, regional and national planning systems;
- Decommission services/interventions that are outmoded and no longer reflect best practice against an appropriate evidence base through a managed process;
- Assure themselves that the potential of emerging technology developments is embedded as part of the mainstream planning and service change process;
- Be confident that proportionate local clinical and service evaluation and cost benefit analyses were undertaken, and that the relevant disinvestment in outmoded technology/equipment was considered and implemented alongside the investment;
- Assure themselves that the behavioural and cultural issues associated with the adoption of new technology were reflected in the local Knowledge Management and Learning Strategies, as set out in NTAC report *Organisational and behavioural barriers to medical technology adoption.*

f) OD implications recognised and provided for

Each organisation should:

- Ensure that the skills sets required to operate technology are identified and systems are put in place to ensure competency can be assured;
- Identify any organisational culture, change management, capacity and capability issues as part of its workforce, service planning and knowledge management strategies;
- Ensure that horizon scanning systems are in place that operate across organisational boundaries;
- Assure themselves that staff have the appropriate skills sets to make best use of current and proposed new technology;
- Undertake a stock take of technology in use across the organisation, to include its use, training and maintenance requirements.

g) Engaging public/key stakeholders

In line with national policy requirements for citizen centred services, and reflecting the Welsh Government Public and Patient Involvement Policy, NHS organisations should aim to derive the maximum benefit from public engagement, to help it to provide relevant, high quality services, services the public want and value.

The requirement for a process of continuous engagement with its local population should be reflected when considering the adoption of technology. The aim is to ensure that local people feel engaged with their NHS and that they can influence decisions about changes in direction and specific service developments.

Within this context, each organisation should:

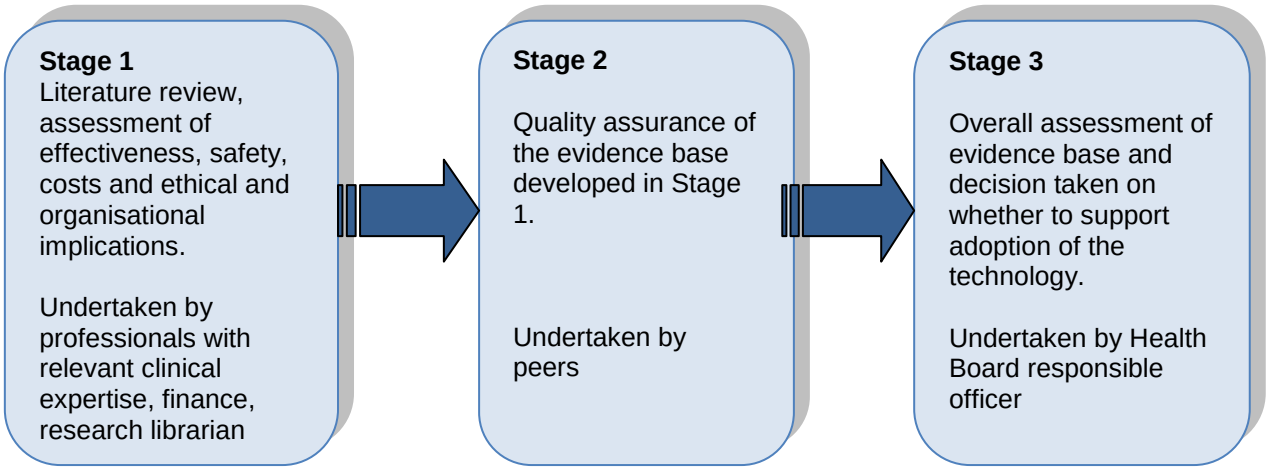
- Ensure mechanisms are in place for engaging public/stakeholders, and that these are clear;
- Ensure other forms of 'bottom up' pressures are identified to inform the development of services.

6. The Technology Adoption Framework

The mini health technology assessment methodology (mini-HTA) set out in this section is a simplified, time efficient, decision support tool that will support NHS Wales organisations in assessing the usefulness, cost effectiveness and appropriateness of new technology, and in making decisions regarding their adoption. Using a mini-HTA will help Health Boards to clarify whether a technology is acceptable, effective and safe and that it can be introduced at a lower or similar cost to existing practice.

The purpose of mini-HTA is to provide a basis to support decisions regarding the introduction of new technology. A mini-HTA helps to provide transparent, evidence based decisions. The assessment process comprises three main stages:

The mini-HTA process



Stage 1 is completed by professionals in the Health Board or Trust with relevant clinical expertise usually with the support of the finance department, a research librarian and others with expertise in critically appraising evidence. There will need to be a literature review and assessment of: effectiveness; safety: costs; organisational implications; and ethical aspects related to introduction of the new technology. This would include at least a basic level of economic evaluation and consider potential disbenefits and effects on equity of care.

Stage 2 involves quality assurance of the evidence produced in Stage 1 and would usually be undertaken by an independent peer from another similar discipline.

Stage 3 would usually be completed by the person responsible for preparing the matter for consideration by the relevant Health Boart or Trust committee or board. This part provides an overall assessment of whether there is sufficient evidence to support adoption of the technology.

<u>When a local decision cannot be made</u>

There will be circumstances where a health board is unable to make a local decision and so decisions need to be taken at a national level, because:

- The method involves a requirement for screening, (the Welsh Government is advised by the UK National Screening Committee);
- The method involves specialist commissioning (dealt with by the Welsh Health Specialised Services Committee);
- The method involves medicines (which fall outside of the scope of this guidance and are addressed by NICE and the All Wales Medicines Strategy Group).

Generating the evidence base: assessment and evaluation

a) NHS Wales Shared Services Partnership should be considered the point of contact to access advice and guidance around procurement implications when considering new products. It is strongly recommended that organisations engage with their local Shared Services Partnership Procurement Manager before proceeding to consider new technology, to review and substantiate the evidence base.

The contact details for local Procurement Managers can be found at Appendix 3.

In addition to Shared Services Partnership, there are a number of additional routes to access advice, guidance and support when considering the evidence base to adopt new technology.

b) NISCHR fund/co-fund a range of programmes that provide opportunities to undertake evaluations of new technologies.

These include the NIHR schemes (Health Technology Assessment, Health Services and Delivery research, Efficacy and Mechanism evaluation, and Public Health Research).

All these schemes have a responsive arm but there are also commissioned research calls and themed calls. For instance, the HTA Programme identifies and prioritises NHS evidence needs and advertises calls for research proposals to address these.

NHS Wales can contact the HTA programme team directly regarding health care treatments and tests for which further evidence of clinical and cost-effectiveness is required. (http://www.hta.ac.uk/suggest/index.shtml)

Within NISCHR's Research for Public and Patient Benefit scheme, there are opportunities for Welsh based researchers to apply for grant funding to:

- Study the provision and use of NHS services.
- Evaluate the effectiveness and cost effectiveness of interventions.
- Examine the resource utilisation of alternative means for healthcare delivery.
- Formally scrutinise innovations and developments.
- Pilot or consider the feasibility of research requiring major award applications to other funders.

c) The Surgical Materials Testing Laboratory (STML) is hosted by ABMU Health Board and provides a national service. Its role includes an assessment of quality, usually to accepted national and international standards, providing end users with a level of confidence in the quality of the products being considered for contract and/or onward clinical use.

d) The NHS Informatics Research Laboratories are a joint venture with Swansea School of Medicine. This facility enables safe testing of new IT innovations centred on improving patient care. The laboratories have been used to test new technologies around telehealth, both in a person's home and electronic test referrals and results

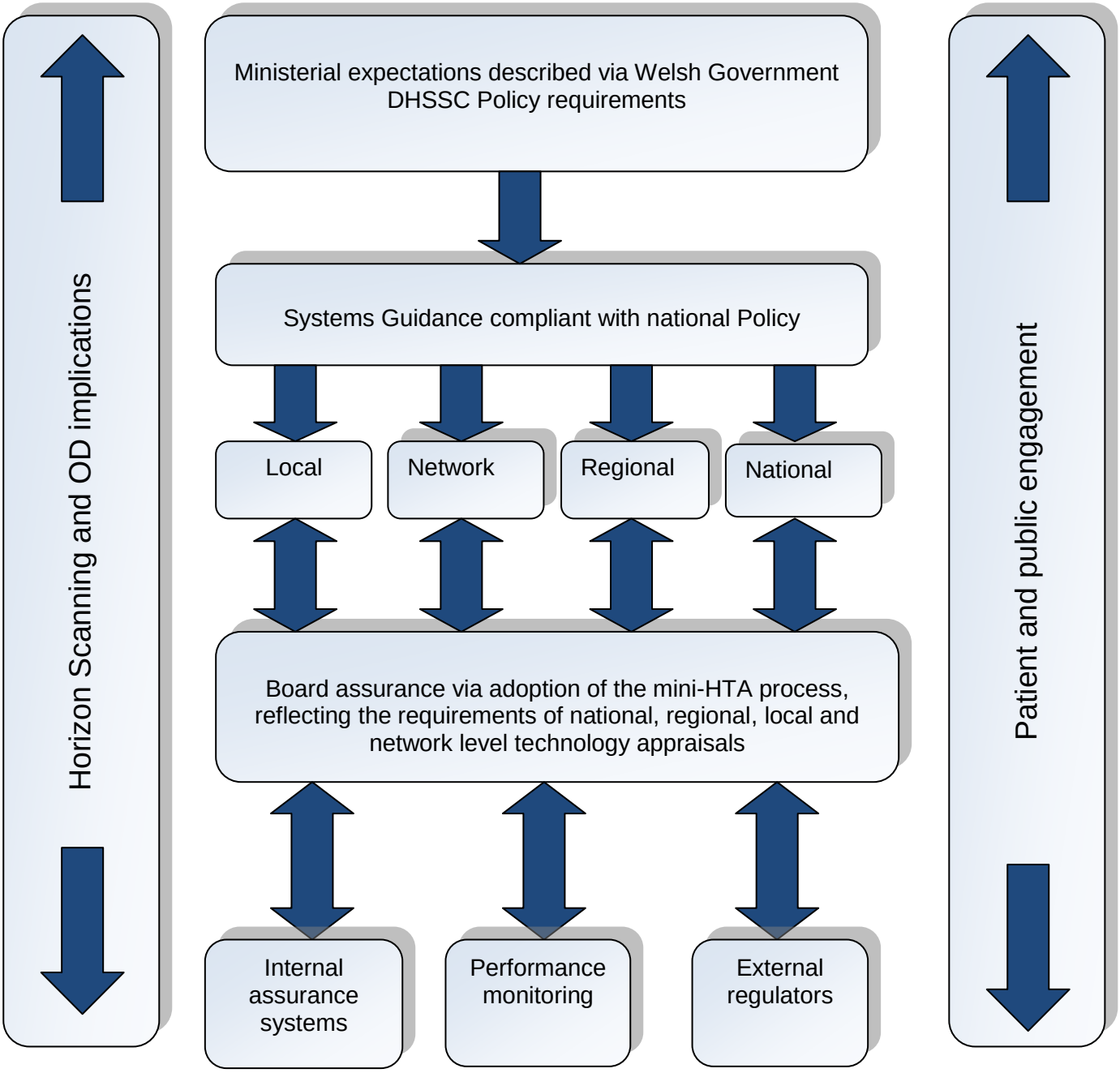
to/from GP practices. The use of these facilities is commended as an example of where new technologies can be safely tested in compliance with Standard 7a.

e) Small Scale Pilot Projects have been successfully used to prove the concept of technology before wider adoption. The NHS Wales Clinical Portal has been used for small scale and controlled testing prior to adoption within a clinical setting.

Publication of completed mini-HTA evaluations

It is recommended that NHS organisations publish completed mini-HTA assessments on their web site so that work is not duplicated and assessments can be shared.

Appendix 1: Outline Systems Process



Appendix 2: Useful Reference/Source Documents

NTAC (NHS Technology Adoption Centre) link to "How to Why to guides" for selected technology
http://www.ntac.nhs.uk/HowToWhyToGuides/How-to-Why-to-Guides.aspx

Other NTAC publications (including the report on "Organisational and behavioural barriers to medical technology adoption") are available at::
http://www.ntac.nhs.uk/Publications/Publications.aspx

NICE resources on medical technology:
http://www.nice.org.uk/guidance/mt/index.jsp

NICE resources on diagnostic technology:
http://www.nice.org.uk/aboutnice/whatwedo/aboutdiagnosticsassessment/diagnosticsassessmentprogramme.jsp

The Scottish Health Technology Group has produced statements of advice on a number of technologies:
http://www.healthcareimprovementscotland.org/programmes/medicines_and_technologies/shtg/shtg_advice_statements.aspx

NIHR Health Technology Assessment (HTA) programme:
http://www.hta.ac.uk/about/index.shtml

There is a funding contribution from NISCHR to this. Results are published in the journal *Health Technology Assessment* available electronically via the above web link.

The NIHR Centre for Reviews and Dissemination (based at the University of York) has a searchable database of systematic reviews, economic evaluations and HTAs (including outputs from the NIHR HTA programme) at:
http://www.crd.york.ac.uk/CRDWeb/AboutPage.asp

Appendix 3: NHS Wales Shared Services Partnership Procurement Managers

		☎	✉
Deputy Assistant Director/ Head of NHS Engagement	Adele Cahill	02920 315483	Adele.Cahill@wales.nhs.uk

Abertawe Bro Morgannwg UHB	Helen James	01792 703972	helen.james10@wales.nhs.uk
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Cwm Taf HB	Esther Price	01685 726365	esther.price@wales.nhs.uk
Aneurin Bevan HB	Graham Davies	01495 745861	graham.davies@wales.nhs.uk
Hywel Dda HB	Stephen Thomas	01267 227636	steven.thomas2@wales.nhs.uk
Betsi Cadwaladr UHB	Simon Whitehead	01745 448448	simon.whitehead@wales.nhs.uk
Public Health Wales Trust	Neil Gazzard	01443 622350	neil.gazzard@wales.nhs.uk
Velindre NHS Trust	Neil Gazzard	01443 622350	neil.gazzard@wales.nhs.uk
Welsh Ambulance NHS Trust	Simon Whitehead	01745 448448	simon.whitehead@wales.nhs.uk

Note: Specific arrangements exist for Powys (t)HB. Please contact SSP for advice.