



# **Cynulliad Cenedlaethol Cymru The National Assembly for Wales**

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

**Dydd Iau, 20 Mawrth 2014  
Thursday, 20 March 2014**

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

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

**Aelodau'r pwyllgor yn bresennol**  
**Committee members in attendance**

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

**Eraill yn bresennol**  
**Others in attendance**

Dr Miles Allison	Meddyg Ymgynghorol a Chyfarwyddwr Clinigol Gastroenteroleg, Bwrdd Iechyd Lleol Aneurin Bevan, ac Is-lywydd Cymdeithas Cymru ar gyfer Gastroenteroleg ac Endosgopi Consultant Physician and Clinical Director of Gastroenterology, Aneurin Bevan Local Health Board and Vice-president, Welsh Association for Gastroenterology and Endoscopy
Yr Athro/Professor Peter Barrett-Lee	Oncolegydd Clinigol Ymgynghorol a Chyfarwyddwr Meddygol, Ymddiriedolaeth GIG Felindre Consultant Clinical Oncologist and Medical Director, Velindre NHS Trust
Dr Richard Clements	Cadeirydd Pwyllgor Sefydlog Cymru a Radiolegydd Ymgynghorol, Bwrdd Iechyd Lleol Aneurin Bevan Chair of Standing Welsh Committee and Consultant Radiologist, Aneurin Bevan Local Health Board
Dr Nazia Hussain	Coleg Brenhinol yr Ymarferwyr Cyffredinol Cymru Royal College of General Practitioners Wales

Lowri Jackson	Uwch-gynghorydd Polisi Cymru, Coleg Brenhinol y Ffisigwyr Senior Policy Adviser for Wales, Royal College of Physicians
Dr Alan Rees	Is-lywydd Cymru, Coleg Brenhinol y Ffisigwyr Vice-President for Wales, Royal College of Physicians
Dr Martin Rolles	Ysgrifenydd Pwyllgor Sefydlog Cymru ac Oncolegydd Clinigol Ymgynghorol, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Secretary of Standing Welsh Committee and Consultant Clinical Oncologist, Abertawe Bro Morgannwg University Local Health Board
Jared Torkington	Llawfeddyg Ymgynghorol Laparosgopig y Colon a'r Rhefr, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Consultant Laparoscopic Colorectal Surgeon, Cardiff and Vale University Local Health Board

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

Chloe Davies	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

*Dechreuodd y cyfarfod am 09:24.*  
*The meeting began at 09:24.*

**Cyflwyniad, Ymddiheuriadau a Dirprwyon**  
**Introductions, Apologies and Substitutions**

[1] **David Rees:** Good morning. I welcome Members to this morning's meeting of the Health and Social Care Committee. We have had no apologies. The meeting is bilingual and headphones can be used for simultaneous translation on channel 1 or for amplification on channel 0. I remind people to turn off their mobile phones or any other electronic equipment that may interfere with the broadcasting equipment. The iPads are okay, as long as you turn the sound off. In the event of a fire alarm, there is not one scheduled for today, so please follow the ushers.

09:25

**Trafod Ymateb y Gweinidog Iechyd a Gwasanaethau Cymdeithasol i Lythyr y**  
**Pwyllgor ynghylch yr Ymchwiliad Dilynol i Leihau'r Risg o Strôc**  
**Consideration of the Minister for Health and Social Services' Response to the**  
**Committee's Letter Regarding the Follow-up Inquiry into Stroke Risk**  
**Reduction**

[2] **David Rees:** You will note that, in the letter, the Minister rejects our request for a timetable to be produced outlining when the committee's recommendations would be delivered. However, the response provides a detailed set of timescales for actions that he has identified, which is very important for us. What we really wanted is to see when things were being done, and I believe that the Minister has provided that in his response. However, there is one area on which I think we still need clarification. If it is okay with Members, I would like to write to the Minister requesting clarification on the timescales for the delivery of the recommendation relating to carotid surgery, as that remains unclear. Are Members satisfied

with that? I see that you are. Thank you very much. I do not have any other comments. Does any other Member wish to raise a comment on the response from the Minister?

[3] **Lindsay Whittle:** On page 5, recommendation 7 and the Minister's response, I appreciate that all the work up to recommendation 7 is about looking after and helping people who have suffered a stroke, but I think that we should really bring forward the preventative measures in order to prevent people from having a stroke. The date given is 2014-15, and I know that we are in 2014 now, but I really think that that should be brought forward a lot more.

[4] **David Rees:** If that is the case, if Members are satisfied, I will include perhaps our hope that he would look at an earlier start for that campaign in the letter that we send to the Minister.

[5] **Lindsay Whittle:** Thank you, Chair. In particular, it should target young people. It is not only older people who have a stroke.

[6] **David Rees:** We will target all people.

[7] **Lindsay Whittle:** Thank you.

**Ymchwiliad i Fynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn  
Dystiolaeth 12  
Inquiry into Access to Medical Technologies in Wales: Evidence Session 12**

[8] **David Rees:** I welcome Professor Peter Barrett-Lee, consultant clinical oncologist and medical director at Velindre cancer centre, Dr Richard Clements, consultant radiologist and chair of the Royal College of Radiologists' standing Welsh committee and Dr Martin Rolles, consultant clinical oncologist and secretary of the Royal College of Radiologists' standing Welsh Committee. I welcome you all. Thank you very much for attending. I also thank you for the written evidence that we have received from Professor Barrett-Lee and from the Royal College of Radiologists. We have some questions based upon that. I ask Gwyn Price, therefore, to start off the questions.

[9] **Gwyn R. Price:** Thank you, Chair. Good morning. How should the patient perspective be considered in the appraisal and commissioning of new technology? Are there examples of how this is done well and how could the role of patients be developed, in your opinion?

[10] **Professor Barrett-Lee:** Something that is close to my heart, obviously, is radiotherapy technology. Patients have been quite involved in that, particularly through charities, and have made their thoughts very well known about new technologies in radiotherapy. There was a lot of discussion in the last couple of years about stereotactic body radiotherapy, which is very intense, localised radiotherapy for certain conditions such as brain tumours or lung cancer. There were quite a lot of patient groups pushing for this technology. There are different types, so some people were supporting CyberKnife—you may have heard of that—and others were talking about other technologies. I think you are right, though; it is really important that we do not spend our whole lives telling people what they need. We need to listen and build them into the argument. Also, they can help us, because they can tell us what their specific needs are. The other thing, of course, is that technology can be a bit frightening. So, it is important that, if patients and the public are on board from the beginning, then they are not fearful of it.

09:30

[11] **Dr Clements:** The royal college is concerned with setting standards, both in clinical radiology, which is diagnostics, and in oncology. In London, we have patient involvement on both faculties. Within Wales, in our current set up, we have no patient advisers or members in any of our committee structures. We are a relatively simple committee, just of representatives from each of the health boards. I believe that that is also true of the Welsh scientific advisory committee, which is part of the Assembly. As far as I am aware, there is no patient representative on that. Neither, as far as I know, is there any patient representative on the national imaging board, which is the practical board that deals with most of the all-Wales aspects of diagnostic imaging in Wales. However, membership of those panels might be a way forward.

[12] **Gwyn R. Price:** From the patients' point of view, getting them involved earlier, as you were saying, is surely a better way forward, in bringing everybody together, and, as you said, the fear factor would not be there with patient involvement from day one.

[13] **Dr Clements:** With the royal college in London, because the majority of lay members on the whole array of committees it has are from the south-east, there would be a very south-east focus. There is not, as far as I know, a particular Welsh focus to that, and that is something that could be developed.

[14] **Dr Rolles:** That is true. There is also a general point about radiotherapy—which is what Professor Barrett-Lee and I do, and we also give chemotherapy—and that is awareness. We recognise that the awareness of the public about radiotherapy and what it is is limited. There is a lot of publicity about new drugs and such things, but, until very recently, there was not very much media interest in radiotherapy as a subject. It was often seen as a slightly dull, esoteric thing that people got. It is only recently, with things like the stereotactic stuff, that there has been a marketing campaign by the manufacturers, akin to the way there is sometimes stealth marketing for new drugs, where the media start putting pressure on and asking, 'Why aren't we given this drug?'—there has clearly been a bit of pharma-inspired nudging. There has been very little, in that respect, for radiotherapy technology. We recognise that public awareness of radiotherapy is important, because the public needs to understand that it is there and that it empowers them to ask the right questions and to demand appropriate services. It also helps us. If we are getting the support and backing of people who understand what it is about, it helps to push the service forward and it benefits the whole patient population.

[15] **David Rees:** Janet is next.

[16] **Janet Finch-Saunders:** What do you think the main barriers are, then, to overcoming this so that we can see more patients involved?

[17] **Professor Barrett-Lee:** I think the first thing, and we will come on to that, I guess, is a clear system for how we approach new technology. That is a problem for professionals at the moment. If we do not understand the system, if there is one, then I do not think that patients and the public can either. So, I think the first step is to be clear on what we, as a society, expect technology to be. How quickly? What is the mechanism for getting it into appraising and then delivery? Then the patients can be a part of that. I think that is the problem at the moment. We are all rushing around not really knowing what the system is.

[18] **Janet Finch-Saunders:** So, there is some strong co-ordination needed.

[19] **Professor Barrett-Lee:** Absolutely.

[20] **Dr Clements:** From the diagnostic point of view, we are very much in the supportive

role, rather than leading the management of certain conditions. So, clinical groups may support physicians, surgeons or radiotherapists who are dealing with a particular cancer, stroke, heart disease or something like that, but they just expect the diagnostics to be there in the background. Speaking internationally now—this is not just in Wales—it is not a field where there are patient groups supporting diagnostic imaging. It is not seen as an entity that would attract charitable interest or anything like that.

[21] **Janet Finch-Saunders:** Okay. Are Welsh patients losing out as a result of this?

[22] **Dr Clements:** Our waiting lists for diagnostics are longer in Wales than in England currently, but I do not know that that is because of a lack of patient groups, because I do not think that there are patient groups involved with diagnostics particularly in England either.

[23] **David Rees:** Okay, thank you. Kirsty is next.

[24] **Kirsty Williams:** I want to come on to the issue of what the system should be. We have a clear consensus that we do not have a meaningful system at present and that we need one. There is less of a consensus about what that system should or would look like and who should carry out these roles. So, from your perspective, what would a co-ordinated, equitable, open and transparent system for adoption and commissioning be? Is there a body that is already there that could do that or do we need to set up a new structure to deliver that?

[25] **Dr Rolles:** We have expert advisory bodies. We have a clinical oncology sub-committee, for example, for radiotherapy, which is an expert group from all three Welsh cancer centres comprising oncologists, physicists and radiographers. That is very closely tied in with the larger bodies in London. So, we have good contacts, and we understand what is going on in England and in the other devolved nations. That could be strengthened and beefed up. Our problem, really, is that we are inefficient in Wales. We are too small to run very big appraisals quickly. What we are trying to do when we implement new technology—. The three centres are working hard just to keep things going, and then they are asked to write large business cases or appraisals on top of that, and it is a slow and laborious system. What we find is that we end up being several years behind England, for example, or Europe, if we are doing that. Really, we have to be more prepared to follow closely and adopt and accept appraisals from the UK or elsewhere. If we accept that we do not have the size and power to do these sorts of things but that we can follow them on and that the standards that apply to England should really be the same as those that apply to Wales, we, as a small country, should be able to be more nimble. There is less inertia and we should be able to do things quickly.

[26] **Kirsty Williams:** So, if we park the issue of the appraisal for one minute, once you have a technology that has been appraised, there is the issue of commissioning and the implementation of that. What are your views on a commissioning arrangement that would ensure that there was timely adoption of a technology where the appraisal had already been undertaken by whomever and was proven to be an effective intervention? How do we then get that commissioned and implemented on an equitable basis?

[27] **Professor Barrett-Lee:** Obviously, I am biased towards technologies for treating cancer, but our support services such as radiology and positron emission tomography scanning and other new scanners are really important as well. My personal view is that we need a central system for—I will say the ‘c’ word—commissioning, because the problem we have at the moment, and let us just take cancer as an example, is that, if you are delivering a particular type of treatment across the whole of Wales, you have to get agreement from every health board through an individual business case. Of course, I understand that health boards are anxious about being told that this is something they have to do. NICE makes proclamations about drugs and they are forced to fund them, regardless of the local

circumstances, so I understand their anxieties.

[28] However, if you put it the other way around, the problem, notwithstanding those anxieties, is that what we have is a system that takes a long time in some instances. Take the intensity modulated radiation therapy story as an example. It is another type of specialised radiotherapy. It took three years to go around the system. Meanwhile, the rest of Europe and, dare I say it, the rest of the UK has gone into the stratosphere. We will catch up but it is very frustrating. So, a central system for deciding how we move those things forward is essential. That is my personal view.

[29] **Dr Clements:** May I talk about the imaging side? When the health boards were rearranged some years ago, one of the things that happened at the same time was that a national imaging board was set up. One of the main drivers for that was to try to ensure that there was a level playing field across Wales. Within the profession we had pushed very hard to make sure that we had a national body, and we do now have that, although it does not have a commissioning role. So, there is a body in place within imaging in Wales that could seek to adopt common standards and approaches. The particular reason why we professionally pushed for it so much was because, with modern data management, it is essential that we are able to move imaging and things across health authority boundaries. So, it was to ensure that we had systems that talked to each other so that you could send something from Hywel Dda Local Health Board to Newport, or from Bangor to Cardiff or wherever, without running into problems with that. So, the structure is there, but perhaps it has not been used enough to implement developments of technology. It does not have a role in assessing new technologies and things like that. I think that it could be strengthened. The problem at the moment is that, although the body is there, it ultimately does not have a power to tell any individual health board, 'You've got to do it'. It can say, 'We believe that the rest of Wales should do this and this is what we want', but if one particular health board says, 'So be it; but we are not doing it', they do not do it.

[30] **Professor Barrett-Lee:** I think that that is the central point, is it not? We have advice coming out of our ears. There is no problem with advice. Experts abound in this, but it is that link between the consensus of the advice, patient involvement, and then the question of who will implement this. That is where it all starts becoming a problem.

[31] **Dr Rolles:** I completely agree with my colleagues here. The other thing to say about new technologies is that it is not just a matter of saying, 'Oh, right; let's try to buy a big flashy machine'. It is more than that. You cannot just buy these things, plug them in and start. There is a process, and it often takes years. There is a large amount of commissioning. There is also the fact that a machine does not run itself. It requires staff, training and knowledge. Any machine requires new expertise. Actually, it is a long process and it requires a long-term strategic view. Really, we have to be thinking five and 10 years into the future, spotting trends and trying to anticipate things, because it is an ongoing process. That really requires central and strategic commissioning. It is very hard for us to do it. The minimum standard is that we have equity of access to resources across Wales, but I think that the basic principle is that we should at least be equal with what is going on in England, for example, but we should also be equal with what is going on in Europe, which occasionally outstrips what is going on in England, and Wales is in a good position to do that. If we are aware of what is going on, we should be able to adopt technologies quickly. We are not talking about wild, wacky stuff that, in five years' time, will be obsolete or disregarded as useless; this is sensible advice and sensible knowledge.

[32] **David Rees:** You have actually raised several questions. So, I will start with Rebecca, and then move on to Lindsay, Leighton and Elin.

[33] **Rebecca Evans:** You mentioned the training needs for staff and so on. I was just

wondering what role new technologies play in the recruitment and retention of staff in your particular field.

[34] **Dr Clements:** In diagnostic radiology we have a looming crisis. In Hywel Dda there are fewer radiologists now than there were 20 years ago, and in other parts of Wales, we struggle to fill posts. We have been in discussion with the chief medical officer about how we can resolve this, and new ways of working will have to come in. However, the new technology of image transfer across Wales enables us to do this, because you could have a CT scan acquired in Bangor, let us say, but it could be reported in Cardiff. We could have something done in Wrexham and it could be reported in Swansea. If you have the infrastructure to transfer these images, it can be done. I am based in the Royal Gwent Hospital in Newport, but our imaging department covers Brecon to Chepstow to Ebbw Vale, Caerphilly and Ysbyty Ystrad Fawr. When I am reporting CT scans in the morning, one scan will come from Nevill Hall Hospital and the next will come from Ysbyty Ystrad Fawr—with modern technology it does not matter, they just come in to a list. We do not work, within Aneurin Bevan, on a site-specific basis. The technology is to move those things forward. Some of these things do not have to be on a hospital site, even. You could hire a building at Treforest, on the estate there, and have that as an imaging reporting centre. It does not have to be on a hospital site as long as it has appropriate networking. There are issues with acquiring the image. We obviously have to have radiographic staff, nursing staff or whatever on site to do the scans. For ultrasound that is very hands-on, so we have to have people on site to do that, but what I am saying is that there are new ways of working out there, and we have to think outside the traditional box if diagnostics in Wales is going to thrive.

09:45

[35] **Rebecca Evans:** What is stopping us from getting to that point? Is it lack of investment, or a lack of willingness to embrace new ways of working?

[36] **Dr Clements:** In terms of the training of radiologists, there has been a lack of investment into the Welsh training scheme. Some years ago England increased the number of training places. Wales agreed in principle with that, but it could not fund it, so, effectively, it did not happen. It did agree to two extra places last year. We know, historically, that only about 70% of our radiological trainees stay in Wales. The other 30% leave. We know that we rarely attract people from training schemes outside Wales to come to work in Wales. So, it is essential that we have a thriving training programme within Wales.

[37] There are new ways of working. In England, some years ago, they set up what was called a radiological academy. There are three of them. One is in Norwich, one is in Plymouth and one is somewhere up north—I cannot remember where. They were not based on the traditional model within a teaching hospital. We have encouraged the chief medical officer to think about setting up a radiological academy in Wales when we saw her last year, but, to date, there has not really been any progress that I am aware of in taking it forward. We have sown the seeds for it, but it has not gone any further.

[38] **Professor Barrett-Lee:** If I could give one example from radiotherapy—it would apply to any technology, really—in terms of cancer radiotherapy, there is a group in the UK that is formulating standards for a centre of excellence. Martin will be aware of this. They have not quite finished the specification, but it is likely to talk about having the required, up-to-date medical technology. What that means is that, if you get designated as a centre of excellence—let us say it could be the cancer centre in Swansea, or Velindre—then you will be on a map that states, ‘This is a centre of excellence for radiotherapy. If you go there, you will have a great career’. If you are not on that map, then there is a struggle, because we are in competition, not just with ourselves in Wales, but with everybody else, even with those in Europe. So, it is about retention of staff, but also encouraging staff to come to work. It is not

all bad news. As you have heard, there are some positives. The all-Wales imaging moves that we have, the developments there, could mean a very attractive prospect, because you would not necessarily be fixed as an incoming trainee—particularly if you had a family—to a geographical location, so that you had to be in a certain place. You might be able to do your work in a more fluid way. So, it is not all bad news, but we need to really up our game in terms of the speed of adoption. Otherwise, we will fall behind, and we will then be marked down by trainees.

[39] **Dr Rolles:** Just to add to what Peter and Richard have said, this is critical. For consultant specialties, we are in competition nationally across the UK. Wales clearly has certain disadvantages compared with the home counties, London or wherever. I do not need to enumerate them. Those of us who live here think that it is a great place, but if you have never been to Wales, you have to think twice when the question is, ‘Am I going to go to Swansea or am I going to go to Guildford?’ There is a big difference. One of the things that we can do is make sure that if people are going to come here, they can practice their craft to the best of their ability. One thing that they do not want to do is to come to a place and try to work in a department that is technically backwards while feeling that they are not able to practice to the best of their professional ability, quite apart from all the other things that they might have in Guildford and not in Swansea. I think that this is important. We do not want to recruit people who cannot get jobs anywhere else. We need to recruit leaders who will bring the service forward and make it better for Wales. I am not talking about them enriching themselves, but there has to be a potential for them to be good professionals, and that really is quite fundamental. It is not just in oncology, but in radiotherapy and the problem in Hywel Dda—the further west that you go, the more difficult that it gets—

[40] **David Rees:** We are aware of the difficulties—[*Laughter.*]

[41] **Dr Rolles:** I am sure.

[42] **David Rees:** Rebecca, are you okay with that?

[43] **Rebecca Evans:** Yes, that is great, thank you.

[44] **David Rees:** I call on Lindsay to speak.

[45] **Lindsay Whittle:** Thank you. Clearly, there is no doubt that we need a national, co-ordinated approach to technology. You have indicated that we should be leaders, and we are not, and I do not think that anyone around this table would argue with you. Some people regard politicians as decision makers. I would not dream of arguing against advice from people as eminent as your good selves. I would not dream of it, I simply would not—[*Laughter.*] That is how strongly I feel, because we have had real evidence that a decision was taken against the advice of experts in the field not to centralise a certain service in south Wales. The public out there would look at the decision makers and seriously question, ‘Should you be here if you are going against the advice?’, because this advice, hopefully, is designed to save or prolong life for the public whom we represent. So, what could you suggest? You must be equally as frustrated as Joe Public. We do not expect the technology in every single hospital in Wales, but what would be the advice that you would give us to drive this forward?

[46] **David Rees:** If I can just clarify, we have received evidence about the health boards not necessarily following clinical opinion, because clinical opinion wanted to focus on a centralised service and the health boards decided against that—I think that that is the position. Do you find the same difficulties in the sense that health boards are making decisions, perhaps where the clinicians think that a central service would deliver better and be more effective in delivering technology?

[47] **Professor Barrett-Lee:** This is from my own experience in the cancer world, and I will defer to Richard on radiology, but my view would be that it is more a problem of not getting a decision at all in terms of when we have a new technology. If you take the All Wales Medicines Strategy Group, I am a great fan of that organisation. I think that it has been a great success. It started out with quite a lot of opposition, but it has really won us over and I think that it is a great organisation. Okay, drugs are a little bit easier to appraise and there is not so much training associated with them. They are simpler, in a way, than physical technology, but I think that there could be some sort of arrangement like that to enable us to appraise a new technology and then to really state, 'This is best practice and it must be implemented' and, perhaps, to work with us on how we do it. To some extent, it does take away the autonomy of local health boards, but these things are really so important that to have no decision, or a decision five years later, is not acceptable.

[48] **Leighton Andrews:** I want to turn to the first question that I wanted to ask. You were giving an example, Dr Clements, of having a centre in Treforest or wherever to read CT scans, and you were describing the work that you undertake, so how many centres in Wales are undertaking the kind of work that you currently undertake?

[49] **Dr Clements:** Every district hospital in Wales will have a CT scanner and will have an MR scanner.

[50] **Leighton Andrews:** I meant the reading and analysis.

[51] **Dr Clements:** Reading will take place on every site, but in some places they are having difficulty in getting the work done, so they are outsourcing it. I do not have figures for where that would be, but I imagine that that is what is happening in Hywel Dda.

[52] **Leighton Andrews:** So, essentially, we have those things going on in every district general hospital, which we probably do not need to have. Is that fair? I am not talking about the actual scanning, but the analysis, as it were.

[53] **Dr Clements:** You need some supervision, so you need arrangements—for example, if you are doing a CT scan, a lot of the scans involve an injection; the majority of the injections are done by the radiographers in the scanner, but if they cannot access a vein or something like that, they come to find the doctor to do it. So, you cannot leave it completely unsupervised. However, there are other models that you could use to make sure that there was medical back-up or medical supervision; it does not necessarily need to be the reading radiologist.

[54] **Leighton Andrews:** I was trying to understand how many sheds such as that in Treforest we needed around Wales.

[55] **Dr Clements:** I think that one would be enough, with enough stations within it. The reading is quite compact; you just need a desk.

[56] **Leighton Andrews:** However, that would cut across health board autonomy, which is the point that was being made earlier. The other point that I wanted to ask about was going back to the appraisal process, which we moved away from. If judgments are made in England or on a pan-European basis about the efficacy of particular technologies, we sometimes like to feel in Wales that we have absolute policy autonomy and that we can get on, just do the job and implement it overnight. Are there any obstacles that you can see from seeing a technology being approved and appraised appropriately in England, or another European country, and then us implementing it?

[57] **Dr Clements:** Usually, it is about capacity. From an imaging point of view, we have longer waiting lists and much of that is because we do not have the same capacity as other places. It is many years ago now, but in my health board, the royal college did a survey of the number of scanners per head of population compared with 180 different hospitals across the UK. The Royal Gwent Hospital was one hundred and eightieth for the number of CT scanners per head of population, which largely explained why we were having such difficulty in getting our scans done and why we had such a waiting list at the time. We have more scanners now, but we are still relatively under-provided compared with other parts of the UK, and we run scanners on Saturdays and Sundays, so we have gone down that line.

[58] **Leighton Andrews:** Beyond capacity, Dr Rolles, you were suggesting—

[59] **Dr Rolles:** I think that it goes back to the central strategy and strong central leadership. Peter and I can sit in a room with a bunch of specialists and say, ‘What they’re doing in Denmark is fantastic; we should be doing it here. There is a level 1 evidence base for this.’ However, we then go, ‘Who’s going to do it? How are we going to do it? Maybe I’ll go and write a business case, get it backed and my health board may or may not approve it’, whereas what you really need is for someone to have some empowerment and say, ‘This is a strong recommendation; Wales needs to have this service and this is how we’re going to deliver it’. It is about having a central specialised commissioning process, I think.

[60] There are financial and infrastructure implications to all of this, and there is a revenue cost to everything. It is always going to be more expensive than what we have already.

[61] **David Rees:** May I clarify your point? We are talking about access to medical technologies and you mentioned capacity. Is the capacity issue a funding issue more than a technology issue?

[62] **Professor Barrett-Lee:** If I could come in on that, there are several issues intertwined here, and they go around in circles. Sometimes, the capacity is in terms of the staff available. So, if you have a new radiotherapy technology, you may need to train staff up to a different level in a different way. That can be an issue, particularly with radiotherapy, but it applies to other technologies and non-clinical staff, such as physicists. This is another group of people who are very undervalued. Physicists—and these are medical technicians, if you like—are absolutely vital to a lot of the technology. Once again, if you do not have the up-to-date technology, they will not want to work in Wales. So, you end up in a vicious circle.

10:00

[63] However, in terms of the adoption of technology, we need to take the best practice, as Martin has said. It needs to be evaluated by a body with enough clout to say, ‘Right, this is the plan’, and then we can make plans in advance to train those staff up and attract them. Once you get over that, the word will get out, you will attract more people and you will have a success story. It is not all bad news; there are many strengths that we have here that we could utilise. We should be able to do all of these things a lot more efficiently and more quickly.

[64] **Dr Rolles:** I would like to go back to the point about capacity and to enlarge on that. Technology and new stuff is a bit of a double-edged sword. We find that what we are doing now, which is much more highly technical work—this applies to diagnostics as well—is miles ahead of what we were doing 10 years ago, and it is undoubtedly better, but what we were doing 10 years ago was very quick and easy. The amount of time it takes to do things to a gold-standard now is many multiples of what it was 10 years ago. So, capacity, in real terms, has shrunk, because we are all spending longer doing something better. It is a bit like going from a simple appendicectomy in surgery to open-heart surgery. One takes six hours

and the other takes half an hour, but they are different things. We have evolved. So, complex stuff is more time consuming than the simple things that we used to do. We are three-quarters of the way up this curve and, from that point of view, complexity will increase over the next few years and it will affect our capacity.

[65] The other thing is that a lot of the technology that we are using is not quite mature yet and we expect increased automation and increased benefits in terms of speed and freeing up capacity as time goes on. So, the capacity from that point of view, with new technology, is a little hard to calculate, because there are conflicting things that affect the balance.

[66] **Dr Clements:** May I add one thing?

[67] **David Rees:** Yes, and then Elin has a question for you.

[68] **Dr Clements:** The adoption of all new technologies that might be promoted by a surgeon, a physician or an oncologist often minimises the support that is needed to make the business case attractive. That applies to diagnostics. They forget to tell you that, to do this wonderful new technology, they need to run a fancy scan to tell them what to do. That is, perhaps, a technological advance from the sort of scan that they had to do for the previous thing. That applies to surgery and the medical management of other conditions. So, if you were to be thinking along the lines of moving to some sort of all-Wales commissioning of new medical procedures, it is essential that you have good input to the supporting infrastructure, which may be, from my point of view, diagnostic imaging, but it may be that you need speech therapists, pathology, audiology or some other things, because those things are often either ignored or minimised in the plans. You cannot have the effective service unless you have funded the whole package.

[69] **David Rees:** We understand that.

[70] **Elin Jones:** I am definitely convinced of the argument for central commissioning for some of the medical technology that you have been discussing. The only question, or downside, I could see is that of how you ensure that the access and use of that technology is rolled out across health boards, for as long as we have health boards, in Wales. How do we ensure that, for Velindre, the Heath, or Singleton, those new technologies are then taken up by oncologists and cancer staff from local health boards that have possibly not been involved in the commissioning process or the sign-up to it? So, how do we ensure the roll-out? There are two issues there.

[71] One would be about the management of other health boards and how they would think, financially, that they would want to buy into that service, or allow their patients to access that service. However, there is also a case—different, maybe, to the adoption of drugs—that with new technologies, there could be medics and personnel working in cancer, or in radiology or any other field, who would be reluctant to work in a different way and would need a lot of persuasion to work in a different way. I am not sure whether that is reality. Something that we have heard in some of the evidence sessions up until now is that there are personnel issues, sometimes, in taking up new technology.

[72] **Professor Barrett-Lee:** If I put on another hat—my chair of the national clinical audit committee hat—the way to evaluate after you have implemented technology is to do clinical audit. So, you would evaluate, first of all, what has been the uptake of this technology—the decision was made that it should be available so you now do an audit to check on that. You also check—something that we do not do as well as we do for drugs—that the benefits that were claimed for that technology in the invention, if you like, are actually being realised. This is something new that a lot of people are talking about, which is that it might be possible to adopt technologies a little bit earlier than we currently do—this is not

just us in Wales; it is a worldwide thought. Adopt things earlier than normal, but evaluate straight away, as you go along. If they do not work out to be as good as you thought, or more expensive than you thought, then readjust, rather than wait. What we tend to do in the UK is to wait until something is a cast-iron certainty and then start to commission it. Meanwhile, we are miles behind everybody else, because, if you wait until things are a cast-iron certainty in medicine, it is usually five or 10 years down the line.

[73] That comes back to Martin's point. Technology is evolving. You cannot be absolutely certain that it will work as well as you thought. So, clinical audit is absolutely necessary. That will throw up areas where it has not been adopted; then you can talk to those people and ask, 'How can we help you?' It could be staff—a lack of staff capacity, a lack of trained staff in the right way, recruitment problems, or, as you say, it might be certain resistance. However, those things can normally be overcome once you identify them. So, I think that audit of drugs, technology—everything—is absolutely crucial, because we often just say, 'Great: big relief; we have this technology now, so off you go'. No-one ever questions whether it is giving us the benefit that we envisaged. So, I think that that is really important.

[74] **Darren Millar:** I wanted to ask about evaluation through commissioning, which is how you referred to it in your paper, Peter Barrett-Lee. To what extent is there an opportunity for more research in Wales, through new technology take-up, and for that potentially to start almost a virtuous cycle? That cycle could bring some income into Wales, assist in overcoming some of the recruitment challenges, because of the cutting-edge nature of some of the technologies that people might be able to do some research in, make sure that we are at the pinnacle and at the forefront of what is available and that we are early adopters of new technology, rather than very late adopters, in the future. Is there an opportunity there that we are missing, which could actually bring some income into the NHS rather than it costing us to put new technology into place?

[75] **Professor Barrett-Lee:** I will just make one comment. My other hat is my research interest. You are absolutely right. If you are behind the curve on technology, you are not going to be able to impress the world with the level of your research. It will be a joke, will it not? You will be behind on technology; no-one will be interested in your research on old technology. So, if you are behind the curve, you will not be ahead of the research curve, you will be behind it. So, you are absolutely right. If we invest in early adoption of new technology, we can be at the forefront of doing the research with that technology as well.

[76] **Dr Clements:** That is completely true. At the very start of my career, I worked with Professor Ken Evans in Cardiff and Professor Brian Peeling on prostate cancer diagnosis. At that time, Cardiff had the first ultrasound detection system for prostate cancer in Europe. It had not been adopted in the US. It was a Japanese development in the mid-1970s, and Cardiff, with that particular thing—the equipment was relatively cheap and it was funded by Tenovus—was able to do groundbreaking research at that time. More recent developments in diagnostic imaging have been in the field of magnetic resonance. Magnetic resonance scanners are really expensive and there is no capacity with any of them really in Wales to do research because there are long waiting lists for NHS patients. That would be why a drug company or some sort of trial company would want to go to the Royal Marsden Hospital in London. They have dedicated MR scanners there that are purely part of the research team. They are not part of the NHS side of the service in that hospital. It would be similar in Cambridge.

[77] **Dr Rolles:** It is critical. It is absolutely critical. The portfolio of trials available using new technologies is growing. From something really fairly basic eight or 10 years ago, there is now a burgeoning lot of national trials. If we participate we draw down funds, so it is important. The critical thing to realise, however, is that trials for something like radiotherapy will be comparing the gold standard with something new and hopefully better. If we are not

performing at the gold standard already, we are excluded from taking part so, immediately, we are handicapped. We have had this problem in the past that we have not been able to take part in trials because we do not have the technology that is just assumed to be normal elsewhere. We are overcoming that, but there is a massive opportunity. The other thing to say is that if we take part in trials we offer our patients a greater range of services. Research-active centres have better results; there is no doubt about it. It is also the way we should be training our staff. Trials have very stringent quality assurance protocols et cetera, which forces the department that takes part to up its game to the absolute pinnacle. Otherwise, you are not allowed to do it. So, it is a very good way of educating ourselves, and we really should be implementing new technology through the means of research and trials. It is the best way of doing it.

[78] **Darren Millar:** So, we are potentially missing out on another income stream and more exciting jobs for those people involved, certainly in your clinical specialities. Patients are potentially missing out on better outcomes as well, and this is all down to us perhaps being too risk-averse, really, before we adopt—

[79] **Dr Rolles:** It is too risk-averse, but it is also a cultural thing, I think. We have been pretty good in the past about doing drug trials. You get a pill or an injection and the pharmaceutical company will pay for the bits and pieces. We have not really had the infrastructure or the mentality for running technology trials. It is a bit different, is it not?

[80] **Professor Barrett-Lee:** I think it is about the infrastructure. I have had companies come to me about a new technology for liver cancer, and what they say is, ‘Who do we go to? We can’t see in Wales who is in charge of this. We’ve tried going round the various local health boards and they say that someone else will have to look at it first’. So, it is really important that we get this single structure that everybody, including the patients, understands. Then we will all know where we are. That does not mean that everything will be a ‘yes’—we understand that—but at least we will know whether it is a ‘yes’ or a ‘no’ a lot quicker than we do now. Then the companies will not be frustrated. The industry really does want to work with us. It sees huge advantages in working in Wales. It sees, actually, a very good workforce that is very willing to try new things in general, but what it comes up against is a lack of structure around how they would get their technology even over the threshold.

[81] **David Rees:** On the single organisational structure you are talking about, would it be an organisation that did commissioning and appraisal or would you consider those to be separate?

10:15

[82] **Professor Barrett-Lee:** Sorry, I could not quite hear.

[83] **David Rees:** Would it be commissioning and appraisal, or would there be separate organisations doing the two parts?

[84] **Professor Barrett-Lee:** It is a simplistic—. There have been criticisms of suggesting an All Wales Medicines Strategy Group type of organisation. It would probably need to have different skills. It is easier to appraise drugs; I am not belittling what it does, but it is a bit easier. I think that, first of all, you would have a single body that would do the appraisal. If we all sign up, then we have to agree and abide by the result. That is the first thing. You get a clear result as to whether this is something that we should do in Wales or something that we should not do. Then, I think, there needs to be a link to the commissioning. I am not an expert in that area; I do not know how that would best be done. My experience is that, if you then approach seven local health boards, it takes a lot longer than having a single point of contact. So, is it a lead LHB, or is it another body? I do not know.

[85] **David Rees:** That is very helpful. Thank you.

[86] **Darren Millar:** In terms of the pitch, as it were, for research funding and income and the opportunity to do research, do you think that that would be better made on a national basis, because a lot of your time is spent firefighting and dealing with patients on a day-to-day basis? Do you think that there ought to be a national approach in Wales for research funding to come in to be able to sell the benefits of Wales as a place in which to do research?

[87] **Professor Barrett-Lee:** It needs to be both ends. We benefit in Wales from a lot of really good entrepreneurs in terms of medical, nursing and scientific entrepreneurs, but that relies on someone being particularly entrepreneurial in one area. So that means that, in Swansea, for example, there is a very good burns unit, and it means that, in Cardiff, there might be something else. However, that is not the right thing for patients. It should be encouraged from the top end as well. You cannot just allow this whole story to develop only where someone has the time and energy to push through all of the problems.

[88] **David Rees:** We are coming to the end of our time, so I thank you for your contribution this morning. It has been very interesting. We have a final question that we ask all those who give evidence in these sessions. I will ask it of Professor Barrett-Lee first, and then I will ask the royal college. If you had one recommendation—. I think that you have stressed very clearly your one recommendation, so how would you want to strengthen that recommendation? Is there anything specific that you have not said that you want to say in support of a single body?

[89] **Professor Barrett-Lee:** I think that you have heard it, but it is about the commissioning as well. It is no good just having a strong piece of advice. In other countries they will have a central committee that says, 'We should have this approach to this radiotherapy technology. There should be two machines there, three machines there, a new PET scanner there', and then there will be a commissioning structure that will make sure that that happens. That is what we need. That is not one answer, is it? [*Laughter.*]

[90] **David Rees:** No, but we have also had evidence in your paper, I think, that is very much about the link and avoiding duplication, which is critical. Should that one body ever link in with NICE in the appraisals that it undertakes as well?

[91] **Professor Barrett-Lee:** I think that the trouble with NICE is that it does not look at everything that we need, but if it is doing something and we can link in with that—. The All Wales Medicines Strategy Group already does that. However, I think that there are specific issues for Wales that are different from the UK perspective, and I think that we need to be able to look at that aspect of it. So, yes, take good advice where it has already been done, but, as far as I know, NICE has not done a lot on radiotherapy machinery, for instance.

[92] **Dr Rolles:** NICE really fell over when it tried to consider intensity modulated radiotherapy. It had a panel that it set up in Manchester, which I attended, and it sat down said, 'We are going to consider IMRT'. Basically, I think that it thought that it was a bit like a drug, and that it was just something that you bought and turned on. When it realised that it was about a process rather than a single machine, it suddenly shut the whole matter down and I do not think that it carried on with the appraisal.

[93] **Professor Barrett-Lee:** That is a lesson. It will be more complicated. If it was easy, we would have done it already, would we not? So, it is clearly more difficult than assessing drugs. However, that does not mean that we must not do something about it, because, at the moment, things are not good.

[94] **David Rees:** What would the royal college recommendation be?

[95] **Dr Clements:** My recommendation would be, in assessing all technologies, to make sure that you have established the funding for the support services—in the broadest sense, not just in my own field—and to make sure that you have the full package for what you are dealing with. At the moment, there is the Welsh medical committee and the Welsh scientific advisory committee, and they do not really interplay, and all the diagnostics, support and everything is on the one side, and the medical committee is on the other. It needs to be more integrated.

[96] **David Rees:** Thank you very much, and thank you once again for your attendance this morning, and the evidence. You will receive a copy of the transcript to correct any factual inaccuracies that may appear. Once again, thank you very much.

[97] We will move on to the next session and wait for the witnesses to come in.

10:20

**Ymchwiliad i Fynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn  
Dystiolaeth 13  
Inquiry into Access to Medical Technologies in Wales: Evidence Session 13**

[98] **David Rees:** I welcome Dr Alan Rees, the vice-president for Wales of the Royal College of Physicians, Dr Miles Allison, consultant physician and clinical director of gastroenterology, and vice-president of Aneurin Bevan Local Health Board, if I am right.

[99] **Dr Allison:** I am vice-president of the Welsh Association for Gastroenterology and Endoscopy, or WAGE.

[100] **David Rees:** I also welcome consultant laparoscopic colorectal surgeon at Cardiff and Vale University Local Health Board, Jared Torkington. I understand you may also have some views from the Royal College of Surgeons.

[101] **Mr Torkington:** Yes. Hello.

[102] **David Rees:** I welcome you all and thank you for your written evidence, and for the royal college's written evidence. Clearly, the evidence always tends to spark some questions to explore things a little further. I will start the questions off, if it is okay with you, with Gwyn Price.

[103] **Gwyn R. Price:** Thank you, Chair. Good morning to you all. How should the patient perspective be considered in the appraisal and commissioning of new technology? Are there any examples you could tell us about? How could the role of the patients be developed?

[104] **Dr Rees:** Are you asking me?

[105] **Gwyn R. Price:** Any one of you.

[106] **Dr Rees:** Well, I think, from the point of view of the patient, that what they want is the best possible care. Their preference would be to have treatment as close to their home as is natural, but with super-specialisations, things have changed. In 1948, when the NHS was set up, each locality had its district general hospital and was able to provide comprehensive healthcare for the population. That is no longer the case, as we all know. That is why we have reconfiguration going on. People are used to coming down from west Wales and north Wales

to have their revascularizations for their hearts, or for treatment at the cancer centres in Velindre or Morriston. So, it all depends on what is wrong with the patient. As individual patients—having had quite a lot of experience in my family—I think they want the best care, and, if necessary, they are willing to travel for it, because that is their priority. So, I think that is the perspective of the patient. If you are able to provide that care locally, all well and good, but there are some conditions, depending on their rarity, of which there may only be three or four such cases in Wales, and to invest in that kind of service for three or four cases may not be cost-effective, and you may need to go elsewhere.

[107] Similarly, I can give you one personal example. I am involved in diabetes, endocrinology and clinical lipidology, and, by chance, we set up, about 20 years ago, a unit in Llandough that provides LDL apheresis. In essence, it is a bit like dialysis, but it cleans the cholesterol out of your blood. It is now the largest such unit in the UK. It has 25 or 26 patients coming over, and we are now providing that service free of charge to people in the Cardiff and Vale health board area, but if you are from another part of Wales you have to raise the money from that health board, which is £35,000 a year, to come down. That is quite difficult to do. It would be far better if this was a service for all of the people of Wales. People who are from, say, the south-east Valleys have great difficulty in getting their local health board to commission this and to pay for this. Also, it is one example of where people from the west of England come into south Wales and bring the money with them. So, it is a kind of service where you hear about people going from Wales to England for specialist services, but it is not always a one-way flow; it can go both ways. This is a good example where people from the west country—about four or five of them—come in and bring revenue with them across the Severn bridge.

[108] **David Rees:** May I expand on that? It is clearly an important aspect of how we use services. I suppose that the question that I am driving at is, if we are assessing medical technologies, how do we encourage patients' perspectives to be effective in the commissioning and appraisal process, and do we have any examples where that is taking place at this point in time?

[109] **Mr Torkington:** The importance of patients is paramount. The NHS is there for patients. It is almost unacceptable these days, I would say, to not have patients involved in every step of planning and commissioning. However, you have to take a step back and say, 'We have all been patients, we all are patients or we are all going to be patients.' So, it is important that their views are heard. They bring a unique perspective—having been through a system or experienced a service—that is very valuable. Equally, sometimes that has to be tempered with the fact that, when you have a condition, it is difficult to be as objective and to recognise that resources are finite. Therefore, it is important that they are part of the process, though not necessarily the main determinant. However, in this day and age, patients need to be involved.

[110] **Dr Allison:** Yes, I would go along with what both of my colleagues have said here. From a gastrointestinal point of view, the issue that has come about recently, I guess, is the bowel screening programme. This is something where people are invited to submit a specimen to be part of a programme. So, they are not patients; they are participating in a national screening programme. Two per cent of them will end up having to have further procedures, and sometimes that opens up a pathology for which they require treatment—different technologies for more minimally invasive options for treating certain polyps and cancers that traditionally would have been treated by an open surgical approach. Clearly, patients will vote for a more minimally invasive approach.

[111] **Kirsty Williams:** It seems that there is a developing consensus, from all of the evidence that we have received, that we need some kind of national approach to at least commissioning and implementation, even if we do not necessarily have the skills to do the

appraisal properly. I am just wondering what, in your view, that kind of organisation may look like. We have had some discussion about whether a replica of the All Wales Medicines Strategy Group approach may be helpful. Sometimes, I have become obsessed with big lumps of kit. However, looking at your paper, Dr Allison, some of the things that you are talking about are very small pieces of equipment that simply are not available here in Wales. Could you tell us a little about some specific examples where relatively small pieces of kit and equipment have not been adopted and are not being used here, and what the barriers have been to that?

[112] **Dr Allison:** There is certainly sometimes a lack of information about how things occur, and sometimes a lack of guidance on how to bid for things nationally, in addition to the context of how things should be provided nationally, perhaps not for a new technology but for an established technology. I gave the example of endoscopic ultrasound, which is a crucial technique for the staging of gastrointestinal malignancies, and also part of the more minimally invasive treatment of some forms of pancreatic and biliary disease. The kit is quite expensive, but not when you look at it in the context of what you have heard from radiology and so forth. However, at the moment, our health boards give priority to—and buy—some kit that is only used once a week, for example. So, this means that there are examples of kit that is being used in Wales just once a week and that is five, six, seven or eight years old. The Welsh Association of Gastroenterology and Endoscopy was part of a multidisciplinary group to try to look at a more national solution for the provision of the service.

10:30

[113] There was a proposal agreement among the clinicians that probably one centre in south Wales would be better for that technology. It went to the meeting of the chief executives of the local health boards to discuss and, at the end of the day, the verdict was that the prioritisation was up to each individual local health board to decide. So, that just underscores the need for a centralised body, perhaps a separate appraisal body, because these technologies, often, have been appraised by others, but also a commissioning body with some external representation, perhaps from specialists and maybe from outside Wales, as well as, obviously, financial people and representation from each of the local health boards.

[114] **Elin Jones:** May I just ask something on that particular issue? You mentioned the agreement by clinicians that having this new technology and one site for south Wales would be preferable, do you mean that all clinicians who were using the eight-year-old kit in different locations in south Wales were all signed up to having the one site and to having a new model of service and that they also failed to persuade their health board managers that this was the way to do it? So, even the clinicians from the inside of the health boards failed to persuade Hywel Dda, Aneurin Bevan, or all of them that this was a better model of service delivery.

[115] **Dr Allison:** A paper was put together, which was put to the group of chief executives, so it was done that way more than any other. Each of the health boards has given a different priority to the service development in this area. There is a service available for all patients in Wales, but the equipment is ageing and, in some places, it does need replacement.

[116] **Elin Jones:** The point that I am trying to get to is that, sometimes, with the development of new technology, there are going to be clinicians who are working in a particular way at a particular site and are quite happy to carry on in that way. Do you find, with the adoption of new technology and new ways of working, that there are personnel in the medical field out there in different places in Wales who are reluctant to change the way that they are working?

[117] **Dr Allison:** We do not work in isolation. There are national bodies that set standards

for how a service should be delivered, including throughput and seeing or staging a certain number of patients to maintain a caseload expertise and competence, as well as to provide training to trainees. There are certain standards that need to be adopted to meet these national standards and national guidance, and the clinicians are very much signed up to that approach. Clearly, it has implications in terms of split-site working and so forth, but this is something that will have to be got around.

[118] **David Rees:** Before I bring Kirsty back in, may I just ask for clarification on that expansion, because witnesses in one of the earlier evidence sessions that we had talked about the clinician-led approach to adopting medical technologies, and you are saying that there are standards within your specialist area that they have to meet? May I ask the two representatives of the royal colleges whether there is an issue where clinicians are the ones driving forward in your areas the adoption of new technology, or are you raising the standards and encouraging people to adopt new technologies as a consequence of those standards? Perhaps Jared could come in first.

[119] **Mr Torkington:** I think that clinicians, by and large—I can talk about only secondary care; I cannot talk about primary care—

[120] **David Rees:** Yes, we appreciate that.

[121] **Mr Torkington:** They are the drivers and the gatekeepers to new technologies. The industry views them as the gatekeepers at the moment, which may or may not be right, because a lot of new innovation has happened because individual clinicians or groups of clinicians become very passionate about them and push forward. Patient groups feed into that. Prostate cancer charities and the robot for laparoscopic prostatectomies are a really good example of that. However, it needs to be championed and it needs to be led by clinicians, and you can argue that that is an advantage or disadvantage of the current system that we have for the adoption of new technologies. So, I think that the robot is a very good example of that.

[122] **David Rees:** Okay, thank you. Would you like to come in, Dr Rees?

[123] **Dr Rees:** I am here representing the Royal College of Physicians, which represents 30 different specialties. Some of those specialties, naturally, are more high-tech than others, and others are more pastoral where the new technology does not apply quite as much. However, if you look at it in the context of reconfiguration in Wales, it could be that a model for acute medicine would be that you would have a separate gastroenterological intake in one hospital, chest and cardiology in one hospital, and after they have had their hi-tech treatment they would go back for recuperation and rehabilitation to other hospitals. So, there is going to be a concentration of the specialty aspect of medicine in far fewer hospitals than there is at present. That is going to happen in Wales; it is certainly going to happen in England. You probably saw the outgoing chief executive of the NHS in England saying that they will have to reduce the number of units.

[124] So, it is in that context that you have very expensive kit coming along that has to be used efficiently—we are talking about 24/7 working or seven-day working with consultants, so you are going to have to have this very expensive kit in a smaller number of hospitals and which will be used in a very efficient way. The cost-effectiveness of the investment is the principle that the royal college would like to emphasise, and that it is going to be clinically led. Most of us in our ologies go to national or international meetings where you can have a feel for how these cutting-edge developments are being developed in various parts of the world, and you can bring that expertise back. Therefore, you have to have some appraising system in Wales as to whether or not it is appropriate to invest in certain technologies in Wales, because we are serving a population of 3 million people. Therefore, that cost-effectiveness is an issue as to whether or not you are going to invest in that technology.

[125] So, there are all kinds of clinically evaluated technologies, and there is also the financial side of it—the cost-effectiveness. That is exactly what the National Institute for Health and Care Excellence does, of course.

[126] **David Rees:** Kirsty, we will go back to you now.

[127] **Kirsty Williams:** I am still interested in this issue of where something is proven and other people are doing it, individual local health boards are still reluctant to take up a particular procedure or technology. Dr Allison, in your paper you talk about radiofrequency ablation. We know that oesophageal cancer is often detected quite late, and once it is detected and people have symptoms, there is often very little that you or your colleagues can do to help them to survive. However, we also know that the presence of pre-malignant cells can give people really good survival options. Why then is Wales, in the presence of all that knowledge, understanding and evidence, the only part of the UK that does not offer that service?

[128] **David Rees:** Before you answer the question, I do not think that you should answer on behalf of the health boards, but to give your perspective on it.

[129] **Dr Allison:** I would not dare answer on behalf of the health boards. Cancer care and pre-cancer care is discussed in a regional multidisciplinary meeting, which includes south-east Wales, south-west Wales and north Wales; that is how these things work. The health boards, though, are serving smaller populations, so to run that type of service—radiofrequency ablation—probably one or two consultants in south Wales should run it. It will not be used very often. Maybe its use will increase, and I am sure that it will in years ahead. However, it is something where a central body, a south Wales-wide body or possibly the cancer multidisciplinary teams would have more of a structure for bidding for this kind of thing in a committee type of way, rather than leaving it to individual clinicians in local health boards to try to flag up something like this, which needs to be offered to other patients in south-east Wales and south-west Wales.

[130] **Kirsty Williams:** Do you have examples, Mr Torkington?

[131] **Mr Torkington:** I do, but I think your example is a really good example of why the outcome of this committee's inquiry is so important to how we commission new technologies. This is why we need an appraisal group that looks and says 'We need an RFA service in Wales'. Personally, I feel that we should have a separate commissioning group that says, 'The appraisal group has said that we need to have an RFA service in Wales', and the commissioning group then decides how it is going to be commissioned. I think the reason that LHBs do not commission it in every site is because they know that there will not be enough patients in every site to make it financially viable. They will not commission it because they think that somebody else might commission it and then there is difficulty with regard to moving funds around. So, it is a really good example of a service that is required in Wales and a really good example of why a new, more transparent approach to appraisal and commissioning is desperately required for new technology.

[132] **David Rees:** Dr Rees, would you like to add anything?

[133] **Dr Rees:** We are talking about a population of 3 million people, and that is why it is very important to have a strategic approach on an all-Wales basis. You do not want to disadvantage people in rural Wales, and you want to make sure that each individual patient gets the best treatment possible. That is why I believe that we have the possibility in Wales, because we have a devolved system, there are only 3 million people, there is easy access between the profession and the politicians and the Executive, which means that we could, in theory, make it work much better in Wales than in England.

[134] **Kirsty Williams:** Will we have to acknowledge sometimes that there are certain services that, because there are only 3 million people, we will never be able to provide in Wales? Are you saying that the commissioning group would then make provision for services over the border?

[135] **Mr Torkington:** Yes, absolutely. That is absolutely critical, but it does not mean that it cannot work both ways. We have a lot of expertise in engineering, in the medical profession, and so on, and just because there is only a handful of patients in Wales who might require a service and therefore there is no point in investing in it does not mean that we should not have cross-commissioning with the midlands or the south-west to take their patients. So, that is critical. I do not think that we need to be insular in thinking that we have to do everything for our own patients; we have to be strategic and say, 'Actually, it is better for us to commission this from somewhere in England' and, equally, we have the expertise and the ability and therefore we should have a contract with the south-west to do its patients.

[136] **David Rees:** Mr Torkington, you have stressed quite clearly that there should be separate appraisal and commissioning bodies; Dr Allison and Dr Rees, do you have similar views?

[137] **Dr Rees:** Yes, I would agree with that.

[138] **Dr Allison:** Yes, certainly.

[139] **David Rees:** A point was raised in previous evidence regarding commissioning with evaluation as well, which, in a sense, combines the two in one element. Is that an approach that we should also be considering or something that we should recommend as a way forward?

[140] **Mr Torkington:** I do not believe that anything should be commissioned without ongoing evaluation. New technology, by definition, is new and therefore the evidence base is often small. Part of the process should be evaluating things that we have commissioned before, so that we can stop doing them if they are not providing the things that we expected them to. So, you can have separate appraisal, and that appraisal needs to look at the clinical needs of people in Wales, as well as the industry coming to them and saying, 'We have a new widget, can you appraise this?' You can then have commissioning once that has been decided by an appraisal group. We do not need to reinvent the wheel with appraisal: if we have a clinical need for our patients in Wales that has not been looked at by NICE, for example, then we should appraise it; if we have a clinical need, but it has already been appraised by half a dozen other bodies, there is no need for us to appraise it again, and we will just say that we need that service, and then we go straight to the commissioning group. However, the commissioning group must have a responsibility when it commissions a service to make sure that there is ongoing evaluation and audit. You may decide to commission it on a small scale, initially, to ensure that those benefits are there, before rolling it out to a wider area. So, commissioning and evaluation go hand-in-hand.

[141] **Dr Rees:** The Royal College of Surgeons and the Royal College of Physicians have invested heavily in Wales in the last year or so. They have huge resources that we can tap into. For example, the Royal College of Physicians hosts NICE and the National Clinical Guideline Centre. There are 30 specialties represented by the Royal College of Physicians, and, if it were to be in rheumatology, for example, you can use these resources to help the appraisal in Wales. That is the basis of the royal colleges. They have a huge resource and huge expertise.

[142] **Leighton Andrews:** I want to go back to the point that Kirsty raised about RFA,

because you said that it was a good example of where some of these decisions are not taken in the way that they should be, or deferred, or whatever, and clearly the capital cost is not significant in that. Do you think that the LHB decisions not to go ahead were to do with revenue costs in terms of training and other things?

10:45

[143] **Mr Torkington:** I do not know any of the specifics about the decisions. Therefore, one can only speculate. You raise a really good point that, actually, new technologies can be low key and have low capital costs, but if there is not education and training put into it, it is a worthless investment.

[144] A really good example and something that Wales has done really well is laparoscopic colorectal surgery. NICE issued a directive saying that this should be available to everyone with colorectal cancer and in the Department for Health in England and in Wales, there was recognition that there were not enough trained surgeons to be able to deliver this service. So, there was a moratorium—not a ‘moratorium’, but a deferral of implementation time; there is a special word for that and I cannot remember it. [*Laughter.*] In England, they invested several million pounds in a big scheme. In Wales, the Welsh Government put money into the Welsh laparoscopic colorectal training scheme, which we ran from Cardiff Medicentre, from the Welsh Institute for Minimal Access Therapy, which is a fantastic place, and we currently have an uptake of laparoscopic colorectal surgery in Wales that is comparable to anywhere else in the world. It is much better than in England. We have done that by being bespoke in the way that we delivered the training and very much by training trainees as opposed to concentrating on consultants.

[145] Therefore, within five years of our programme, people were coming through into consultant jobs in Wales, because we know that if you train in Wales, you are quite likely to stay in Wales and they were coming in and the uptake has been huge. It has been a huge success. So, a lot of the equipment was out there, but the knowledge base and the education for doing it were not. That is a really good example of using education to introduce new technology.

[146] **Leighton Andrews:** Thank you; that is very helpful. It would be useful to get a note from the Government on that.

[147] **David Rees:** We will make a note of that.

[148] May I ask what you think the role of WHSSC will be in all this if we change and recommend that a new body should undertake appraisals? It has gone quiet. [*Laughter.*]

[149] **Dr Rees:** A lot of the structures in medicine are being reviewed at present. From looking at a review of the advice that the Government is getting, I think that there are 56 or 57 different bodies advising the Welsh Government regarding the provision of healthcare in Wales. It does need rationalisation and streamlining. I think that that is about all that I am prepared to say about it.

[150] **David Rees:** That is fair enough.

[151] **Mr Torkington:** For me, if WHSSC were a computer programme, it would be ready for an upgrade in terms of moving it on. When it started, it was clearly very important that it represented the LHBs, but we have now reached a stage where we have the health technology fund that provides big capital investment and then we are going to another body to ask for revenue. So, the two are disconnected and there needs to be a better working relationship between these bodies.

[152] The other thing that I feel about WHSSC is—and a lot of people have had different experiences—that the individual patient funding request process is outdated and is not used in the most appropriate way. WHSSC talks about it being used for new, novel, developing or unproven techniques, but, sometimes, I find that we are using the IPFR for NICE-approved and NICE-recommended treatments for individual patients and I am not sure that that is the way that it was set up. I think that we are conscious of this, as well. I do not think that this is news. We need to just look at those processes and there is potential for WHSSC to take a major role in any new commissioning process, but the way that it works and the way that it was set up, I think, leads to some difficulty, particularly with the IPFR.

[153] **David Rees:** Obviously, the IPFR is being reviewed, so we will not go into that at this point, unless anybody has specific questions on the role of IPFR with technology. Kirsty, I see you are itching to come in there.

[154] **Kirsty Williams:** Well, I have just had some recent experience of that for a constituent and it just seemed to be a very opaque process. What was disturbing to me was that we were successful in obtaining funding for my constituent, but I am also aware that there were three other Welsh people on that same list, on that day, who did not get it. I am not quite clear why some people get it—

[155] **David Rees:** Your opaqueness, I think, is being reflected.

[156] **Mr Torkington:** I can give you a really good example. One of the services that we provide is sacral nerve stimulation for faecal incontinence, which, as you can imagine, is an incredibly distressing condition to have. Up to 2% of the adult population will suffer with it at some time. People do not talk about it; people are amazing in their ability to deal with it and adapt. NICE released interventional procedure guidance in 2004 supporting the use of sacral nerve stimulation for faecal incontinence. It then released clinical guidelines in 2007 for sacral nerve stimulation and it was part of the algorithm for the management of it. We are the only people who have managed to do it. This is where the process is not working: IPFRs go to WHSSC, then WHSSC sends them back to the health board and says, ‘This is your responsibility’ and then the health board sends it back to WHSSC. By and large, the majority of patients who we have done have involved their Assembly Member in order to try to push this through. So, it is inequitable. Sacral nerve stimulation is something about which an appraisal body should say, ‘Yes, okay, we need to provide this technology in Wales’, or, ‘no’, and then a commissioning body should decide how it is going to be done. While we have lots of good examples, sacral nerve stimulation is really good example of where it is not particularly working very well. You can get access to that in other parts of the UK relatively easily.

[157] **David Rees:** That is very interesting; thank you for that. Do any other Members have questions?

[158] **Darren Millar:** Mine relates to the cost-benefits and the value for money, if you like, of new technology. In your paper, Dr Rees, under point 8, you made reference to the fact that some of your members had contacted you to say that, often, some of the older technologies are more expensive than some of the newer technologies and that there can be a cost-benefit to the Welsh NHS if a newer technology is adopted and implemented. However, for whatever reason, there is sometimes reluctance for the Welsh NHS to invest in the newer technology, even though it has already been appraised and deemed to be suitable and delivers, perhaps, improved patient outcomes. Why do you think there is reluctance for investment in new technology when there is a cost benefit to a health board, especially in these difficult times?

[159] **Dr Rees:** It is difficult to second guess who makes these decisions, but my personal

experience in getting new, innovative treatments is that a lot of people are very risk averse in making these decisions. I have just finished sitting on a NICE guidelines panel. It is forensic in the way in which it looks at the cost-effectiveness. So, if NICE guidelines come out recommending something—whether it is a new drug or a new technology—you can rest assured that it has gone through a forensic evaluation. I have not been privy to anybody making these decisions, but there is a huge fiscal pressure on people to come within budget. That fiscal pressure is around short-term pressures, whereas the benefits are often long term. I suppose it is exactly the same as politics: people make political decisions based on relatively short-term benefits, rather than decade-long benefits. So, human nature being what it is, I would ask the politicians to reflect on the nature of the way in which they make their decisions, as it is probably the same way as people who are in charge of budgets within health boards.

[160] **Darren Millar:** You seem to be making the point that there is often a purchase or an investment in a piece of kit that is perhaps less technologically advanced, but more expensive, which is still going to have a longer term cost, and an additional up-front cost, perhaps, to a health board. So, it is not just about longer term savings, is it? It is also about shorter term savings.

[161] **Dr Rees:** I think it comes down to the royal college's view that we should have a strategic view over the next five to 10 years. I am not always convinced that that appropriate, clinically led, strategic view is considered in making these decisions. Depending on the size of the health board, the horizons are relatively small. If you are looking at an all-Wales basis, logically, it would be a much better way of making decisions.

[162] **David Rees:** May I ask an extension on that? To return to financials, you are three different specialists, and the silo question has come up in previous evidence. Long-term costs may be expensive in a particular department, but savings could be seen in other departments down the line. Are you experiencing that approach as well? Do you experience those difficulties?

[163] **Dr Allison:** In gastroenterology, not looking specifically at kit, one good example is the biological drugs, the anti-TNF drugs, which are used to treat inflammatory bowel disease. These cost a lot of money; it is around £10,000 a year to maintain each patient, or £20,000 depending on their weight and other factors. This is consuming a large amount of the gastroenterology budget, but there are savings. In the old days, we used to see people on the wards with fistulating wounds on their abdomen who were in for weeks or months, and sometimes would succumb to their disease. This is an example of an agent that sustains remission, but it is a very expensive one. It comes out of the pharmacy budget, but the savings are very much elsewhere within the health system.

[164] **Dr Rees:** There is also the evolution of medical practice. If you go back to when I was training, over 35 years ago, you would have the ologies as silos. Now, in modern medicine, you have multi-disciplinary teams. For example, in gastric cancer, you would have the oncologist, the surgeon, the gastroenterologist, the radiotherapist and the radiologist. So, there is a coalescence of ologies in certain groups of certain diseases, which makes it easier to have an overview of the benefits, rather than looking on your own at how many days a patient has been on the gastroenterology ward and is then readmitted under surgery or whatever. The evolution of medical care is that we are grouping into bigger groups to look at the patient journey in its totality, rather than breaking it up into small steps.

[165] **Darren Millar:** I want to ask about one of the issues that we explored with the previous witnesses, which was the potential for research income from new technology and the early adoption of new technology in NHS Wales. I know that there has been some discussion already about commissioning an evaluation of the efficacy of new technologies, but is there

potential to draw in research income to NHS Wales and deliver more exciting careers for members of your organisations, allowing them to get more involved in research? Are you doing enough to pitch at the research investment that we could draw in? Should that be done on a more national basis, rather than, perhaps, a local clinician with a specific interest in research?

[166] **Dr Allison:** One of the key factors for gastroenterology is the shortage of academics. We are starting from a very low base. We have 58 consultant gastroenterologists in Wales, although a lot of endoscopy is done by surgeons and some other specialities as well. There are only two academic posts in the whole of Wales in gastroenterology; one is just about to retire and may not be replaced. In general, the theme of having research funding and industry funding tends to be brought in by people who have the time, resources and academic infrastructure to attract it in the first place.

[167] **Mr Torkington:** You have hit on a really important issue; we are getting better at it—that is the answer. We welcome the restructuring and reorganisation of the National Institute for Social Care and Health Research, which is an important, good, strong thing for Wales to have. From a surgical point of view, 30% of patients come into hospital for some form of surgery, but only 2% of medical funding comes to surgery in the UK. So, the Royal College of Surgeons is certainly taking a real hard look at that. It has set up surgical research units in England—they are funded by England—and we would certainly welcome that sort of approach in Wales.

11:00

[168] The point that Miles made is also something that we have not talked about, namely clinical leadership. With all of these things, it is really important that we have strong clinical leadership, but it is very difficult to be a strong clinical leader in the modern NHS when, actually, clinical leaders are really on the front line. Creating space and time for people to do research and education and for them to still be there right at the front door looking after people is quite a difficult thing to do. I believe very passionately that clinical leaders should still be doing clinical work.

[169] Getting a balance is quite difficult. It is difficult for the health boards, because they want the maximum out of their consultants in terms of delivering work, and it is difficult for the wider community, whether it be research or beyond, because you need clinical leaders to do other things and advise on other things and be part of other things. I do not think that anywhere has that right, but all of these things need strong clinical leadership. Again, the balance between getting people doing the things they are good at, like operating or seeing patients with diabetes, and getting them to push forward other things as well is a tricky one, and I do not think that anyone has it completely solved.

[170] **Darren Millar:** May I just take up the point you made about the need for health boards to, effectively, get maximum productivity from the clinicians they employ because, obviously, they have a day job to do in terms of clearing waiting lists, or whatever it might be? Is there not an opportunity here for more funding to come in from those clinicians than their cost to the health board as a result of the research income that could be generated?

[171] **Mr Torkington:** Absolutely, but it takes time to generate research applications. They are incredibly long. Bureaucracy for attracting research money is incredibly complex. It is the same with relationships with industry. That is difficult. We have an amazing juxtaposition, do we not, at the moment? We have a £100 million bioscience fund, which is really exciting, to generate business and to create profits and to make SMEs that are fantastic, but that life sciences sector is completely and utterly dependent on the NHS, which cannot spend any money and cannot do anything. I may be drifting out of my knowledge area here, but my

understanding is that legislation exists to stop health boards having an equity share in medical start-ups. You have to have a carrot and a stick somewhere along the line, and the relationship is a peculiar one. We have a big life science drive and we have the NHS, which is really having to tighten its belt and may have to do so even more in future. Getting a middle ground is difficult. So, with research, yes, there is a lot of opportunity. There is a lot of opportunity to bring in industry money and to bring in research money. However, getting a research grant—. We just got a £1 million research grant; it has taken us two years and a lot of work to get there.

[172] **David Rees:** I am sure that that will be in the thoughts of Members when we ask questions of the Minister for Economy, Science and Transport at some point in future. Thank you for your time today. Before you go, I have asked every other witness this question: if there was one recommendation that you would want to suggest that this committee might want to consider, what would it be? We will go from left to right.

[173] **Dr Rees:** I think that we need to think strategically on a national basis in Wales. We need to be more innovative in taking new ideas on board. I perceive that there is a certain level of risk-averseness in terms of developing new ideas in general. So, I think that we should have an innovative national strategic body to look at things such as research, which Darren has just asked about. For example, we have a national familial hypercholesterolemia register in Wales. We are the only country in the world to have that. It is a fantastic resource. We have a national diabetic retinopathy service, with all the data on the eyes and the vasculature of all the diabetics in Wales. It would lend itself ideally to innovative research. That has not happened. We did ask for a clinical lead in diabetes in Wales, as had happened in England; that did not happen. I think that that could have oiled the wheels. Jared has already talked about the difficulties, if you are a practising clinician, in getting the time to do these things. I think that you need to have a group of people to strategically look at innovation, income generation and research in Wales.

[174] **Dr Allison:** I would support that and also underpin it with the plea that communication needs to be improved in this area. As clinical director, I am often given some bid where there is a three-day deadline to get it submitted. There is a lot of end-of-year sort of hurriedness and financial discussions, procurement and last-minute decision-making. A strategic approach, but underpinned by better communication of what is available and how you should go about seeking it, as well as the strategic national body, is vital.

[175] **David Rees:** We have not talked about horizon scanning today. Would you like to comment, Dr Torkington?

[176] **Mr Torkington:** I would make a plea for a transparent, user-friendly appraisal board that makes decisions—‘yes’ or ‘no’. All of us are comfortable with ‘no’; it is when there are no decisions that it is difficult. That leads on to an obvious commissioning body that also takes advice from outside on how things are commissioned, for all of us to see and that is really clear. It needs to be user-friendly. We need to know how to get into it and we need to see that the decision is black and white. You can say ‘no’, but put a review in. Say, ‘No; we cannot afford RFA now’—people understand that; everyone understands that—‘but we will review that decision in three years’ time’. It has to be clearer.

[177] **David Rees:** Thank you very much for your evidence this morning. You will receive a copy of the transcript to check for factual inaccuracies, which you can let us know about. Once again, thank you for your time.

[178] I propose that we now take a short break and return at 11.20 a.m.

*Gohiriwyd y cyfarfod rhwng 11:07 a 11:23.*

*The meeting adjourned between 11:07 and 11:23.*

**Ymchwiliad i Fynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn  
Dystiolaeth 14  
Inquiry into Access to Medical Technologies in Wales: Evidence Session 14**

[179] **David Rees:** Welcome back to this morning's session. I welcome Dr Nazia Hussain, who is representing the Royal College of General Practitioners in Wales. Good morning. I thank you for the submission from the royal college into the written evidence. Obviously, that tends to raise questions, and we have Members who have some questions for you this morning. I will start with Gwyn Price.

[180] **Gwyn R. Price:** Good morning. How is the primary care voice heard in strategic planning currently? How could this be improved in your opinion?

[181] **Dr Hussain:** Good morning, everyone. I speak in my capacity as an RCGP member, so I am not sure if my views would be specifically shared with the RCGP itself. To be honest with you, my honest answer is, 'I don't know'. I went digging around to find out how exactly we assess and look into new medical technologies, but I do not think there is a specific group within the RCGP per se that addresses this. There is something called the Clinical Innovation Research Centre—the CIRC. It is involved with developing innovation within the college itself, but, looking into its planning, it has mainly been related to work on antimicrobial resistance, as well as work dealing with the flu pandemic. However, it has not addressed the issue of dealing with medical technologies and developing them itself. There are positive steps, though, in the sense that this year it has introduced a new fellowship scheme, the Sowerby fellowship scheme, which is available to a limited number of general practitioners. It began to recognise that the limits to GPs being participants in innovation with regard to progress in general practice are, first, funding and, secondly, time. Even though GPs may be keen to pursue new developments, they do not have the time. So, this is a scheme that runs for a year, giving GPs funding and time out to develop those things.

[182] **Gwyn R. Price:** So, there is not really a voice at this moment in time, as far as you know.

[183] **Dr Hussain:** Not as far as I am aware. I will definitely go back to head office itself and try to find out and write back to you. However, within RCGP Wales itself, I could not see anything like that.

[184] **David Rees:** On a personal basis, as a GP, do you have a voice in technology selection and appraisal?

[185] **Dr Hussain:** I work as a locum GP in the Aneurin Bevan trust, and I have also gone across to west London, and, to be honest, the answer is 'no'. As a general observation, there tends to be ad hoc take-up of medical technologies. So, general practices have access to certain technologies—simple things like blood pressure machines, sats monitoring for oxygen levels, electrocardiogram machines and defibrillators. However, this generally tends to be ad hoc. So, in a practice meeting, for example, if there is a little bit of spare money left over, someone may suggest that the practice should invest in a home blood pressure monitoring scheme or 24-hour ECG monitoring, because it is appreciated that these things are difficult to access and that there are long waiting times for them.

[186] **David Rees:** I appreciate that your experience might be limited because of the locum side of things, but is it your experience that there is a GP within a practice who is driving that technology and the desire to have it?

[187] **Dr Hussain:** It does not tend to be one person. It might happen through anecdotal patient interaction, where someone has complained and said, ‘Well, the waiting time is too long; what can you do for me?’ If there are funds available for that financial year, it might come up for discussion at a practice meeting, and someone might say, ‘Yes, let’s invest in this 24-hour ECG monitoring equipment, so that our patients have better access to this and shorter waiting times.’

[188] **Lindsay Whittle:** Good morning, Dr Hussain. Thank you for sparing the time to come to see us. I am aware that GPs probably have visits from salespeople from the larger drug companies, urging them to recommend a particular drug for their patients. Do you have similar salespeople coming to advise you, not on the major technology machines but on the smaller machines that you mentioned—the machines for ECGs, blood pressure et cetera?

[189] **Dr Hussain:** Again, I have not come across any personal contact with sales representatives from the medical technology side of things, and I am not aware of it, per se. However, on the pharmaceutical side, yes, that is definitely more prevalent.

[190] **Lindsay Whittle:** How do these new machines come to the attention of the GP sitting in her or his surgery at the edge of the Valleys?

[191] **Dr Hussain:** Again, it is difficult to say. It probably happens more on an ad hoc basis. A sats monitor, which may cost £20, is something that I just decided to invest in myself because I thought that it would be useful on home visits. It was not a case of a sales rep coming to me. It was just through my observing what a useful piece of equipment it was at other practices as a central piece of equipment available in that practice.

[192] **Lindsay Whittle:** I see. Thank you.

[193] **Kirsty Williams:** Dr Hussein, a lot of the discussions that we have had in the committee so far has been focused very much on big pieces of kit in secondary or tertiary care. Could you give us an understanding of the potential for investing in technology in primary care, and what that might mean for improved patient outcomes or experiences? Could it potentially take pressure off secondary care services if we could do more in primary care settings?

[194] **Dr Hussain:** Absolutely. I think that you have hit the nail on the head. In general practice, we are in such a privileged position because we can access the masses. So, the opportunity to invest in lower cost technology that may have a huge impact on the economics and the patient safety aspect of things would have huge potential. One example is the opportunity for near-patient testing, but this would need to be researched. That is the main thing that is lacking. On paper, it sounds like a good idea, but somebody needs to look into the quality of the evidence for it from a clinical aspect and an economic aspect and, as well as that, what the patients want. They are an important factor in this, and if a test or a technology is not acceptable to them, there is no point getting all excited about the theory of it and bringing it in. It is not uncommon for people to get excited about equipment like the 24-hour ECG monitoring, invest hundreds and thousands of pounds in it and for it just to be sitting there because of a lack of training or understanding of how to interpret the information that it gives.

11:30

[195] However, potentially, I think that things like near-patient testing would be fantastic. From a patient point of view, accessing a service that is close to home avoids an unnecessary hospital admission for which they may be waiting for hours and where they may pick up other

infections while they are there. This is particularly the case for things like troponin testing, which is a test to check for heart attacks, and deep vein thrombosis screening tests that are near-patient tests. Again, from clinical experience, the patient does not want to go in, but I do not want to miss something as serious as a heart attack, which does not always present with a crushing chest pain; it may just be a little bit of heartburn, and I have seen people having rip-roaring heart attacks with that. So, if I had access to a near-patient test that was acceptable to the patient and that was going to say with a high degree of specificity and sensitivity that it is or is not a heart attack, then that would be absolutely fantastic.

[196] **Kirsty Williams:** So, if we were able to enable GPs to do more of that kind of diagnostic testing in their surgeries, or perhaps in small community hospitals, would there be a need to develop links so that the GP could not only have a look at the results, but have the technology that might allow them to send that to a secondary care centre or a specialist centre to have those results interpreted by a consultant or—

[197] **Dr Hussain:** It depends what the technology is, because if it is a straight positive/negative test, then that probably would not be necessary. However, again, I suppose that that ties into the integration of IT systems within secondary care. So, for example, if you had a patient with complex diabetes care, if you could somehow link the results of a near-patient test for their diabetes control with the HbA1c test and the secondary care physician was automatically made aware of that, then that would definitely decrease the amount of paperwork and administration required for that.

[198] **Kirsty Williams:** May I ask about your experience of being able to access records across systems? Recently, I was lucky enough to see a GP who could access hospital records, which made a big difference to his understanding of what was going on, but previous GPs had not been able to do that. Could you tell us about some of the barriers that you face as a GP, trying to access patient records, maybe across the healthcare experience or the healthcare history?

[199] **Dr Hussain:** Sure. Within the Aneurin Bevan trust, we have something called the Clinical Work Station portal, which has been revolutionary, to be honest with you, and I think that that is a great starting point in order to take the development of technology forward. It is amazing how little information patients know, first, about even what their disease is and, secondly, the medications that they take—they say, ‘Oh, it’s the little blue tablet, Doctor,’ and I have no idea what that is. It is going to make a huge difference to my plan of action, because if somebody has had a heart attack—it is quite common for people not to know whether they have had had a heart attack or not, and they are coded on the computer as having ischaemic heart disease—that is going to be a huge factor in my decision-making processes as to whether to admit a patient who may sound like he has some gastric pain, but because of the previous history, is at a higher degree of risk for having a heart attack. So, it has been revolutionary, to be honest with you, especially with our ageing populations, if they do not have community support or family support or have memory issues, or if they are not sure what their diseases are, when they last saw the doctor and what investigations they have had. So, the beauty of that is being able to avoid replication of unnecessary investigations, and saving money that way, and to look at images, potentially, as well as up-to-date letters from outpatient clinics.

[200] The only thing that is sometimes questionable is the quality of the discharge summaries. They have improved, I must say, because, with some of them, they have to write exactly what happened during the admission of the patient, but, sometimes, it is just a case of having a list of drugs that have been changed or updated. I definitely think that there is room for more improvement from that point of view, particularly from the point of view, again, of introducing the patient into the equation, because we have a number of appointments with patients coming to us and asking, ‘When is my appointment for this?’ and we have access to

that information via the CWS, but it is a wasted appointment and a waste of our resources. They could be introduced into that so that they can chase up their appointments and have an idea about waiting times to save time, from our point of view.

[201] **Kirsty Williams:** That is interesting. Thank you.

[202] **David Rees:** Elin wants to come in on this one, I think.

[203] **Elin Jones:** It is not particularly on this, but you have reminded me that, although I do not have memory loss, I would not be able to tell you what the names of the tablets that I took this morning are; I would probably say that one was a large white one and one was a little white one. Anyway, I digress. What you have described to us already in terms of the adoption and take-up of new diagnostic machines by GPs sounds very ad hoc; it does not seem strategic at all. I would have hoped that you could have told us that the local health board looks at what the GP practices could be doing in a different way—you mentioned deep vein thrombosis testing—so that they could give advice to their population. For example, if you had a concern around DVT, you could go to the GP and not to casualty, because your local GP practice would be able to test you. However, that does not seem to exist at all; it seems to be left to individual GPs or to individual practices. How do you think the system could be improved and does it need to be improved in terms of making local health boards more proactive in how they are either persuading or funding GP practices to invest in particular pieces of kit?

[204] On the funding, would you say that GP practices would expect that anything that they were asked to do by the local health board would necessarily have to be funded by the local health board? Would they see that advice to all GP practices that they should invest in DVT testing kit would be the responsibility of the GP practice, or would it have to be funded by the LHB?

[205] **Dr Hussain:** To answer the first part of your question, we definitely need a strategy for this and there are multiple facets to that. We need investment in the research of it, because, as I said, it may sound like a good idea on paper, but we need to look into the economics of it and the quality of it. We have seen with the recent problems with metal-on-metal hips, as well as PIP implants, that not all technology is good. So, we need good-quality technology and someone to oversee that, as well as to appraise the ongoing process, so that, when something new turns up to replace the old, we know whether it is worth investing in that or continuing with the old version. So, we definitely need a strategy from that point of view. We have the AWMSG, which oversees the drug side of things, and there could be a similar arm overseeing the medical device side of things to appraise that. Perhaps it could go on to make a tariff bank of the kind of things that it thinks are cost-effective and clinically effective, which could be filtered down to local health boards for them to decide what they want to invest in.

[206] It is a difficult thing, because everyone's pocket strings are tight, and there has to be a cost-effective side to it as well. GPs care for their patients as well, and if it is within their abilities to help patients as best as they can, even if that comes from the practice income, I would not have a problem with that. However, it depends, obviously, on the level of investment that is required. For example, with the near-patient DVT test kits, I think that the consumables cost about £10—that is to replace the cartridge. When you look at that compared with an in-patient admission, which may cost from hundreds of pounds to thousands of pounds, as a GP, I would think that that is cost-effective and it will be clinically effective as long as there is someone to check that within the research, and my patient will be happy, rather than me having to sit there for 10 minutes plus sometimes just trying to get through to medical admissions, for a simple, 'Hello, can you see this patient to rule out a DVT?'

[207] So, we definitely need an overall strategy. At what level that happens, it is difficult to be certain, because, yes, at the moment we have overall guidance from NICE, but, looking into that, it has 16 published medical devices, but only two of them are relevant to general practice. One was related to a blood test for testing for heart attacks, but in its writings it says that there is no evidence at the moment to suggest that it is better than what is already available. The second device, which I think has huge potential, is the blood pressure machine that also detects atrial fibrillation, which affects 1% of the population and, at the moment, there is no screening for that. Again, that is ad hoc. So, if we can buy a £100 kit to potentially save many from strokes and the morbidity and mortality associated with that, then it would make sense. However, somebody needs to be checking the quality of the evidence for this.

[208] **Darren Millar:** I am really grateful for this evidence, as it shows that there is huge potential, really, in primary care to avoid further pressures on secondary care and to reduce diagnostic waiting times in particular. However, I am a little bit concerned that, while it might be easy for larger practices to invest and train members of staff—nursing staff, even—within practices to undertake some of these diagnostic tests, in small rural practices, or satellite practices as they sometimes are—little branches of a larger surgery down the road—this might not always be available. So, how do we overcome that in Wales to make sure that there is equal access for everybody, no matter where they might live?

[209] **Dr Hussain:** I think that is where the strategy planning comes into it. I think you have to separate it into the less expensive technologies, with regard to which GPs, potentially, could be left to their own devices to decide whether they want them or not, versus the more expensive technologies that, by virtue of their price, will not be available in every practice. So, it would be a case of, perhaps, developing neighbourhood networks within that, or communities saying, ‘This one device serves your area’, or ‘This is the specialty practice that deals with this condition’.

[210] I am doing some work at the moment on the provision of long-acting reversible contraceptives, and I did a questionnaire with the doctors in the Aneurin Bevan Local Health Board to see who exactly is providing Mirena coils as a form of long-acting contraception. Surprisingly, about 10% of the doctors—and there were approximately 85 respondents—are still referring patients to hospital to obtain this device. So, thinking about the economics of that, it is not really viable. If, for example, we invested in £100-or-so-handheld ultrasound units and if there was one centre that did ultrasounds on ladies who were at high risk of endometrial cancer, for example, and people were referring patients to that centre and someone was trained to do the coil, you could have a separate satellite clinic doing that, which could divert patients from going into hospital and avoid waiting times from that point of view. That is something that I am keen to be working on, and we are still working through that at the moment.

[211] **Darren Millar:** You are obviously young, keen and enthusiastic and want to embrace change, but a large part of the GP workforce is perhaps older and stuck in its ways, and reluctant even to adopt new technologies or to change their working practices and will want to continue, as you have just clearly indicated, to refer people to secondary care. So, how do you think we can persuade that sort of GP to adopt and embrace the sort of change that you are clearly embracing in the way in which you work? It seems to me—and this is a perspective from outside the NHS—that GPs are largely motivated by their pocket, or can be, and that there may be a role here for some sort of direct enhanced services to be developed in order to promote the sort of activity that you are suggesting ought to be the norm.

[212] **Dr Hussain:** I probably would disagree with that. Looking back over the last 20 or 30 years, GPs have evolved and have adapted to whatever has been thrown at them, particularly from an IT point of view. General practice is one of the most developed specialties with regard to IT. Many developments have come through, and GPs have changed and adapted to

that from that point of view. Anybody is reluctant to change, but it is about setting out the proposal and saying, 'Look, this is beneficial for your patients, it is quality based, it is evidence based, and it will make a difference'. We care about patients further down the line as well, and we appreciate that we are in a key position to try to help to make savings by avoiding things being passed to secondary care, but it works both ways: if you are moving things into general practice, there is the question of who will fund it. Enhanced services may be a way of doing that, for example, because it has to come out of someone's pocket, in a sense, does it not? However, I believe that GPs would be keen, from that point of view.

[213] Time is the other factor that can go against these things. So, again, with increasing comorbidity and the increasing age of the population, if I have to deal with someone's asthma or diabetes and there is a query of a DVT, if the technology takes 10 or 15 minutes to give an answer, it is just not feasible to deal with all of these things in a 10-minute capacity, as a GP. So, it has to be feasible as well.

11:45

[214] **Darren Millar:** In terms of what you have just said, obviously, you are doing lots of these things on a voluntary basis, because you are keen to trial this technology in your own working life. Other GPs would need to be motivated through contracts, direct enhanced services, et cetera, and I accept that. However, on this issue of capacity, this is where, potentially, it falls down, does it not? We know that there are already workforce pressures in Wales in the GP workforce and that, in some parts of Wales, it is difficult to recruit. So, is there scope here for expanding the nursing workforce, the technician workforce and the healthcare support workforce in GP practices in order to deliver these sorts of tests?

[215] **Dr Hussain:** Absolutely. I agree with you. Again, that is the strength of general practice—the multi-disciplinary team. Another person to include in that would be the pharmacist, for example. At the moment, pharmacists are doing random checks of blood pressure, but there is no reason why they could not be trained up to near-patient testing of cholesterol or diabetes and such things. So, I think that we could definitely draw upon all team members. It does not necessarily mean that it has to be the GP who offers that.

[216] **David Rees:** Could I expand on something before I call Rebecca in? You talked about the development of individuals. Is the royal college a member? Does it set standards to ensure that some new technologies may be part of the process of development of GPs, particularly with regard to the revalidation process? Is it looking at whether it should make some form of usage of new technologies, or changes in approach, part of that revalidation process?

[217] **Dr Hussain:** Again, not as far as I am aware. That is something that I will go away and look into and write back to you about. However, the fact that the technology is in existence does not mean that it is good, in a sense, so, at the moment, it is not part of our revalidation that you must use a certain technology, or be involved in its development or anything like that, as far as I am aware.

[218] **David Rees:** Thank you. Rebecca is next.

[219] **Rebecca Evans:** You mentioned the importance of an evidence base before adopting new technologies. Does it concern you that the threshold for evidence for new technologies to be adopted is so much lower for the technologies than it is for drugs, for example?

[220] **Dr Hussain:** Yes, absolutely, because if the evidence is not rigorous then on what basis are you using that? So, again, that needs to be addressed in the strategy planning of how we are accepting devices from the market. I think that it is an area where the status quo needs

to change from that point of view.

[221] **Rebecca Evans:** To what extent are GPs involved at the moment in the appraisal of new technologies?

[222] **Dr Hussain:** Again, as far as I am aware, I do not think that we are.

[223] **Rebecca Evans:** I also wanted to ask whether there is any kind of audit—I think that I can guess the answer—of the kind of new technologies that GPs are using. Does anybody know who is using what, where?

[224] **Dr Hussain:** Again, as far as I am aware, no.

[225] **David Rees:** You are a unique opportunity for us in one sense, because you said that you work in west London as well. Do you see differences between the work that you do in Wales and the work that you do in west London, in the sense of the use of technology, access to technology, and perhaps the funding of technology?

[226] **Dr Hussain:** I can probably just comment on the access and the use of it. I am not too au fait with the funding side of things. To be honest with you, I think that my experience has been better in Wales. I have been working in west London, and they do not even offer blood testing in the surgery or ECGs; you have to go to the central hospital to have a blood test or an ECG done. So, that shocked me a little, because every practice here in Wales does its own blood tests. They have access to all of the simple equipment, such as defibrillators and ECGs, but, for example, the thing that sticks out for me here is the advancement of the telemedicine services with regards to dermatology. I have not seen anything like that in London.

[227] **David Rees:** I will highlight, obviously, that London is a large area and you are talking about a single practice. However, I just thought it was an opportunity that we would take, that is all. Do any other Members have questions? No. In that case, I will ask a question that we always ask our witnesses: as a practising GP, in this case, if you had one recommendation that you would want the committee to consider in this approach to looking at access to medical technologies, what would it be?

[228] **Dr Hussain:** Definitely, it would be the potential for the development of the near-patient testing equipment, because I think everybody will benefit from it. There will be an economic saving and there will be a patient satisfaction increase, as well as, hopefully, clinical improvement from that point of view, as long as things are researched and assessed appropriately.

[229] **David Rees:** Do you think that that would be best done by a central body that does that on behalf of GPs across Wales?

[230] **Dr Hussain:** Yes, I believe so. I think it is better to have an external, independent body doing that. Whether that body is responsible for the commissioning, I do not know. It is difficult, but, I suppose, as long as they are independent, there should not be an issue with regard to conflict of interest. With everything else going on, it just would not be feasible to expect GPs to be commissioning and researching the appropriateness of new medical devices, although we definitely would be keen on having an input or discussion about it.

[231] **David Rees:** I am going to ask the final question. Clinical audit was mentioned this morning, so, are GPs involved in clinical audit as well?

[232] **Dr Hussain:** Yes, absolutely.

[233] **David Rees:** I just wanted to clarify that, because we talked about the larger hospital and health board side of things and I just wanted to know the involvement at GP level.

[234] **Dr Hussain:** With regard to medical technology, no, we are not involved, but it is part of our revalidation that you must perform an audit every five years. That is normally in-house, looking at referrals or quality standards, with regard to NICE information, for example.

[235] **David Rees:** So, the introduction of clinical audit for modern technologies would be something that you could actually follow into quite easily.

[236] **Dr Hussain:** Yes, absolutely. If, for example, the blood pressure machine that detects atrial fibrillation was introduced, it would be very easy to do an audit of how many people were picked up and what interventions were made.

[237] **David Rees:** Okay. Thank you very much for your time this morning and for your evidence. You will get a copy of the transcript to check for any factual inaccuracies that may exist, though we hope that they do not. Once again, thank you very much.

[238] **Dr Hussain:** Thank you very much for the opportunity.

11:52

### **Papurau i'w Nodi Papers to Note**

[239] **David Rees:** The papers to note are the minutes of the meeting on 6 March. Are you happy to note those? I see that you are. Before I go on to the next item, I would like to remind Members that the next meeting of the committee will be on Wednesday 26 March, when we will be taking evidence from the Minister for Health and Social Services on the inquiry into the availability of bariatric services.

[240] **Elin Jones:** May I raise a point, which is about the Minister? We are about to launch our Healthcare Inspectorate Wales report. I have just seen a statement that has been sent to us by the Minister on health inspection. He has just sent that out now; I have just seen it on my e-mail. He will know, I expect, that we are about to launch our report and he has sought, in advance of the publication of that report, to put his views on changes to health inspection a few minutes, really, before we launch our report to the press. I cannot recall a Minister as proactively, or pre-emptively, striking first on an issue such as this. I think that we should write to him to say that it would have been courteous of him to have seen our report first before putting out such a statement, which responds to a number of the concerns and issues that we have raised in our report. [1]

[241] **David Rees:** I will, I think, write to him—

[242] **Elin Jones:** In fact, I have seen it on Twitter, rather than e-mail, sorry. I have just seen it on Twitter.

[243] **David Rees:** I will write to the Minister on behalf of the committee, seeking clarification as to the timing of the release. However, obviously, we also are aware that, unfortunately, the report was leaked over the weekend and the BBC ran with the report on Tuesday. We therefore provided the Minister with an early copy of the report as a consequence of that, as we did with HIW. I will seek clarification as to why we were not provided with the opportunity to see the response in the first instance.

[244] **Kirsty Williams:** You have just got it on Twitter, have you? I do not have anything on e-mail.

[245] **Elin Jones:** Sorry, it is on Twitter, not on e-mail—

[246] **David Rees:** Before we go any further, is it satisfactory, Elin, that we write to the Minister?

[247] **Lynne Neagle:** Can we also place on record our unhappiness as a committee that this leak took place? In the whole time I have been here, I have never known a committee report be leaked like that. We always operate on a cross-party basis on the basis of trust. It is really worrying that this has happened. It will affect our engagement with future inquiries plus our engagement with the BBC.

[248] **Darren Millar:** Chair, I would like to say—

[249] **David Rees:** In a second; I will call on you. We will put that on record. I will let Darren have his comment.

[250] **Darren Millar:** I completely second the statement that Lynne has made. It is disappointing that there was a leak from this committee. I do not know whether it was a Member or a member of support staff. It was not very comfortable reading to wake up, as a committee member, to the fact that the BBC had obviously seen a copy of the report or part of the report. I have not known that to happen in any committee since I have been an Assembly Member. It is disappointing that the Minister has chosen to issue a statement to the media without first letting this committee know of his response, and it looks as though this is a response to the report in some way.

[251] There are times when, on other committees, there appears to be—how can I put this?—the impression that Ministers sometimes have a heads-up on the contents of a report in advance of it appearing in the media, because very often we see responses from them to all sorts of committees, including the Public Accounts Committee in the past. That is a practice that we somehow have to avoid as committee members as well.

[252] **David Rees:** I clarify, as I stated earlier, that the Minister had a copy of the report after the leak. We felt it would be inappropriate for him not to have a copy once the leak had been made. We will put on record the committee's disappointment at the leak. I also assure you, as I understand it, that this is the first time that this has happened in the Assembly. The Presiding Officer is also very disappointed that this has happened. As a committee, we need to look at that, but we will do that in a private session.

[253] **Elin Jones:** May I also make the point, in having had the privilege of seeing the report two days before its release, it is very disappointing that the Minister has used that privilege to—

[254] **David Rees:** You have made that point and we will write.

[255] **Darren Millar:** It is discourteous of the Minister not to give us a heads-up on his announcement today, given the fact that we were courteous in providing him with a copy.

[256] **David Rees:** Darren, the point has been made. I have answered the question and we will respond.

[257] **Darren Millar:** Will it be a written response?

[258] **David Rees:** We will write to the Minister.

[259] **Darren Millar:** Will that be shared with committee members before it is issued?

[260] **David Rees:** It will be shared with committee members before it is issued, by e-mail.

[261] **Darren Millar:** That is fine.

[262] **Elin Jones:** Or Twitter.

11:58

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Eitemau  
1 a 2 yn y Cyfarfod ar 26 Mawrth**  
**Motion under Standing Order 17.42 to Resolve to Exclude the Public from the  
Meeting for Items 1 and 2 of the Meeting on 26 March**

[263] **David Rees:** Before I close the meeting, I move that

*the committee resolves to exclude the public from the meeting for items 1 and 2 of the meeting on 26 March, in accordance with Standing Order No. 17.42(ix).*

[264] Are you happy with that?

[265] **Darren Millar:** What are those items?

[266] **David Rees:** The items are our approach to the inquiry into the Welsh Government's cancer delivery plan and our forward work programme for the summer term. I see that Members are content. Thank you.

*Derbyniwyd y cynnig.  
Motion agreed.*

*Daeth y cyfarfod i ben am 11:58.  
The meeting ended at 11:58.*

[1] It was clarified after the committee's meeting on 20 March that the ministerial statement to which Members referred related to new arrangements for dealing with serious concerns about NHS services and organisations. These revised arrangements emanated from work undertaken by the Wales Audit Office and Healthcare Inspectorate Wales about governance arrangements in Betsi Cadwaladr University Local Health Board.