



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

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

**Dydd Iau, 8 Mai 2014
Thursday, 8 May 2014**

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynndi 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

Bryan Beardsworth	Arweinydd Gwasanaethau Deintyddol, Bwrdd Iechyd Lleol Hywel Dda
Karl Bishop	Dental Services Lead, Hywel Dda Local Health Board Cyfarwyddwr Meddygol Cyswllt, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Associate Medical Director, Abertawe Bro Morgannwg University Local Health Board
Mark Drakeford	Aelod Cynulliad, Llafur (Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (The Minister for Health and Social Services)
Ifan Evans	Dirprwy Gyfarwyddwr, Arloesi Gofal Iechyd, Llywodraeth Cymru
Stuart Geddes	Deputy Director, Healthcare Innovation, Welsh Government Cyfarwyddwr Cymdeithas Ddeintyddol Prydain yng Nghymru Director of British Dental Association in Wales
Yr Athro/Professor Huw Griffiths	Pwyllgor Cyngorol Gwyddonol Cymru Welsh Scientific Advisory Committee
Christine Morrell	Prif Ymgynghorydd Gwyddonol (Iechyd) Dros Dro, Llywodraeth Cymru
Peter Nicholson	Acting Chief Scientific (Health) Adviser, Welsh Government Orthodontydd Ymgynghorol, Ysbyty Brenhinol Morgannwg a Chymdeithas Orothodontig Prydain Consultant Orthodontist, Royal Glamorgan Hospital and British Orthodontic Society
Yr Athro/Professor Stephen Richmond	Athro mewn Orthodonteg, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro a Chymdeithas Orothodontig Prydain Professor of Orthodontics, Cardiff and Vale University Local Health Board and British Orthodontic Society

Warren Tolley	Cynghorydd Deintyddol Gofal Sylfaenol, Bwrdd Iechyd Lleol Addysgu Powys a Chymdeithas Orthodontig Prydain Primary Care Dental Adviser, Powys Teaching Local Health Board and British Orthodontic Society
Yr Athro/Professor John Watkins	Pwyllgor Cynghorol Gwyddonol Cymru Welsh Scientific Advisory Committee

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

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

*Dechreuodd y cyfarfod am 09:15.
The meeting began at 09:15.*

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

[1] **David Rees:** Good morning and I welcome Members to today's meeting of the Health and Social Care Committee. The meeting is bilingual; headphones can be used for simultaneous translation from Welsh to English on channel 1 or for amplification on channel 0. I remind Members to switch off all mobile phones or any other electronic equipment that may interfere with the broadcasting equipment. In the event of a fire alarm, there is not one scheduled for today, so please follow the directions of the ushers. We have not received any apologies. We will go into today's business. I remind Members that we have the morning session to have the final evidence session for the inquiry into access to medical technologies, and this afternoon we will have the first evidence session for our inquiry into orthodontic services.

09:16

**Cynnig o dan Reol Sefydlog 17.42(ix) i Benderfynu Gwahardd y Cyhoedd o'r
Cyfarfod
Motion under Standing Order 17.42(ix) to Resolve to Exclude the Public from
the Meeting**

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

the committee resolves to exclude the public for item 3 in accordance with Standing Order No. 17.42(ix).

[3] I see that the committee is in agreement.

*Derbyniwyd y cynnig.
Motion agreed.*

Daeth rhan gyhoeddus y cyfarfod i ben am 09:16.

The public part of the meeting ended at 09:16.

*Ailymgynullodd y pwyllgor yn gyhoeddus am 10:03.
The committee reconvened in public at 10:03.*

**Ymchwiliad i Fynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn
Dystiolaeth 15
Inquiry into Access to Medical Technologies in Wales: Evidence Session 15**

[4] **David Rees:** May I welcome the public back to this morning's session of the committee's meeting? We move on to our evidence session on access to medical technologies in Wales. I welcome Professor Huw Griffiths and Professor John Watkins, both from the Welsh scientific advisory committee, which advises the Minister and the Welsh Government. Good morning and welcome. We will go straight into questions if that is okay with you, and I will start with Gwyn Price.

[5] **Gwyn R. Price:** Good morning, both, and welcome. You are one of several committees approved by the Welsh Government and I was wondering whether you could tell me the functions that you fulfil, for example, on horizon scanning and identification of new technologies. How is your programme of work decided?

[6] **Professor Griffiths:** The Welsh scientific advisory committee is a network of professionals covering all the sciences related to healthcare. As you say, we are constituted to advise the Welsh Government. So, each member of the committee will have their own professional contacts, research interests and clinical interests and I think that everybody has a full-time NHS job. I am not sure whether there is anybody who is full-time university, although some of them are university employees, but they have a clinical commitment. So, people are horizon scanning all of the time, through their professional contacts and research interests. Research conferences are a very good vehicle for that. Therefore, the committee is in a good position to alert the Welsh Government to the latest developments and how they are being used clinically, perhaps experimentally, in other areas of the world. So, that is the horizon-scanning function.

[7] In terms of our programme of work, we have a forward work programme in the committee and that is documented. I am not sure if it is on the website, but it is certainly available. That is revisited at every one of our four-monthly meetings. There are also action points, so it is quite an active programme of work. That is in addition to the normal actions from each meeting, which are documented in the minutes.

[8] **Gwyn R. Price:** You look at the identification of new technologies as they come along.

[9] **Professor Griffiths:** We do. In fact, last October, we held a very successful symposium just over the way in the Pierhead building. That was specifically to address new technologies. We knew that this inquiry was taking place because you had already issued your gathering of—I forget the exact terminology, but it was when you were drawing up your terms of reference, and you invited comments on the terms of reference.

[10] **David Rees:** It was a call for evidence.

[11] **Professor Griffiths:** Yes. So, we knew that that was coming. We had also had the idea of doing our very first symposium and making that on new technology because several headline-grabbing new technologies have been implemented in Britain and now in Wales,

such as some of the advanced radiotherapy techniques. So, those two things combined made it very clear to us that we should make our symposium on new technologies in healthcare, with six specific questions for speakers to follow, such as barriers and the appraisal processes. That was a very good symposium and the symposium report and the abstracts are on the Welsh Government website, on our web page.

[12] **David Rees:** Could you clarify as to how you prioritise the work of the advisory committee?

[13] **Professor Griffiths:** I am not sure that we have a rigid system of priorities. There are certain things that naturally come out as high priority. A recent example is a paper, which we published as a guidance document on the website, on the reporting of critical, unexpected and untoward findings in radiology. There would be no disagreement whatsoever on that being a very high priority item because there have been several incidents in NHS Wales when either a scan had not been reported in a timely way or it had been reported and the report had not got to the referrer in time; I believe that there was one patient fatality as a result of this. So, that naturally came to the top as a very high priority issue very swiftly. Certainly, I, as chair, did a lot of work out of committee on that with the radiologist on the committee. So, I think that the prioritisation happens naturally. We do not have a rigid system.

[14] **Rebecca Evans:** Gwyn Price's first question referred to the six advisory groups—the seven advisory groups, sorry. How does your group interact with the other six? Do you have any formal mechanisms for sharing information or joint working?

[15] **Professor Griffiths:** Yes, we do. I should explain that I am the immediate past chair; I stood down as chair of the Welsh scientific advisory committee on 11 March. My successor, Professor Julian Sampson had a previous commitment today and could not come, so I am grateful to my colleague, Professor John Watkins, for accompanying me here.

[16] I, as chair, have had a seat on the Welsh medical committee, which I attended regularly. That was a very useful source of information. It created a two-way flow of information and was good intelligence gathering for me. We have a Welsh medical committee representative on the Welsh scientific advisory committee. We do not formally have representatives of the other advisory committees, but I used to attend the Welsh therapies advisory conference and there used to be a good flow of information via the chief scientific advisor for health, who also has a remit for therapies.

[17] **Professor Watkins:** I sit on the Welsh scientific advisory committee as a representative from Public Health Wales, but I also chair the public health national service advisory group. Many of the other committee members have cross-membership into other areas.

[18] **David Rees:** Does that therefore avoid duplication of work, or does duplication still occur?

[19] **Professor Griffiths:** I do not think that there is much duplication between our committee and the other committees. There may be a little between some of the NSAGs—the national specialist advisory groups. Some of that co-operation works very well indeed. For example, there has been a report that represents a large amount of work on radiotherapy capacity in Wales, which, again, has just appeared on our website. I am sure that Members are well aware of the fact that in Wales we are lagging behind England and Europe in terms of the number or fractions of radiotherapy per head of population. There are various reasons for that, some of which are not fully understood yet. So, that is an ongoing piece of work. That was the fruit of a very good collaboration between the clinical oncology sub-committee of the Welsh scientific advisory committee and the cancer NSAG. With other NSAGs there is not

such good contact, and that is being addressed as part of the review that is under way at the moment of the advisory structure. So, that is a concern that has been raised, and there is room for improvement.

[20] **David Rees:** The reason that I ask is because, clearly, you have just told us about the radiotherapy work that you have undertaken, but we are keen, obviously, to look at where that leads into the access to technology as a consequence of the evidence that you find. What happens as a consequence of that report, and where do you advise on technologies?

[21] **Professor Griffiths:** The advice on technologies goes through a number of paths. We have a direct line of advice to the Welsh Government through the chief scientific adviser for health. John is on the All Wales Medicines Strategy Group.

[22] **Professor Watkins:** In terms of the way that other things are handled in terms of technology appraisal, my experience is that I sit on where the National Institute for Health and Clinical Excellence technology appraisal committee—which generally appraises medicines—is nationally, and I also sit on the All Wales Medicines Strategy Group. In fact, we had a meeting yesterday, which I chaired. The process by which those sorts of committees work is that the work plan is sort of externally defined; so, in other words, the National Institute for Health and Care Excellence technology appraisal, which defaults generally down to medicines appraisal, is defined by NICE being asked either by the Department of Health or by others to look at particular therapies. The All Wales Medicines Strategy Group works in a slightly different way in that the routes into that can be via governmental things, or it can be via other bodies in the pharmaceutical industry itself. So, that is the way that it comes in. The Welsh scientific advisory committee tends not to have that programme, and there is not actually a clear mechanism either within Wales or within the UK of how all technologies enter. Quite a lot of things enter by them suddenly being invented or produced and then starting to get used. The evidence and machinery for effectiveness, and the publication of that evidence in peer-reviewed journals, are not necessarily as clear-cut for the sorts of technologies that are not therapeutics, really.

[23] **David Rees:** Kirsty has a keen interest in radiotherapy. Can you come in on this one? Lindsay will then come in.

[24] **Kirsty Williams:** Thank you. The issue of intensity-modulated radiation therapy and the frustrations that clinicians had about getting this technology into Wales when there was a clear clinical benefit to patients to have it was one of the reasons why I was particularly interested in taking this inquiry forward. It seems to me that the IMRT experience shows how not to do it in Wales. I am just wondering, as a result of that experience, whether you could give us any guidance of how we could prompt the Welsh Government to create a system that would allow for faster take-up of technology where the efficacy and the appropriateness of it was not in question, so that the process of getting it into Welsh hospitals or for Welsh patients could be sped up or be more strategic and streamlined than the IMRT example was.

10:15

[25] **Professor Griffiths:** I think that the first part went very well, because the then Minister for Health and Social Services, Edwina Hart, was very supportive. The need for IMRT and its potential benefits were highlighted through the WSAC, through the clinical oncology sub-committee in the way I described—by people knowing what is happening elsewhere in the world and being aware of the data. When the capital moneys had been provided and it came then to asking the health boards to provide revenue, I think that there was quite a delay. I remember discussions in my own health board about where the revenue was going to come from, and I do not want to blame the health boards for everything but I know that the overall delay was something like two to three years. When it arrived in my own

health board—and I am speaking now as an employee of the Abertawe Bro Morgannwg University Local Health Board—there was not the scientific resource to commission the IMRT and to set up all the infrastructure that there had been in Velindre, for example. So, it was all very piecemeal. I am pleased to say that people worked very hard and worked extra hours to do it, but it was quite a painful process. Do you want to add to that, John?

[26] **Professor Watkins:** I think that, looking at the sort of well-honed machinery we have now for managing the introduction of medicines, especially very high-cost medicines, one of the reasons for doing that in the first place was around getting rid of the postcode lottery of the provision of services. The way that that now comes along is that, once NICE or, for that matter, the All Wales Medicines Strategy Group in Wales recommends a therapy, there is a sort of mandatory emphasis for health boards to provide that. By and large, that is generally then provided within current resources and there is an expectation that people will have access to it. However, it does not necessarily have the huge step cost of some technologies. Quite a lot of technologies that are not medicines will come in with a huge capital cost at the front end and then decay over time.

[27] So, I think that the difference between these two, if you wish to introduce them, is actually that there needs to be some mechanism—. You can have the technology appraisal that says, ‘This is really good’. I have put down that they tend to fall into three areas, really. There will be testing and diagnostics-type things; there will be interventional-type technologies; or there will be disruptive innovations, such as keyhole surgery and things like that or robots or other things that change the way that you actually do things. Now, the evidence base is less than clear-cut for those to start with, as opposed to medicines, and the step cost is probably quite high as well. However, you could set up a mechanism, if you can answer those first two bits, where you could sort of mandate things and say, ‘This is something that the population of Wales should have and there is an expectation that health boards will provide it.

[28] **David Rees:** Is there a problem with the fact that we often look at some of the technology and look at the capital costs initially when there is also an issue of the revenue, the training and the development. Is that not always taken into account in the appraisal of the technology?

[29] **Professor Griffiths:** Yes, and it is not a new problem. It certainly is a problem. The very fact that it was taken up at different speeds in the different health boards—. Having local choice is a very good thing in many ways, of course, but, in this case, some were a lot slower to take it up than others. There was the argument that, because IMRT conforms the radiation dose field much more closely to the tumour—which is how you can escalate the dose in the tumour region and spare the surrounding tissue—it would provide more effective treatments, which would mean that there was less recurrent disease and, eventually, it would save money. However, that was really a very tenuous argument. The main benefit of doing it is a better quality of treatment for the patient. So, I think that funding the revenue tail is a big problem.

[30] **David Rees:** Is your question on this issue, Leighton?

[31] **Leighton Andrews:** Yes. I was interested in Professor Watkins’s characterisation of different kinds of technological innovation, ranging up to what you called ‘disruptive innovations’. In any field of technology and any field of public service, it is actually quite difficult to identify what is going to be a disruptive innovation, as distinct from others. I just wonder what kind of processes you went through to make that kind of judgment. This is not a simple process.

[32] **Professor Watkins:** In coming up with those categorisations, I was just looking back, perhaps even over the last five to 10 years’ time window, at the sorts of ways in which

technology has moved on. I think that the digital age and the coming together of computing power with ways of sharing information have completely revolutionised this. However, disruptive information is almost a retrospective look, is it not, because with most of the disruptive innovations, if you think about it, such as the iPads that many of us have around the table, we did not know that we wanted them until some three years ago, when they were invented?

[33] **Leighton Andrews:** I can understand why it is easier to look back and say, ‘That was disruptive’. The difficulty always is trying to identify what might be disruptive, going forward. Does your horizon scanning, then, embrace a look at technologies that might radically alter delivery, as it were?

[34] **Professor Watkins:** Absolutely, but you are not quite sure whether something is a false dawn or a real innovation until you actually put together a pool of evidence. That is why there have been many false starts in therapeutics, for example: the cures for cancer, the turning back of chronic disease and the potential benefits of stem cells for new organ generation. They have all been false dawns in many ways, so the important thing is that if something is, potentially, a new way of doing things, then it needs to have a process that is threefold: the first is identification of what it is and its science base; the second one is going to be around the development of good studies that will show whether this truly is a disruptive innovation, its effectiveness and where it sits; and the third one is how you bring that into practice. The two dimensions of technology innovation that both NICE and the All Wales Medicines Strategy Group look at are not only the effectiveness, but the cost-effectiveness. So, if you have a new technology that comes in—I am thinking back over the last six months, and one of the most difficult appraisals that we have had has not been on the drug that costs £1 million and buys you a week of life; that is not a difficult decision. The difficult decision is the drug that costs a penny more and does not have much of a benefit, but is a different way of doing things. So, as an example of that, we looked at a new therapy for diabetes. Diabetes comprises 15% of healthcare costs in Wales; it is a common cause of blindness and renal failure et cetera. It is a new drug that does something different, but, actually, when you look at the studies for the health outcomes, it probably does not make much difference; it is just a different way of doing it, and lots of cancer therapies and, I suspect, technologies would be the same.

[35] **David Rees:** I call on Lindsay Whittle.

[36] **Lindsay Whittle:** Thank you, Chair. They say of the NHS that our best asset is the staff there, but do we have the right experts here in Wales to identify, appraise and commission all of these new technologies, and do you have any experience, when this new technology arrives at all hospitals and the point of delivery, of it being used well, because so often in times of austerity the first budget to be cut is training budgets? There is no point in buying the best equipment in the world if you have not trained people to use it.

[37] **Professor Griffiths:** We do have a lot of expertise in Wales, and, in fact, we should celebrate that and promote Wales as a test-bed for every new technology or potentially for every new technology. The Welsh Government has been very supportive over the years in funding training places in the sciences. They are very competitive training places. In my own area of medical physics, we have five in Wales every year, funded by the Welsh Government, and there are over 200 applicants for those places. We have a very high quality of young scientists joining us, so that is a very good thing. When it comes to taking up permanent positions, it is harder the further west you go, or the further north you go. We have a wonderful geography in Wales, but it is off-putting to some people, although it should not be. What helps to retain people in Wales is having these state-of-the-art technologies and these opportunities.

[38] Our symposium threw up some very interesting answers to these six questions that we posed. Things like ‘not invented here’, which seemed to be a barrier in many ways, really was not seen to be much of a barrier. However, one thing that was identified by a number of groups was the lack of scientists’ time in NHS health boards for optimising new technologies. The particular example given was for the next-generation sequencing equipment, which was being purchased by the recent health technology fund. To use the phrase given by the speaker, it is not ‘plug and play’ technology. You have to spend time optimising it, gathering data, altering the parameters and getting the best out of the technology. In my quite long experience in the NHS, it has always been a problem that when you are delivering a clinical service, the service pressures mount up and it is the development time that gets squeezed, and that is still seen to be a problem. So, rather than just present you with a problem, I think we do have some good examples of solutions to that, and that is to appoint joint posts between universities and the NHS with protected research and development time. I have certainly set one up in my present post in Swansea, and it has been very successful. We have an associate professor in radiotherapy physics who has seven protected university sessions a week. A lot of that time is spent doing the teaching, training these bright young graduates, but there is also time for research and development that is clinically focused. He also spends three sessions in routine radiotherapy clinical work. I think, John, you have had experience of some of these posts elsewhere.

[39] **Professor Watkins:** Absolutely; I was in one myself for quite a while. In answer to your question, there are three bits to the process. One is around whether there is an evidence base out there. That requires a certain amount of knowledge and skills within the specific area to understand what it is, see what it is and interpret it. The next bit of the process is the appraisal of the technology both in terms of the broader brush of what is out there in terms of the published literature plus the grey literature, and how that translates into the economic arguments. Then the third bit is around the implementation, which is around the training and that. Disruptive innovations are talked about; molecular diagnostics, if you like—PCR for identifying influenza and other viruses, where we look at the nucleic acid sequences rather than what we used to do, which was to try to look for the virus or an antibody et cetera. That is a disruptive innovation, but it requires a totally new set of skills, and some of those skills can be plug and play, but quite a lot of them are not. They are around good laboratory techniques, managing it, et cetera.

[40] In other places, the collaboration between the appraisal organisations and universities is quite a close one. NICE has contracts with universities across England mostly, to look at both economics and health technology—with Southampton, York, Oxford, Birmingham et cetera. So, there has to be a machinery that exists, which might be a sort of strong core of people who are skilled in particular things. In Wales, the All Wales Medicines Strategy Group relies on health economists based in Glamorgan, Swansea and Bangor, so we already have a core of people who are skilled in the economic evaluation. Each technology will be different, though, but we will certainly have scientists, and clinical scientists, in Wales who are plugged into the processes. So, if they do not have the skills themselves, they will know places that do.

10:30

[41] **Lindsay Whittle:** So, having Welsh hospitals working with Welsh universities can benefit the whole of Wales.

[42] **Professor Watkins:** Absolutely, yes.

[43] **Lindsay Whittle:** You mentioned other towns and cities, in England.

[44] **Professor Watkins:** What I am saying is that, basically—

[45] **Lindsay Whittle:** If the expertise is brought to Wales, they tend to stay in Wales, do they not? That is, if they train in Wales, they tend to stay in Wales.

[46] **Professor Watkins:** We plug into people across the whole of the country. Therefore—

[47] **David Rees:** You use the networks that exist.

[48] **Professor Watkins:** Yes, we use the networks that exist. In molecular diagnostics, for example, there is close collaboration between the laboratory service in Public Health Wales and what was the Health Protection Agency in England, and there is a sort of network that still exists across the boundary between the two administrations.

[49] **Darren Millar:** I am just struggling to really understand how you fit into the overall structure, in terms of appraisal and making recommendations about the availability of new technologies in Wales. It seems to me that you are quite a low-profile committee, really; you have been in existence for a good number of years, obviously, and you have made some important recommendations around radiotherapy in recent years, but what other recommendations have you made, and do you make, to the Welsh Government? How often do you meet, how often do your sub-committees meet and how is that information made publicly available? There is not much about you on the internet, for example. I cannot see much out there.

[50] **Professor Griffiths:** With respect, I disagree. We have the most prolific website of all the advisory committees. We have between 20 and 30 pieces of published guidance on our website—it is a Welsh Government website, under ‘scientific advisory’—and I think that the largest number by any other committee is something like three or four. So, we are very prolific. We have a high profile in NHS Wales, because we actually act on the guidance. We have managed to get, for example, every radiology department in Wales to fill in a pro forma—well, I hope that they are filling them in. We have got them to agree to fill in a pro forma for every time a patient has their MRI scan denied or delayed, due to a lack of scientific advice beforehand—these are for people who have a conditional implant, and the radiographers are not sure whether to go ahead with the scan or not. So, that is something that arose from one of our sub-committees—two of our sub-committees, in fact, working together—and it has now been rolled out across Wales.

[51] In terms of technology appraisal, I would agree with you; we are not set up to appraise technologies. We do not have the infrastructure to do that, because everybody has a full-time clinical job or scientific job in the NHS. We do not have the industry that the All Wales Medicines Strategy Group or NICE have behind them in order to do the very detailed work that they do. So, our role in technology is to highlight to the Welsh Government the technology advantages that are going to be important.

[52] **Darren Millar:** You are giving regular advice, and you are publishing guidance and documents. Is your advice always taken up? What happens if it is not taken up?

[53] **Professor Griffiths:** We try very hard to influence the health boards. You asked me what other advice we give; there is a lot of advice on audiology, for example. The audit programme has now been accepted on the all-Wales official list of audits, and that has resulted in the quality of the service going up—there are various quality indicators, which were all hovering around the 60% to 70% mark; they are all up over 90% now, because all the audiology departments in Wales are doing this. There has been point-of-care testing, and a lot on the radiological sciences, a lot on genetics and laboratory sciences, but very little on engineering, which is something that I have tried to encourage. If it is not taken up, then the fact that it is published—and this is a very important point—on the Welsh Government

website means that it is official Welsh Government advice, and it is a considerable lever to persuade our clinical colleagues to take up that advice. In fact, there is always a bit of clinical inertia from some colleagues, and it has proved very useful to have these things as official guidance.

[54] **Darren Millar:** Is there ever a time lag?

[55] **David Rees:** Perhaps Professor Watkins would like to add something first.

[56] **Professor Watkins:** To follow on from that point, I agree with you, but the committee was not set up to do what you are suggesting. The drive in medicine over the last 20 to 30 years, and particularly over the last 10 to 15 years, has been on evidence-based medicine. That started almost like a religious movement, and it started on the basis that, while the knowledge that, say, aspirin, reduced the number of deaths from heart attacks was there 40 years ago, it took 25 years for it to be brought in as common practice. So, anyone who has a heart attack now is given an aspirin on their way into the hospital. So, it was about short-circuiting that and moving the knowledge down.

[57] We have done that in therapeutics, but we have not necessarily done it in technology. The way that technology comes in is often through, as we have talked about, the network process. That is, somebody has an interest, they hear about it and read about it, they think it would be a good idea, they lobby for it, the piece of kit is purchased, they go off and do some training, it is introduced and then it is disseminated slowly and diffuses through the system. That is one scenario; the second scenario is that two places within a very small area decide to do it, so you now have two pieces of kit that are underused and under-resourced. The situation should be that you should try to eliminate the postcode lottery in access and you should try to introduce technologies that are effective. Again, there are difficulties with the evidence base and the economic arguments, but those should be identified. The third thing is that you should back it up with training programmes that ensure that those services are manned by people who really know what they are doing and that the access to them is universal. That may mean health boards buying in to other health boards' use of technology.

[58] **Darren Millar:** May I pursue the issue of your advice always being published online? Are there any time lags between the publication of advice online and the time at which you provide it to Ministers or the Welsh NHS?

[59] **Professor Griffiths:** The mechanism that is operated fairly amicably—well, totally amicably—is that, although we are an independent advisory committee, we could post our advice without the agreement of the chief scientific adviser for health. It has certainly always been my attitude that we want something that he or she is happy with as well. So, I always give them the opportunity to comment on the final draft, and we do make alterations if we think that they are correct alterations. So, by the time it goes on the website, it already has the approval and knowledge of the chief scientific adviser for health. So, that is our route into the Welsh Government.

[60] **Darren Millar:** I note that you have five-yearly reviews—is that right?

[61] **Professor Griffiths:** Of?

[62] **Darren Millar:** Of the committee. Well, you had a five-yearly review in 2001. That is the last one that there seems to be any information available about.

[63] **Professor Griffiths:** I do not know about that. That was before I joined it. The constitution is reviewed. Do you mean the constitution?

- [64] **Darren Millar:** Just a review of the way in which your committee works.
- [65] **Professor Griffiths:** Well, all of the advisory committees are being reviewed at the moment, and we are participating fully in that process.
- [66] **Darren Millar:** However, that was the last time that you had a review, back in 2001, was it?
- [67] **Professor Griffiths:** Very possibly, although our constitution is reviewed every two years.
- [68] **Lindsay Whittle:** That is not within the committee's inquiry.
- [69] **David Rees:** Yes, I am aware. It is fair to ask the question, though. Elin is next.
- [70] **Elin Jones:** Just quickly, I have a question on your views on commissioning through evaluation. One of the differences between technologies and drugs in the NHS is that there have been a lot of clinical trials and evidence-based development on drugs, with pharmaceutical companies, primarily. However, with technologies, quite often there is not that evidence base to back up early implementation. We have had a discussion and some have advocated early commissioning and then having an evaluation during the implementation as part of the gathering of the evidence. Do you have views on whether that is appropriate, or should all evidence be there to back up commissioning before commissioning takes place?
- [71] **Professor Watkins:** The problem with technologies is that they are not clear-cut. Technology also covers drugs and what we are talking about is a fairly heterogeneous mix of all sorts of things, which is why I deliberately divided them up into tests and diagnostics—interventional stuff and disruptive innovation. The tests and diagnostics, I think, can have a clear evidence base, which can be on a par with the sort of gold-standard evidence that you have with therapeutics, for example, because tests have what we define as sensitivity and specificity. In other words, are they valid, reliable and do they show what they are saying? That is why we screen for breast and cervical cancer, but we do not screen for prostate cancer, because of the availability of the tests and so on. That is a debate for another day, really. So, there is potential for an evidence base in that.
- [72] Some of the other things, such as interventional-type procedures, will be more difficult and I suspect that the way to take them forward is not to go down the road of 'not invented here'. If they are used in other places and in other countries that are of a similar ilk—irrespective of the structure of our NHS in the UK or Wales as compared with the US and Australia—the differences in how we fund these things is not necessarily as great in terms of how we deliver services and care. However, what you need is the machinery to capture that and evaluate that to bring that in.
- [73] On the disruptive innovations, as I said, that is much more difficult because you can end up with false dawns and all the rest of it. I suspect that they should probably be in the realms of research within very well structured sorts of things. So, I guess your question is probably on the middle area, and I would suggest that it is the 'not invented here' that you should go and seek, seeking out where it is, rather than doing little pilot schemes here and there, which often do not have the power to demonstrate effectiveness anyway.
- [74] **David Rees:** We are coming close to the end, and I have one question for you. We have seen several witnesses who have given us an indication that perhaps there should be an all-Wales-type approach to assessing medical technology—something like the All Wales Medicines Strategy Group, which is for medicines. Is it your view that there should be a similar body for technologies? Would it be your view that that should be an arm of the

AWMSG or a separate body to the AWMSG, because of the differences?

[75] **Professor Griffiths:** I, personally, would broadly welcome that. It could call for advice on bodies like Cedar, the evaluation centre at Cardiff University, and our own committee and others.

[76] **Professor Watkins:** In terms of grafting it on to the All Wales Medicines Strategy Group, while it is a good idea, I actually think that it may be additional work, which the All Wales Medicines Strategy Group, as currently configured, could not do, but only because of time and back-up and all the rest of it. However, I think using that model would address the issue of postcode lotteries, and it would address the issue of technology being introduced in a standardised way, et cetera. What you need to think about is not just having the group that appraises it, but the background infrastructure of how you manage that process. Apart from having the people with the knowledge—we could point to people with knowledge of genetics and radiological knowledge and all the rest of it—it is actually about the machinery of people who can do the technical stuff around gathering the evidence, processing the stuff, appraising the evidence, and putting it together in a cogent way so that people who may not be specialists in a particular area can actually say, ‘Yes, I now understand that, and therefore I am in a position to make a judgment’. So, it is not just about having the group, but around what infrastructure you will have. I suspect that having academic support is really quite important.

[77] **David Rees:** Very quickly, just as a final point, is it worth having an all-Wales commissioning body or should we look at how that works separately because different technologies might require a different approach?

10:45

[78] **Professor Griffiths:** The implementation of technologies is a lot more complex, as I think we have tried to point out, than of drugs, because there are many ways of configuring them. So, there has to be a certain amount of flexibility, because what might work very well for Cardiff and Vale might work differently in Aneurin Bevan, et cetera. All-Wales commissioning could help to overcome the different speed of take-up in the different health boards, which is a problem that should be addressed.

[79] **David Rees:** Thank you for that. Thank you for your evidence session today; it has been very much appreciated. You will get a copy of the transcript to check for any factual inaccuracies you may identify for corrections. Thank you again for coming in today to give evidence.

[80] **Professor Griffiths:** It has been a pleasure.

[81] **David Rees:** I propose that we have a break before we start the next item.

*Gohiriwyd y cyfarfod rhwng 10:46 a 10:54.
The meeting adjourned between 10:46 and 10:54.*

**Ymchwiliad i Fynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn
Dystiolaeth 16
Inquiry into Access to Medical Technologies in Wales: Evidence Session 16**

[82] **David Rees:** I welcome Members back to this morning’s session where we will continue to take evidence on access to medical technologies. Our final session in this inquiry is with the Minister. I welcome you, Minister, and thank you for your written evidence. Will

you introduce yourself and your team for the record?

[83] **The Minister for Health and Social Services (Mark Drakeford):** I am Mark Drakeford. I am the Minister for Health and Social Services in the Welsh Government. I ask my colleagues to introduce themselves.

[84] **Ms Morrell:** I am Christine Morrell, acting chief scientific adviser for health in the Welsh Government.

[85] **Mr Evans:** I am Ifan Evans, deputy director for healthcare innovation in the Welsh Government.

[86] **David Rees:** Thank you very much for that. We will go straight into questions if that is okay. Gwyn Evans—Gwyn Price will start the questions.

[87] **Gwyn R. Price:** Gwyn Evans, thank you very much. I think that you have done that to me as well, Minister. Good morning, to you all.

[88] Although only recently developed, have there been any benefits seen from the publication of the board's technology adoption systems guidance? How well is that being implemented?

[89] **Mark Drakeford:** Gwyn, thank you for that. The guidance was the product of the innovation board that Lesley Griffiths established. That advice has now been provided to the NHS in Wales, but, as you say, it is very early to know exactly what impact it has had. It is still advice that health boards are absorbing and acting on. You can see it beginning to make a difference already in the plans that local health boards have submitted as part of the new financial flexibilities regime. For example, Aneurin Bevan Local Health Board, in its plan, placed a particular emphasis on the part of the advice that the innovation board gave about technology discard. As well as introducing new technologies, a very important part of this field is to stop using technologies that have been superseded by better things. The board's advice was very clear to local health boards: they needed to look at what they were already doing and to stop doing things that were no longer the most current and effective. There are 52 different bits of NICE guidance in that area too. The Aneurin Bevan plan has quite a lot to say on that, and I think that you can see the board's influence there. Cardiff and Vale focuses very much on innovative technology in primary care and the links between secondary and primary care. For end-of-life care, it also talked quite a lot about new technologies. Hywel Dda has a lot in its document about new funds that it has secured from Europe and the plans it has to try to secure additional funds from Europe in the telehealth and telecare fields. It is early days; I cannot say that we have a lot of evidence on the impact of it. But, I think that you can see it emerging as having an impact on the way in which health boards are thinking and planning.

[90] **Gwyn R. Price:** You will obviously be monitoring this as it evolves.

[91] **Mark Drakeford:** Absolutely.

[92] **David Rees:** I notice that there is a lot of inconsistency in the sense that there is a lot of variation across those plans. Was it expected to see such variation in the plans?

[93] **Mark Drakeford:** This is the first time that health boards will have had to produce plans in this way. I do not think that it is a surprise that, first time around the track, there is variation between them. I feel that my job has been to make sure that we, in Welsh Government, do the things that we committed to doing when the National Health Service Finance (Wales) Act 2014 was going through the Assembly. That was to take a rigorous

approach to our assessment of those plans and only to afford financial flexibility to those organisations whose plans are sufficiently convincing to have merited it.

[94] **David Rees:** Lynne.

[95] **Lindsay Whittle:** May I ask, Chair—

[96] **David Rees:** I will bring you in after Lynne.

[97] **Lynne Neagle:** We have had some evidence that there should be a more uniform approach across Wales, including some witnesses who have suggested that there should be a separate all-Wales medical technologies assessment body. What is your view on that suggestion?

[98] **Mark Drakeford:** It is an interesting suggestion. There is a lot of evidence that you will have heard and this committee's report will be influential in the Government's thinking on that point. Medical technologies is a complex field. We already have significant advantages through some national programmes of which we are a part.

11:00

[99] So, our subscription to NICE, which costs us £1 million a year, gives us full access to everything that it does in this field. The health technology assessment programme, again, is a UK programme led by the Department of Health, but we pay a subscription through the National Institute for Social Care and Health Research to be full members of that programme.

[100] Therefore, there are national pieces of work—not just Welsh national, but beyond Wales as well—that we are able to draw on. The question on which I think the committee has heard evidence is whether we should move to use, for example, AWMSG in a new and extended role to do some national appraisals for us too. There are strong arguments for that and Members here will have seen those arguments also deployed in the two reports that we have recently published—the orphan and ultra-orphan drugs report and the report on the individual patient funding requests process that we are now consulting on. Both of those talk about making better use of AWMSG and the toxicology and therapies centre, to have a more national approach to some of these things. So, I have not reached a decision on it, and what you say in your report will be important, I think, in helping to guide our thinking on that. AWMSG does not have expertise directly in medical technologies, but it has health economists and generic appraisal expertise that we might be able to put to work in this field if we get its remit adjusted and right.

[101] **Lindsay Whittle:** I want to ask, Minister, whether you have had any discussions with health boards on their training budgets for new technology, because you could have the best machine in the world, but you need to train staff to use it. So often in times of austerity, the first budget to be cut is the training budget.

[102] **Mark Drakeford:** That is a very important point, Chair. It is one that NICE makes in the document that it published only a couple of years ago on the whole approach to medical technologies. However, the technology is only one part of the picture here. The brightest and best new machine will not do the job for you if you do not have staff who are sufficiently skilled and able to make full use of that machine. We have seen a little bit of that, I think, in Wales recently with the robot that is now available at Velindre, which is very much a new medical technology and there has had to be significant investment in staff training, including sending people outside Wales to where these machines are used to make sure that they are able to make best use of them. NICE points to a third arm, as well; it says that you have to have the technology and the staff, but actually you have to have the service change, as well.

You cannot just parachute a piece of equipment into a service and leave the service as it was before. The service has to be re-engineered to make sure that proper use of the technology is being made and that is part of the complexity of this field.

[103] **David Rees:** On that point, does the service change respond to the greater efficiency of the systems or the technology because of the training? One of the points that were made in the previous session was that, very often, they need time to optimise the equipment to ensure that it becomes an efficient and quite effective use of the technology.

[104] **Mark Drakeford:** I am sure that that is absolutely right. However, the service change is, in some ways, a slightly different point. It is often about cultural change. If you have a new service with a new and expensive piece of equipment, that equipment will not do the job that you want it to do if, for example, other clinicians in other parts of the system do not make referral calls for its use. So, the system has to be re-engineered, not just in the immediate vicinity of the new technology, but along the whole pathway of people who might end up needing it. I am not sure whether Ifan wanted to add something.

[105] **Mr Evans:** Yes. I just wanted to comment on the interrelationship between training and technology and how sometimes it works the other way around, in that training or changing practice will highlight the need for a technology, or will even throw up ideas for new technology. So, for example, you have had Jared Torkington from the Welsh Institute for Minimal Access Therapy in Cardiff Medicentre giving you evidence. That is the UK's leading laparoscopy training centre. Off the back of the training and learning that they do there, they have invented some new technology, which they are commercialising at the moment through Cardiff University. It is a smoke removal machine. Sometimes, technology will come off the training and, at other times, you will need the training in order to implement the technology. It works both ways.

[106] **Lindsay Whittle:** That is interesting. Thank you.

[107] **David Rees:** Rebecca, is your question on this point?

[108] **Rebecca Evans:** Yes. Do you see a role for the investment in, and adoption of, new technologies in the recruitment and retention of staff in areas to which it is difficult to recruit? I am thinking, obviously, of west Wales.

[109] **Mark Drakeford:** I am absolutely sure that that is right, Rebecca. I generally say that if you want to attract the best people to come to work anywhere in the NHS, you have to have three things available to them: people want to be able to teach; they want to be able to research; and they want to be able to practise. If they want to be able to practise in a way that puts them at the forefront of what their particular branch of medicine is doing, you have to be able to invest in the things that allow them to practise in that way. You must have all of those three things together. I think that new technology has an impact on all of those three things.

[110] **Rebecca Evans:** Is Government, in conjunction with the health boards, taking a strategic approach to that at the moment?

[111] **Mark Drakeford:** I would not want to overpromise what I think we have been able to achieve so far. It is not an easy thing to take a strategic grip of. In its document, the very first point that NICE makes is that the rapidity of development in this field means that what looks like the most advanced thing that you can get today can be very rapidly overtaken tomorrow, and often in an unpredictable way. It is different to pharmaceutical developments, where you tend to get a longer line of sight to the new things that are coming along. It is easier in some ways to take a strategic view of the medical technologies driven often from industry, so, not from inside Government. They are often overtaken very rapidly by

something else that someone else is bringing forward. So, taking a completely strategic view of it is not as easy as it sounds, but obviously our aim is to have an all-Wales approach to the appraisal of these things, as we have just been discussing, and then to have commissioning arrangements that blend together the fact that there will be some things that you will want to commission on a Wales basis, but there will be other things that are quite properly left to local commissioners to decide. When you took evidence from Professor Phil Routledge, I think that he made the observation to you, from his experience as chair of AWMSG, that this is very much an area where one approach will not do. It has to be a blended approach.

[112] **David Rees:** There is a question on commissioning that will probably come up afterwards. I call Christine.

[113] **Ms Morrell:** In the strategic approach to training and to the recruitment of staff, one thing that we are looking at is the development of a radiology academy, because there are problems with recruitment across radiology and radiography. It is in the early stages of being looked at. We have been to look at other centres. In areas where they have done that, where they have put specialist centres for training, and with new technology—digital technology—such as that, they have managed to increase their recruitment. We are looking at that. The options that we are looking at generally are to spread training outside of the Cardiff area. So, to the west or to the north are among those options. It is very much part of the case for that.

[114] **Rebecca Evans:** That is good news, because we did have some strong evidence on radiology.

[115] **Ms Morrell:** Radiology is one that we are particularly looking at, where there are issues. I also come back to the training one, and the specialism of training. Again, there is the complexity of technology, but there is the specialist technology training for genetics and molecular in specialist centres, where they are not plug and play, and you need development time, research time, and a national approach. For another technology, like point of care technology, where you are testing patients in GP surgeries, there is a lot of training at a completely different level and you are moving the services out of where they are traditionally done—in laboratories. There has to be governance there. So, it is a whole pathway of training; it is a much bigger picture, which companies can get involved in. However, there must be different aspects of training that we are investing in.

[116] **Kirsty Williams:** I want to pick up—[*Inaudible.*] The Welsh Government has made a commitment to deliver care closer to people's homes, and I would share the view of the analysis in the Minister's paper on the benefits of new technology within primary care and community care settings. The evidence that we have received during this review is that there is, overall, a lack of leadership in this area and that, often, technology adoption was done on an ad hoc basis with no strategy, necessarily, behind it. Can you explain what the Welsh Government is doing to ensure that technology uptake at a primary care level is done on a more strategic basis, given the benefits that it has for patients as well as potential cost savings for the NHS as a whole and, perhaps, an opportunity to cut waiting times for diagnostic tests?

[117] **Mark Drakeford:** Thank you for that. Members will know that the health technology fund that we have had for the past two years has continued into this financial year, but now as the health technology and telehealth fund. It has had £9.5 million in it, and it has had a much bigger emphasis on investment in primary care technology. The announcement that I made at the end of last month about all this shows that we are putting significant sums of money from that fund into, for example, making sure that pharmacists, optometrists and dentists will all have new technology-driven ways of referring people between primary and secondary care because we know that there is a great deal more that can be done in primary care if we get that flow of information correct. I was lucky enough to be able to make the announcement of the funding in the university optometry centre in Cardiff. At the centre, they were directly

able to demonstrate how optometrists were able to send images electronically to consultants so that the consultants did not need to see the patient, just the image. They are then able to send the advice back to the optometrists and the patient could get all the care they needed on the high street, without the need for them to turn up at hospitals or outpatient clinics and all those sorts of things. So, it is a very good example, I think, of the point that you made, namely that, if you invest in a concerted way in the primary care end, you can get all sorts of benefits there.

[118] We are using some different technology in the optometry field in particular. It is open access technology, which is a great deal cheaper, enabling us to do this right across Wales in a way that we would not have been able to do even a year or so ago. It is clinicians who have been primarily influential in that. We have had Adam Cairns, as the chief executive of Cardiff, taking a lead in this field to try to make sure that we have a more concerted approach to it across Wales. In some parts of Wales, we have good policies and documents. There is a rural health plan, for example, which we are still using in parts of primary care to make sure that telehealthcare is improved and used to a greater extent. Quite a lot of the money that we have used from that fund this year has been for not particularly innovative technology. I heard Professor Griffiths say to you that iPads were innovative only three years ago. We are using that sort of technology, which people are used to using in their everyday lives, for all sorts of other things to make sure that people can use it in the health field as well. So, using the fund, having better leadership and making sure that we have got the policy perspective right mean that we are going to be able to make some significant advances in the primary care field over the next year or so.

[119] **Mr Evans:** May I just add something here? Some of it depends on the breadth of your interpretation of what technology means. There has been an awful lot of progress in standardising and reducing the number of different digital systems that are used in GP surgeries, for example, and we are down to two systems across Wales in GP surgery primary care, which helps to provide a platform for other things. Some of the investments that were being made by the health technology and telehealth fund helped to push that out into point-of-care testing, which enables GP surgeries and others to plug directly into them.

11:15

[120] In other areas, though, I think that it goes further than primary care, as we traditionally conceive of it—the four professional practices—into residential care settings. It even goes to patients themselves being able to access their patient records and other things, and that leads technology into much more of a consumer environment, and, sometimes, a self-paid environment. The Government's approach at this moment, through the health technology fund, is to provide the platform, the enabling infrastructure that will allow that to happen. At the moment, it is hard to think how direct Government intervention can pay for devices that are in the hands of the 3 million people who are living in Wales, for example. We have to work towards a bring-your-own-device approach and to align ourselves with the way that health technologies are being consumerised. That will help us to get people more engaged in their own health, it will help us with earlier preventative interventions, with self-management of care and various other things. However, at the moment, the NHS Wales Informatics Service policy is about the platform infrastructure, and we are moving towards finalising the commissioning of quite a number of national systems for exchanging data, information, images and other things, and have made significant progress over the last few years in that area.

[121] **Elin Jones:** Os caf i ofyn i'r **Elin Jones:** If I could ask the Minister for an Gweinidog am farn ar gomisiynu drwy opinion on commissioning through werthuso, achos yr un peth sydd yn wahanol evaluation, because the one thing that is very iawn, efallai, rhwng y defnydd o gyffuriau o'i different, perhaps, between the use of

gymharu a thechnolegau newydd yn yr NHS yw efallai nad yw'r gwaith ar dreialon clinigol a fyddai wedi cael ei wneud gan gwmnïau *pharmaceutical* yn cael ei wneud, felly nid yw'r *evidence base* yno, wastad, i gymryd penderfyniadau ar gomisiynu, yn enwedig yn yr agweddau mwyaf blaengar o'r gwaith, gydag eithriadau weddol brin ar hyn. Felly, beth yw'ch barn chi? Rydym ni'n sicr wedi cael tystiolaeth gan rai yn dweud bod yr egwyddor o gomisiynu, gwerthuso ac wedyn cymryd penderfyniad o fewn pum neu dair blynedd a oedd yn werth buddsoddi neu beidio yn un y dylid ei chaniatáu yn weithredol yng Nghymru mewn amgylchiadau gweddol unigryw, siŵr o fod, ond ei bod yn egwyddor y dylai'r Llywodraeth fod yn caniatáu i gomisiynwyr ei dilyn.

[122] **Mark Drakeford:** Diolch. Rwyf wedi gweld y dystiolaeth sy'n dweud hynny. Mae diddordeb gennyf fi a'r Llywodraeth hefyd yn y rhaglen newydd yn Lloegr, y *commissioning through evaluation*. Rydym ni'n mynd i fod yn rhan o'r rhaglen hefyd. Dim ond dau beth sydd ar y gweill ar hyn o bryd yn y rhaglen honno, *selective internal radiotherapy* a *selective dorsal rhizotomy*. Bydd pobl o Gymru yn rhan o'r rhaglen ar bob ochr ac rydym ni'n mynd i gael yr holl wybodaeth mas o'r rhaglen i'n helpu ni yng Nghymru i ddeall a dysgu o'r hyn sy'n dod mas o'r rhaglen. Rydym ni wedi cytuno hynny nawr gyda'r DoH ac rydym ni'n mynd i fwrw ymlaen i'w wneud.

[123] Yn fwy cyffredinol, yr egwyddor oedd cael pethau yr ydym yn gallu eu dysgu pan fyddwn ni'n eu gwneud nhw, nid dim ond ar ôl eu gwneud nhw. Rwy'n meddwl ein bod ni'n gwneud hynny'n barod nawr, ac yn enwedig o dan y rhaglen newydd, achos rydym ni wedi rhoi i mewn i'r rhaglen y gallu i ddysgu wrth wneud pethau. Bydd Ifan yn gallu esbonio yn well na fi beth rydym yn ei wneud yn y fan honno sy'n newydd.

[124] **Mr Evans:** Hoffwn wneud dau bwynt. Mae'r un cyntaf yn ymwneud â'r gronfa *telehealth*, gan ei bod yn wahanol i'r gronfa a oedd yn rhedeg y llynedd. Roedd honno'n bennaf yn buddsoddi mewn technoleg a oedd wedi ei phrofi ac offer gweddol sylweddol mewn ysbytai. Mae'r

medicines or drugs compared with new technologies in the NHS is that, perhaps, the clinical trials work that would have been done by pharmaceutical companies is lacking, so the evidence base is not always there to make decisions on commissioning, especially in the more forward-looking aspects of the work, with rare exceptions. So, what is your opinion? We have certainly had evidence from some people who think that the principle of commissioning, evaluation and then taking a decision in five or three years as to whether it was worth investing or not is one that should be allowed in Wales in quite unique circumstances, probably, but it is a principle that the Government should be allowing commissioners to follow.

Mark Drakeford: Thank you. I have seen the evidence that says that. I have an interest and the Government is also interested in the new programme in England, commissioning through evaluation. We are going to be involved in the programme as well. There are only two things in progress at the moment within that programme, selective internal radiotherapy and selective dorsal rhizotomy. People from Wales will be involved in the programme on all sides, and we are going to get all the information out of that programme to help us in Wales to understand and to learn from what comes out of the programme. We have agreed that now with the DoH, and we are going to be progressing to do that.

More generally, the principle was to get things that we can learn while we are doing them, not just after we have done them. I think that we are doing that already, and especially under the new programme, because we have put into the programme the ability to learn while we are doing things. Ifan will be able to explain better than me which new things we are doing there.

Mr Evans: I would like to make two points. The first is about the telehealth fund, given that it is different to the fund that was in place last year. That was chiefly investing in technology that was proven and quite substantial equipment in hospitals. The new scheme, which runs during the current

rhaglen newydd sydd yn rhedeg yn ystod y flwyddyn ariannol gyfredol yn buddsoddi mewn rhywfaint o stwff sydd yn galluogi pethau drwy NWIS yn ddigidol, ond hefyd mewn nifer o brosiectau sydd ag elfen llawer iawn amlycach o brofi technolegau newydd a'u gwerthuso nhw wrth inni fynd.

[125] Rwy'n credu mai'r pwynt mwy cyffredinol yw bod y rhaglen *commissioning through evaluation* yn gyfyngedig iawn yn y nifer o dechnolegau y bydd hi'n gallu edrych arnynt. Mae NICE yn rhoi barn ar y pum neu chwe thechnoleg newydd bob blwyddyn, ond mae'r dystiolaeth yr ydych wedi ei derbyn oddi wrth WHSSC yn dangos bod 500,000 o wahanol dechnolegau yn cael eu defnyddio yn y system iechyd drwy Ewrop o ran offer a *diagnostics*. Nid oes ffordd y bydd yr un rhaglen yn gallu arbrofi y rheini i gyd; mae llawer o'r dechnoleg honno'n stwff gweddol sylfaenol, felly mi fydd marc CE arno yn barod. Yr hyn sydd ei angen, ac mae ei angen yn ddirfawr ar gynhyrchwyr a datblygwyr y dechnoleg honno, yw modd i gael hynny i mewn i osodiadau iechyd er mwyn arbrofi wrth fynd a chael adborth gan glinigwyr ac oddi wrth y cleifion ynglŷn ag a yw'r dechnoleg honno'n gweithio a sut y gellir gwella'r dechnoleg honno.

[126] Rwy'n siarad â nifer o fusnesau rhyngwladol, rhai ohonynt wedi'u lleoli yng Nghymru yn barod, a rhai yr ydym yn ceisio eu denu i Gymru, ac rwy'n gwybod eu bod yn cael bod yr NHS drwy Brydain Fawr i gyd yn rhwystredig o ran medru cael mynediad i ysbytai neu at ddoctoriaid neu unrhyw fan arall er mwyn gallu profi gwerth eu technoleg, a hefyd er mwyn cael gwneud yr achos ariannol sydd o gwmpas y dechnoleg. Mae'n anodd iawn casglu'r dystiolaeth honno mewn ffordd effeithiol, ac rwy'n credu bod cyfle go iawn i Gymru i wneud hynny oherwydd bod y system yng Nghymru gymaint yn fwy integredig, syml a hawdd ei deall nag yw'r system yn Lloegr, er enghraifft.

[127] Mae'r dystiolaeth gawsoch oddi wrth MediWales yn sôn am yr angen am ddrws ffrynt i'r diwydiant fedru dod i mewn i'r system iechyd. Rwy'n credu bod cryn dipyn o werth i hynny, nid yn unig i'r system iechyd ei hun ac i gleifion a fyddai'n cael

financial year, invests in some things that enable work through NWIS digitally, but also in a number of projects that have a much greater element of testing new technologies and evaluating them as we go.

I think that the more general point is that the commissioning through evaluation programme is quite limited in the number of technologies that it can look at. NICE appraises five or six technologies every year, but the evidence that you have had from WHSSC shows that 500,000 new technologies are used in the health service through Europe in terms of equipment and diagnostics. There is no way that a single programme can test all of those things; many of the technologies are quite basic forms of equipment, so there will be a CE mark on them already. What needs to be done, and what the developers and producers of those technologies need, is a way to get that into health settings so that they can be tested as they go along, with evaluation from clinicians and patients to see whether the technology works and how it could be improved.

I talk to a lot of businesses internationally. A lot of them are based in Wales already, and there are many that we are trying to attract to Wales, and I know that they find the NHS throughout the UK to be quite difficult with regard to getting into hospitals and accessing doctors and other parts of the service in order to prove the value of their technology and to make the financial case for bringing this technology in. It is very difficult to get that information, and there is an opportunity for Wales to do that here, because the system in Wales is a lot more integrated and a lot easier to understand than the system in England.

The evidence that you had from MediWales talked about the need for a front door for industry to be able to come into the health system. I think that there is a lot of value in that, not only for the health service itself and to patients who would be able to use that

defnyddio'r dechnoleg honno, ond i ddiwydiant hefyd, gan y byddai'n hynod ddeniadol iddo.

[128] **Elin Jones:** Dyma gwestiwn i ddilyn hynny. Ble mae'r drws ffrynt yn y gwasanaeth iechyd yng Nghymru? A yw gyda'r byrddau iechyd—y saith bwrdd yn unigol—neu a oes elfen o ddrws ffrynt cenedlaethol? Ar adegau, fe all byrddau iechyd fod yn unigol yn araf i godi unrhyw dechnoleg newydd, ac efallai nad oes gan glinigwyr unigol ddiddordeb mewn gwneud hynny. Felly, a oes rôl i arweiniad cenedlaethol yn hyn yn fwy strategol? Os yw bwrdd iechyd penodol bach yn araf yn manteisio ar ryw ffordd newydd o weithio neu dechnoleg newydd, fe ddywedodd un o'r tystion blaenorol y bore yma am rôl genedlaethol Llywodraeth i fandadu byrddau iechyd i weithio mewn ffordd benodol.

[129] **Mark Drakeford:** Wrth siarad am y berthynas rhwng gwasanaethau iechyd a diwydiant, mae gwasanaeth newydd gennym, sydd wedi bod ar waith ers blwyddyn. Mae'n dod o dan NISCHR—y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd—a Health Research Wales yw enw'r gwasanaeth. Mae'r gwasanaeth hwnnw'n rhoi drws ffrynt i'r bobl sydd am ddelio â'r gwasanaeth iechyd yma yng Nghymru i'w helpu. Os dywedant fod ganddynt ddiddordeb yn hwn a hwn, rydym ni'n gallu dweud, drwy Health Research Wales, dyma'r lle y mae pobl sy'n arwain pethau yn y maes hwnnw'n gweithio ac a all eu helpu gyda phopeth arall y mae'n rhaid iddynt ei gael. A oes rhywbeth arall?

[130] **Mr Evans:** Oes. Dywedwn i fod, ar hyn o bryd, nifer o ddrysau. Mae mwy o ddrysau sy'n edrych fel drysau ffrynt nag oedd rhai blynyddoedd yn ôl. I esbonio beth rwy'n ei feddwl wrth hynny, mae drws ffrynt ar gyfer pwrcasu, sef yr *NHS shared services partnership for procurement*. Maen nhw wedi rhoi tystiolaeth i chi yma. Un porth ar gyfer pwrcasu sydd gennym ni yng Nghymru, ond wedi dweud hynny, mae'n diffinio pwrcasu yn weddol gyfyng ar hyn o bryd.

[131] Mae un porth ar gyfer ymchwil masnachol drwy Health Research Wales, a

technology, but also to industry, as it would be very attractive to it.

Elin Jones: Just as a follow-up question to that, where this the front door to the health service in Wales? Is it with the health boards—the seven of them individually—or is there an element of a national front door? At times, health boards can be very slow individually to take up any new technology, and individual clinicians may not have an interest in doing that. So, is there a role to provide national leadership for this more strategically? If a specific health board is a little slow in taking advantage of a new way of working or new technology, one of the previous witnesses today talked about the national role of Government to mandate health boards to work in a specific way.

Mark Drakeford: When we are talking about the relationship between the NHS and industry, there is a new service, which has been in place for a year. It comes under NISCHR—the National Institute for Social Care and Health Research—and the name of that service is Health Research Wales. What that service does is to provide a front door to those people who want to deal with the health service in Wales, to help them. If they say that they have an interest in this or that, we can say that, through Health Research Wales, that is where you need to go to find the people who are leading in this field and the people who can help you with everything else that they need to have. Is there anything else?

Mr Evans: Yes. I would say that, at the moment, there are many doors. There are more doors that look like front doors than was the case years ago. To explain what I mean by that, there is a front door for purchasing, which is the NHS shared services partnership for procurement. They have provided evidence to you here. That is one portal for purchasing that we have in Wales, but having said that, it defines purchasing in quite limited terms at the moment.

There is one portal for commercial research through Health Research Wales, which was

sefydlwyd blwyddyn a hanner yn ôl. Un o'r pethau diddorol am Health Research Wales yw ei fod wedi cael derbyniad da iawn oddi wrth y diwydiant, ond mae'n gynyddol yn cael ceisiadau am gyflwyniadau—fel rhyw fath o *brokerage service*—gan gynhyrchwyr a datblygwyr offer a thechnoleg, achos ymchwil ffarmacolegol yw prif bwrpas Health Research Wales.

[132] Wedyn, mae cryn dipyn o waith wedi cael ei wneud dros y ddwy neu dair blynedd diwethaf o'r adran economi er mwyn cefnogi'r diwydiant yng Nghymru, a rhan bwysig o hynny yw helpu diwydiant i ffeindio'r bobl iawn yn y system iechyd. Mi fydd—nid wyf yn siŵr beth yw *hub* yn Gymraeg; 'hwb'? Felly, mae'r 'hwb' gwyddorau bywyd yn mynd i agor rownd y gornel yn ystod yr haf eleni. Pwrpas hwnnw yw bod drws ffrynt i'r system iechyd a'r gwyddorau bywyd yn ei chyfanrwydd yng Nghymru, gan gynnwys yr NHS. Byddwn yn dweud bod llawer iawn mwy o gysylltiad yn awr nag yr oedd ddwy neu dair blynedd yn ôl rhwng yr adran iechyd ag adran yr economi, a rhwng adran yr economi a'r NHS. Mae'r Llywodraeth wedi adeiladu ar y gwaith y mae MediWales wedi bod yn ei wneud ers blynedd—mae wedi ceisio pontio rhwng y rhain ac wedi dod â'r tîm gwyddorau bywyd, y gwaith y mae NISCHR yn ei wneud, a'r gwaith y mae'r tîm arloesi yn adran yr economi yn ei wneud, llawer yn agosach at y system iechyd nag yr oedd, ac mae stwff yn parhau i ddatblygu wrth inni fynd ymlaen.

[133] **Elin Jones:** Ar y cwestiwn ynglŷn ag a yw'r byrddau iechyd yn araf i gomisiynu unrhyw agwedd newydd o dechnoleg, mae teimlad y dylai hynny fod yn digwydd ym mhob rhan o Gymru. A oes le i Lywodraeth Cymru i roi mandad ar hynny, mewn rhyw ffordd, fel y dywedwyd wrthym mewn sesiwn dystiolaeth yn gynharach heddiw?

[134] **Mark Drakeford:** Mae'n syniad diddorol ac yn werth meddwl amdano. Mae NICE yn gwahaniaethu rhwng yr hyn mae'n ei wneud yn y maes ffarmacoleg a'r hyn mae'n ei wneud ym maes *medical technologies*. Yn y maes ffarmacoleg, mae'n rhoi mandad, ond nid yw'n defnyddio'r gair '*mandation*' wrth wneud y gwaith ar *medical*

established year and a half ago. One of the interesting things about Health Research Wales is that it has been very well received by the industry, but it is increasingly getting applications—like some kind of brokerage service—from the producers and developers of equipment and technology, because pharmacological research is its main purpose.

Finally, quite a lot of work has been done over the last two or three years from the economy department to support the industry in Wales, and an important part of that is to help industry to find the right people in the health system. There will be—I am not sure what 'hub' is in Welsh; 'hwb'? So, the life sciences hub will be opening just around the corner this summer. The purpose of that is to be a front door to the health system and the life sciences in their entirety in Wales, including the NHS. I would say that there is far more links now than there were two or three years ago between the health department and the department for the economy, and between the department for the economy and the NHS. The Government has built upon the work that MediWales has been doing for years—it has tried to bridge between these and has brought the life sciences team, the work that NISCHR is doing, and the work that the innovation team in the department for the economy is doing, much closer to the health system than previously, and there are things still developing as we move forward.

Elin Jones: On the question about whether the health boards are slow to commission any new aspect of technology, there is a feeling that that should be happening in all parts of Wales. Is there a place for the Welsh Government to be mandating that, in some way, as was said in an evidence session earlier today?

Mark Drakeford: That is an interesting idea and worth thinking about. NICE differentiates between what it does in the field of pharmacology and what it does in the field of medical technologies. In the field of pharmacology, it does mandate, but it does not use the word 'mandation' in its work on medical technologies. So, it is possible that

technologies. Felly, mae'n bosibl bod rheswm nad yw'r syniad yn gweithio'n dda, ond mae'n werth i ni ei ystyried. Nid oes gennyf ateb y bore yma.

there is a reason why that idea does not work well, but it is worth thinking about. I do not have an answer this morning.

[135] **David Rees:** Kirsty, do you want to come in on this point?

[136] **Kirsty Williams:** No, the Minister has clarified his view on mandation.

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

[138] **Darren Millar:** In terms of the reviews that have been ongoing, you touched earlier on in your evidence, and indeed in your evidence paper, on the IPFR review that has been undertaken and the ultra-orphan and orphan drugs piece of work that has been done. I seem to recall that there was mention of a Welsh patient access scheme at some point in respect of drugs. Will that equally apply to technologies and, if so, who will manage that scheme, given that the All Wales Medicines Strategy Group has no role in terms of technologies other than drugs at the moment?

[139] **Mark Drakeford:** To take the last point first, access by Welsh patients to unlicensed drugs will be part of a UK scheme, and that will be managed through the Medicines and Healthcare Products Regulatory Agency. It will, on a UK basis, agree with the industry which unlicensed drugs are to be made available and they will then be available on a UK basis. However, it is very much pharmaceutical rather than related to technology. I have seen nothing, Darren—. I have not looked specifically at your question, but I cannot recall seeing anything in the advice that I have had that suggests that it would be anything other than the unlicensed drugs that that system will provide.

[140] On your first point about the two reviews, they both come to some common conclusions about the need to have better alignment between the different parts of the decision-making process in Wales: so, better alignment between AWMSG, WHSSC and the individual decision-making panels, for example. They both talk about the scope for some greater national role for the therapies and—is it toxicology, Christine?

[141] **Ms Morrell:** Yes, toxicology. It is the All Wales Therapeutics and Toxicology Centre.

[142] **Mark Drakeford:** That is the place AWMSG gets its specialist advice through, and then it makes that advice more authoritative through the system. So, while those reports do not directly deal with the subject matter that is in front of this inquiry, as Gwyn, in his first question, was suggesting, there is scope, it seems to me, for learning some of the lessons from that, and then, if we are going to be making changes there, to make sure that we align what we are going to be doing here in the same way. We do not want to end up making some parts of the system more coherent only to find that there is another part of the system standing outside that that we could have encompassed in that change.

11:30

[143] **Darren Millar:** We certainly have heard about inconsistencies, bits of duplication in the process as well, and sometimes WHSSC almost reappraising issues that have already been appraised and approved by AWMSG. However, just in terms of this specific possibility of Welsh patient access schemes, you have mentioned these before and suggested that they might be a useful opportunity in terms of drugs. What about other technologies aside from the MHRA programme, and the benefits that that might bring?

[144] **Mark Drakeford:** We do not have a separate programme, either in Wales or on a UK basis, that is about individual patients gaining access to innovative technology in the same way. It is actually quite difficult to imagine how that would happen, because whereas a drug is administered directly to the individual, a new piece of technology could not just be for the one person, or very rarely. It would be, as we were saying earlier, more something that would be available as part of a changed service in that area. Would it be useful to give one example, Chair?

[145] **David Rees:** Yes, of course.

[146] **Mark Drakeford:** It is an example that I think has something to say about various points that people have raised so far. In the latest set of announcements on the telecare scheme, one of the things that we are going to be doing in Wales is to offer microsurgery to people suffering from lymphoedema. Up until now, lymphoedema has been a very painful and unpleasant condition for which there is no cure; it is just a matter of managing the condition. However, there is a new technology. It is only available in one hospital elsewhere in the United Kingdom. It offers, for some patients, the opportunity to have surgery that will cure the condition. However, you could not just have that equipment for one patient. It has got to be a new technology that is available to the whole range of patients who might benefit from it. As it is very expensive, we are only going to be able to provide the operations themselves in one centre in Wales, and that will be in Morriston, because plastic surgery surgeons tend to have a role to play in this. However, because it is very important to be able to do the pre and post-clinical care where people live, there is another part of the technology that will be run through Tenovus and its mobile lymphoedema clinics. So, in every part of Wales, people will be able to come forward for this new service. They will have all the preparation and testing and things that are needed done close to where they live. The new technology will allow all that information to be sent electronically to Morriston, and everything that the patient needs prior to the operation will be relayed back to them through the Tenovus mobile units close to where they live. You can see that this requires a new service model. It requires specialist training for the staff who are going to be providing it. It requires a close technological relationship between the specialist service where that will take place and the service that is much more widespread right across Wales where patients live, taking Kirsty's point about the primary and secondary care interface. It is technology that will allow a cure for a condition that, up until now, no cure has been available for—for some, not all, patients; it is very important to say that. However, it is for some people who have lymphoedema. However, to get it right, you have to have all those three things in place, and then it is a service not aimed at individuals quite in the way that I think Darren was asking about in his question, but at a whole cohort of patients who will benefit from it.

[147] **Darren Millar:** May I just ask you about the review of the advisory structure in health, and how that might fit in, reduce the opportunities for duplication and help to focus the decision making that might arise from recommendations arising from advice that you receive, Minister? We heard this morning from the Welsh sciences advisory committee, but there are many other committees that are giving you advice. Can you tell us a little more about the rationalisation that may arise from that?

[148] **Mark Drakeford:** Thank you. Very early on after becoming the Minister for health, I had a meeting with Colin Ferguson, who is a vascular surgeon in ABMU and head of the Royal College of Surgeons in Wales. He came to see me because he had used the sabbatical that consultants in Wales are able to have after so many years in service to go to New Zealand to see how things are done there. One of the things that he came back very enthused about, and was very keen to say to me, was that they had had a thoroughgoing review of their advisory structure, which had grown up over many years. As a result, they had simplified the structure fairly radically in a way that clinicians felt gave them a more direct and more influential voice in the way that services would be planned for the future. Colin was definitely

saying to me that he thought that the Welsh system could do with something of the same approach.

[149] So, I discussed that with Dr Chris Jones, the deputy chief medical officer, and others. I will say this in a pejorative way—I do not mean it quite as it sounds—but it seems to me that the review of the advisory structure has been a little bit like scraping the barnacles off the bottom of a boat. Over the years, the system has grown up with lots of things accreting to it. Stripping it back and trying to find a way—. What I am keen on—. It seems to me that an awful lot of people in Wales with a very strong sense of public service put hours and hours into the meetings of our advisory structures. They give a lot of their time and experience, and so on, and I am not sure that that advice resonates locally enough in the places where decisions and policies are made, because there is just too much of it. The messages get lost in the babble of advice that is there. So, what I am keen to do is to streamline the system and make sure that the voice of those people who can give us good advice is heard more authoritatively and a bit more loudly, I guess, where decisions are made.

[150] That will be true of this area too, I think. There are lots of the advisory committees that, from time to time, will have something to say about medical technologies, and you heard from probably the most significant one this morning. However, it is scattered among them all. It probably does not come together coherently enough. As a result, its impact is not what it could be.

[151] You will not be surprised to learn that if you try to change a system that people are involved in, people are fearful that their bit of it will not be in the new system and they will not get the chance they have had in the past. So, there will inevitably be a bit of turbulence in moving through the system. However, the aim of it for me is to make those people more influential in what we do, not less. I think that simplification will help that.

[152] **David Rees:** Kirsty, did you want to come in?

[153] **Kirsty Williams:** Yes. Taking the Minister back to the point that he made about the development of a lymphoedema service and how you could not envisage that there would ever be a situation where the technology would apply to just one person, we saw evidence earlier that there could be new technologies and new interventions that simply would not be cost-effective for Wales to invest in, because the number of patients in Wales would not justify, financially or even clinically, in terms of clinical governance, that service. So, where do the commissioning, the appraisal and the pathways for those patients sit in this system to identify innovative technology treatments that could never be done in Wales but which Welsh patients could benefit from? We were given the example of treatment for pre-cancerous cells in the oesophagus, for instance. It is something that we cannot do here; there are not enough patients. So, where does that sit in the system?

[154] **Mark Drakeford:** Christine might have a better answer than I.

[155] **Ms Morrell:** Radio frequency ablation is one—

[156] **Kirsty Williams:** Yes, that is it.

[157] **Ms Morrell:** There are about 20 centres in the UK, and currently we are commissioning that through an individual patient funding request process or through WHSSC. That, I think, sits within the commissioning within WHSSC—generally, or potentially, that is where it should sit. However, it is currently going through an IPFR, and there can be inequity in the system. That is evidenced in NICE. It is less invasive. Where that sits currently is with the individual patient funding request process. The IPFR review was concentrated very much on the access to drugs, but about 40% of those applications are not

for drugs; they are for access to technologies. That is part of the review of how we do this. This has informed it and we have had a lot of questions on that one.

[158] **David Rees:** Minister, do you want to add to that?

[159] **Mark Drakeford:** Yes. It is one of the themes that come through the IPFR review. One of the ways in which it can be improved is that there will come a tipping point, in a way, at which, instead of making these decisions on individual basis, it becomes clear that there is a class of people here for which a service needs to be commissioned. At that point, it ought to move from being an IPFR process to being a WHSSC process, where WHSSC commissions it. That is part of why the report is so clear that better alignment between AWMSG, WHSSC and IPFR is part of what needs to happen.

[160] **Kirsty Williams:** Okay, thank you.

[161] **David Rees:** In that case, may I ask a question, coming back to that point? You have already mentioned NICE guidance this morning and the funding that the Welsh Government gives to subscribe to NICE. What action does the Welsh Government take when it receives the NICE guidance, particularly in relation to technology?

[162] **Mark Drakeford:** We have a way of disseminating NICE guidance. I just wish to make the point again that NICE guidance in this field is about discard as well as adoption, so we try to make sure that those things go out. I met with NICE not that long ago to talk to it about what more it could do to help us to make sure that its advice is properly communicated and then adopted in the Welsh NHS. As a result, we have a new group set up, with senior people from each local health board, but the deputy chief executive of NICE comes to that and is a member of it. What I hope that group will be able to do is to make sure that senior clinicians in the Welsh NHS get some early indications of work that NICE is doing, so that people can be preparing for it. However, where there is information coming out of NICE that people might not, in their busy lives, get to attend to, there will now be a way of communicating that on to people. So, I am keen for us to be able to do more to make the maximum drawdown against the money we provide to NICE to make its work effective in Wales. I made that point to it and it has responded by making a pretty senior member of its staff available to us to help us to do that.

[163] **David Rees:** Okay. Does any other Member have any other questions?

[164] **Darren Millar:** May I just ask one? Obviously, when NICE guidance is produced, it applies to the NHS without having to have a ministerial sign-off. It is a very different situation with recommendations from the All Wales Medicines Strategy Group. Do you think that it is really necessary for you as Minister to sign off its recommendations, given that you obviously hold it in very high regard?

[165] **Mark Drakeford:** Well, it is a question I have asked myself, because it is time-consuming from its point of view and it is not a small dossier that lands on the desk when it arrives so it takes a lot of time there too. I think that the Kalydeco test is the one that we have to think about, though. It is the only example where, ministerially, AWMSG's recommendation has not been upheld. However, if you did not have that final backstop ability of the Minister, we would not have adopted Kalydeco in Wales because AWMSG did not recommend it, so—

[166] **Darren Millar:** But, with respect, you could always override the decision regardless, could you not, as has happened in other nations within the UK even though they have had automatic sign-off?

[167] **Mark Drakeford:** I suppose that you could. However, that is a fairly—. The process there does not look to be a clean one to me if the process is that it makes the decision and the Minister has nothing to do with it but the Minister can still intervene when the Minister does not happen to like what the decision is. I do not quite like the sound of that as a system. Our system is perhaps more laborious in the way it does it, but it allows the Minister an identified part in the decision-making process.

11:45

[168] I will think more about what you said because it is a point that has occurred to me. However, so far, I think to myself that if we did not have the ministerial backstop here, a decision would have been made that we around this table would probably not have been comfortable with, and we were able to do it differently.

[169] **David Rees:** Thank you, Minister, for your attendance. We have a couple of minutes, so is there anything that you wish to add to what you have said today?

[170] **Mark Drakeford:** I do not think that there is a great deal further that I would add, apart from perhaps two very brief points that did not come through quite as strongly in this evidence session as maybe they did in the others. NICE is very clear that one of the other differences between this field and pharmaceuticals is that the clinical evidence for new medical technologies is not usually as clear-cut or as easy to identify as it is in some pharmaceutical cases. So, that is another reason why it is not just possible to immediately translate how we do things in the one area into this.

[171] NICE also makes a point that has not quite come through this morning, which is that lots of medical technology advances are in the field of diagnostics, but an advance in diagnostics does not automatically mean an advance in outcomes for patients, because unless you have treatment advances that are able to tell you more quickly and more precisely what your problem is—if there is not something that allows you to do something about the problem that you have identified—it does not automatically lead to a better outcome for the patient. On that hinge between a lot of investment by the industry in medical advances in diagnostics and outcome, I think that NICE is saying that you could spend a lot of money on improving your knowledge that there is not a lot that you can do for somebody. So, there is a relationship that you have to be aware of in this field between investment that you make in diagnostics and investment that you make in finding new treatments, new cures and new abilities to be able to respond to the diagnosis that you have made. We do not always think that through clearly enough, and I think that that is what NICE is saying.

[172] **David Rees:** Thank you for that Minister. I appreciate those points, but there is also the early diagnostics that can be provided, which is an important element.

[173] **Ms Morrell:** It is about the research and developing drugs. You need the diagnostics on a genetic basis; you need the diagnosis to be able to develop the drugs. It is all a part of that.

[174] **David Rees:** We will stop there. [*Laughter.*] Thank you for your time. You will receive a copy of the transcript to check for factual inaccuracies, if there are any. Thank you

[175] We will break for lunch and reconvene at 1.15 p.m.

*Gohiriwyd y cyfarfod rhwng 11:48 ac 13:20.
The meeting adjourned between 11:48 and 13:20.*

Ymchwiliad i Wasanaethau Orthodontig yng Nghymru: Sesiwn Dystiolaeth 1
Inquiry into Orthodontic Services in Wales: Evidence Session 1

[176] **David Rees:** Good afternoon. May I welcome Members and the public back to the committee's session today? The purpose of this afternoon's session is to begin the evidence gathering on the committee's inquiry into orthodontic services in Wales. I am pleased to welcome Stuart Geddes, director of the British Dental Association Wales, and Peter Nicholson, consultant orthodontist at the Royal Glamorgan Hospital, who is representing the British Orthodontic Society. Good afternoon and welcome. May I also thank you for the written evidence that has been received? Clearly, it raises questions, and we have some questions from Members. If it is okay with you, we will go straight into questioning. I see that it is, so we will start with Gwyn Price.

[177] **Gwyn R. Price:** Thank you, Chair. Good afternoon. Could you tell me whether you think the Welsh Government should fund a one-off waiting list incentive to clear the backlog of patients waiting for orthodontic treatment?

[178] **Mr Nicholson:** I think that I had better take that. Far be it from me to say 'no' to funding. I think that some funding for waiting list initiatives may be a good idea, but it would have to be extremely carefully managed. For example, if we take south-east Wales, where there are 5,000 patients on new-patient waiting lists in the specialist practices, if somebody came in and saw all those patients in six months, I think that all hell would break loose, quite frankly. If you look at the workload in the hospitals, an awful lot of the work is tertiary referrals from specialists. We want to see those patients, obviously, but there would be huge knock-on effects. There would be knock-on effects on the hospital orthodontic service and on the hospital oral surgery and maxillofacial service. So, I think that some sort of big bang would not be terrifically helpful.

[179] What it would also do is move all those patients from new-patient waiting lists—okay, we know that some of them would disappear, because they were not appropriate, they were under the level for NHS orthodontic treatment, but all that you would do would be to transfer a big bunch of patients to treatment waiting lists, and the bottleneck in specialist practice is in treatment capacity. It is a bit hidden at the moment, because the way that specialist practice works is that practitioners take patients on only when they have treatment capacity. So, they just sit there. I think that that is wrong and I would like to see a change in that, but I think that it would be naive to think that you could just chuck a lump of money at it and you would get an instant solution. I think that you would need to look at it down the line.

[180] **Gwyn R. Price:** Do you have a view?

[181] **Mr Geddes:** Like Mr Nicholson, I would never refuse money if it came my way. I wonder whether it would not be better to use any money that was available to educate general practitioners on what is an appropriate referral. That would go a long way to reducing the waiting list for the orthodontists. General practitioners, generally, are not very good at diagnosing orthodontic treatments, because it is not part of the undergraduate curriculum. If they could be educated, shown what is an orthodontic problem and shown how to use the index of orthodontic treatment need properly, that would go a long way towards reducing the waiting lists, which is the problem that you are trying to address.

[182] **Gwyn R. Price:** So, the answer is 'yes' if there is money, but 'No, you don't think it is the answer'.

[183] **Mr Nicholson:** I think that we can use it, and I think that it should be used—

[184] **Gwyn R. Price:** Clinical need.

[185] **Mr Nicholson:** Yes, I have a solution, which I am quite happy to expand on if you want me to, or we can deal with it later.

[186] **David Rees:** You can expand upon it now.

[187] **Gwyn R. Price:** Expand on it, because it is a solution.

[188] **Mr Nicholson:** If you were asking me for one way that we might be able to improve things, it would be to get a shift of those specialist practice new-patient waiting lists into specialist practice treatment waiting lists if necessary, but at least we would know what we are dealing with. We would then have patients whose needs had been validated using a proper index. We would know what we are dealing with.

[189] In the previous inquiry in 2010-11, one of the questions I was asked was, ‘There are 5,500 new patients waiting to be seen, what does that represent?’ We did not know. I think that the Chairman was sitting over there. We went out and did an audit of 600 patients very shortly afterwards—600 new patients seen both in hospital and specialist practice. The numbers are somewhere in my paper—I was looking for them just a second ago. There were only about 5% of patients who were totally inappropriate and did not know why they were there. They had rotten tooth brushing and could not see what it was all about. There were about 15% to 20% who were below the cut-off point for NHS orthodontic treatment. Having said that, most of those required a specialist opinion, because I do not think that it is within the skillset of a GDP to make that decision, particularly when it is border line. I also, as a result of the last time, gave three or four courses on the index of orthodontic treatment need to general dental practitioners. I did one for the BDA out west, I do the DF2s, and I did one for Cardiff and Vale, but that was it. There was a little flurry of activity. I put a lot of work into a presentation and nobody has asked me since. I do not think that it was because it was a bad presentation; I just think it is that things move on. A lot of the young dentists have moved on. It needs to be a continual process. One of the recommendations, which I think was my view at the time, was that training on the IOTN should be much the same as training in the regulations related to taking x-rays. It is a core CPD and should be done every five years by every dentist. Nobody took up on that, but that is my view.

[190] **Gwyn R. Price:** That is your point of view.

[191] **David Rees:** Out of curiosity, would it reduce the number of people on the waiting lists if a GDP had that knowledge? How much training would they require to be able to say—

[192] **Mr Nicholson:** It might make a 5% to 10% difference in fewer people being referred. It would certainly not be a panacea. The trouble is that there are a lot of cases that are close to that cut-off point. I think that the average GDP would feel uncomfortable having to make that decision and I think that a lot of parents would demand a second opinion anyway.

[193] **David Rees:** We have talked about the demands on the waiting list, not for treatment, but the waiting list to see a specialist. Do we have sufficient capacity on the orthodontic treatment side of things to deal with it in Wales?

[194] **Mr Nicholson:** No, I do not think that we do. If you look at the waiting list numbers in hospitals, they are validated. The protocols of the hospitals are to only take on very complex cases and almost exclusively those that require multidisciplinary care, and there were 1,500 patients in the four hospitals, not including Cardiff, if we just take south-east Wales. As I said before, the bottleneck in specialist practice is treatment capacity. They only take patients on when they have slots available and because of the way that they run it, we

end up with these unknown quantities, which are those on the new-patient waiting list, which could mean anything. Worryingly, there are patients on there who should be in hospital. Almost on a weekly basis, I get a frantic phone call from a specialist saying, 'I've just seen this person for the first time, they have been on my waiting list for two years and they should be seeing you people, can you squeeze them in?'

[195] **Rebecca Evans:** The previous committee—I was not a Member then—expressed concerns at a lack of co-ordination between waiting lists and that some patients were on more than one waiting list. Is that still a problem now?

13:30

[196] **Mr Nicholson:** I do not know the answer to that, certainly. Our audit would suggest that there were patients on the wrong waiting lists; I do not think that our audit would have actually picked up on duplicates, to be fair. However, one of the advantages of a gradual shift to having short waiting lists, both in primary and secondary care, is that you would not get this scattergun effect of, 'Well, I will put a referral in to all three specialist practices and the hospital and one of them will come up sometime soon'. It is usually me, because I have a short new-patient waiting list, because that is my role—we always have had short new-patient waiting lists in the hospitals, and long treatment waiting lists—and also because we have referral-to-treatment targets. So, I see them and they say, 'Oh, yes, we were going here and we have had this there', and that usually—. You would probably want to cover your ears if you heard my response in the letters that I send to the general practitioners, because I think that it is appalling. That is why we needed to validate these waiting lists. Actually, the best way to validate them is to get rid of them, in my view.

[197] **Mr Geddes:** I think that that was the problem in that general practitioners who did not carry out any orthodontic treatment themselves would know who their local specialist practitioners were, so they would send a referral to all of them on the grounds that, at some point, you will come to the top of the waiting list.

[198] **Leighton Andrews:** I wonder what you think the responsibility of the profession is here. You referred earlier on to having carried out some courses yourself to help people to upgrade their own skills. Dentists, at the end of the day, are independent contractors to the health service, effectively—not all, but largely. In most professions, there is an expectation that you will maintain a level of continuing professional development and I am just not clear, from what you are saying, whether that appears to be effectively integrated into practices, so that they are aware of how and when they should refer, or indeed, what they should refer.

[199] **Mr Geddes:** I think, possibly, when Peter and I, who are roughly both the same age, were at dental school, we were given a basic course in orthodontics. It has moved on from what was the old removable type of appliance, which was made and used with a varying degree of success. It is now a very specialist subject with fixed appliances and all those sorts of things. Orthodontics is different; it is now a post-graduate subject. It deserves and has a two-year course—

[200] **Mr Nicholson:** It is three years, full time.

[201] **Mr Geddes:** It is a three-year course, which is a Master's course now. General practitioners are not expected to be able to carry out orthodontic treatment. They should, in my view, know how to diagnose orthodontic problems, but as Mr Nicholson says, there are those for whom it is very evident that they do not need it and there are those for whom it is very evident that they do need it, and then there is this batch in the middle. That is where the problems arise.

[202] **Leighton Andrews:** Sure, but I certainly was not suggesting that all general dental practitioners should be carrying it out; what I was simply raising was the issue of diagnostic techniques and understanding, and the responsibility of the profession to continually develop those. My constituents on the whole—I will be very careful what I say—would expect dental practitioners to keep up to date with developments and so on.

[203] **Mr Geddes:** I think that the AA principle applies here, ‘I can’t do it myself, but I know someone who can’. I think that you need to know what your own limitations are and what to do with a patient if they need treatment.

[204] **Leighton Andrews:** Yes, but you responded to me in the context of initial dental training, rather than what goes on as people develop their practices.

[205] **Mr Geddes:** Well, orthodontists are specialists—

[206] **Leighton Andrews:** No. I am talking about general dental practitioners and their ability to recognise and then pass on appropriately.

[207] **Mr Geddes:** I think that they do, but there is this area of children who fall into a category of maybe or maybe not. Those are the ones who need to be referred, together with the ones who do need treatment. I think that GDPs are very capable of dealing with those at both ends, but it is the ones in the middle, when it is a case of, ‘Well, maybe if we wait there will be a bit of development’. I have to say that a bit of parental pressure also comes into it sometimes, which will tend to push them towards a specialist referral.

[208] **Mr Nicholson:** As I said before, as an orthodontist I would like to see it as a core CPD subject.

[209] **Leighton Andrews:** Okay. Thank you.

[210] **David Rees:** Obviously, with the managed clinical networks that exist now, the BMA seems to have indicated that it believes that they have improved relationships between local health boards and orthodontist practitioners. Is it your view that the managed clinical networks are helping the situation, or are there still issues that need to be addressed?

[211] **Mr Nicholson:** I think that they are helping hugely. The managed clinical networks were largely clinician initiated. I have an e-mail somewhere that I sent to all my colleagues in south-east Wales in 2009, saying, ‘I think that we should have an MCN’. I think that the health boards have welcomed us with open arms. I know that you have people from the health boards in the second session, but none of them, as far as I am aware, are involved in the management of orthodontics. If you speak to the people whose role it is to manage primary care dentistry—. They were delighted when we turned up because they did not really know what they were doing. It was an area that they were not sure about. It is a different area. The managed clinical networks, I think, have really worked terrifically well. I have been delighted with what has happened. I think that if you speak to the people on the management side in the health boards, they will tell you that they have been delighted as well. Again, if you look at those 18 recommendations from the previous inquiry, I went through them the other day and thought that I could reasonably tick off seven. Certainly, six of those were really because of the MCNs and the way that the MCNs have worked.

[212] **David Rees:** Your MCN, obviously, is south-east Wales.

[213] **Mr Nicholson:** Yes.

[214] **David Rees:** It has undertaken a recent audit—an independent treatment outcome

audit. Have you found the information from that to be beneficial, and have you been able to share that information with other MCNs?

[215] **Mr Nicholson:** Yes. We have undertaken a new-patient audit, as I described earlier. Last year was the first year that we did the outcome audit on a sort of formal basis throughout the MCN. It was a bit chaotic; it did not really work as well as it should have done. We sat down with the person who was managing that, and we have made a lot of upgrades to the process for this coming year.

[216] **David Rees:** What I am trying to find out is whether there is any formal process for sharing good practice and information.

[217] **Mr Nicholson:** For sure, yes. Apart from the fact that the chairs of the other two MCNs are good mates of mine, and we are on each other's e-mailing list about anything to do with the MCNs, we do have the strategic advice forum that was set up by the chief dental officer, which gets together a couple of times a year. We try to make sure that everyone is working to roughly the same pattern—exactly as you say—to share good practice and to look to the way forward.

[218] **David Rees:** I turn to Darren.

[219] **Darren Millar:** Thank you for the evidence that you have provided. I know that the previous inquiry picked up some very similar things. There is a sense of *déjà vu* sometimes when you look at the papers.

[220] **Mr Nicholson:** I did not quite believe, when I got the e-mail, that there was another inquiry.

[221] **Darren Millar:** Yes. May I just ask you something? To what extent do the waiting lists contribute to further pressure on the waiting lists, because dental practitioners might be making referrals earlier than they ought to because they know that the waiting list is a long time?

[222] **Mr Nicholson:** It is exactly that. Again, this is why I would like to see that shift in the balance of the waiting lists in specialist practice. Thirty-six weeks is what we work to, although we are actually way under that, generally, in the hospital service, but if you knew that your patient was going to be seen within six months, you would not need to scattergun refer, and you would not need to refer three years earlier on the grounds of thinking, 'By the time that they get there, they should be about right', and all of those kinds of things. If there was one thing that I could change, that would be it, because I think that it would get rid of a lot of other problems.

[223] **Darren Millar:** To what extent do you think that people might be referring to a number of centres, rather than just one centre on the basis that, 'Well, if I make two referrals, you might be seen a bit quicker down the road'? Is that happening? To what extent are people double counted?

[224] **Mr Nicholson:** Our audit did not really pick up on that because there would not have been a mechanism to do so. However, yes, I am sure that it goes on because, as I said earlier, I have a fairly standard snotty letter that goes to anybody I find doing it. I think it is appalling.

[225] **Darren Millar:** In terms of the demographics of the referrals—the age profile of the individuals who are referred for orthodontic treatment—do you have any data? Are people being referred as young as eight or nine, on the basis that there is a long waiting list?

[226] **Mr Nicholson:** I do not have the full audit—

[227] **Darren Millar:** And their teeth may not have fully developed and it is difficult to see—

[228] **Mr Nicholson:** One of the questions within the audit was whether patients had been referred on time, more than a year too early or more than a year too late. There was a spread. There were undoubtedly—I just cannot remember the numbers off the top of my head, but there might have been 10% or 15% who were a year too early. Of course, that is annoying for everybody but I would rather that than a year too late. Of course, one of the issues that the dental public health paper brought up—and I may want to say a few words about that at some point if I get a chance—was that, at that stage, although not generally, there was this sort of multiple review approach where you got a unit of orthodontic activity each time you saw someone in the build-up to treatment. That is gone. Certainly, in south-east Wales, that has gone. We have all agreed that there is one assessment and then you do the treatment. So, there is no virtue from the orthodontist's point of view of getting early referrals. They will still review them to make sure that they get them at the right time to do the active treatment, but they are not getting paid for it.

[229] **Darren Millar:** So, your assessment is that people are referring, sometimes, too early on the basis of the longer waiting lists—

[230] **Mr Nicholson:** Indeed.

[231] **Darren Millar:** —and that that could be adding to the waiting list pressures and that the competency among general dental practitioners could perhaps be improved to sharpen up how they assess in order to potentially reduce the number of referrals. However, when you have people who are waiting longer times—and you mentioned time being of the essence and they could potentially be waiting up to 40 months in some parts of Wales—to what extent are people then losing out on the opportunity for orthodontic treatment because they are over the age of 18?

[232] **Mr Nicholson:** Well, being over 18 is a separate issue, and I will come back to that in a second, if I may. Undoubtedly, there is an ideal time window for an awful lot of orthodontic treatment. A lot of the treatment modalities rely on enhancing growth or kind of getting it to work for you. Yes, if patients wait a long time, they might have missed that slot and, while they will almost certainly still be treatable, it might not be quite the ideal treatment that you could have used a year or two earlier. However, of course, that is an issue of treatment capacity, not the new-patient waiting list particularly—

[233] **Darren Millar:** However, do the extra-long waits—if you are having to start treatment too late—then choke the capacity even further?

[234] **Mr Nicholson:** Not necessarily.

[235] **Darren Millar:** Okay, they do not stay in the system longer—

[236] **Mr Nicholson:** If they are really delayed, something that might have been treated orthodontically can end up as a joint orthodontic-surgical case in the hospital, and that is a different issue.

[237] **Darren Millar:** And post-18—

[238] **Mr Nicholson:** The contracts in Wales are all for under-18s, and that does create a class of people who are above the threshold for NHS orthodontic treatment and there is

nobody to treat them. We do not take them on in the hospital because we have enough problems with our waiting lists for the very complex cases and they are in a bit of a black hole. Sometimes, there are lots of reasons for that but, very often, it is because, at 18, they suddenly take control of their own lives. It is their parents who perhaps have not done the right thing by them because they have not taken them along to the dentist and the orthodontist. So, I feel very sorry for them and, back in the day, I used to have a sneaky waiting list for adults who I thought needed care, but it was not multidisciplinary and they had missed out. I realised that they were staying on it indefinitely, and I just had to close that. I think that that is a problem. We have had discussions, both at the managed clinical network and at the strategic advice forum in orthodontics, about the eligibility date of those patients. If they have been sitting on a waiting list since they were 16, and they are 18 when they get off it, then, as far as I am concerned, they are eligible for treatment. The business services authority that manages the health service—the paymasters down in Eastbourne, or wherever they are these days—just see ‘over 18’ and say, ‘This patient isn’t eligible for treatment’, and that is something that we would like to address.

13:45

[239] **David Rees:** Before I bring in Kirsty and then Elin, do you have some figures that you could provide to the committee on the number of people who are perhaps a year early and the people who are a year late?

[240] **Mr Nicholson:** Yes, I can provide that. The figures are on my computer.

[241] **David Rees:** Thank you. That would be helpful. Kirsty is first and then Elin.

[242] **Kirsty Williams:** It seems that there are long waits across Wales, but I am interested in your views on regional variations and where we have particular problems where the waits are even longer. I am also interested in the physical access to that service when somebody does get an appointment, so people having to travel to get treatment when they do come to the top of the list. So, are there particular areas where we just have really poor geographical cover and people are having to travel long distances?

[243] **Mr Nicholson:** The simple answer is ‘yes’, as I am sure that you are only too aware. One of the problems that I think people do not always understand, and Stuart would say the same for dentists as well, is that orthodontic practices are businesses. You see these huge numbers bandied around about practice earnings and all the rest of it, but somebody who wants to set up an orthodontic practice in west Wales or mid Wales has to buy premises, they will have to service the loan on that, or they will have to pay rent, and they will have to equip it, which is £150,000 per surgery, probably. They will have to pay their reception staff, nurses et cetera, so there are huge costs in running an orthodontic practice, which is not the case for doctors, who have a health centre built for them. The way that it works with the new contract is that orthodontic contracts are within PDS—personal dental services; I am not quite sure where that comes from—and, essentially, they are time-limited contracts. So, you could imagine going to the bank manager and saying, ‘I want to set up a practice in Llandrindod Wells; can you loan me £0.75 million? By the way, I have got a three-year contract that may or may not be renewed’. It puts them in a difficult position. Dentists have to buy their own practices, but they do at least have the advantage of a rolling contract, in effect. So, yes, there are areas where access is difficult, but you have this tension between economy—the cost-effectiveness of running a service—and access. I think that there are ways around it, possibly.

[244] **Kirsty Williams:** Which are?

[245] **Mr Nicholson:** There are three solutions, as far as I can tell. I was thinking about it yesterday. There is the dentist-with-extended-skills model. I do not think that there is any

place for dentists with extended skills in south-east Wales. There are plenty of specialists, and I think that, if a specialist can do the treatment, then the specialist should. However, we know that the model works fairly well in north Wales. However, the dentist with extended skills does need access, and I think it only works well if they have a continuing relationship with the consultant or a specialist so that they can do the treatment plan, review it part way through, and probably just before finish, in an ideal world. The difficult bit about orthodontics is not actually the mechanics from week to week; it is actually the treatment plan and the case management. We can teach therapists to put brackets on teeth fairly quickly, but it takes three years to train a specialist, because they need to develop those skills of assessment and case management. So, one is the dentist-with-extended-skills model and the other is the community dental service model, which does work. Interestingly enough, I was doing a manpower review last week, because I thought that somebody might ask me how many orthodontists there are in Wales, and I thought that I had better know the answer. There are not that many community orthodontists, but they do have the advantage that they can be reasonably peripatetic and maybe only go to one, two or three centres. So, that is one solution.

[246] As for the other solution, I ran a small—six hours a week—specialist NHS practice in Barry for 15 years. It had an orthodontic problem. There is a population of 50,000 in Barry, and it is a surprisingly inaccessible place. What was then South Glamorgan wanted some orthodontics there, and rented me the community clinic. I brought my own nurse, my own materials, and all the rest of it. Being terribly peripatetic is not much fun for the clinicians, but it is a model, and there are plenty of community clinics and probably other premises that are not used full time. I paid a rental, and they had a surgery that was lying idle. So, it worked for me and it worked for the patients. That is a possible model. Those are the three models that you could use.

[247] **Mr Geddes:** May I come in on that point? There is a fourth model, namely specialist practitioners who might want to just go off to another surgery and do a session there. That is quite attractive, because the specialist orthodontist is coming into your general dental practice to provide a service, and the specialist can know that, if there is a problem, it can be managed with a little bit of training and co-operation between the specialist and the GDP. That does work and has been available in parts of south Wales, but mainly in south-east Wales. It would be an ideal situation for dealing with areas such as the area in which you live in Powys and those areas where the basic demographic of the population means that there are not enough children in the appropriate age group to support a proper orthodontic practice.

[248] **Mr Nicholson:** Yes; I used a community clinic, but it would work equally well in general practice. The issue has probably been the availability of orthodontists to do that. I was appointed in 1982, which is an awfully long time ago, and there was at least one orthodontist who we probably both know who used to go around with a toolbox, effectively, from practice to practice. That is not a good model, and not an attractive model for someone who has just done three years' training.

[249] **David Rees:** No, not with a toolbox.

[250] **Kirsty Williams:** No, it is not a good look.

[251] **Mr Nicholson:** It was a posh toolbox. [*Laughter.*]

[252] **David Rees:** Is there a problem recruiting orthodontists? You have talked about a three-year training programme beyond the traditional programme. Is it difficult to encourage people to take that on board, because it is another three years out of their career?

[253] **Mr Nicholson:** No. Next week, or the week afterwards, I will be going down to national recruitment in London, because it is now rather like medicine in that we have gone

through a national recruitment for training posts. I believe that there will be 37 training posts throughout the UK, and the shortlist will be of 108, because that is the maximum that they can interview successfully, even with about 20 or 30 consultants there. It is quite a circus, and the interviews take place over two days. That will be oversubscribed, and we get excellent candidates. Whether, subsequent to getting their specialist training, they want to come to work in Wales is another issue.

[254] **David Rees:** That was going to be my next question. Where is the training undertaken? Where is the three-year period spent?

[255] **Mr Nicholson:** It is undertaken all over the country. There is a training programme in Cardiff. At any one stage, we have six registrars in training. There are two in each year group, and they spend time in the regional hospitals with me and with my colleague in Merthyr.

[256] **Mr Geddes:** Dental students, like many university students, come out of their university course with a considerable degree of debt, and there is pressure on them to clear some of that. I believe that the training courses are—. Are they half-time funded or full-time funded, Peter?

[257] **Mr Nicholson:** They are full-time funded, but the fees are scary.

[258] **Mr Geddes:** You have to pay your fees out of that. So, that is further pressure on the bank balance, I am afraid.

[259] **Mr Nicholson:** There is no difficulty in recruiting trainees, however. The issue is retaining them in Wales, I suppose. The 2006 contract effectively capped orthodontics at the levels that were there at the time. It is also fixed it largely by locality. If you were in far west Wales and there was no orthodontics there at the time, there would be no orthodontics there afterwards—because of the three big specialist practices in Cardiff, most of the specialist care orthodontics was done in those three specialist practices. All the money went into Cardiff and Vale. That was part of the motivation behind those of us who were not in Cardiff and Vale making sure that the MCN was set up and things remained equitable, because that resource represented patients who had originally come from Cwm Taf and Aneurin Bevan health board areas, and all those places. There was a suggestion in the very early days that practices should prioritise Cardiff patients, and I for one jumped up and down a lot at that stage to make sure that that did not happen.

[260] **Mr Geddes:** That is quite an issue, not just for orthodontics but for all specialist services. Getting patients referred into, for example, Cardiff dental hospital, which is a specialist centre, from anywhere that is not within the Cardiff and Vale boundaries is very, very difficult.

[261] **David Rees:** Elin, you had a question.

[262] **Elin Jones:** Yes. I want to go back to age-appropriate referral. There is obviously a maximum age of 18 for treatment that is decided by funding. Would it be beneficial at all to have a minimum age for trying to stop the early inappropriate—

[263] **Mr Nicholson:** The inappropriate early referrals. There are some issues that become apparent among seven or eight year olds for which a short interceptive treatment at that stage can save problems later on. There is a fee structure for that. I think that it is three units of orthodontic activity. They are usually simple treatments that involve four to six months, such as for front teeth coming through the wrong way round at six. Pop them round the right way, very simply, at that age, and you may not need to do anything else.

[264] **Elin Jones:** So, you have that small group of very early referrals with a specific issue around it. However, regarding the mass, the big teenage years referrals—

[265] **Mr Nicholson:** Sure. The vast bulk of patients are treated between the ages of 12 and 14. In a lecture I give to dentistry undergraduates I say that the age of nine is a very good time for dentists to have a serious look at some issues. I do not want to be too technical about it, but there are some issues that become apparent and it helps to have an earlier referral so that you can monitor growth and provide interceptive treatment. So, I do not think that you can put a cut-off point. Again, part of the course that I ran on the index of orthodontic treatment need also said when you should refer early, but how much that was taken on board I am not entirely sure.

[266] I have to say that, with the new referral form—because, subsequent to all that, we created a common referral form that is used throughout south-east Wales; you are not allowed to refer on anything else—anecdotally, the practices are looking at those forms and triaging cases to some extent, and trying to pick out, where there is enough information, cases that they perhaps ought to see sooner.

[267] **David Rees:** Darren, do you want to come in on this?

[268] **Darren Millar:** Yes. May I just ask this? You mentioned earlier the fact that many of these practices are independent businesses that are contracting to deliver services with the NHS. The current contractual arrangements make it difficult for people to plan for their investment and perhaps even to raise the money—the capital finance—in order to invest in their businesses. To what extent would longer minimum contracts, if you see what I mean—there is a referral to a potential five years or five years plus in some of the evidence that we have received—actually produce economies of scale for the Welsh NHS and reduce costs overall perhaps for each referral?

14:00

[269] **Mr Nicholson:** I am not sure that it would reduce costs.

[270] **Darren Millar:** You do not think so.

[271] **Mr Nicholson:** No, I do not think so. I think it would put—

[272] **Darren Millar:** I would expect you to turn white when I say things like that about reducing costs.

[273] **Mr Nicholson:** My view is that those contracts need to be rolling contracts.

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

[275] **Mr Nicholson:** One of the things that the MCNs are working on with the chief dental officer at the moment is a common set of key performance indicators for practices. The current ones have been plucked from somewhere, and they need to be appropriate for orthodontics. I think that if you have a practice that is meeting its KPIs, then its contract should roll and it should have that confidence that it is going to roll, and then it has the confidence to invest, et cetera. I am not particularly sure that it—. The costing that it would save is the costing of re-tendering. The south-east has generally reallocated contracts. The south-west has gone out to tender, and that has involved a lot of expense both for the practitioners and for the health board. In a way, it has also paved the way for the big corporates to come in, and I think that most of us are pretty uncomfortable with the model that they are producing.

[276] **Darren Millar:** Just very quickly on the way that the contracts work, people are paid when a course of treatment starts rather than when it is completed or when there is a satisfactory outcome for a patient. Is that right?

[277] **Mr Nicholson:** Can I say 'no'?

[278] **Darren Millar:** How does it work? Tell me how it works.

[279] **Mr Nicholson:** If you look at it baldly, that is exactly what happens. What happens is that an orthodontist takes on to do a certain amount of treatment for the health board. They get paid for that an annual salary, effectively; it is chopped into 12 parts and paid on the month. The way that that activity is measured is in units of orthodontic activity. Those units are awarded at the time of starting treatment.

[280] **Darren Millar:** Is that a good way to do it?

[281] **Mr Nicholson:** The British Orthodontic Society did not think that it was when the contract was discussed initially, but I think that, if you are going to change it, again it is one of those things that would have to be done gradually because it would upset finances and practices all over the place. I think that this idea that, 'Oh, they are paid upfront', is just a little bit too easy to say, and not actually true.

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

[283] **Mr Geddes:** We would certainly support the idea of a rolling contract, however, because orthodontic treatments go on for much longer than a general dental services type of treatment and if there is no certainty that the practice is going to be there at a certain date, you will not take on cases that might go on beyond that.

[284] **Darren Millar:** I note from the paper that we have received that the waiting times are much longer for very complex cases. Is that because if people are paid upfront they are going to concentrate on the easier to treat cases first?

[285] **Mr Nicholson:** No. The longer waiting lists for complex cases are within the hospitals. They are largely because of consultant capacity. If you look at the manpower within the hospitals, it is essentially consultants and trainee orthodontists.

[286] **Darren Millar:** So, just to get this right, there is no disincentive under the contract for people who are contracted to deliver a certain volume for the NHS each year to avoid more complex cases.

[287] **Mr Nicholson:** No. I am constantly surprised at the cases that the guys—and girls, sorry—do take on in specialist practices. It is a very simple system, but it is a swings and roundabouts system. You all know that there are cases that will take nine months, and there are cases that you will be slogging away at in two and a half years' time. Everyone just takes it on the chin and gets on with it, I think.

[288] **David Rees:** I have Leighton on this point, and then Kirsty.

[289] **Leighton Andrews:** I was wondering about the comment that you made about discouraging big corporates. Could you just explain to me why you would want to do that?

[290] **Mr Nicholson:** The corporate model is working very much on the use of therapists. I do not have a lot of first-hand experience of therapists, but my colleagues in Swansea, who

are involved in one of the main UK training programmes for therapists, are of the view that orthodontic therapists are helpful, in practice, but actually cost money—the only way that you can make therapists pay, if that is your prime reason, and maybe the corporates are more financially orientated, is by having quite a lot of therapists and not too much supervision. Of course, the General Dental Council, in its wisdom, decided that therapists could be supervised by any qualified dentist, which caused howls of protest among the orthodontists; we feel that it should be specialists.

[291] **Leighton Andrews:** I want to push this a little bit, because, you know—.

[292] **Mr Nicholson:** Of course.

[293] **Leighton Andrews:** I would like to know what evidence base there is for the assertions that you made about corporates. Secondly, how do I know that we are not just hearing some professional protectionism here?

[294] **Mr Nicholson:** Good point. This is anecdotal, because I cannot—. I do not have major research. One of the issues with the corporates is that they are very slick and very good at tendering, and there have been a couple of contracts that have come up for which very sound bids were made by locally based specialists, but they lost out to larger corporates, and I—.

[295] **Leighton Andrews:** You are all in the private sector, at the end of the day, so you are either big private sector or small private sector. That does not necessarily tell me anything about the quality of the services that you are providing.

[296] **Mr Nicholson:** No, but I think that it is a bit like your family dentist, is it not? If your family dentist—somebody you have got used to and have built a relationship with over a period of years—is taken over by a corporate, and then you find that, every time you go, there is a new dentist who has come from somewhere in the European Union probably, but from places that do not actually have the same breadth of training, necessarily, as in the UK, you probably feel uncomfortable.

[297] **Leighton Andrews:** Okay. I am hearing professional protectionism. I have sympathy with what you say about the relationship, of course I do. One wants to build a relationship, particularly with dentistry, with someone one sees regularly and consistently, and who knows the issues. I can understand that as a patient; that is probably how I would feel. However, I think that I would rather hear some more evidence about the particular point that you put forward before just buying it on sale.

[298] **Mr Nicholson:** Okay. Fair point. I think that the worry is that, if you look at the M4 corridor, there is one corporate that has taken over about half of the orthodontic practices, probably. I think that there is just the danger of a monopoly supplier, and the downside of the—. As you said, it is about big business and small business, but if the big business is so big that there are no small businesses left, we know that there is—

[299] **Leighton Andrews:** Is there any evidence on the efficiencies of a monopoly supplier?

[300] **Mr Nicholson:** I do not think that we are at that stage yet, but I think that it is something that we should be concerned about.

[301] **Mr Geddes:** I think that the big danger with corporates is that they take up so much of the market that they could, actually, pressurise the health boards to provide only certain services at a certain price; that is one problem.

[302] **Leighton Andrews:** Well, that is a reasonable public-interest argument; I accept that.

[303] **Mr Geddes:** There are other issues, however, about where their manpower is. I would be very happy to talk to you about corporates outside this meeting, if you would like.

[304] **Leighton Andrews:** I think that I would like to hear more evidence from both organisations, really, about their concerns about this.

[305] **David Rees:** If you have any further information or evidence, we would be very grateful to accept it. Elin is next.

[306] **Elin Jones:** I just wanted to ask about the tendering process and the new contracts that are awarded. You seemed to allude, earlier on, to there being a different process that south-east Wales had gone through as compared to the one in the south west, where they had gone out to full tendering. Somehow, in the south east, there had, somehow, managed to be an extension in contracts to the existing providers. I am just curious to know how the two areas can run different tendering processes. Surely, there is a requirement to run a full tender process every time.

[307] **Mr Nicholson:** I suppose the question that you have to ask is, 'Is that a good idea?' If you have well-performing practices meeting their key performance indicators, my view would be that they should be on a rolling contract basis.

[308] **Elin Jones:** Yes. I do accept the role and I have a bit of sympathy with the rolling contract scenario, but I have this question: how did the south-east manage to do that in a way that the south-west has not done, which has now put everything in jeopardy?

[309] **Mr Nicholson:** I remember talking to one of my friends who has a specialist practice around the middle of March, at the end of their first personal dental services contract—I suppose that would have been 2009—and he said, 'I haven't heard from the health board, I don't know what's happening; in theory my funding could run out in two weeks' time. What would I do with my x thousand patients?' It is not thousands, but what he meant was, 'All these patients that I have under treatment'. I think that they almost fell into it, at least the first time. I am not entirely sure, legally, whether they have to tender. I think, by and large, that it is a wasteful process with practices that are well run and well performing, I should say. If you have some new money—

[310] **Elin Jones:** So, you are almost saying—

[311] **Mr Nicholson:** If someone gave us some new money and said, 'Let's put a service into wherever', then obviously that should be tendered for.

[312] **Elin Jones:** So, the fact that, in the south-west, they have decided to go through a full tendering process and anybody could turn up tomorrow, go for the tender and win it, and existing businesses would be out of work or out of that contract, means that they are jeopardising the development of the longer term service in that area, if you are—

[313] **Mr Nicholson:** I do not think that it has been a helpful exercise.

[314] **David Rees:** I have a question from Darren, which is a very small one, and then Kirsty to finish off.

[315] **Darren Millar:** Very briefly, I want to follow on with tenders. If you have 50% of the market taken up by one player in south Wales and you can have rolling contracts, is that

not defeating the argument that you wanted some diversity in the sector?

[316] **Mr Nicholson:** Yes, I suppose that it is.

[317] **Leighton Andrews:** And defeating the nature of the—*[Inaudible.]*

[318] **Darren Millar:** Absolutely. However, eventually you are going to have 50% of the market taken up by one supplier, are you not?

[319] **Leighton Andrews:** So, that constitutes a legal monopoly.

[320] **Mr Nicholson:** Yes. The dilemma is that if we keep on tendering, at some point they will have 100% of the market, because—

[321] **David Rees:** You have given us something to think about.

[322] **Leighton Andrews:** Whether there is a real market—*[Inaudible.]*

[323] **David Rees:** Kirsty, your question is next.

[324] **Kirsty Williams:** We kind of assumed at the beginning of this session that the Welsh Government and the Welsh NHS have a role in providing orthodontic treatment. I was greatly concerned by the chief dental officer's suggestion, when he came to the committee, that maybe we should not be doing any of this free of charge for children under the age of 18. Other people who have sent evidence to the committee have talked about rationing the service either to level 4 and level 5 patients and taking level 3 patients out of the system or applying a means test to the ability of a child's parent to contribute and pay for treatment. I was wondering what your views were and what the consequences would be if we were to follow the suggestion of the chief dental officer and just stopped doing this altogether.

[325] **Mr Geddes:** I do not think that we should stop the service. What we need to do is look at who needs it rather than who demands it. I think that there is a lot of demand at the moment rather than need. If there is more money to go into dental services in Wales, I would like to see the priority going towards preventive practice. We need to address some of the issues that we have with the high levels of disease that we have in Wales. We are now at the bottom of the UK pile. That, from my point of view and the BDA's point of view, would be where the money should be focused. Let us deal with basic dental disease and then we can look at the cosmetics and the add-ons of orthodontics, if we have extra money later on. At the moment, there is money there. It probably does need to be rationed. Mr Nicholson and I are not going to fight on this one.

[326] **Mr Nicholson:** We agreed not to fight.

[327] **Kirsty Williams:** That is because you might need orthodontic treatment yourselves. *[Laughter.]*

14:15

[328] **Mr Nicholson:** Orthodontic treatment is based on need. I was particularly disappointed with one of these papers—I am sure you probably know which one I am talking about—that seemed to suggest that orthodontics was some invention to make money for orthodontists. That is unsubstantiated, ill-informed and out of date. It is an affront to orthodontists. The treatment is based on need. The suggestion that maybe we lose that little group, between IOTN 3 and the high aesthetic index, would in some ways simplify things, but it would reduce access for about 5% of patients according to our numbers. The better-off

parent will fund it privately; the people who lose out will be the less privileged in society. On the view in that one paper, and the view that Stuart has just expressed, as to where we spend our money, I was appointed to Mid Glamorgan in 1982—it was a long time ago—and I have seen an enormous amount of money put into prevention and prevention schemes and there is an awful lot of evidence out there that they do not work. If you wanted to sort out most of the problems, you would fluoridate the water. I know, politically—

[329] **Kirsty Williams:** No, we are coming back to that. [*Laughter.*]

[330] **Mr Nicholson:** When I was appointed in 1982, there was a fluoride works somewhere up in one of the valleys, just above Merthyr, and it broke down about the time I arrived. I used to see kids with pretty rubbish tooth brushing, but at least their teeth were not rotting. I do not want to knock prevention stuff, but I think that Designed to Smile, if you look at it critically, is not working. The recruitment is great among patients who are already dentally aware and it is appalling among the patients we really want to get at. I am not saying that we should not spend money on prevention, but please do not take it away from a service that is working effectively, is treating need, is cost effective and has measurable outcomes and stick it into something as vague as some of these prevention schemes.

[331] **David Rees:** We will leave it there; time is up for this session. Thank you very much, both of you, for your evidence this afternoon. It has been interesting and has caught some interesting views. You will get a copy of the transcript to check for factual inaccuracies. Thank you very much. We will now move on to the next session.

14:19

Ymchwiliad i Wasanaethau Orthodontig yng Nghymru: Sesiwn Dystiolaeth 2 Inquiry into Orthodontic Services in Wales: Evidence Session 2

[332] **David Rees:** Good afternoon and welcome to this afternoon's second session of our inquiry into orthodontic services. May I just remind you that the meeting is bilingual and if you wish to use the translation service, it is on channel 1 and the amplification is on channel 0? The microphones will automatically come on if you speak.

[333] I welcome Professor Stephen Richmond, who is a professor in orthodontics and is representing Cardiff and Vale University Local Health Board. I also welcome Karl Bishop, who is associate medical director at Abertawe Bro Morgannwg University Local Health Board. We also have Bryan Beardsworth, who is dental services lead at Hywel Dda Local Health Board, and Warren Tolley, who is primary care dental adviser at Powys Teaching Local Health Board. Good afternoon and welcome. I thank you all for the written evidence that we have received and we now have some time for questions. We will go straight into questions if that is okay with you and I will start with Gwyn.

[334] **Gwyn R. Price:** Good afternoon, everybody. I have asked the other witnesses whether the Welsh Government should fund a one-off waiting list initiative to clear the backlog of patients waiting for orthodontic treatment, or do you have a different view on how the health board would address this situation?

[335] **David Rees:** We will go from left to right, as it is easier for me that way, so perhaps Professor Richmond would like to answer that first.

[336] **Professor Richmond:** Okay. I think that it was the last time that I visited this committee that I suggested that a one-off payment would help—not for everyone, but in the instances where there are large waiting lists. It should be targeted at people, particularly those on the older side from 14 to 17 years of age. If you look at some of the documents, some of

the waiting lists range from about 12 months to 36 months, and some of those waiting lists need validating from the point of view of their entry at nine or eight years of age. However, I would say that a small amount of money would aid some of the difficult pressure areas. I did say that at the last committee as well.

[337] **Mr Bishop:** I completely agree with what Stephen is saying. It has to be done in combination. We need to ensure that the current waiting lists are validated and appropriate and then target the money into the areas where there are longer waiting lists and those waiting lists have been seen to be appropriate and validated.

[338] **Mr Beardsworth:** I would echo those sentiments. While it would be very welcome, clearly there needs to be a more detailed plan around resolving this matter in the long term. For me, a one-off single investment would improve the situation as it is at present, however, we would slowly get back to the point of where we are at at this moment in time with significant waiting times.

[339] **Mr Tolley:** I am not convinced of that. Yes, it would help in the short term, but I think that you need to plan orthodontics with a long-term strategy rather than these quick fixes. I just think that it is throwing good money after bad, really, personally.

[340] **Professor Richmond:** May I come back on that?

[341] **David Rees:** Yes.

[342] **Professor Richmond:** This is a quick fix. It is sustainable after that.

[343] **Mr Tolley:** Then it has to be sustainable. Just giving it a lump of money and expecting the problem to go away—.

[344] **Professor Richmond:** I think it is reasonably sustainable.

[345] **David Rees:** It is always nice to have a mix of views. *[Laughter.]*

[346] **Gwyn R. Price:** You would suggest bringing it in and targeting it at chunks, then.

[347] **Professor Richmond:** If you look at the Cardiff and Vale report, some people have 18-month waiting lists and some have three-year waiting lists. That three-year waiting list has to be validated as to why there are differences—maybe the units of orthodontic activity were not allocated properly or there may be other issues. So, these things need to be investigated. If there are long waiting lists, particularly for the age group between 14 and 18, it would be appropriate to target those in order to bring the mean age in line with the rest of Wales. In the last report that I did in 2010, the shift of age for treatment was very minor compared to 1997-98, which was when they did the last one. I suspect that it has not changed that much since across the whole of Wales, either. Therefore, you will get variations, where it is large and short, and it is a question of matching them up where there is spare capacity, or having an evening out of capacity.

[348] **Darren Millar:** The evidence that we seem to have received paints a picture of a lack of capacity in Wales to be able to deal with the demand coming through the doors for orthodontic treatment. You have mentioned, Professor Richmond in particular, the need to validate the lists that are already out there to ensure that they are appropriate lists and that, perhaps, there is not duplication between the different lists when people have been referred to two or three different centres for treatment. However, what do you make of the suggestion that we have just heard from the British Orthodontic Association, which was that we need to raise the level of competency among general dental practitioners to be able to help them to

identify more carefully the inappropriate referrals they might be making in order to avoid making them?

[349] **Professor Richmond:** The number per year that the system refuses ranges from about 10% to 25%. It depends how you calculate it. It is about 25% of the cases that are coming in as treatment starts, but 10%—

[350] **Darren Millar:** Some of those will need assessment though, will they not, by a specialist practitioner in order to—

[351] **Professor Richmond:** What I am saying is that the number refused by the orthodontist is quite a small percentage. So, the system is working reasonably well. However, you will get regional variation because—forget the data—some people have a 40% refusal rate. So, it requires targeting, which I did mention in my orthodontic report, which I did in 2010. I did suggest an academic detail to help target these individuals because we are getting down to small instances of individuals and peculiar practices. One thing that has changed significantly since 2010 is that the number of assess-and-reviews has gone down by more than 10,000.

[352] **Darren Millar:** May I just come back on that? We have just heard that around 5% of referrals are entirely inappropriate and that between 15% and 20%, following assessment, did not go on to have treatment thereafter. Are you disputing the evidence that we have just heard?

[353] **Professor Richmond:** I am just saying what I have told you, which is that it is between 10% and 25%, depending on how you calculate it.

[354] **Darren Millar:** So, you clearly have a different view to the British Dental Association.

[355] **Professor Richmond:** I am right. [*Laughter.*]

[356] **Darren Millar:** Do you not think that there might be merit, given that there is a significant proportion and you could open up some capacity here, in training more carefully, if you like, and investing in the training of the general dental practitioner workforce in order to upskill it in order to avoid inappropriate referrals in order to open up capacity and reduce waiting lists?

[357] **Professor Richmond:** I think that there are issues with individual practitioners, but generally I think that they are doing a pretty good job. The other issue is that the patient always has the right to a second opinion. So, where there is some contention, they will seek a second opinion, as you will see in the numbers you have seen. So, you are always going to have noise at the lower end. However, there are some areas where orthodontists or practitioners will receive referrals from people that may be higher than the average and they need to be targeted. It is not a blanket approach but a focused correction.

[358] **Mr Bishop:** May I just add something? You were talking about validating waiting lists. One of the processes of validating is to see the source of the referrals. When we have done that previously, we have highlighted individuals and practices that are outside the norm rather than the whole norm. So, that is another advantage of having a robust validation of the waiting list. You are able then to identify those individuals who might be referring inappropriately and to address that by targeting the education and support for those individuals.

[359] **Darren Millar:** So, you have done that in your own health board, have you?

[360] **Mr Bishop:** No, not in our health board, but we are in the very early stages in our health board. We have only really just started to get accurate data. Where we have validated has been in other areas in other specialties where we have looked at referral patterns. So, there is more of a move to have a central referral process, where data can be recorded and then these out-on-a-limb referral patterns can be identified and the resources can be targeted there rather than having a widespread resource to all general dental practitioners.

[361] **Darren Millar:** When you refer to having a more centralised referral practice, are you talking about a Wales-wide centralised function?

[362] **Mr Bishop:** No. Where we have done it in our health board with other specialties, we have centralised referrals into one point. They are logged at that point. So, at that point, you can see where the referrals are coming from, the patterns and numbers. At the moment, referrals go directly to the specialist practitioner and we just get numbers coming back. So, there is nothing to stop us getting those data from specialist practitioners, but that is an evolution to be able to put the resource in to get those data coming back.

[363] **David Rees:** I want to expand a bit on that question before I bring you back in. Clearly, there is an issue here, if you are talking about data collection on that basis, because we are already aware of the long wait that some people have. There is quite a long run-in to identify where patients are coming from, if they are inappropriate, because they may not be seen for two or three years.

[364] **Professor Richmond:** I go back to my original point. If you look at the curve—it is a bell-shaped curve—you will see a peak around about 14 when people get treatment. It has not changed very much going back from 2010 to 1989. So, if you get a significant shift of, say, more than a year, then it is a real problem, but if it is within about three months it means that they are pretty much on course. Also, the way you look at waiting lists means that there is usually a bell-shaped curve. It should peak at 14 and tail off and finish at 18. Also, it could start below nine, but there is usually a small line.

14:30

[365] If you have a flattened curve, it means that you have more people at the higher end and more at the lower end, but you still have the same volume within that. So, the technicality is how you look at waiting lists, but what you basically have to do is to have a comparison between curves and mean ages. Some people say you should start putting people in the lower age group at nine years of age, anticipating that they will be treated in two years' time. So, you could have a long waiting list, but you would not treat them, then; you would wait for two years. So, there are ways of managing and understanding those waiting lists.

[366] **David Rees:** You are talking about a narrow standard of deviation, are you? You have a narrow standard of deviation.

[367] **Professor Richmond:** Yes, you can go that far and put standard deviations on it, but once you see the pictorial patterns, you can see where they are at. It is interesting, and I have noticed this before, but not all contracts go up to the age of 18, some go up to the age of 17, but I do not know what the variation is.

[368] **Darren Millar:** Oh, right.

[369] **David Rees:** I am sorry, Darren, you go ahead.

[370] **Darren Millar:** May I just check in terms of the capacity of the service to be able to

deal with the referrals coming through? I appreciate that some people may be referring early because they are anticipating a long wait, and that may slightly distort the figures, but, in your own health board, Mr Bishop, around 5,000 people are waiting for a consultation, is that right?

[371] **Mr Bishop:** For assessment, yes.

[372] **Darren Millar:** For their first appointment. However, capacity is only 1,600 patients per year; that is what you are contracting for.

[373] **Mr Bishop:** I think that capacity is slightly higher than that for assessment and treatment. It is around 2,000, and that has been fairly steady. It was based, primarily, on the work that came through from Steve's work in 2010, to look at what our need was at that time and what the capacity was. So, we have worked on that. I think that you are right, in the sense that there is a feeling across most health boards that the demand for orthodontics, despite some of the work that has gone into this, is still increasing, and that is what we need to answer, namely whether that demand is a true need and what that need level is.

[374] Another issue, as you have indicated, is that we are seeing earlier referrals, and it is about how the health board manages those, because there may well be an educational issue in there. People refer earlier, but then, what happens is that they slow the process down, because there are more individuals within the process. So, it is about how the health board then manages that. However, to be fair, I think that health boards are only really—since the managed clinical networks have been established over the last two to three years—starting to go down the line of how they manage some of these processes.

[375] **Darren Millar:** So, there is increasing demand and there are increasing numbers of referrals coming through, but the same sort of capacity is having to cope with that demand. Would that be a fair assessment?

[376] **Mr Bishop:** Yes, but we have to differentiate between demand and need.

[377] **Darren Millar:** Yes, I appreciate that. We all know that there are people who just want a Hollywood smile, regardless of the fact that there may not be a clinical need for them to have one. However, what proportion of people is turned down on the basis that they do not have a clinical need when they are referred? You mentioned earlier on—

[378] **Professor Richmond:** It is between 10% and 25%, depending on how you calculate it.

[379] **Darren Millar:** That is pretty consistent, is it, or has it been going up?

[380] **Professor Richmond:** I think that it is reasonably consistent, actually.

[381] **Darren Millar:** So, what is the answer? Why is this increasing demand so significant? It is not—

[382] **Mr Tolley:** I think that, to be fair to the general dental practitioners, there is a huge range of skills, which we probably know. With specialisation, orthodontics is very much a postgraduate subject, and it has gone down that route. Most practices now only practice if they have a contract, so they have to have a certain level of skill. The average general practitioner is doing a bit of everything, so they are probably a little more risk-averse now than they were 10, 15 or 20 years ago, when it was perhaps more within their normal skill range to do some orthodontics. So, I think that that has probably led to some of the increase of referrals, and they need an opinion, occasionally—

[383] **Darren Millar:** But where is the evidence of that? Professor Richmond is telling us that the rate of people being turned down as being inappropriate or not needing further treatment is consistent.

[384] **Mr Tolley:** I do not think that being turned down and, basically, not having any treatment offered is necessarily an inappropriate referral. They may be referring for a second opinion, for a specialist opinion, where they cannot make that decision themselves. Sometimes, for instance, you could refer someone early, because you feel—I am just going to give a clinical example—that the canines are going off course, or something, which would need an opinion, and that patient would have an assessment, but no orthodontic treatment was needed at that particular moment in time.

[385] **Darren Millar:** I understand that, but if the level of turn-away, if you like, or of no further treatment being required is consistent, which is the suggestion that Professor Richmond has made, that would not back up your suggestion that this is all because people are more risk-averse, would it? They would be consistently risk-averse. They would be consistent in how risk-averse they are if there is a consistent pattern in terms of the percentage of patients who are not—

[386] **David Rees:** May I ask a question here? Mr Bishop identified the fact that he was talking about collecting data, and it seems to me that you are now in the process of collecting those data. Are all health boards that you represent now actually collecting the data appropriately so that we can have an analysis of the information and be able to say whether this is going on, and which practices perhaps need some training, and with how many it is being decided that no further treatment is required? Are the health boards now in a position to have those data in their possession?

[387] **Mr Tolley:** The assessment and review data are available through the reporting.

[388] **Mr Beardsworth:** From a Hywel Dda perspective, we have moved on and have a single point of referral. It is at a very early stage, and we are treating it as a pilot scheme, but we hope that that information will come out. I agree with Warren, because my feeling, from meeting and working with general dental practitioners, is that they are becoming more risk-averse, and they would want to get a specialist opinion. On that basis, I am seeing an increased number of referrals into the service. So, we have now implemented an assessment-only service in Hywel Dda, which acts almost as a gatekeeper approach to the service, and hopefully from that we will have that information that you are referring to.

[389] **David Rees:** I have questions now from Elin and then Kirsty.

[390] **Elin Jones:** In some areas of Wales, access to orthodontics is pretty poor in terms of waiting times but also in terms of distance to practice. The issue here of course is that you have young children and teenage children who are taken out of school for lengthy periods in order to attend appointments that may take a day rather than an hour out of school because of the distances involved. I represent Ceredigion, where the postbag can have quite a number of letters on orthodontic access. Our previous evidence session identified ways of plugging some of these gaps, delivering a service in a different way to just having the PDS contract with the independent contractor. It outlined the options of a dentist with extended skills, a community orthodontic service and directly provided outreach orthodontic clinics, and I was wondering—and this is possibly for the two more rural health boards in particular—whether you are investigating investing in some of these alternative methods of provision.

[391] **Mr Tolley:** In Powys, we have commissioned across border through service level agreements and through PDS specialist contracts for the north of the county. There is a little

bit of a distance, approximately 35 miles one way, for patients to travel. We have not found that to be an issue with anyone who is accessing that service in the north. In mid Powys, we have used community dental clinics by renting them out to visiting specialists to use. In the south, we have a contract with visiting hospital consultants, and we are looking at that model at this very moment. We have lost the old senior dental officer in orthodontics posts over the years, and it has almost been impossible to attract that sort of person back into a salaried position. That was a very useful post as it took a lot of heat out of the system. They were salaried and quite often could work in a couple of clinics, and you could be flexible, depending on the need. You could alter the timetable and that worked very well, and they were employed usually in the community dental service with a consultant link. They were also able to triage some referrals and offer those orthodontic opinions without clogging up the practice-based system. So, that is a model that can work for rural areas.

[392] **Elin Jones:** So, when you say ‘we have lost’, what does that mean?

[393] **Mr Tolley:** I am speaking UK-wide here. There are not many—

[394] **Elin Jones:** So, those people are still there—they are trained orthodontists, but they are not being employed in the NHS—

[395] **Mr Tolley:** They are not available to recruit. In terms of recruiting someone into a salaried post within a community dental service as a senior dental officer in orthodontics, there are not many of those people around anymore. The ones that have been in post have retired and they have not been replaced. That is partly because you cannot compete with the practice-based model of salaries, to be perfectly honest. I think you need to separate hospital orthodontics out from practice orthodontics, as they are two different models. Personally, if I had a blank canvas and was able to alter the contract, then what I would do—and I think it would solve an awful lot of these issues outright—is, rather than paying the specialist practitioner upfront to carry out the orthodontic treatment, perhaps it could be 50% with the balance paid on completion. I think that that would focus their mind on the sort of patients who are taken through to treatment. You could also have that final payment based on independent peer assessment rating scores being carried out on a random basis in a significant number of cases, and then the balance is paid based on satisfactory outcomes. You could also validate the index of treatment need score, to make sure that the patient was appropriately assessed in the first place, because you would get the before and after models. I honestly think that that would solve an awful lot of these problems, I really do.

[396] **Elin Jones:** So, in Hywel Dda—

[397] **Mr Beardsworth:** We list the models that Warren referred to, but it is certainly something that we are looking at at this moment in time. We have been in contract for service provision for quite some time, and those contracts are due for either renewal or new tender processes in the not-too-distant future. So, those are very much the options that we are looking at at the moment: how we can do things smarter, and how to get a better reach-out to our patients. Clearly, at the moment, we do have patients who travel from Aberystwyth down to Carmarthen to receive their treatment, and it is very challenging for them to access these services.

[398] **Mr Tolley:** To be fair, that model, regardless of orthodontics, works very well in rural areas.

[399] **Mr Bishop:** Can I just add something? You have highlighted the dentists with enhanced skills and dentists with special interests. We have three in ABMU, and that is a historic hangover, if you like, from these practitioners who had an interest in orthodontics and carried that on as part of the general dentist service contracts. As Warren has highlighted, it is

very much more difficult for those individuals to be identified and recruited. However, if you look nationally, and across the border, I know that it is not necessarily good to say these things, but you will see that dentists with enhanced skills across all specialties are seen as the way forward, because there is a gap in what a general dental practitioner is able and confident to provide, but also, from what a specialist provides, there is a gap in the service. Now, that gap in the service is at the moment probably being picked up by the specialist level, and that is across all specialties, including my specialty. So, in England in particular—and we are monitoring it—and if you look at the national health plan—that is why it mentions dentists with enhanced skills—it is seen that there is a model there that we may need to be able to develop. For that to develop, however, it needs the educational support for these individuals to train, to be part of managed clinical networks, and to be supported through. You do not become a dentist with enhanced skills overnight; you need a structure around you. I think that, in Wales—and I am sure that the CDO has that in his mind at the moment—it is something that we do need to be focusing on, developing this intermediate level of skill to take pressure off specialist services, but also to provide services in rural areas.

[400] **David Rees:** On that point, are the health boards looking at supporting a lot of training and development themselves?

[401] **Mr Bishop:** I can only speak for my health board. Our health board has, on the basis of endodontics—which is another pressure in the hospital service—developed a model for that and is looking to put that model into the Baglan resource centre, because there is a nice facility there with community dentists and training dentists coming through. So, there is a model in ABM to do that. Like everything else, it is then a matter of identifying the moneys to do it, because there is always a financial issue, and then identifying individuals. In ABM, we set up a joint project with the University of South Wales to develop these individuals, to get them to the level where they are ready to be acting as dentists with enhanced skills in endodontics, not in orthodontics, because we see endodontics, not only here, but around the country, as another pressure point for the specialist services going forward with an ageing population.

[402] **David Rees:** With just a very quick ‘yes’ or ‘no’ answer, are other boards doing the same?

[403] **Mr Tolley:** Yes.

[404] **Mr Beardsworth:** Not at present.

[405] **Professor Richmond:** Yes.

[406] **David Rees:** Okay; thanks.

[407] **Kirsty Williams:** Mr Tolley, I am slightly bemused, because, listening to you, it sounds as though Powys has it all sorted with this variety of ways of commissioning the service, yet I still get contacted by constituents who are concerned about long waits. Also, there seems to be anecdotal evidence that, depending on where you are in the county and where you are referred to, you may be seen more quickly. So, if you are able to travel to Cardiff, rather than wait for an appointment in Brecon, you will be seen more quickly, and if you can get a referral over the border in England, you may be seen more quickly. So, not only do we have disparity across Wales, even within a county, anecdotally, it seems that people are waiting different times.

[408] **Mr Tolley:** It is a big county, and there are certainly no orthodontics access problems in the north of the county, but we inherit what we inherit when we take over the services. Part of my role is to look after orthodontics, so I can take the blame now.

14:45

[409] In Brecon, there have been issues, because there has been a problem, in Cwm Taf, to recruit a consultant. Even at that distance from Cardiff, recruitment difficulties increase quite a lot. Fortunately, it has made an appointment within the last four weeks, and a new consultant is starting. So, things will hopefully plateau out there. We are looking at a plan and have a couple of models available, but I like the idea of a flexible salaried post or clinical assistant post with consultant support. The one thing that we do not want is to have an isolated person working in isolation and not having that consultant link. At the end of the day, orthodontics is a very specialised subject and you want the right person to do the work that is being carried out on your child. That is important. So, it is important to get everything in place.

[410] **Kirsty Williams:** Some of the evidence that we have heard—and, indeed, the chief dental officer, when he came to the committee previously, seemed to suggest that orthodontics on the NHS was simply a service that Wales could not afford to—

[411] **Mr Tolley:** I believe that you have misquoted him there—*[Interruption.]*

[412] **Professor Richmond:** What he said is that there are competing needs. He did not say that it should be eradicated, but that these were challenging times.

[413] **Kirsty Williams:** Well, I am asking you whether it is a service that we can afford. Public Health Wales has some very challenging things to say about orthodontics, and we have had suggestions that maybe we should tackle some of the waiting lists by rationing the service to those at the higher end of need, or that there should be means testing so that certain people can pay, if they have the means to do so.

[414] **Mr Tolley:** My view is that everyone has the right to have a reasonable smile in a civilised society, and I do not think that anyone would disagree with that. Obviously, if you deviate from the norm, there are probably some psychological implications. That is, there are psychological health benefits to having a nice smile. As for the health benefits in terms of reducing caries and periodontal disease and all of that, I am totally convinced on that, but I am not an orthodontist.

[415] I will go back to my initial suggestion regarding the contract. You can tinker around the edges and we can debate and argue all we like about having appropriate referrals et cetera—

[416] **Kirsty Williams:** The 5% here and 5% there.

[417] **Mr Tolley:** Yes. Unless that contract is tweaked at source and changed—. It is very much a business model and it needs to be addressed. Then, you will see improvements in access for all and, also, you may get other posts that become more attractive. I am going to keep going back to that, because I believe that it is an important point.

[418] **David Rees:** Does anyone else want to give a view on the importance of that?

[419] **Mr Bishop:** May I add something that I feel I have to add for the profession as a whole? We listened to the conversation earlier, and health boards are highlighting that there needs to be a continued investment in prevention, and Designed to Smile is looking to deliver that. So, the argument that prevention on a wide scale in Wales is unlikely to work or that targeted action—which is what Designed to Smile is—aimed at key individuals, the high-risk individuals, is not a sound investment is wrong. I need to put that completely straight now. I

am sure that you will ask the CDO about that in due course as well.

[420] On the question that you asked regarding whether orthodontics should stop, I believe that that is wrong. We are a civilised society. However, we need to ensure that our resources are used appropriately. The Welsh Government is very much about prudent healthcare, and that fits in with that idea. If we go back to Steve's report of four or five years ago, Steve made a number of recommendations, but, broadly, he felt that the capacity in Wales was sufficient for the need. Despite that, we see increasing numbers of waiting lists. We need to address that, and the Welsh Government needs to address why we are seeing that. We need to consider whether we have enough capacity. If not, then we need to rectify that. Perhaps there is enough capacity, but we have not made the right assessment of need. The Welsh Government has to advise us on that as well.

[421] Steve's report also highlighted a number of other initiatives that would free up capacity, but we have yet to get to the stage where they have been implemented—primarily because we are in the early stages with regard to the managed clinical networks. However, things like changes within the contract to reflect volume and who is delivering, whether an orthodontic therapist, a dentist with special interest, or a specialist, may, in their little segments, have an impact on the resource that we have to use.

[422] **David Rees:** Does anyone else want to come in?

[423] **Professor Richmond:** There is room for everyone. We are chuffed to have an across the board measure of all provisions, otherwise it would not fit and you would have more complaints than anyone. There are more complaints here at the Assembly, and in Parliament as well, about orthodontic treatment than anything else. You always have more complaints if there is an issue. However, I still think there is a general need across the board. There are competing needs. The important things are efficiency drives, which I have been trying to do in orthodontics, and there is still a way to go there, so it is an iterative process. That should be done in other aspects of dentistry as well, because you have to find space and capacity.

[424] **Mr Tolley:** It is worth pointing out as well that the hospital orthodontic service is, generally speaking, dealing with a different type of patient than the practice. It is dealing with skeletal deformities, clefts, and all the—

[425] **Kirsty Williams:** The big stuff.

[426] **David Rees:** Before I ask Elin to come in, you talked about the fact that you have to identify capacity. Have you done that yet, and how far off the levels of capacity are we at this point in time?

[427] **Mr Bishop:** The best person to refer that question to is Steve. I am not trying to pass the buck, but he wrote the report in 2010 on capacity, and he will have a far better handle on where we are with it, I think.

[428] **Professor Richmond:** There are capacity issues across Wales for various reasons. There are still issues of a high number of assessments being done compared with treatments. That still needs to be done in some health boards. Some health boards are better than others in addressing that. The ratio of treatment starts to completion is very variable. The other issue regarding the number of starts in terms of the total UOA value is that that percentage can vary from zero up to 89%; it is very high. It is about that sort of range. So, what we try to do is to look at efficiency measures. There are other issues about retreatments, some of which I did not have the information on back in 2010, namely the number of retreatments, because that will affect capacity. If we keep on having retreatments in the system, it will go around and around. That will be more of a problem in the big city areas, because they can cross borders in

about 10 miles or 14 miles. It is not a problem in west Wales, because they have to travel a long way. So, there are other things in terms of efficiency drives, but, as I said, it is an iterative process. There will not be a big bang to connect everything at once. It is about the things that go over five to 10 years. We will probably have the only one with sufficient services in the world by the time we finish.

[429] **David Rees:** I will bring Elin in now.

[430] **Elin Jones:** In the previous evidence session, we had a bit of a debate around rolling contracts with independent providers versus fully tendered three-year contracts, because of the benefit of rolling contracts being the ability of independent contractors to invest in and develop their service, and to plan it more effectively versus the issue of economies, possibly, from a fully tendered service. I just want to know how you, as health board commissioners, view a better system that looks at a better longer-term plan system, and whether the current system, which is meant to be a three-year tendered contract, is providing the security for the profession to develop its work in every part of Wales. I do not mind who goes first.

[431] **David Rees:** We will start again from left to right because it is easier.

[432] **Professor Richmond:** It used to be three years but I think that we have just gone to five-year contracts. In my report, I did say up to 10 years, but 10 years is a long time and you need get-out clauses to make sure that the quality of care is still being delivered. Businesses may change hands and have different philosophies. So, you need to have that long-term security so that a provider can develop their practice and invest in it. However, you must have that cost-volume, quality contract in there. The quality of treatment is the key thing.

[433] **Mr Bishop:** I do not disagree. As a health board, the tendering process that we have to go through is a laborious one anyway. It does introduce a degree of competition in the sense that where we have done tendering exercises across a number of services, we have found quite innovative methods of delivering a service that have come through the tendering process. So, I think that Steve is quite right; I can see the advantage, but I think there is a trade-off. If we want a rolling contract, we have to be very clear that we are getting a quality service and about how we manage and measure that. Within that, we need a get-out clause that says that if we are not happy with that service, it can be terminated. The last thing that any health board would want to do is to tie into a five-year service and find that there are problems with the service that it cannot really deal with, or that it is not made aware of problems. So, it has to go hand in hand; we have to look at how we manage the quality of a service and the outcomes, which would give us a degree of confidence to look at more long-term contracts.

[434] **David Rees:** That would apply in a tendering process as well, would it not?

[435] **Elin Jones:** Presumably, your three or five-year contracts have quality control within them.

[436] **Mr Bishop:** We are in the infancy with that. They are very simple ones at the moment that have come through from Welsh Government. We need to be building some of these in as we develop and as we get more knowledge about the service itself.

[437] **Professor Richmond:** The only thing I should mention about longer term contracts is that they are more attractive to corporate organisations.

[438] **Elin Jones:** That gets us back to an earlier conversation.

[439] **David Rees:** We will come back to that in a minute. Let me turn to the two health

boards first.

[440] **Mr Beardsworth:** It is a very tricky balancing act. While the security for the providers is paramount, we also need to be clear about what our exit strategy is from any contracts that we may enter into, and for which we may wish to re-tender at some point in the future. My take on this is that, if I was to draw an agreement to a close with my current providers tomorrow, I would be left with an awful lot of patients in the mid-course of treatment who have, in essence, already been funded. That provider, once the contract expired, would therefore have no responsibility for them. So, I think a balancing act needs to be done there, and the solution that we need to find needs to meet both criteria. I cannot give an answer as to what I would foresee that being at the moment.

[441] **Mr Tolley:** From a business point of view, I would be very sympathetic to the specialist practices that are running orthodontic services. They are on short-term contracts and I can understand the concern of that. I think that most people who run a business would be very concerned about that. However, at the same time, we need to make sure that the outcomes are satisfactory.

[442] **Leighton Andrews:** I want to pick up on this comment that long-term contracts are more attractive to corporates. Arguably, long contracts are more attractive to all business, are they not, as Mr Tolley has just said?

[443] **Professor Richmond:** What I meant was this system where they had recent contracts, where they have changed over. Where there was the original orthodontist principle, they sold them on to corporates. So, it is—

[444] **Leighton Andrews:** In designing a contract, you can put in place terms and conditions that protect against contracts being sold on. That is standard practice.

[445] **Professor Richmond:** I do not think that it was not standard practice at the time, because it happened on quite a few occasions.

[446] **Leighton Andrews:** It is standard practice in many areas of industry. So, if it has not become standard practice in the health service, perhaps it needs to. I see your colleagues nodding, so, perhaps it is standard practice.

[447] **Mr Tolley:** No, it is not standard practice.

[448] **Leighton Andrews:** Well, it should be.

[449] **Mr Tolley:** I think it should be.

[450] **Leighton Andrews:** Okay. We are all agreed that it should be. Fine. So, if it can be standard practice, there are ways of dealing with that, but what is the problem with corporates? The corporates might be more efficient than some of the—

[451] **Professor Richmond:** I did not say that there was a problem with corporates.

[452] **Leighton Andrews:** You said it in such a way that suggested that you felt that there might be problems with corporates.

[453] **David Rees:** Before you answer the question, I think, to be fair, the comment was that it is more attractive to corporates.

[454] **Professor Richmond:** That is right. I did say that. It is an issue that who you had the

original contract with has suddenly changed, without your knowledge, as a contractor.

[455] **Leighton Andrews:** Well, we are clear what we guard against, but the reality is that all of these practitioners are in the private sector, so it is not as though, suddenly, you have a lot of corporate privates and you have a lot of others that are in the public sector; they are not, they are all private practitioners.

[456] **Mr Tolley:** Okay. I think the issue is that if a practice has a long contract, then the goodwill of that practice will increase a lot. So, basically, what happens is that it becomes so that the average person will not be able to afford to buy that practice and take it over, which is what we have seen in some general dental practices—the goodwill has gone up. So, that is the issue—

[457] **Leighton Andrews:** However, in the previous session, we had evidence that if you are trying to establish an orthodontic practice, the upfront investment is very significant in any case. So, to be able to do that against the background of simply a three-year contract is really problematic.

[458] **Mr Bishop:** I think that it is the same for the set-up of any dental practice. There are quite substantial set-up costs and anyone setting up practice would be looking at the model that they are going into.

[459] **David Rees:** I think that that was mentioned on both sides. Rebecca is next.

[460] **Rebecca Evans:** I wanted to ask you to describe the rates of non-completion of treatment in your health board areas and to describe what the reasons for that might be and the implications for the health board and for patients.

15:00

[461] **David Rees:** Let us go for Mr Tolley first—

[462] **Mr Tolley:** I do not have those data in front of me at the moment, but we are getting tied up with an assessment and not having treatment. I prefer to look at it as a consultation—

[463] **Rebecca Evans:** No, I mean non-completion, where you start treatment and then the treatment, for whatever reason, is not completed.

[464] **Mr Tolley:** Oh, sorry. I do not have those data, but I can get them for you.

[465] **Rebecca Evans:** I understand that the figure is quite high.

[466] **Professor Richmond:** It is about 7% of treatment that is discontinued—[*Inaudible.*]

[467] **Elin Jones:** You look like a *University Challenge* team conferring there. [*Laughter.*]

[468] **Professor Richmond:** Do we look that intelligent? [*Laughter.*]

[469] **David Rees:** Professor Richmond, did you just say 7%?

[470] **Professor Richmond:** Yes, I said 7%. The issue is that not all forms are completed—the FP17s. They are very good at filling out the initial forms, because they are associated with payment, but the forms for completed treatment range from 0% to 95% completed. I think that, in Darren's submission, from Q Dental, he said that the forms are a different type of form. Sometimes, it is not the same type of form as the initial one. Obviously, a lot of people

fail to complete it, which is an issue when you are looking at the data because, if you have lost 25% or 50%, you do not know whether the treatment was discontinued or abandoned—that was the other category, ‘abandoned’—so you just have that hole and you do not know what happened to the outcomes. So, it runs at about 7%, but we do not know because all the data are not available.

[471] **David Rees:** Is this data collection process improving?

[472] **Professor Richmond:** It is getting better. I just received some recent returns. In 2010, the postcodes of patients were not put on in about 1,500 cases, which is quite a lot of the cases treated. I think that, for the start anyway, there is a completion rate of about 95%. However, the finishes are still not so good. Something we discussed the last time I came here—and which I mentioned in my report—is to defer some payment to the end so that you get completion. I have noticed from some e-mail correspondence in England that I have been included in that some authorities are asking for all the forms to be completed before payment is made because it is mandatory to complete the forms. Technically, you cannot be paid unless they have been completed.

[473] **David Rees:** They are paid because they are paid upfront.

[474] **Professor Richmond:** They are paid upfront. Some are even asking for information for IOTNs when they are refused, so they want all the information—all the boxes filled—and they are being returned in England, but that is not necessarily so in Wales. We are going to have to be a bit more bullish.

[475] **Rebecca Evans:** On a different topic, what are the procedures for ensuring that looked-after children get the orthodontic treatment that they need?

[476] **Professor Richmond:** Sorry, what children?

[477] **Rebecca Evans:** Looked-after children—

[478] **Professor Richmond:** In care.

[479] **Rebecca Evans:** Yes, children in care.

[480] **Mr Tolley:** My other job is clinical dental director for the community dental service. We tend to have good relationships with the carers and social services and then get referred in to the children’s service. It is always a safety net for them, so I think that they are pretty well looked after.

[481] **Darren Millar:** I am still interested in this whole capacity issue within the services. I am just wondering to what extent missed appointments are an issue and what impact they have on waiting times for patients. I noticed in your report of 2010, Professor Richmond, that you mentioned missed appointments and the possibility of charging for them.

[482] **Professor Richmond:** That is mentioned by Darren Hills from Q Dental. He is suggesting that, because you have spare capacity there, he wants some penalisation, but I think—

[483] **Darren Millar:** Is that something you would like to see considered, given the impact on patients—charging for missed appointments?

[484] **Mr Bishop:** It is the same question for general dental services—

[485] **Darren Millar:** Yes.

[486] **Mr Bishop:** —and I think that the feeling is that it would be inappropriate and there is the question of how you impose it and make it effective. It is probably impractical. I think that, more importantly, you need to look at your systems to minimise missed appointments and to ensure that there is a degree of education within the system. I am coming from a hospital environment, as you know, and hospital environments are very sensitive to these things. We are very slow compared with general dental services and specialist practices with regard to how we ensure that appointments are kept by contacting patients in advance through texts and things such as that. So, it is more about managing the process, I suspect, rather than—and this is my personal view—actually charging for a missed appointment, because I think that enforcing that, and—. Just purely thinking of the practicalities, say you are a mother of three children and one is ill, and that is your priority on the day, you may miss an appointment. How do you then enforce a collection of fees? It is just impractical to do that. That is my own view.

[487] **Darren Millar:** They can always phone up and say, ‘I cannot make the appointment’.

[488] **Mr Bishop:** That is the process, then, is it not?

[489] **Darren Millar:** They can be responsible about it. In terms of the Government’s message on trying to ensure and promote patient responsibility, it is absolutely right. Yes, of course we should give reminders to people with appointments. I do not know what the prevalence of missed appointments is for orthodontic appointments—I have no idea—but, generally, it is about 11% across Wales, which seems to be pretty significant in terms of the resource that that may be absorbing, and the lengthening of waiting lists that might be resulting from it. So what measures can we take to ensure compliance with appointments or better feedback if someone cannot make them? Is there a point where there should be a penalty for a patient if they are refusing to turn up all the time? You are making these appointments, you have the staff on to see them, and there is a cost and a drain on the NHS. How are we going to sort that out?

[490] **Professor Richmond:** The problem is that the get-out clause is the abandoned treatment system. So, with repeat offenders, it goes straight to ‘abandoned’.

[491] **Darren Millar:** Okay. How many times would you give them an opportunity to turn up?

[492] **Professor Richmond:** It is usually about two—I think that is what the health boards usually operate.

[493] **Darren Millar:** Then you drop them straight out.

[494] **Professor Richmond:** They would have to be referred back to a private dentist again on the issue, because sometimes people do have issues.

[495] **Darren Millar:** Would they go back to the top of the list in terms of—

[496] **Professor Richmond:** No. Obviously, if they have appliances on, they need to be there, because you cannot leave people with appliances on, because there is that risk.

[497] **Darren Millar:** For a first appointment, though, how does that work? Do they go back to the back of the list, as it were, and have to wait longer?

[498] **Mr Bishop:** I think Steve is probably talking about the hospital side of things, which

is slightly different, and a slightly different group of patients as well. I think you tend to have a bit more tolerance with hospital-based patients because of their needs and the complexity of the cases. I am not sure whether, from a contract point of view, there is uniformity in the process of dealing with missed appointments. I suspect each contractor may well have their own internal process within their own practice that suits them. I have to say that a missed appointment is not to the advantage of the contractor, either. It is in their interests to ensure that the patients are attending as well.

[499] **Darren Millar:** Of course. In terms of data, however, do you have any data on missed appointments, such as percentages? You must have, within your hospitals, must you not?

[500] **Professor Richmond:** Hospitals have those data, and if someone is efficient in their practice, they would have them as well, if they have computerised systems.

[501] **Darren Millar:** Perhaps the witnesses could provide that information. That would be helpful.

[502] **David Rees:** Kirsty is next.

[503] **Kirsty Williams:** Could I clarify a technical issue about people who have been placed on a waiting list but who do not get an appointment before their eighteenth birthday? Are they allowed to stay on that list and get NHS treatment?

[504] **Mr Tolley:** I have taken a pragmatic view. If they have been on a waiting list before they were 18, and then they see the orthodontist after they were 18, we fund it as a health board, because I think that is appropriate.

[505] **Kirsty Williams:** Is that the same across Wales?

[506] **Professor Richmond:** Yes, that is generally the case across Wales, I believe.

[507] **Darren Millar:** Could I just ask what happens if they then move to another health board area? So, say they were 16 when they were referred, waited for two years, did not get their appointment, and within that two-year period, after 18 months, moved elsewhere within Wales: do they go back to the bottom of the list and therefore are non-eligible, or does the Welsh NHS allow them to pick it up? Also, what happens if they go into England?

[508] **Mr Beardsworth:** We have recently had quite a few patients who have come into the service from outside, so we would want to satisfy ourselves of that original referral date, and, as long as that was below the age threshold, then we would happily treat them—fund the treatment, sorry. We generally will do our utmost to ensure equitable access to our services.

[509] **Darren Millar:** So, in the Hywel Dda area, if they have moved in from outside and they have had a referral that has been going on in another part of the UK, or indeed another part of Wales, you are treated as from the first referral date.

[510] **Mr Beardsworth:** Yes.

[511] **Darren Millar:** Is that consistent across all health boards or not?

[512] **Mr Bishop:** I am not sure what our policy is, but the only concern that I have with this is that the link is the patient; the ownership is with the patient. There is no process, as far as I am aware, to track a patient through health boards if they move area. So, the onus would be on the patient to inform the new health board that they had been on a previous list. That is

as far as I am aware, anyway, but I can check that.

[513] **Mr Beardsworth:** Just to clarify what I said there, we would expect to see evidence of the original referral. We would not necessarily just ask the patient to give us the date that they felt that their original referral took place. We would expect some documentation to evidence that.

[514] **Kirsty Williams:** It was probably so long ago that they would not remember.

[515] **Mr Beardsworth:** Well, that original referral will be somewhere in the system over in England, so we generally would ask for that to be—

[516] **Darren Millar:** The reason I ask about the protocol when people move is that, while it was not for orthodontic treatment, I have had cases in my constituency where people have been receiving a course of treatment, usually over the border in England, and have been under the care of a consultant, but have moved into Wales and, rather than being allowed to access secondary care consultants again, they had to go on waiting lists for a referral for 30-odd weeks. However, you are saying that that is not the case for the health boards that you represent.

[517] **Mr Bishop:** From a hospital point of view, we would consider that a tertiary referral, and continuity of care would mean that it would go straight to the front. They would not even go onto a waiting list, they would come straight on, because there is a continuity-of-care issue and a responsibility. From a hospital point of view, what we would expect to happen is that the referring consultant would write to us and give us all the details, and we would carry on with the care. We would not put them on a waiting list in those scenarios.

[518] **Darren Millar:** Okay, but it would be a referring consultant.

[519] **Mr Bishop:** I think that it is the same the other way, in my experience of referring to consultants in England.

[520] **Darren Millar:** Well, it is sensible. Okay, thank you.

[521] **David Rees:** Are there any other questions from Members? There are not. I just have one final question, if you do not mind. We have talked about the waiting lists and we have talked about people waiting to be assessed. We have had people being put on the waiting list early, to allow for the waiting list gap, and also people have been put on the waiting list late. What I have not had an answer about is about those people who were put on late and will have to wait and, basically, their health deteriorates as a consequence. Do we have any record as to the severity of treatment required because a patient's health may have deteriorated during that wait?

[522] **Mr Tolley:** I am not an orthodontist, but I do not think that there is much deterioration, anyway, with orthodontics, generally speaking—

[523] **David Rees:** Well, I just want to know if there is—. In a previous evidence session, somebody said that they had seen a patient that they reckoned they should have seen two years ago.

[524] **Professor Richmond:** Quite often in orthodontics, you have cases where the dentist missed an impacted canine, and they come in later than normal, in which case, we try to accelerate their position, because it can cause damage, we call it resorption, which is an eroding away of the roots of the adjacent teeth. That is not uncommon, and we give priority to those individuals.

[525] **David Rees:** Okay. In that case, thank you very much for your evidence this afternoon. Thank you for your time. You will be given copies of the transcript of the meeting to check for factual inaccuracies.

15:12

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

[526] **David Rees:** Can we note paper 1, the health and wellbeing best practice and innovation board final report?

[527] **Leighton Andrews:** Are we going to discuss this, because—[*Inaudible.*]

[528] **David Rees:** There is also paper 2. Can we note both papers?

[529] **Darren Millar:** Noted.

[530] **David Rees:** Thank you very much.

[531] Before we close the meeting, may I remind Members that next week we are meeting with the focus groups as part of our inquiry into the cancer delivery plan? They will consist of patients from across Wales, who had been invited to share their views and experiences of cancer services with us next week.

[532] **Gwyn R. Price:** Are we coming here first?

[533] **David Rees:** It will be in the Pierhead building. If we meet here at 9.55 a.m., say, we will all go across to the Pierhead building together.

[534] **Elin Jones:** It is a formal meeting of the committee, is it?

[535] **David Rees:** It is an informal meeting, because it is engagement with the focus groups.

[536] **Lindsay Whittle:** That is on Wednesday, is it not?

[537] **David Rees:** It is on Wednesday. We will meet them in the Pierhead, but if we meet here at about 9.55 a.m., we can go across together as a collective.

[538] I therefore close the meeting, thank you very much.

*Daeth y cyfarfod i ben am 15:13.
The meeting ended at 15:13.*