Health and Social Care Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
Thursday, 18 September 2014

Meeting time:
09.15

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:
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Agenda

At its meeting on 16 July 2014 the Committee resolved under Standing Order 17.42(vi) to exclude the public for item 1 of the meeting on 18 September 2014

1 Inquiry into progress made to date on implementing the Welsh Government's Cancer Delivery Plan: consideration of draft report (09.15-10.00) (Pages 1 - 63)

2 Introductions, apologies and substitutions (10.00)

3 Papers to note (10.00) (Pages 64 - 87)

4 Inquiry into access to medical technologies in Wales: evidence session 17 (10.00 - 10.45) (Pages 88 - 110)

Dr Anna Kuczynska, GP Locality Director, Cardiff and Vale University Health Board
Charlotte Moar, Director of Finance, Cardiff and Vale University Health Board
Anthony Tracey, Assistant Director of Informatics, Hywel Dda University Health Board

Break (10.45 - 10.50)

5 Inquiry into access to medical technologies in Wales: evidence session 18 (10.50 - 11.35) (Pages 111 - 119)

Dr Mark Vaughan, Royal College of General Practitioners Wales
Dr Nazia Hussain, Royal College of General Practitioners Wales
Dr Peter Horvath-Howard, British Medical Association Cymru Wales
Dr Charles Allanby, British Medical Association Cymru Wales

6 Inquiry into access to medical technologies in Wales: evidence session 19 (11.35 - 12.20) (Pages 120 - 136)

Andrew Bell, Social Services Improvement Agency
Sue Evans, Association of Directors of Social Services (ADSS) Cymru
David Williams, Association of Directors of Social Services (ADSS) Cymru

7 Motion under Standing Orders 17.42(vi) and (ix) to resolve to exclude the public from items 8, 10, and 11 (12.20)

8 Inquiry into access to medical technologies in Wales: consideration of evidence received (12.20 - 12.30)

Lunch (12.30 - 13.30)

9 Scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health: general and financial scrutiny (13.30 - 15.00) (Pages 137 - 207)

Mark Drakeford AM, Minister for Health and Social Services
Vaughan Gething AM, Deputy Minister for Health

Andrew Goodall, Director General, Health & Social Services
Albert Heaney, Director of Social Services & Integration
Ruth Hussey, Chief Medical Officer
Martin Sollis, Director of Finance

10 Supplementary Legislative Consent Memorandum - Criminal Justice and Courts Bill: consideration of draft report (15.00 - 15.20) (Pages 208 - 215)

11 Inquiry into new psychoactive substances ("legal highs"): consideration of itinerary for engagement activity (15.20 - 15.30) (Pages 216 - 221)

Agenda Item 1

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Agenda Item 3

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 – Senedd**
Meeting date:	**Wednesday, 16 July 2014**
Meeting time:	**08.45 – 13.00**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf

Concise Minutes:

Assembly Members:	**David Rees AM (Chair)** **Leighton Andrews AM** **Andrew RT Davies AM** **Ann Jones AM** **Elin Jones AM** **Darren Millar AM** **Lynne Neagle AM** **Gwyn R Price AM** **Lindsay Whittle AM** **Kirsty Williams AM**
Witnesses:	**Keith Evans** **The Rt Hon Ann Clwyd MP, Review of the NHS Hospitals Complaints System (NHS England)** **Mr Phil Banfield, BMA Wales** **Tina Donnelly, Royal College of Nursing** **Rory Farrelly, Abertawe Bro Morgannwg University Health Board** **Dr Chris Jones, Cwm Taf Health Board** **Carol Shillabeer, Powys Teaching Health Board** **Nicola Williams, Abertawe Bro Morgannwg University Health Board**

Committee Staff:	**Llinos Madeley (Clerk)** **Helen Finlayson (Second Clerk)** **Rhys Morgan (Deputy Clerk)** **Victoria Paris (Researcher)** **Philippa Watkins (Researcher)**

1 Introductions, apologies and substitutions

1.1 Apologies were received from Rebecca Evans and Janet Finch-Saunders. Ann Jones acted as a substitute for Rebecca Evans and Andrew RT Davies acted as a substitute for Janet Finch-Saunders.

2 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for the following business:

2.1 The motion was agreed

3 Inquiry into progress made to date on implementing the Welsh Government's Cancer Delivery Plan: consideration of the key issues

3.1 The Committee considered the key issues that have arisen from the inquiry.

3.2 The Committee agreed to write to the Ministry of Justice in relation to the European Data Protection Regulations.

4 Inquiry into the NHS complaints process: evidence session 1

4.1 The witness responded to questions from Members.

5 Inquiry into the NHS complaints process: evidence session 2

5.1 The witness responded to questions from Members.

6 Inquiry into the NHS complaints process: evidence session 3

6.1 The witnesses responded to questions from Members.

6.2 The witnesses agreed to provide more information on the following:

of the total complaints received, the proportion which related to primary and to secondary care within the NHS in Wales for every local health board in Wales; and

more information about the methods adopted by local health board(s) to measure patient experience, including patient feedback and views about the complaints process.

7 Inquiry into the NHS complaints process: evidence session 4

7.1 The witnesses responded to questions from Members.

8 Papers to note

8.1a The Committee noted the minutes of the 26 June and 2 July meetings.

8.1 The Committee's forward work programme: September - December 2014

8.2 The Committee noted the forward work programme for September to December 2014

9 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the remainder of the meeting and for item 1 of the meeting on 18 September 2014

9.1 The motion was agreed

10 Inquiry into the NHS complaints process: private consideration of evidence received

10.1 The Committee considered the evidence received on the inquiry.

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF MD 2136 14

David Rees AM
Chair, Health and Social Care Committee

12 July 2014

Dear David,

You will recall that when we debated the Health and Social Care Committee's report on the work of Healthcare Inspectorate Wales in plenary on 4 June that I signalled my intention to conduct a review of Healthcare Inspectorate Wales. I announced that Ruth Marks, the former Older People's Commissioner for Wales, had agreed to lead on this work.

I have now agreed the terms of reference for the review and attach a copy for information.

Mrs Marks will report her findings and proposals in the autumn of 2014.

Best wishes
Mark.

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

cc
Elin Jones AM
Darren Millar AM
Kirsty Williams AM

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Welsh Government

Review of Healthcare Inspectorate Wales

Terms of Reference

Background

In July 2013 the Health and Social Care Committee announced their decision to conduct a short inquiry into the work of Healthcare Inspectorate Wales (HIW). Their report was published on 21 March 2014.The Committee recommended the Welsh Government should undertake a fundamental review of HIW to reform, develop and improve its regulatory and inspection functions. The Welsh Government agreed that ten years after its creation - and now with a very different set of legislative powers available to this National Assembly - the time was right for such a review. In the decade of its operation HIW has, undoubtedly, acquired a series of additional responsibilities. The review will consider whether its remit is, now, sufficiently coherent and look for ways in which it may be able to be streamlined and certainly to be strengthened. The review will also consider the legislative powers of the Welsh Ministers which are exercised by HIW.

Purpose

This independent review will therefore address the following areas:

- To review HIW's existing functions and responsibilities. This will include plotting HIW's history and describing the additional responsibilities that it has acquired during its 10 year history, to determine: if any best sit elsewhere; or if there are any gaps across healthcare settings that need to be addressed.

- To consider the remit of HIW in respect of the NHS and the independent healthcare sector to determine if there is sufficient synergy across the sectors and application of common standards. This should cover both the inspection and regulatory arm of its remit.

- To draw on the experiences of inspectorates elsewhere, for example, identifying what lessons Wales can learn from methodologies being developed in Scotland, Northern Ireland and England.

- To look at the existing web of legislation underpinning HIW and form a view on where its needs to consolidated, simplified and/or strengthened, taking into account the changing provision of healthcare services and shift to more community based care.

- To take into account the wider related work, including the Audit, Inspection and Regulation Review, Regulation & Inspection Bill, Community Health Council reform and the relevant actions arising from the Williams Commission, in order to consider the potential implications of this for the operation of HIW.

- To undertake a period of engagement with key stakeholders to seek wider views on the future function and responsibilities of HIW

- To develop proposals to inform part of a green paper setting out the scope for an NHS Quality Bill and make recommendations for any immediate actions that could be put in place ahead of any legislative change.

The review will commence in July 2014 and will report its findings and proposals in the autumn of 2014.

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF-MD-2016-14

Kirsty Williams AM
Darren Millar AM
Elin Jones AM

14 July 2014

Dear colleague,

Health Professional Education Investment Review

The Welsh Government invests more than £350m each year supporting 15,000+ students and trainees across Wales undertaking health-related programmes including undergraduate, postgraduate and continuing professional education. I want to make sure that arrangements underpinning this investment are helping towards the workforce changes required to deliver sustainable services in the future. I have, therefore, appointed a panel to review Wales' investment in health professional education

The review will be led by Mel Evans, Chair of Powys Teaching Health Board. He will be joined by Dr David Salter, the former Deputy Chief Medical Officer for Wales, Professor Ceri Phillips, Professor of Health Economics at Swansea Centre for Health Economics and Mr Dick Roberts CBE, Pro-Chancellor at Cardiff University and former Chief Optometric Adviser for Wales.

The review will consider a number of issues including:

- The nature of the current investment in health professional education - what we are funding and whether this is delivering the required support for the Welsh healthcare workforce;
- The return on this investment;
- The current arrangements in place for medium and longer-term planning within the NHS and whether they facilitate multi-professional working;
- The extent to which incentives and/or conditions would assist the education, training and retention of health professionals across Wales;
- How healthcare needs and standards inform planning, role design and education commissioning.

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The Terms of Reference for this review are attached together with further information about the panel members.

I expect the panel to deliver its findings by the end of the year.

I am copying this letter to the Chair of the Health and Social Care Committee and given the cross cutting issues of the review I am also copying to the Chair of the Children, Young People and Education Committee.

Best wishes,

Mark

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

Health Professional Education Investment Review

Terms of Reference

Purpose of Review

The Panel's primary function will be to undertake a formal review of the way the Welsh Government currently invests in the planning, development and commissioning of the health Workforce in Wales.

Key areas

In carrying out this review the panel will:

- explore the arrangements currently in place and identify strengths and weaknesses in the system.
- undertake an analysis of the Investment made in health education in Wales; assess the current level of return on Investment and whether it is at an appropriate level.
- consider the current 'managed model' for education commissioning adopted in Wales alongside other approaches in the UK / other countries and provide recommendations about an approach to be adopted in future.
- consider whether the establishment of a single body which brings these functions together would be beneficial to Wales and if so what functions should it include.
- consider the extent to which incentive based arrangements could be beneficial to the education and training agenda in Wales.
- consider the wider policy approach in respect of prudent healthcare and what this means for education and training of healthcare professionals and staff groups.

Timescale

The Panel will report their findings through a formal report to the Minister for Health and Social Services by the end of December 2014.

Approach

The panel will meet to agree an approach to the Review.

Engagement

The panel will identify key stakeholders and determine appropriate methods of engagement with individuals / organisations to enable conclusions and recommendations to be based upon appropriate evidence.

Support

The Review will be supported by a Review Manager within the Workforce and OD Directorate of The Welsh Government.

Panel Chair and members

Mel Evans - Chair

Mr Evans is currently Chair of Powys Teaching Health Board. Educated at Ferndale Grammar School and Liverpool University Mr Evans is a qualified accountant and has had a career in finance in the wider public sector and the NHS.

Previous posts include Director of Finance for Mid Glamorgan Health & Family Health Services Authorities, Director of Finance & Director of Contracting at the Bro Taf Health Authority and General Manager of Rhondda Cynon Taff Local Health Group, until 31 March 2003. At which point Mr Evans became Chief Executive of the successor body – Rhondda Cynon Taff Teaching Local Health Board until 2009, concurrently with this post, from 2007 to 2009, and was also Chief Executive for Merthyr Tydfil Local Health Board.

Prof Ceri Phillips – Panel Member

Professor Ceri Phillips is Professor of Health Economics and Deputy Head of School (Research) at Swansea University with close links with the Wound Healing Unit and the Centre for Disability Research at Cardiff University and the Pain Research Unit based at The Radcliffe Hospital in Oxford. Professor Phillips has undertaken commissioned work for a range of organisations, including WHO, Welsh Government, Department of Health, Department of Work and Pensions and a range of health authorities and pharmaceutical companies.

Professor Phillips is a member of a wide range of groups and boards including The Bevan Commission, the All Wales Medicines Strategy Group (AWMSG), Vice Chair of its New Medicines Group and has been a member of NICE Programme development Groups on a range of public health issues.

Professor Phillips has published extensively in the field of health economics and health policy, with over 130 books and journal articles.

Dr David Salter - Panel Member

Dr David Salter is a retired former Deputy Chief Medical Officer for Wales. As Deputy CMO, Dr Salter provided independent professional advice and guidance on health and healthcare matters to the First Minister, Welsh Government Ministers and the National Assembly for Wales. In his role as Deputy CMO, Dr Salter led on many issues affecting the health of the people of Wales. This work included a review of the E Coli outbreak in 2006. The review made recommendations to reduce the risk of reoccurrence.

As part of a Scrutiny Panel in 2013, Dr Salter produced a report on service change proposals regarding neonatal services in relation to Glangwili Hospital, Carmarthen and Withybush Hospital, Haverfordwest.

Mr Dick Roberts CBE – Panel Member

Mr Roberts is currently Chancellor at Cardiff University. As former Chief Optometric Adviser for Wales Mr Roberts was responsible for the Wales Eyehealth Examination and the establishment of the Wales Low Vision Scheme and managed to convince the profession to undertake further training and accreditation to establish even higher levels of competencies than that required nationally.

A Member of the General Optical Council 1981-2006 during which he chaired the Investigating Committee for 20 years and served as a visitor for the General Optical

Council charged with visiting all the universities responsible for undergraduate optometric education following and produced the Roberts Report on the disciplinary processes of the Council and the adoption of change.

Mr Roberts has lectured as a visiting lecturer in the school of Optometry and Vision Sciences at Cardiff University and has been a senior examiner for the British Optical Association and the Royal College of Optometrists.

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MB/MD/2595/14

David Rees AM
Chair
Health and Social Care Committee
National Assembly for Wales
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17 July 2014

Dear David,

HSC Committee 26 June - Cancer Delivery Plan Inquiry Session

At the Health and Social Care Committee on 26 June I agreed to provide Members with information on the following;

1. a note on the delivery of treatment and services for patients with neuroendocrine tumours at an all-Wales level, as an example of services being delivered for the less common cancers;
2. confirmation that the technology is in place to support the timely reporting at GP, GP cluster and national levels of the reviews of lung and gastrointestinal cancer cases dealt with by each GP in Wales in 2014;
3. a note to update the Committee on the 'trialogue' discussions of the draft EU regulations on data protection, and the potential impact on cancer research in Wales;
4. the paper submitted by Public Health Wales to the House of Commons Science and Technology Committee's inquiry into National Health Screening;
5. a note on whether there is resource and capacity for bowel scope screening to be provided in Wales.
6. provide your views about the concerns expressed in relation to the iWantGreatCare surveys;
7. set out the actions that you are taking to ensure everyone has equitable services and access to end-of-life care.

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1. Neuroendocrine Tumours (NETs) are rare (4 per 100,000) and particularly difficult to diagnose as the symptoms are often identified as other conditions. While there is only one specialist centre in Wales, the Multi Disciplinary Team for Neuroendocrine Tumours, based in Cardiff, supports the diagnosis and advice on treatment options for patients throughout Wales. In delivering treatment patients are referred to various specialist centres across the UK, whilst patients in the Cardiff and Vale LHB area are treated in the Cardiff centre. For rarer cancers, where services can not be delivered by individual LHBs, responsibility for ensuring services across LHBs are delivered will fall to either WHSSC or the Cancer Networks.

2. The current technology allows for GP referral activity to be reported in real time. It does not, as yet, allow for capture of the analysis of pathways of care though this is the ambition of the Cluster work. For 2014/15, GP practices will review the care of patients newly diagnosed with lung or digestive system cancers which will have a specific focus on the diagnostic process, the appropriateness and speediness of the diagnosis and learning points to be used in GP cluster discussion to understand better the patients experience, to identify learning points and to act on that learning.

A workshop is planned for October 2014 to collate the priorities identified by Cluster networks, and this will include priorities for information and technology development for officials to take forward in discussion with NWIS and stakeholders. As part of this, officials will be working with the Cancer Network to explore what data is required at each level to ensure continuous learning and service development. Primary Care Clinical Leads will also be gathering examples of good practice to inform data analysis and reporting in the future. This builds upon the work of individual practices and the Royal College of GPs and Macmillan GP Advisors who are supporting practices and local networks to improve early diagnosis and cancer outcomes.

Key GP cluster themes and actions will be part of GP Cluster Network Annual Report.

3. The Welsh Government does have concerns over the potential impact of the proposed EU Data Protection Regulation on use of data to support NHS service delivery, and particularly the potential damage to health and scientific research.

Scientific research generates many important benefits by improving our understanding of society, health and disease. However, the EU Parliament has recently accepted amendments to Articles 81 and 83 of the proposed Data Protection Regulation as part of a block vote supporting all proposed amendments. These amended Articles as they stand provide a significant threat to health and scientific research - making much research involving personal data at worst illegal, and at best unworkable.

The original draft Regulation set out a proportionate mechanism for protecting privacy, whilst enabling health and scientific research to continue. It included a requirement for specific and explicit consent for the use and storage of personal data, but provided an exemption for research. This approach recognised that individuals' interests can be protected through robust ethical and governance

safeguards, such as approval by a research ethics committee. The amended versions of Article 81 and 83 significantly reduces the scope of this research exemption. The use of personal data in research without specific consent would be prohibited, despite the fact that this research is subject to ethical approval and strict confidentiality safeguards.

If enacted, the current draft of the EU Regulation would put at risk significant Welsh, UK and European investments in research, including genetics, cohort studies, biobanks, disease registries and the use of routinely collected data to support research.

For example, Welsh Government has invested more than £7 million in the Secure Anonymised Information Linkage (SAIL) databank to date, including £3.9 million from the National Institute for Social Care and Health Research (NISCHR). The novel methodologies used by SAIL allows routinely collected data to be anonymised and linked so that it can be utilised for research in a safe and secure way. The capacity and expertise that has been developed to support and enhance the conduct of health and social care research will be seriously undermined, and significant achievements will be left redundant if Article 81 and 83 of the current draft Regulation are adopted.

The Ministry of Justice is leading negotiations with EU on behalf of the UK in order to find a way to ensure that the Regulation can protect valuable research while protecting privacy. Welsh Government officials in NISCHR have provided briefing, along with other UK health departments, Research Councils and medical research charities, to support Ministry of Justice in lobbying for change to the proposed EU data protection regulation.

The EU Justice and Home Affairs Council is currently working towards an agreed position for the EU Council on the draft Regulation, with the next meeting of the Council scheduled for October 2014. Once the EU Council formally adopts a position on the draft Regulation, trilogue discussions between the Parliament, Council and Commission will begin.

Welsh Government officials will continue to support Ministry of Justice colleagues in raising the issue of the damaging implications and influencing a change to the current proposed Regulation as the legislation passes through the EU Council and trilogue processes.

In my oral evidence I suggested that the Health and Social Care Committee might consider sending a letter to the Minister for Justice to encourage efforts to lobby against the amendments to Articles 81 and 83 of the draft EU Data Protection Regulation.

4. A copy of the Paper by Public Health Wales to the House of Commons Science and Technology Committee's inquiry into National Health Screening is attached at Annex A

5. In March 2010, the UK National Screening Committee (UK NSC) recommended the introduction of flexible sigmoidoscopy (FS) to the existing bowel cancer screening programme. This recommendation was followed by a commitment from the Department of Health to invest £60m for the development of a FS screening service in England. The pilot of FS screening for people aged 55 years in England started in March 2013 and is rolling out incrementally aiming to achieve national coverage by the end of 2016.

Scotland started a pilot in January 2013 in four health boards and is currently inviting people aged between 59 and 61 years of age. The pilot will be time limited and formally evaluated before a decision on the way forward is made. There are no plans to implement FS in Northern Ireland.

A decision to introduce FS as a screening programme in Wales has not been made. Currently, PHW is working with Professor Wendy Atkin, who led the original trial in 2010, to ascertain the potential impact of a FS screening programme on the population of Wales. This work will inform the feasibility of having such a programme that complements the existing bowel screening programme.

Flexible sigmoidoscopy only looks at the left side of the bowel, where the majority of polyps and bowel cancers start, therefore faecal occult blood (FOB) screening still needs to remain to cover cancers arising in the right side of the bowel.

The Wales Screening Committee discussed FS at its June meeting. The benefits of this screening intervention were recognised, however it was agreed that implementing such a service in Wales would be challenging given the current low uptake of bowel screening by FOB, and within the current endoscopy provision.

6. We recognise the importance of the patient voice in improving services, particularly at the end of life when understanding the needs of the individual are essential to providing effective services. As the Marie Curie report 'Listening to Dying People in Wales' states, our Delivering End of Life Care Plan emphasises the strong role patient and family feedback plays in improving services.

The Marie Curie Palliative Care Research Centre (MCPCRC), Cardiff University, recently undertook a study of iwantgreatcare to;

o Establish whether the questionnaire is understandable in terms of content, wording and sentence structure;

o Explore whether the questions are pertinent to participants;

As a result of this study a number of changes to the survey are being made to drive up participation and make the survey tool more user friendly. This includes simplifying its user interface and removing complex wording from the document. The survey remains a good tool for capturing in real time the views of patients in the service, the changes made following review will drive up participation.

7. Actions to ensure equitable end-of-life care services are set out in the Delivering End of Life Care Plan. Some achievements in this area include:

• Establishment of seven-day working by clinical nurse specialists and access to Consultant advice 24/7 throughout Wales.

• Funding for specialist and respite hospice beds and development of Hospice at Home services.

• Improving access 'out of hours' to emergency drugs and an anticipatory prescribing programme, through 'Just in Case' boxes.

• A funding formula for specialist palliative care services, ensuring a minimum level of specialist service across Wales (£6.4m distributed by Welsh Government to support services).

• Healthcare support workers appointed into specialist acute teams to assist in meeting patients' priorities at the end-of-life by supporting families, maintaining dignity and respect for patients in the terminal phase, particularly in busy acute settings.

• Formalised links throughout Wales between clinical nurse specialists and nursing homes to support staff caring for residents with end-of-life care needs.

• Development of a palliative care clinical information system.

• A national patient evaluation programme (Iwantgreatcare)

• Wales palliative care website with open access providing information on all aspects of clinical care and strategic work programmes.

• Development of a GP short course in palliative care

Best wishes,

Mark.

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

Evidence to Commons Science and Technology Select Committee Enquiry into National Screening Programmes

Author: Dr Rosemary Fox Director Screening Division Public Health Wales

Date: 08.04.14	**Version:**

Purpose and Summary of Document:

This paper is to provide the Commons Science and Technology Select Committee with written evidence on national screening programmes, with particular emphasis on the Welsh experience.

1 Executive Summary

- This submission is prepared for the Committee by Public Health Wales.

- The process by which the UK National Screening Committee examines the evidence for non-cancer screening programmes is thorough, systematic and robust.

- Evaluation of evidence regarding cancer screening is less systematic, with the trigger being a decision taken on a case by case basis by the Director of the UK National Screening Committee.

- Evidence regarding risks of screening is less systematically collected than evidence of benefit

- The balance of benefit and harm is poorly understood by public and professionals alike

- Communication of benefits and harms is complex. Information developed to allow individuals to make an informed choice about participation may need further refinement to meet the needs of people with low levels of health literacy.

2 Public Health Wales

Public Health Wales was established as an NHS Trust on 1 October 2009.

Public Health Wales has four statutory functions:

- To provide and manage a range of public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases;
- To develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters;
- To undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival; and prevalence of congenital anomalies; and
- To provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health related matters.

The Screening Division of Public Health Wales provides the following population screening programmes in Wales:

- Breast Test Wales, screening approximately 100,000 women aged 50-70 each year
- Cervical Screening Wales, screening approximately 220,000 women aged 25-64 each year
- Bowel Screening Wales, screening approximately 350,000 men and women aged 60-74 each year
- The Wales Abdominal Aortic Aneurysm Screening Programme, screening approximately 16,000 men aged 65 each year
- Newborn Hearing Screening Wales, screening approximately 35,000 babies each year.

Public Health Wales will shortly take responsibility for Newborn Bloodspot Screening Wales.

Public Health Wales also hosts the managed clinical network for Antenatal Screening in Wales, although the delivery of antenatal screening remains a Health Board responsibility.

3 What evidence are the NHS Screening Programmes based on and how often is it reviewed?

Screening policy in Wales is set by Welsh Government, which has established the Wales Screening Committee to advise the Minister for Health & Social Services. The committee has members drawn from Government, Public Health Wales, Welsh Health Boards and Community Health Councils.

The Wales Screening Committee considers the recommendations of the UK National Screening Committee (UKNSC). The UKNSC advises Ministers and the NHS in the four UK countries about screening. It evaluates the evidence for proposed and existing screening programmes against a set of internationally recognised criteria covering the condition, the test, and the programme. Evidence is reviewed regularly, and the schedule for review is published on the UKNSC website: http://www.screening.nhs.uk/about.

The evidence reviews carried out on behalf of the UKNSC are of a very high standard, and are made publically available as part of the public consultation involved in review process. Two UKNSC members are from Wales, including the Director of the Screening Division of Public Health Wales.

The UKNSC is responsible for making recommendations for screening across all clinical areas, and is the source of advice for Welsh Government, and therefore for screening in Wales.

However, in the case of cancer screening the Director of the UKNSC takes a view on a case by case basis on whether a proposal by the English cancer screening programmes constitutes a major change. When such a proposal is deemed to warrant a UKNSC policy, the arguments put to the English Advisory Structure are sought and presented to the UKNSC, in the form of a review against the UKNSC criteria. Thus the trigger for reviews of the evidence for cancer and non-cancer screening evidence differs, with non-cancer screening evidence being reviewed regularly according to a published timetable, and evidence relating to cancer screening being reviewed in a more 'ad hoc' basis.

As Welsh Government Policy is based on UKNSC advice, this can lead to uncertainty about the timescales for decisions about new evidence regarding cancer screening. For example the UKNSC did not examine the evidence for the age range and frequency of cervical screening until 2012, nine years after the English NHSCSP had changed its policy.

4 Could the evidence base and sources of scientific advice to government on health screening be improved?

The UKNSC is currently reviewing its role, terms of reference and membership. It is consulting on proposals to strengthen the lay membership and ethical representation on the Committee. In the opinion of Public Health Wales this would be a positive step.

A literature review undertaken as part of the review process suggests that the criteria used by the UKNSC in its appraisal of the evidence are robust. Public Health Wales agrees with this.

Public Health Wales would like to see a systematic approach to regular evidence review applied to cancer screening as it is to non-cancer screening.

5 How effectively are the potential risks and benefits of health screening communicated and understood by the public?

Public Health Wales believes that risks and benefits of screening are poorly understood by both professionals and the public, with benefits typically being over-estimated, and risks under-estimated. This is reinforced by a tendency to focus on levels of participation in screening as a measure of programme success.

The UKNSC explicitly considers harms of screening as well as benefits when considering evidence. However, much of the quantitative evidence considered by the committee relates to benefits- mortality reduction is a common end-point, for example. Risks are rarely as well quantified. Without robust estimates of the magnitudes of harms, it is difficult to give

a definitive estimate of the precise balance of good and harm resulting from screening. This is borne out by the recent review of the evidence for breast screening led by Prof Michael Marmot's team.

The breast screening leaflet developed by the DH Advisory Committee on Informed Choice in Cancer Screening will be launched in bilingual format in Wales in the near future. Communication of benefit and risk is complex even when the estimates are robust. Focus Group work carried out by Public Health Wales' Screening Engagement Team has found a resistance amongst volunteers to information regarding risks of screening, and provision of meaningful information balancing risks and benefits to groups with low levels of health literacy will remain very challenging.

6 How does health screening provided in the UK through the NHS compare with that offered by other countries?

Public Health Wales has little evidence on the organisation of, or effectiveness of screening programmes beyond the UK.

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MB/MD/3616/14

Elin Jones AC
Kirsty Williams AC
Darren Millar AC

Cynulliad Cenedlaethol Cymru

27 Awst 2014

Annwyl Aelod,

Ysgrifennaf i'ch hysbysu fel llefarwyr y gwrthbleidiau ar Iechyd fod Dr Philip Jones wedi cael ei benodi yn Arweinydd Clinigol Cenedlaethol ar gyfer Gwasanaethau Strôc yn dilyn cystadleuaeth agored.

Swydd Dr Jones fydd goruchwylio'r gwaith parhaus o weithredu'r Cynllun Cyflawni ar gyfer Strôc. Mae'n Feddyg Ymgynghorol sydd â diddordeb mewn gofal ar gyfer yr henoed a diddordeb is-arbenigedd mewn niwroleg ac adsefydlu. Mae'n gweithio yn Ysbyty Cyffredinol Bronglais, Aberystwyth.

Anfonaf gopi o'r llythyr hwn at David Rees AC, Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol.

Yn gywir

Mark.

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

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Mark Drakeford AC / AM
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Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MB/MD/3616/14

Elin Jones AM
Kirsty Williams AM
Darren Millar AM

National Assembly for Wales

27 August 2014

Dear colleague,

I am writing to inform you as opposition spokespeople for Health that, after an open competition exercise, Dr Philip Jones has been appointed as the National Clinical Lead for Stroke Services.

Dr Jones's role will be to oversee the continued implementation of the Stroke Delivery Plan. He is a Consultant Physician with an interest in care of the elderly and sub-speciality interests in neurology and rehabilitation. He works at Bronglais General Hospital, Aberystwyth.

I am copying this letter to David Rees AM, Chair of the Health and Social Care Committee.

Best wishes,

Mark.

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

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Document is Restricted

Cardiff and Vale University Health Board response to the National Assembly for Wales Health and Social Care Committee inquiry into access to medical technologies within primary care.

Introduction

1. Cardiff and Vale University Health Board (UHB) is well positioned to realise the potential of medical technology in primary care. The UHB is fortunate to have good quality primary care (across all contractors) and a real interest and engagement from practices to trial new technologies and champion successes. Consequently, there are pockets of the use of medical technology supporting good clinical practice and this paper refers to some of examples.

2. However, the potential is far greater if both the spread and the ambition extends. Cardiff and Vale are not only well placed in terms of good quality primary care with real enthusiasts to champion developments but also with the UHB's information platform. In Cardiff and Vale, PARIS is our information system of choice for community and mental health services. This is well received by primary care and can provide linkages to secondary and tertiary care. The system is widely used by staff at clinical bases and on a mobile basis. Information on care joined up at patient level and visible is essential to maximising the benefits of an integrated organisation, an opportunity that is unique to Wales.

3. This paper sets out the vision within Cardiff and Vale that would build upon the solid foundation of good quality primary care and a solid information platform for the use of medical technologies within a whole system.

Cardiff & Vale – Current Situation

4. Cardiff & Vale UHB are the only Health Board in Wales to have an information system (PARIS) that supports the full electronic patient record for mental health and community services (including Local Authority delivered elements) and which can 'talk' to the hospital systems and share information both ways. Previously these services had manual systems or, at best, poor IT infrastructure that did not 'join up' across services.

5. The design and implementation of the PARIS system has been service user led from the start which the UHB regards as critical to the successful implementation. With over 4000 users across approximately 150 clinical teams, there are 700 clinical assessments recorded each day and 7000 case notes recorded.

6. To build upon this initiative and to remove the need for staff to return to their bases to collect and update records, a mobile-working solution was sought. Following pump priming funding via Welsh Government Invest to Save, mobile working was comprehensively rolled out in April 2011.

7. This is a solid foundation for supporting integrated working across primary care, social care and hospital care.

8. The following provides some examples of the current use of technology in primary care. It should be noted that the technology support changes in pathway (shifting care in the

community from hospital services) and also requires a change management to ensure they are fully embedding into everyday new ways of working.

Teledermatology

9. The teledermatology service focuses on bridging the gap between hospital based specialists and doctors in primary care. The teledermatology service links specialist dermatologists with patients and doctors in approximately 40 GP practices throughout Cardiff and the Vale of Glamorgan saving an estimated 700 out patient appointments per year. Benefits include much faster access to specialist dermatology advice, helping to develop doctors' experience and skills, and also cutting down waiting times for patients and referrals to hospitals.

ECG

10. Electrocardiograms (ECGs) are regularly used in primary care both for diagnostic and screening purposes, and to support referral to specialist services. Approximately 80% - 90% of GP practices have purchased ECG for use in Primary Care. It is difficult to estimate the number of patients who undergo ECG monitoring in primary care however the benefits are great. Early detection leads to early action and treatment moving diagnosis for some conditions such as stable AF from the acute hospital setting in to primary care allowing GP's to develop and provide a more proactive and preventable model of care.

Level 4 INR

11. Level 4 INR monitoring was introduced in Cardiff & Vale Primary Care in 2007. Initially only a small number of practices were commissioned to provide this service however over time this has increased to a total of 41 practices providing this service. INR level 4 provides point of care testing for INR monitoring within the primary care environment. This allows 'One stop' care to be provided within the GP practices: testing, analysing, dosing and prescribing in one visit which improves quality & safety for patients, improves patient experience and reduces diagnostic lab test requests within secondary care. Approximately 2450 patients are monitored using INR level 4.

Ambulatory Blood Pressure Monitoring (ABPM)

12. National Institute for Health and Clinical Excellence (NICE) are recommending ambulatory monitoring part of routine practice for the diagnosis of hypertension in primary care. Use of ABPM may rule out 25% of patients currently misdiagnosed and treated for high BP. The use of ABPM within primary care is relatively recent with only approximately 25-30% of practices across C&V approximately investing in ABPM monitoring equipment for the diagnosis of hypertension since 2011. The benefits of using ABPM in the diagnosis of hypertension are clear; the use of ABPM has been shown to improve accurate diagnosis of hypertension whilst reducing workload in practice releasing significant savings in time for the practice as well as inappropriate prescribing whilst also reducing the incidence of TIA/Stroke.

Spirometry

13. Spirometry is a type of pulmonary function test that measures the amount of air taken in (volume) and exhaled as a function of time. This is a core function of GP's in primary care for the treatment and management of patients with COPD as well as some asthma patients and is in place within all C&V practices. Approximately 7000 COPD patients undergo spirometry within primary care in Cardiff and Vale per year. The benefits of using spriometry in primary care include the early identification, treatment and management of COPD allowing GP's to develop and provide a more proactive and preventable model of care managing and maintaining patients within primary & community care avoiding exacerbation and unscheduled care attendances.

Vision for the Future

14. Unlocking the potential of an integrated system is challenging when the history of the system is made up of different organisations with different priorities and different cultures. However, the potential is significant and therefore the challenge must be met. One of our first successes in Cardiff and Vale is within diabetes. With up to one in five medical patients having diabetes, and diabetes becoming commoner still, it is essential that clinicians across all care settings (in primary, community, secondary and tertiary care) are competent in managing diabetes.

15. A new model of diabetes care started in Cardiff and Vale in the autumn of 2012. The model arose from the observation that more care could be provided in the community setting for diabetes, further engaging local people and patients, and enabling experts to work closely with general practitioners and practice nurses. Through this approach, it helps increase professional knowledge, awareness and engagement in diabetes care among primary care practitioners, and has the potential to reduce the need for hospital-based services.

16. A shift within the model of care has been agreed so that medical consultants specialising in diabetes care now spend time working with local GPs, in their surgeries, to discuss the care and management of their patients with type 2 diabetes. The benefits of this new approach are clear. Patients seen in the outpatient department can potentially be discharged back to routine GP care more quickly, as specialist input will continue through the practice. More people with newly diagnosed diabetes can now be started on their medication in the community without needing an outpatient attendance, which is beneficial for both the patient and the NHS. GPs can use their enhanced knowledge and experience of dealing with cases of diabetes on other patients under their care and in their practice.

17. In the first six months of the model, referrals to secondary care outpatient appointments dropped by one third. It is projected that the new pathway will free up consultant time; this freed up resource could be used for increasing training to medical and allied staff, or for patient and carer education. Taking things a step further, this resource could be reallocated to preventing diabetes altogether, for example through individual or population-based interventions on known risk factors for the condition.

18. Whilst many benefits can be realised through the above model these could further enhanced with the implementation of system-wide multi-disciplinary team (MDT) tele-conferencing. Such systems bring professionals and organisations close together building a virtual team around the patient. At its most basic this would be access to secondary care opinion on patient cases at a set time but could facilitate the following:
    a) Full MDTs across primary and secondary;

    b) ‘Hot access’ to a secondary care opinion for patients starting to fail in the community (ie urgent assessment services in the community);

    c) Training and educational opportunities;

    d) MDTs to include wider partners such as Social Services and the Third Sector;

    e) Facilities in nursing homes to support maintaining patients in their own homes; and

    f) Transition clinics eg adolescent diabetes.

19. There is still more to be done in fully implementing the diabetes model and technology is an important enabler to this. However, lessons can be learnt from the early implementation of the diabetes model of care which can provide a blueprint for the

management of chronic conditions as pathways are remodelled to support patients in the community as opposed to within hospital services whenever possible. The implementation of system-wide teleconferencing facilities joins us services and partners in a virtual setting with the following benefits:

a) Continuity of care with an impact on quality and safety and effective use of resources (eg avoidance of duplication/gaps of referrals/services, travel expenses);

b) Impact on RTT waiting times as referrals may be avoided or care provided in an alternative setting (close to home); and

c) Support to patients to self-care.

20. Whilst this model could be rolled out to manage chronic conditions, elements of this model could also support the management of the elderly frail population. The principles of 'team around the patient' through system-wide teleconferencing could support the step-up care provided to patients to avoid admission and support maintenance in the community and also the pull from hospital.

21. Chronic conditions management and the care of the elderly are key areas of focus for both scheduled and unscheduled care and such a model would have an integral role in supporting these patients to live as independently as possible in the community.

22. Considering further opportunities where medical technology could support new ways of working, is the use of technology to communicate with patients and obtain data on patients whilst maintaining them in the community. This could support the following:

a) How patients book appointments, access prescriptions or even hold their own health record;

b) Mandating e-referrals;

c) Receive health data from direct from patients;

d) Ensure alerts in place where health data is outside of expected parameters;

e) Manage patients whose health data indicate a decline remotely; and

f) Share information with all relevant parties

23. The benefits that the PARIS (mental health and community information system) has had within Cardiff and Vale UHB can be extended with the All Wales procurement of a joint health and social care system. In a modern care system this would seem as essential to maximising the benefits in Wales of integrated health systems and the join up with social care.

Making it Happen

24. The technology is rapidly improving and there are plenty of options available.

25. *Webex* is a teleconference/meeting piece of software which allows HD video, voice (via computer or traditional telephone), text chat and screen sharing through a single piece of software. Currently, up to 8 people can be on a single call, although early applications have usually been between a single patient and either one or two clinicians. The UHB are trialling MDTs where staff may be located across the region – the host of the meeting is able to share documents from their screen, and all of the attendees are able to see each other as well as the shared documents. Where Webex is superior to the likes of skype or facetime is in its security – the connections between individuals are made securely

through webex's servers and as such it is appropriate for use in our environment unlike skype and facetime.

26. Webex will probably not be the long-term tool of choice. NHS Wales Informatics Services are implementing Microsoft *Lync* infrastructure (Lync is essentially the same as Webex, but is a Microsoft-branded product) on behalf of health boards in Wales – the UHB would be keen to move to this infrastructure as an early adopter. Having staff using webex now will allow us to capitalise on this infrastructure once it is in place. The UHB has also configured a mobile working device to use webex, and it has proved to have a reliable, stable connection.

27. Such a system would support real-time communication and decision-making, avoid hand-offs and reduce travel (thereby reducing time and expenses).

28. *Florence Simple Telehealth* uses text messaging (SMS) to communicate information to patients and to receive health data from them. The received data is presented cleanly and simply to the responsible clinician. The system has a level of built-in intelligence so that if readings are too high or too low, the patient can be asked to re-submit their reading or, ultimately, contact the relevant clinician. Because the responsibility for action remains with the patient, clinicians are not expected to respond to alerts (although these can be configured). Florence is not meant to be a patient record system – received data can be exported to the patient record if it needs to be kept, and the only patient information held on the system is their name, NHS number (optional) and mobile phone number. Because of this, set-up for new patients is very quick.

Commissioning and funding position

29. The UHB has limited funding available to support capital investment in this area, however desirable as the physical infrastructure in which the UHB works in terms of estate, core IT and medical equipment is very old and subject to frequent failure. Capital is prioritised towards statutory compliance and essential backlog maintenance and there is currently a significant backlog of expenditure required to enable the environment in which we care for patients to be fit for purpose. Revenue investment opportunities are similarly tight given the challenging financial position of the UHB.

30. The UHB believes that pump priming investment in technology would deliver short-term and long-term benefits which are quantifiable both in terms of patient quality of care, access to services and financial savings in terms of administrative staff and would welcome an approach by Welsh Government which supported this.

Conclusion

31. Given the experience in Cardiff & Vale of PARIS and specific one-off developments achieved to date, the UHB believes that it is ideally placed to maximise the benefits of an integrated organisation.
    a) The UHB has a good foundation on which to build – good quality and engaged primary care and a well-developed information management platform which integrates primary care, community, mental health, acute and tertiary patient information.
    b) Technology is pivotal to delivering our vision of safe and effective care as close to home as possible within an integrated organisation.
    c) Benefit for population is clear plus the impact on scheduled and unscheduled care.
    d) Investment is required to pump-prime medical technology and should be targeted against expected benefits.

Sue Morgan: Head of Operations and Delivery, Primary, Community and Integrated Care

Charlotte Moar: Director of Finance and Performance

6 August 2014

	National Assembly for Wales Health and Social Care Committee.
Purpose:	The Welsh NHS Confederation's response to the inquiry into access to medical technologies within primary care.
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Officer, Welsh NHS Confederation **Nesta.lloyd-jones@welshconfed.org** Tel: 02920 349857
Date created:	14 August 2014.

Introduction

1. The Welsh NHS Confederation, on behalf of its members, welcomes the opportunity to respond to the inquiry into access to medical technologies within primary care. We are pleased that the Committee is providing a more detailed consideration to access to medical technologies - a multi-faceted issue that has significant future potential.

2. By representing the seven Health Boards and three NHS Trusts in Wales, the Welsh NHS Confederation brings together the full range of organisations that make up the modern health service in Wales. Our aim is to reflect the different perspectives as well as the common views of the organisations we represent.

3. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. Members' involvement underpins all our various activities and we are pleased to have all Local Health Boards and NHS Trusts in Wales as our members.

4. The Welsh NHS Confederation and its members are committed to working with the Welsh Government and its partners to ensure there is a strong NHS which delivers high quality services to the people of Wales.

5. The Welsh NHS Confederation previously responded to the Committee's inquiry into access to medical technologies in November 2013. In this additional response we highlight the ways in which medical technology is already being used within primary care, the barriers that may prevent the timely adoption of effective new medical technologies and make recommendations on how some of these barriers can be overcome.

6. Medical technology is a priority for the NHS in Wales. As the Welsh NHS Confederation's discussion paper 'From Rhetoric to Reality - NHS Wales in 10 years'[i] time' highlights: '*With the public adopting new technologies at such a rapid rate, the NHS in Wales must move beyond the 20th century, and make the most of technologies that are user friendly, and with which patients already have experience'.* While there are already examples of good practice in this area, it is important we address the inconsistencies of provision and roll out technology across Wales. While the clear thrust of the debate on technology is that the NHS cannot stand still,

expectations of how much technology we can adopt must be realistic and the debate must remain considered and evidence-based.

The terms of reference

i) To examine how the NHS assesses the potential benefits of new or alternative medical technologies;

7. Overall there is currently a lack of integration of primary, secondary, community and social care systems in Wales. It is important that there is further development in integrating IT systems because currently hospital systems are often bespoke and do not fit well with GP systems. Although increasing efforts have been made to develop portals to access medical results, there is no way to access actual imaging and other information for example.

8. The ability for primary care contractors to share data, images and other information electronically and securely is vital. This speeds up the pathway for patients and opens up the potential for alternative ways of working and delivering care. An example of this exists within the primary care environment, where GPs are restricted to only seeing patient pathology/radiology results for the Local Health Board area that they belong to. This presents a significant issue for border patients who receive care from neighbouring Local Health Boards because the GP is unable to view the pathology/radiology result.

Examples of how new technologies have benefited primary care services.

9. There are many good examples of how new technologies, and the health technology fund investment, has benefited primary care services.

10. The new primary care GP clinical systems under the Welsh GP IT framework contract have the potential to share access with the wider health community, but this is not being driven at a national level. When introducing new national applications consideration needs to be given towards full integration with GP clinical systems rather than the current piecemeal approach.

11. There are good examples within Hywel Dda University Health Board (UHB) in relation to how new technology is benefiting primary care services.

a. The health technology fund investment to connect optometric practices to NHS net and access Open Eyes is welcome. Furthermore, the health technology fund has been prioritised for the development of a web-based IT system in community pharmacy that will be able to transfer data to GP clinical systems. This will open up opportunities for innovation and prudent healthcare.

b. In relation to telehealth, Hywel Dda UHB is the Welsh partner in a multi-national (European) EU funded research project. The project is not assessing the clinical effectiveness of telehealth but the factors affecting the large scale implementation of the technology. The evidence base, while not being totally unequivocal, does strongly suggest that telehealth is clinically effective for a range of chronic conditions that are generally managed in primary and community care. Telehealth could be clinically effective to treat diabetes, chronic obstructive pulmonary disease (COPD) and hypertension. At present what is not as clear from the evidence is how telehealth systems should be implemented on a large scale.

c. Hywel Dda UHB is working with Pfizer to develop Chronic Conditions Dashboards in order to better utilise data and develop service change based on peer review and analysis of unwarranted variation. It is working with NHS Wales Informatics Service (NWIS) to pilot the use of Audit + to answer audit and evaluation queries. The primary care division at NWIS has

been a key factor in the organised development of IT systems in general practice. It is important that this continues to ensure the systematic and integrated development of technology.

12. Cardiff and Vale UHB has realised the potential of medical technology in primary care. Cardiff UHB is fortunate to have good quality primary care (across all contractors) and a real interest and engagement from practices to trial new technologies and champion successes. Consequently, there are pockets where the use of medical technology is supporting good clinical practice. The following provides some examples of the current use of technology in primary care. The technology supports changes in pathways (shifting care in the community from hospital services) and requires a change management to ensure they are fully embedding it into everyday new ways of working.

a. Cardiff and Vale UHB is the only Health Board in Wales to have an information system (PARIS) that supports the full electronic patient record for mental health and community services (including Local Authority delivered elements) and which can 'talk' to the hospital systems and share information both ways. Previously these services had manual systems or, at best, poor IT infrastructure that did not 'join up' across services. This is well received by primary care and can provide linkages to secondary and tertiary care. The system is widely used by staff at clinical bases and on a mobile basis. Information on care which is joined up at patient level and is visible is essential to maximising the benefits of an integrated organisation - an opportunity that is unique to Wales. The design and implementation of the PARIS system has been service user led from the start which the UHB regards as critical to the successful implementation. With more than 4,000 users across approximately 150 clinical teams, there are 700 clinical assessments recorded each day and 7,000 case notes recorded.

b. The teledermatology service focuses on bridging the gap between hospital-based specialists and doctors in primary care. The teledermatology service links specialist dermatologists with patients and doctors in approximately 40 GP practices throughout Cardiff and the Vale of Glamorgan saving an estimated 700 outpatient appointments per year. Benefits include much faster access to specialist dermatology advice, helping to develop doctors' experience and skills and cutting down waiting times for patients and referrals to hospitals.

c. Spirometry is a type of pulmonary function test that measures the amount of air taken in (volume) and exhaled as a function of time. This is a core function of GPs in primary care for the treatment and management of patients with COPD as well as some asthma patients and is in place within all Cardiff and Vale practices. Approximately 7,000 COPD patients undergo spirometry within primary care in Cardiff and Vale per year. The benefits of using spriometry in primary care include the early identification, treatment and management of COPD allowing GPs to develop and provide a more proactive and preventable model of care managing and maintaining patients within primary and community care and avoiding exacerbation and unscheduled care attendances.

d. Webex is a teleconference/meeting piece of software which allows HD video, voice (via computer or traditional telephone), text chat and screen sharing through a single piece of software. Currently, up to 8 people can be on a single call, although early applications have usually been between a single patient and either one or two clinicians. Cardiff and Vale UHB is trialling MDTs where staff may be located across the region. The host of the meeting is able to share documents from their screen, and all of the attendees are able to see each other as well as the shared documents. Where Webex is superior to the likes of Skype or Facetime is in its security – the connections between individuals are made securely through

Webex's servers which makes it more appropriate for use in our environment. Webex will probably not be the long-term tool of choice as NHS Wales Informatics Services are implementing Microsoft Lync infrastructure on behalf of Health Boards in Wales. Cardiff and Vale UHB has also configured a mobile working device to use Webex, and it has proved to have a reliable, stable connection. Such a system would support real-time communication and decision-making, avoid hand-offs and reduce travel (thereby reducing time and expenses).

ii) To examine the need for, and feasibility of, a more joined up approach to commissioning in this area.

13. With the development of shared services, notably procurement, this may be possible. However, for medical technologies, this may prove problematic as increasing the number of stakeholders, where their requirements are due to clinical service provision, may be different and this could prove difficult.

14. One company may not be able to provide technologies where 'one size fits all'. This can result in the purchasing of equipment that does not meet the needs of each organisation fully as a compromise. There is increasing evidence that recent large procurements of clinical services and equipment across the UK have failed or have over-run considerably, due to the complexity and the resources required to implement and manage on a large scale, often negating the perceived benefits of large commissioning projects.

15. Large commissioning projects could lead to the monopolisation of the provision of a device and its associated consumables. This may have financial benefits but increases the clinical risk considerably as the scale of any failure in the continuation of service provision would be much larger and more difficult to rectify quickly.

16. However, any commissioning needs to be done jointly, linking initially with localities to understand the needs of the population and the plans to address these. New forms of technology need to be introduced at an early stage to address need, rather than develop an implementation plan for an existing technology which may not fit as well.

17. Stronger coordination and collaboration is required both between Health Boards across Wales, but also between providers of telehealth and telecare.

iii) To examine the ways in which NHS Wales engages with those involved in the development/ manufacture of new medical technologies.

18. As previously highlighted, there are several ways in which this can be, and is being achieved.

a. The development and launch of Health Research Wales (HRW) in May 2013 will facilitate the engagement of the NHS, Higher Education Institutions (HEI) and industry partners.

b. Development of strong partnerships between the NHS and academia facilitates the engagement between suitable partners and scientific / clinical specialties. This has been enhanced through the development of University Health Board status and the development of South East Wales Academic Health Science Partnership (SEWAHSP) and its industry working group.

c. One area that could be developed is 'patient led' device development. Developing devices that the patients consider would be helpful to them, their condition and quality of life, at the 'idea stage', rather than having NHS professionals and academics assuming the position on making the decisions and developing devices on their behalf.

19. In addition, on a practical level, the NHS in Wales would seek to draw on experts when initially presented with a problem to allow the development and commissioning of technologies which are fit for purpose.

iv) To examine the financial barriers that may prevent the timely adoption of effective new medical technologies, and innovative mechanisms by which these might be overcome.

20. There is always a limited budget to enable new equipment and software to be invested in, however it would be helpful to have clarity around what is prioritised. The main financial barriers can be divided into two areas:

a. Funding resources required to support the validation / evaluation of new technologies and the safe and effective delivery / implementation and future monitoring of new technologies.

b. Purchasing the medical technologies is often a barrier, even when the case for the clinical and financial benefits is clearly made. This is particularly the case when capital is required and replacing equipment takes priority over new technologies.

21. Health Boards generally have limited funding available to support capital investment in this area, however desirable, as the physical infrastructure in which the UHB works in terms of estate, core IT and medical equipment is very old and subject to frequent failure. Capital is prioritised towards statutory compliance and essential backlog maintenance and there is currently a significant backlog of expenditure required to enable the environment in which the NHS care for patients to be fit for purpose.

22. The Welsh NHS Confederation believes that pump priming investment in technology would deliver short-term and long-term benefits which are quantifiable both in terms of patient quality of care, access to services and financial savings in terms of administrative staff. We would welcome a strategic approach by Welsh Government which supported this.

23. For many primary care contractors the purchase of all equipment and technology is the responsibility of the contractor (with limited exception of some IT for general medical services and community practice). This leads to great variation in the age, quality and consistency of medical devices and technology. There would be greater consistency if it was centrally funded because there has been some significant investment by some contractors and not others.

Other barriers

24. As well as financial, there are other barriers that may prevent the timely adoption of effective new medical technologies.

a) Public engagement can be a barrier to accessing and developing medical technology. As the Welsh NHS Confederation's discussion paper 'From Rhetoric to Reality - NHS Wales in 10 years' time'[ii] highlighted: '*The most important consideration in the debate around technology must be the patient, and their willingness to engage with any technology that is introduced. While we constantly consider the challenges of broadband and mobile coverage*

in facilitating new technologies, we must ask if everyone is able to engage with the new technologies we seek to adapt, or indeed ask whether they want to do so'.

b) Training and backfill time is a critical factor. Taking clinical staff away from front line service delivery, without the opportunity to backfill, usually results in time delay or added cost.

c) The increased information governance requirements when dealing with patient identifiable information results in some technology being implemented more slowly into the health sector (e.g. mobile devices).

d) Rurality adds complexity as wireless or mobile signal does not uniformly cover the whole geography. This impacts on remote working and use of technology which, in a more urban or connected environment, might be easier.

e) Inter-connection is critical. We still have multiple systems which do not talk to each other. Although these have been rationalised somewhat, this continues to limit the sharing and use of information systems and technology.

f) Care homes essentially function like micro hospitals, with some in excess of 100 beds, yet there is a lack of NHS network access. Despite this, it is expected that NHS staff enter and operate services without access to the patient's electronic medical record. Priority needs to be given to all care homes having NHS network access.

Recommendations

25. A potential and ground-breaking, yet affordable, solution to the problems highlighted above is to transfer the ownership of the record to the patient using online records. This would allow patients to have access to their health and social care record online, granting access to any health or social care professional as required. This could be developed before the end of the current GP IT framework contract. Examples of this already exist and are available in prestigious US Healthcare Institutions (http://www.myopennotes.org/) where 3 million patients can see their online health records which is shared with clinicians. Another example is Malta where they have invested in health information technology to the benefit of patients where good managerial and technological support systems can ease healthcare delivery pressures. Maltese patients are able to read all hospital letters and test results online.

26. Mobile Healthcare (mHealth) technology needs to be explored more to empower patients to take proactive action in their own health monitoring. An ever-increasing ageing population and rising numbers of people suffering from long-term conditions, such as diabetes, are creating significant pressures for primary care healthcare delivery. mHealth devices now proliferate the market and can be linked to powerful mobile phone technology, these devices have the ability to assist with addressing the provision of primary healthcare due to the number of health apps that are available and will enable patients to interact with their GPs in a better, faster, less expensive and more accessible way. In addition, there could be the ability for GPs to video call patients on their mobile phone if there is a need to medically intervene. Currently a significant amount of the healthcare budget is spent on treating chronic conditions which require constant care and reduces the availability of the GP workforce. The investment in mHealth may be funded through the potential reduced costs for chronic disease management and freeing up GP time with better access to patient data.

27. NICE guidelines on hypertension, which advise using a 24-hour Blood Pressure recorder for diagnosis, have not only produced fewer and more accurate diagnoses [by 25%], but are cost-effective after 2 years of use. This reduced cost is through the reduction in use of unnecessary

anti-hypertensive drugs. Although many practices have taken up these medical technologies, their adoption across the whole of primary care has not occurred and a national initiative to fund the purchase and provide training is required. This would be funded through reduced drug budgets and savings.

28. Mobile Echo Cardiogram and ultrasound technology is available. However training for its use in primary care would need to be widely available and realistic in terms of time commitments for health care professionals, alongside the establishment of clinical governance arrangements for diagnostic services in primary care.

29. New technology should only be introduced where there is a direct benefit to patient care, and not just cost. Further opportunities where medical technology could support new ways of working include the use of technology to communicate with patients and obtain data on patients while supporting and treating them in the community. This could support the following:

- **a.** How patients book appointments, access prescriptions or even hold their own health record;
- **b.** Mandating e-referrals;
- **c.** Receiving health data from direct from patients;
- **d.** Ensuring alerts in place where health data is outside of expected parameters;
- **e.** Managing patients whose health data indicate a decline remotely; and
- **f.** Sharing information with all relevant parties.

30. The benefits that the PARIS (mental health and community information system) scheme has had within Cardiff and Vale UHB can be extended with the all Wales procurement of a joint health and social care system. In a modern care system this would seem essential to maximising the benefits in Wales of integrated health systems and the join up with social care.

Conclusion

31. Unlocking the potential of an integrated system is challenging when the history of the system is made up of different organisations with different priorities and different cultures. However, the potential is significant and therefore the challenge must be met. Technology is pivotal to delivering our vision of safe and effective care as close to home as possible.

32. As our discussion paper 'From Rhetoric to Reality - NHS Wales in 10 years' time'[iii] highlights, we should '*showcase the good work we're doing, by all means, but where Wales finds itself behind the curve, we must demand more. With other countries much further down the line of technology adoption, more capital investment is required in Wales. Indications are that this is available, despite the austere times. Together with the right leadership and direction, this will facilitate the implementation of exciting and potentially transformational changes'*.

[i] The Welsh NHS Confederation, January 2014, From Rhetoric to Reality – NHS Wales in 10 years' time
[ii] The Welsh NHS Confederation, January 2014, From Rhetoric to Reality – NHS Wales in 10 years' time
[iii] The Welsh NHS Confederation, January 2014, From Rhetoric to Reality – NHS Wales in 10 years' time

RCGP Wales

Evidence submission to inquiry into access to medical technologies

The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the 'voice' of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 47,000 members, 1,884 in Wales, who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

RCGP Wales welcomes the opportunity to participate further in this inquiry.

New Technologies

New technologies are having an increasing effect on the delivery of health care worldwide especially in primary health care settings. General practice in the UK was quick to adopt IT solutions. There is a strong underlying architecture to the IT systems used in practices in Wales and NWIS has been an important agency supporting the rollout, standardisation and upgrading of IT systems in Wales.

This supplementary paper concentrates on novel new technologies that are becoming available in primary care.

Increasingly, medical devices are becoming cheaper, more reliable, more portable, more durable and easier to use. The pace of technological change makes it hard to predict the type, price and availability of devices in the future.

Many practices now have devices that would have been hard to imagine in general practice a decade ago. These include low-cost defibrillators, sophisticated ECG machines, sophisticated lung function testing devices, pulse oximeters and ambulatory monitoring devices such as ambulatory 24-hour blood pressure monitors and ambulatory ECG monitors. These are in addition to point-of-care testing devices using reagent strips - blood glucose, ketones, INR.

Ultrasound is a potential application in primary care both for general examination and cardiac examination. The World Health Organisation recommends ultrasound as a primary diagnostic tool in low cost environments. So far these devices have only been used in pilot projects and by enthusiasts in the United Kingdom.

More and more devices are becoming available which can do blood tests at the point of care. Low-cost devices are now available to test for troponins and D-dimer for example. Many of these tests were previously only available in a hospital laboratory. Many current clinical algorithms do not allow

for the availability of some of these new tests and will need to be rethought in the face of rapid technological change.

Smart phones can be used increasingly for patient monitoring and data sharing but it may be too early to distinguish fitness gimmicks from genuine healthcare applications.

New technologies pose new challenges in healthcare with the promise of timely point-of-care information leading to more convenient services and earlier diagnosis but there are dangers in the rapid pace of change without both sufficient flexibility and clinical governance.

Many new technologies have been introduced without difficulty but the debate over ultrasound illustrates some of the tensions.

Requests for imaging in secondary care are outstripping resources UK wide. A recent paper in the BMJ suggested that this is related to a lack of facilities and trained radiologists and radiographers. In Wales, in the first month of 2014, 31% patients had been waiting for more than 8 weeks for non-obstetric ultrasound. The dilemma is whether to move the point of care using cheaper technology to primary care or invest in more centralised expert care. A mixed solution with strong clinical governance is a credible alternative. Less reliance on experts and moving the locus of care will require considerable training and refocusing of investment. Ultrasound in primary care however has been shown to be timely, accurate, easy to use at the bedside or in the surgery and capable of providing rapid diagnosis in an emergency. Apart from training issues, diagnostic error, false positives and false negatives, difficulty in storing images and data; calibration, safety and maintenance also need to be considered.

For commissioners it will be important to judge how best to support the introduction of new technologies in primary care. Substitution, duplication and governance are likely to be the main issues but commissioners will need to be bold and above all flexible to avoid stifling innovation. Commissioners will need to recognise the need to pilot and often pump-prime new activities.

The pace of change is also important. With all new technologies the diffusion of ideas suggests that there are early adopters and enthusiasts, the majority and laggards. Clinical change cannot occur without ownership.

RCGP Wales welcomes the challenge that the introduction of new technologies poses for primary care and in particular the advantages for patients, especially timely and convenient point-of-care diagnosis.

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BMA CYMRU WALES

National Office
Swyddfa Genedlaethol

29 August 2014

ACCESS TO MEDICAL TECHNOLOGIES – CALL FOR FURTHER EVIDENCE ON ACCESS WITHIN PRIMARY CARE

Inquiry by National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a further response to the inquiry by the National Assembly for Wales' Health and Social Care Committee into access to medical technologies, focusing on this occasion on access to such technologies within primary care.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales is aware that there are a number of positive examples across Wales of new medical technologies being used effectively in primary care settings. We are also pleased to note the leading role in the use of ICT that has been undertaken by primary care within the NHS in Wales. However, in relation to the use of new technologies, we also know that there is much variation in application, and concern amongst our members regarding barriers to accessing such technologies. We recognise that technology has enormous potential to make significant and cost-effective contributions to healthcare (both mental and physical), especially where it can assist in preventing the need for patients to access secondary care services. Such an approach is entirely in accord with the principles of prudent healthcare as recently advocated by the Bevan Commission[1] and also has the potential to enhance self-management by patients of certain chronic conditions.

For these reasons we welcome the Committee's inquiry in this area and are delighted to have the opportunity to contribute this further response on behalf of General Practitioners in Wales, which focuses specifically upon access to medical technologies within primary care.

In gathering evidence to inform this submission, we canvassed views from BMA members across Wales. Amongst the responses we received, the following examples of medical technologies being used effectively within a primary care setting were highlighted:

[1] http://www.bevancommission.org/sitesplus/documents/1101/Bevan%20Commission%20Simply%20Prudent%20Healthcare%20v1%2004122013.pdf

Ysgrifennydd Cymreig/Welsh Secretary:
Dr Richard JP Lewis, CStJ MB ChB MRCGP Dip IMC RCS (Ed) PGDip FLM

- Oxygen saturation monitoring (e.g. for patients with COPD).
- 24-hour monitoring of blood pressure.
- Heart monitoring using ECG (electrocardiogram) machines and hand held ultrasound machines.
- Hand-held dopplers for management of chronic ulcers.
- Telephone consultations (e.g. for patients living in remote areas, for patients who may have a high domiciliary care need or for giving test results).
- Some GPs find it useful for patients to text pictures to them – e.g. of skin rashes.
- Electronic transmission of video or still images for consultant opinion (e.g. dermatology).

Areas and suggestions for progress

ICT systems

Within the NHS in Wales, we would consider that primary care has taken a leading role in driving forward ICT development. We note that a national programme is underway to centralise systems and data storage, refining the software options for practices down to two clinical packages.

BMA Cymru Wales also notes, however, that the level of development that has taken place in primacy care ICT has not been matched within secondary care settings. As such, we would consider that Wales is still a long way from achieving a single health record that can, where agreed, be accessible across primary and secondary care using systems which operate effectively and robustly.

In our view, additional investment is greatly required in secondary care ICT systems to bring them up to the standard that exists within primary care so as to enable an effective electronic interface to be created between the two. We note for instance that the current systems in place do not allow electronic data sharing in ways which many people would consider basic, such as accessing images electronically (e.g. x-rays). The Welsh Clinical Communications Gateway (WCCG) for instance does not permit the sending of files greater than 8 MB in size, thereby preventing many images being sent electronically at sufficient quality. Such limitations need to be addressed. We further believe that investment also needs to be made to enable an effective ICT interface between health and social care, which we observe is almost non-existent at present.

We believe that an integrated and effective ICT system, with capability to operate across primary and secondary care, would offer the single most effective solution to improving the patient pathway in NHS Wales. Developments such as the Welsh Clinical Portal are seeking to address this. It aims, for instance, to overcome the problem of different systems not 'talking to each other' e.g. systems handling information such as test results, discharge letters, secondary care referrals or general administrative details. At present because different systems used within the NHS are not integrated, valuable time may be wasted by clinical teams, such as district nurses, having to spend time duplicating clinical entries on more than one system

In addition to helping facilitate electronic referrals and the management of test results and requests, greater use of software systems that are accessed online also provides the advantage of centralised upgrading and maintenance. Disadvantages may result from a reliance on central servers as well as difficulties for GP practices and healthcare providers in the border areas of Wales as they aren't currently able to use these systems effectively for cross-border referrals. Indeed thought needs to be given to how cross-border communications can be improved. At present GPs on the Welsh side of the border for instance can't straightforwardly email consultants across the border for advice as they are not within the Welsh NHS systems. Nor are Welsh practices presently able to use WCCG for cross-border referrals to secondary care, and there is a lack of a connection from Wales into the *Choose and Book* system which operates within the NHS in England.

A further consideration which needs to be borne in mind, particularly in relation to more rural parts of Wales, is the variability that still exists in terms of access to sufficiently fast broadband and cellular networks which may preclude access to some ICT solutions in certain localities.

As we have already indicated, there may be benefits for patients in certain circumstances in being able to undertake telephone consultations with GPs. This might be of particular benefit to patients living in remote areas or to those patients who may, because of their medical condition, have difficulty in travelling to a GP's surgery. A further development of such an approach might be the use of video conferencing using software such as Skype which can be readily accessed using smart phones or tablet computers. One note of caution that may need to be considered, however, is the outcome of a recent study by researchers at Exeter Medical School[2] which concluded that consultations undertaken over the phone do not reduce workload pressure in busy GP surgeries because patients who receive such a consultation are then more likely to require a follow-up appointment. Other concerns on the use of telephone consultations include a loss of access to non-verbal cues which can otherwise aid diagnosis, potential issues around other parties being unknowingly present and how such consultations are recorded.

Commissioning

We recognise that technological solutions need to be integrated into existing and future care models. A more joined up approach to the commissioning of new technologies would certainly be very much welcomed by GPs. A clinically-led approach to commissioning would, in our view, make a huge difference to effective service delivery.

We do not consider that the use of local commissioning expertise is currently well facilitated in Wales. We would note, for instance, that GPs are rarely involved in the local management of the NHS. At present, GP cluster networks are not supported adequately and are also vastly variable across Wales. We believe that they do, however, offer considerable potential to improve local commissioning – provided they are used for more than just administering the Quality Outcomes Framework (QOF) as is currently the case in some parts of Wales.

A major barrier that our members identify in adopting or investing in some of the more expensive medical technologies is uncertainty about the longer-term commissioning commitments and priorities of local health boards. For instance a practice may determine to invest in an effective new medical and diagnostic technology only for the local health board to then change its priorities months later, potentially rendering the technology useless in that practice and hence a waste of investment.

We would therefore recommend that key to overcoming such financial barriers would be the identification of specific dedicated funding streams that could cover the introduction of new technologies within primary care.

It has to be recognised that the funding GP practices receive is allocated to cover the existing costs of the services they provide and, like other parts of the NHS in Wales and other Welsh public services, GP practices are already under considerable financial pressure after a number of years of below inflation funding increases.

This also needs to be taken in context with the fact that the NHS in the UK as a whole already provides considerable value for money in comparison to the healthcare systems of comparable industrialised nations, as evidenced by the most recent report on this issue published by the Commonwealth Fund[3]. That report ranked the UK's NHS as first overall, including for the quality of the care provided and its overall level of

[2] http://www.bbc.co.uk/news/health-28602156
[3] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

efficiency, despite it costing less per head than all but one of the other ten national healthcare systems assessed.

The challenge for both Welsh Government and local health boards in this current financial climate is therefore to determine how resources might be freed up from elsewhere to cover the costs of introducing new technology solutions, particularly if the use of such technology solutions might reduce costs overall in addition to providing other potential benefits, such as improving the self-management by patients of chronic conditions and furthering the principles of prudent healthcare.

We would suggest this might be achieved by looking at creative approaches to resource allocation. For instance, if the introduction of some particular new technology usage within primary care might reduce or eliminate the need for patient referrals to secondary care (e.g. by enabling diagnostic testing or treatment monitoring to be undertaken within primary care far more cost effectively) then anticipated savings from secondary care budgets could be captured in advance. This could enable funding to be transferred to primary care budgets to cover the costs of introducing the new technology in the first place.

If it is not deemed possible to capture such savings in advance, however, then an alternative approach might be to look at an 'invest to save' fund to pump prime the use of new technologies within primary care. This may involve financial benefits being realised over subsequent years, an approach that may be able to be better facilitated by the recent decision to move to a three-year budgetary cycle for local health boards. Such an 'invest to save' approach would also be consistent with the Welsh Government's recent establishment of an intermediate care fund.

It is important that the whole costs of introducing new technologies are fully taken into account. For instance, a fund might be created to facilitate the purchase of new equipment but it may also need to cover the funding of any training needs that might be required to enable the equipment to be used, maintenance costs of the equipment, or the cost of any consumables that may be required for its use on an on-going basis.

Putting financial considerations aside, thought also needs to be given by Welsh Government and local health boards as to how decisions to commission new technological solutions might be driven forward, rather than this just being left to individual practices that are already overstretched to consider in an ad-hoc manner. Individual practices may lack the expertise to be able to identify what technologies could be worthy of investment. We would therefore suggest such commissioning decisions might be driven forward at the level of GP cluster networks. By adopting such an approach, this could enable more effective negotiation of costs with suppliers as well as assisting in the identification of manufacturers. A cluster-led approach to commissioning would also be better tailored to the needs of the particular local population served.

Near patient testing

BMA Cymru Wales believes that the use of new technologies can provide opportunities within a primary care setting to expand on the existing use of near patient (or point-of-care) testing, thereby covering a greater number of conditions and illnesses than is currently the case and reducing the need for patients to be referred on to secondary care for different types of testing or treatment monitoring.

The following examples derived from articles that have been published in the British Journal of General Practice, provide illustration of the sorts of near-patient solutions that might be identified:

> *Example 1 – May 2012*[4]
>
> *'The D-Dimer test in combination with a decision rule for ruling out deep vein thrombosis in primary care: diagnostic technology update':* This review looked at studies on the effectiveness of testing for suspected Deep Vein Thrombosis (DVT) by testing for D-dimer – a small protein fragment present in

[4] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338064/

the blood after a clot is degraded by fibrinolysis. It concluded that this test could enable DVT to be ruled out by a point-of-care testing method in about half of patients with suspected lower leg DVT, negating the need for them to be referred to secondary care for an ultrasound scan.

Example 2 – Nov 2012[5]

'Point-of-care INR coagulometers for self-management of oral anticoagulation: primary care diagnostic technology update': This review looked at studies undertaken on self-management through use of a home monitoring device for INR (international normalized ratio) as a measure of the effectiveness of oral anticoagulant therapy (e.g. use of warfarin). It concluded that the use of such point-of-care testing is as accurate as tests carried out in a laboratory setting.

Example 3 – Nov 2013[6]

'Association between point-of-care CRP testing and antibiotic prescribing in respiratory tract infections: a systematic review and meta-analysis of primary care studies': About 80% of patients with respiratory tract infections (RTIs) are prescribed antibiotics despite the fact RTIs seldom require antibiotics for treatment. Increased use of antibiotics is significantly associated with the development of drug-resistant bacteria. This review demonstrated a clear correlation between the use of point-of-care testing for C-reactive protein (CRP) – an acknowledged biomarker to diagnose bacterial infection – and reduced prescription rates of antibiotics for RTIs.

In relation to *Example 2* above, we would note that this could be of particular benefit to patients who might otherwise need to travel long distances to hospital for monitoring to be carried out (e.g. following transplant surgery).

Near patient testing in GP surgeries offers the potential for delivering more convenient provision of services for patients. We are also aware of a pharmacist-led warfarin/INR service operating in the Abertawe Bro Morgannwg University Health Board area.

One consideration in the use of near patient testing, however, may be the acceptability of such diagnostic testing to patients themselves. Sometimes a patient will want to be referred to a specialist for the sake of their 'peace of mind', so consideration may also need to be given to patients' acceptance of such tests taking place within primary care settings.

Sharing best practice/identifying target populations

We would consider that it is important to facilitate effective communication between GP practices and health boards in order to share best practice, including identifying and reviewing the use of new technologies and better ways of working.

We would wish to highlight two areas where we consider general practice in Wales is making good progress in this regard.

Firstly, we would point to the involvement of general practice in Wales with the SAIL Databank[7]. SAIL (which stands for Secure Anonymised Information Linkage) is an initiative funded by the Welsh Government's National Institute of Social Care and Health Research (NISCHR). It is a Wales-wide research resource which focuses on improving health, well-being and service delivery. It brings together a wide range of routinely collected health-related datasets from different origins in a way that enables the data to be robustly anonymised. Because it holds only anonymised data, it enables researchers using the data it collects to carry out their work without knowing the identities of the individuals represented in the datasets.

[5] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3481522/
[6] http://www.ncbi.nlm.nih.gov/pubmed/24267862
[7] http://www.saildatabank.com/

Although signing up to SAIL is voluntary, 58% of GP practices in Wales have signed up to date. By health board area, this breaks down as follows:

Aneurin Bevan – 47 %
Betsi Cadwaladr – 50%
Cardiff and Vale – 49%
Cwm Taf – 38%
Hywel Dda – 70%
Powys – 47%
Abertawe Bro Morgannwg –100%

Secondly, we believe that the recent development of GP cluster networks offers a key potential for the sharing of best practice and experiences of the use of new medical technologies. Cluster networks however need to be fully operational in all parts of Wales in order for this to be effective; currently this is not the case. As we have indicated previously in this response, we believe it is important that cluster networks are properly developed.

Future developments

We recognise the potential offered by smart phone apps, especially in areas such as self-health monitoring and management. Tablets, smartphones and even 'non-smart' standard phones can be used to offer diagnostic, monitoring, and therapeutic functions. A recent article in *The Guardian*[8] outlined how mental health care in particular might benefit from the use of such technology:

> *"…researchers at Oxford and elsewhere[9] have shown that SMS and voice-calls can be used to assess mental health status, deliver talking therapies (eg cognitive behavioural therapy) and stimulate behavioural change. Higher-spec devices such as smartphones and tablets can perform the same functions in more user-friendly ways, for instance through multimedia apps, and can also draw on a wider range of sensors and capacities – eg accelerometers, GPS and camera – to generate richer data and smarter interventions. The Mobilyze! system developed in Chicago[10], for example, uses 38 smartphone sensor values alongside user input to predict psychological status and deliver tailored therapeutic interventions for unipolar depression. Mobile mental health already has the capacity to revolutionise the way we evaluate, monitor and treat mental illness, especially in poorer countries where mental health workforces barely exist."*

Other considerations

The pressure that already exists within general practice at this time of on-going restraint in the financing of public services and increasing difficulties in GP recruitment has to be recognised. Whilst the use of new technologies may bring many benefits, including in certain circumstances avoiding the need for patients to be referred to secondary care for diagnostic testing or treatment, the potential workload implications on already overstretched GPs needs to be fully taken into account. In order for GPs to free up capacity in the working day to take on the use of new technologies, it may therefore need to be accepted that something else would have to give. Creative solutions to this might involve elements of GP's existing workloads being undertaken by others within wider primary care teams, but that in turn will have a resource implication. It is therefore important to ensure that any transfer of workload from secondary to primary care as a result of the use of new technologies is adequately resourced, and properly evaluated in order to avoid any unintended consequences.

[8] http://www.theguardian.com/healthcare-network/2014/aug/12/technology-treat-mental-health-conditions
[9] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921773/
[10] http://www.jmir.org/2011/3/e55/

Conclusions and key recommendations

BMA Cymru Wales very much recognises the potential benefits that could be derived from increasing the use of medical technologies within primary care settings, as well as the enthusiasm that exists amongst many of our GP members to drive such initiatives forward. However, in order to develop a less piecemeal approach to the use of such new technologies than exists at present, it is important to overcome the key barriers that GPs face in having sufficient time and funding to develop such approaches.

We would recommend that the Committee gives thought to calling on the Welsh Government and local health boards to look at creative solutions to overcoming these barriers, such as looking at ways in which financial resources might be transferred from secondary to primary care to match the transfer of work from secondary to primary care that the use of a new technology within primary care could facilitate. This might be undertaken through capturing anticipated savings from secondary care budgets in advance, or by looking at the creation of 'invest to save' funding that could pump prime the use of new technologies. Similarly, we believe that thought also needs to be given as to how capacity can be created that could enable GPs and wider practice teams to be able to utilise and realise the benefits of the wider use of medical technologies.

BMA Cymru Wales also believes that GP cluster networks offer significant potential to drive forward the commissioning of new technology solutions within primary care. We recognise, however, that this would require the concept of GP cluster networks to be further developed in many localities than is currently the case.

Ensuring existing ICT systems used within the NHS in Wales can be better integrated should also be regarded as a key priority in our view. We recommend that a clear investment strategy is brought forward to ensure that secondary care ICT systems can be brought up to the standard that already exists within primary care in order to assist in the development of a single health record that can be accessed across both primary and secondary care.

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Social Services Improvement Agency
Asiantaeth Gwella'r Gwasanaethau Cymdeithasol

Written Evidence to the National Assembly for Wales, Health and Social Care Committee

The impact of Assistive Technology within Social Care

August 2014

WLGA • CLILC

Leading Social Services in Wales
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru

Llywodraeth Cymru
Welsh Government

1. Introduction

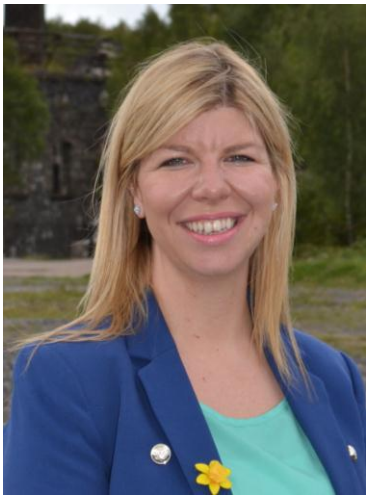
The Social Services Improvement Agency (SSIA) welcomes the opportunity to present evidence to the Health and Social Care Committee and share our experience from work in regards to the use of technology to help people remain safe and independent.

The SSIA was officially launched during the Social Services Summit in March 2006. Funded by the Welsh Government we are a bespoke and specialist team dedicated to supporting improvement within social care across Wales. Hosted by the Welsh Local Government Association we work closely with key organisations across the social care sector, which include Association of Directors of Social Services Cymru, Care Council for Wales, Care and Social Services Inspectorate Wales and Wales Council for Voluntary Action. We maintain strong working links with elected members and local authority officers. Working in partnership and sharing our learning from specific work programmes helps drive improvement across Wales.

A key theme within our work over the years has been early intervention and prevention with a focus on ensuring the service user remains safe, independent and where possible within their own home. This was driven by a national review of local authorities' older people's services which focussed on the role of reablement services in supporting people to 'relearn' skills to remain independent. The role of Telecare, Telehealth and Assistive Technology can all be seen to play a key role in enabling people to keep their independence and remain safe and closely links to the reablement agenda. This paper broadens the focus from medical technology to the work on Telecare and Assistive Technology which has shown a real positive impact on the delivery of social care. Telecare can be seen as a service that enables people, especially older and vulnerable people, to live independently in their own home. It is a way of enabling them to call for assistance, at any time of the day or night. Depending on the equipment installed, it may also be able to summon help automatically when sensors in the home are triggered by unusual behaviour patterns,

or lack of them. Key to any Telecare system is a response centre whose trained staff respond to all calls.

Assistive technology is ‘any device or system that allows an individual to perform a task that they would otherwise be unable to do, or increases the ease and safety with which the task can be performed’ (Royal Commission on Long Term Care, 1999). This umbrella term includes rehabilitation technologies, Telecare, Telehealth and electronic technology. Products range from ‘low-tech’ items such as walking sticks and grab rails, through mechanical and electrical equipment such as manual and powered wheelchairs, to electronic and information and communication technology (ICT) systems such as Telecare.



Emily Warren
Head of SSIA

Andrew Bell
SSIA Knowledge Manager

2. SSIA – Supporting the role of Assistive Technology in social care

The SSIA current work programme includes a specific commitment to explore and support the role of assistive technology in social care and understand the key aspects of such an approach in supporting people to remain safe and independent. Working in partnership with the Welsh Government, Directors of Social Services and the Care Council for Wales we are supporting a national network of key individuals from across social care and health to share learning and look to explore consistency in approaches. Through a multi sector workshop we have explored the key challenges and barriers and areas identified further consideration by this group were:

- Mapping of current provision of service to gain a national understanding and look at opportunities to learn from each other
- Staff training, and sharing and identifying good practice including outside of Wales
- Engagement with commissioners and understanding the needs of users and also needs of other services such as health and housing
- Connection to professional groups such as GP's, rehabilitation staff, therapists
- Use of task groups to look at specific aspects such as charging, mapping provision, develop a strategy, innovation and research
- Keeping up to date with new technology and the testing of products

Further work will be carried out to explore how this important service can become more mainstreamed in the way services are delivered with an all Wales event on the 18 September 2014. All resources developed by this work as they are published will be made available on the SSIA website at www.ssiacymru.org.uk.

As we can seen within the case studies that follow the range of equipment is broad ranging from sensors, intruder alarms and fall detectors to name a few and importantly the client groups across Wales who receive this support range across older people, adults with learning or physical difficulties, mental health to children with learning or physical difficulties. Highlighting that such interventions are supporting the most vulnerable within our society.

The full impact and extent of assistive technology across Wales is not clear at present but it can be seen in earlier studies this approach has shown a significant positive impact on the individual. Such an approach will also bring real benefits to the organisation in allowing them to manage risk effectively, reduce the need for traditional services which in turn can be costly and not always the best outcome for the individual.

3. CASE STUDIES

The following examples highlight the significant importance assistive technology has had for individuals across Wales and the UK. These examples illustrate that often non-intrusive and low level interventions can have a significant impact on the well-being and safety of vulnerable individuals.

Case example 1 – Managing risk and gaining independence

C is in her mid twenties and has learning disabilities which require her to need support an hourly basis and as such she lives within a supported living environment shared with 4 other service users; however C's goal is to live an independent life with as little intervention as possible. The project team including the supported living manager and Newport Telecare team , therefore carried out an assessment of her individual needs and determined that by introducing specific Telecare equipment into her home such as

a personal pendant that would link her to staff if needed; this could be achieved. The introduction of the Telecare adaptations has allowed C to live with significant increase to her independence **s**upporting her to have a gap between visits for up to 8 hours. The Project Team found managing risk in a positive way has enabled them to reduce the intervention required and at the same time enable C to remain safe and independent.

Case example 2 – Supporting people with dementia with assistive technology

Mrs B had dementia and had lived in an EMH unit in Residential Home for 3 years. She appeared settled and had a good rapport with the staff. Staff had noticed that during the night Mrs B was attempting to climb onto the white sink basin in her room believing it to be a toilet; this was putting her at huge risk of falling and loss of dignity.

Mrs B`s Social Worker carried out a Mental Capacity test in order to identify if Mrs B had the mental capacity to make an informed decision about the provision of Telecare equipment. This test identified that Mrs B did not have the mental capacity to make an informed decision about the provision of Telecare equipment so a Best Interest decision was made to provide the least restrictive option of Telecare provision in order to keep her safe.

An Infra-Red Bed Exit sensor was provided which alerted staff if Mrs B attempted to get out of bed. This enabled staff to assist Mrs B to her toilet, provide her with reassurance and settle her back to bed safely.

Case example 3 – Supporting people with dementia with assistive technology

Mrs C was 91 years old, has dementia and poor mobility which required assistance of one Carer to walk with her Zimmer frame. She had lived in an EMH unit in a Residential Home for 11 months. She had suffered 3 falls in the past 3 months due to her attempting to get up from the chair in her room and walk independently.
Mrs C`s Social Worker carried out a Mental Capacity test in order to identify if she had the mental capacity to make an informed decision about the provision of Telecare equipment. This test identified that Mrs B did not have the mental capacity to make an informed decision about the provision of Telecare equipment so a Best Interest decision was made to provide the least restrictive option of Telecare to keep her safe. A chair exit sensor was provided which would alert staff if Mrs C attempted to get out of her chair unaided. This enabled staff to attend Mrs C and provide her with the assistance she requires. Mrs C still lives in the same EMH unit 2 years later and has not suffered any further falls.

Case example 4 – Safeguard from falls with assistive technology

Mr D was 82 years old, he lives in a Residential Home, he has poor mobility and suffers with nocturnal Tonic Clonic epileptic seizures. He does not require rescue medication but becomes disorientated following a seizure and often gets out of bed and falls.

Following a Specialist Telecare Assessment Mr D agreed to the provision of a bed based epilepsy sensor which would alert staff if he

was in bed. Staff could then attend Mr D, provide him with reassurance following a seizure and ensure that if he does need to get out of bed he does not fall. Mr D still lives in the same Residential Home 2 years later, he still has nocturnal tonic clonic seizures but he has suffered no further falls.

Case example 5 – Supporting people with dementia with assistive technology

Mrs A is 87 years old; she has dementia and has lived in an EMH unit for 6 months. Over the past month Mrs A has occasionally left her room during the night and entered other resident's rooms believing she was looking for her mother. This has caused Mrs A distress, it has also caused distress to the other residents concerned.

Mrs A`s Social Worker carried out a Mental Capacity test in order to identify if Mrs A had the mental capacity to make an informed decision about the provision of Telecare equipment. This test identified that Mrs A did not have the mental capacity to make an informed decision about the provision of Telecare equipment so a Best Interest decision was made to provide the least restrictive option of Telecare provision in order to keep her safe. During the Best Interest meeting the Home Manager identified that on the occasions Mrs A has become distressed and attempted to look for her mother it has been during the hours of 10pm and 6am.

Door exit sensors were installed on to Mrs A`s room door which would alert staff if her door was opened between the hours of 10pm and 6am. If staff were alerted they could attend Mrs A, provide her with reassurance and settle her back to bed safely.

Mrs A`s door exit sensors did not need to be active during the daytime so she was able to enter and exit her room without staff being alerted.

Case example 6 - Using Telecare Memory Reminders and Prompts to Support Independence

S is a young man with neurological problems resulting in epilepsy and severe short term memory problems. S's memory problems meant he forgot to take his medication and have meals. Because of these difficulties S also had two 30 minute calls each day to support him with medication and meals.

In order to promote S's independence, it was decided to programme his Telecare lifeline unit with reminders that would assist him to take medication and have regular meals. A reminder buzzer would sound and S would hear the monitoring centre manager's voice reminding him it's time to prepare a meal and/or take his medication. S then presses a button to acknowledge the reminder. If the cancel button isn't pressed an alert would be sent to the monitoring centre.

The carers confirmed S was responding to the prompts from his lifeline unit and was successfully managing to prepare meals and take his medication at appropriate times. The use of Telecare prompts was cost neutral as S already had a lifeline unit (although he was given an updated lifeline). As a result of this intervention, S no longer requires daily calls and is currently only receiving one call per week. The cost of his care package has reduced from £92.96 per week (or £4833.92 per year) to £6.64 per week (or £345 per year).[1]

4. Conclusion

The Social Services Improvement Agency, are strongly committed to working with Welsh Government and local authorities, to ensure that where appropriate, use of technologies can lead to a more positive experience for the citizen, increasing independence, control and confidence. However, it is important to note that use of such technologies can only be fully effective where the individual has had an assessment that reflects that the most effective and least intrusive option is adopted.

Assistive technology alongside other preventative interventions such as reablement can be seen to play an important role for individuals to remain independent and safe. From the evidence presented, there is now a growing focus on assistive technology in social care, to increase independence and better management of conditions. It is important that in Wales, there is a clear national message the use of assistive technology in the delivery of health and social care is recognised, and welcomed, and that further focus is placed on emerging technologies by the Welsh Government. It is also important that health and social services develop a coherent approach in this area, recognising the need for the individual and their family to find the most appropriate solutions, without having to navigate complex service boundaries. Currently, across Wales there is a developing picture, which would benefit from a clear national commitment, and direction, to support development, enable the market and deliver welsh based solutions.

The SSIA will continue to support this important area of work, via our Assistive Technology Learning and Improvement Network (LIN) which has been established with the support of the welsh government, local authorities and the health service. It is a clear demonstration of the commitment of welsh local government to this important area, and a developmental step towards learning from each other and work collaboratively on the challenges of this approach.

Leading Social Services in Wales

Yn arwain Gwasanaethau Cymdeithasol yng Nghymru

ADSS Cymru Response to the National Assembly for Wales – Health and Social Committee

Access to medical technologies in Wales

August 2014

1. Introduction

The opportunity to provide comment to this consultation is welcomed. Assistive technology is an important issue for Health and for Social Care in Wales as we seek to ensure that our services are fit for purpose and sustainable, meeting people's needs as they live longer and have access to a greater range of information than ever before.

We have a particular interest in ensuring that technology supports the welcome emphasis on greater integration across health and social care in Wales, in giving seamless and 'joined up' services to our citizens, and does not become a barrier to effective care coordination. There are four strands to the terms of reference of this inquiry:

* To examine how the NHS assesses the potential benefits of new or alternative medical technologies;

* To examine the need for, and feasibility of, a more joined up approach to commissioning in this area;

* To examine the ways in which NHS Wales engages with those involved in the development /manufacture of new medical technologies;

* To examine the financial barriers that may prevent the timely adoption of effective new medical technologies, and innovative mechanisms by which these may be overcome.

We offer some general observations as well as comments against each of the strands.

2. Overview comments

There is no common standard definition of medical technology and so there is potential linkage or cross over with other terms such as telemedicine and telehealth. The former is generally understood to cover technology linking patient to hospital or GP practice to hospital whilst the latter term is used to relate to technology that is usable in a patient's home to help support their medical treatment.

A definition drawn from web research is very broad: *'Medical technology is the use of a device or invention to extend the life of patients, relieve pain and reduce risk of disease. Examples of medical technology include medical and surgical procedures, medications, medical devices and diagnostic tests.'*

A clear definition of what is included in medical technology would be welcomed, and confirmation that this can include devices used in home and community settings. If primary and community care settings are included in the remit of medical technologies – as we believe they should be – then there is a greater case for interoperability being built into the design and development of new equipment.

Within the UK the Medical Technology Group (MTG) is a collation of patient working groups, research charities and medical device manufacturers committed to raising the profile of and investment in medical technology. The UK spends 4.5% of the national healthcare budget on technology compared to a European average of 6.3%. As a result some technology based procedures are more common elsewhere in Europe than in the UK – pacemakers are implanted in Germany at twice the rate as that in the UK, for instance.

This position has been recognised by the UK Government making commitment to invest more in Life Sciences and the '3 million lives' campaign to increase use of telehealth building on from the outcomes of the Whole System Demonstrators which covered Kent, Cornwall and Newnham Councils. This campaign has not been as been transformative as was hoped, with some concern that it took too much of a 'top down' approach, placed a strong reliance on manufacturers/suppliers changing the market, and failed to engage fully at operational level or to link across to social care, third sector and user groups. There are lessons to be learnt from this in Wales, and a key is to engage at all levels, so that front line practitioners – GP's, District Nurses, Social Workers, Therapists and others – can see the benefits of technology in delivering good care outcomes.

This has been key for the take up of Telecare – so that front line staff, carers and service users see a benefit. This ranges from carer 'peace of mind' that they can go out, knowing there is some monitoring in place, to care managers targeting care visits to when needed rather than put in care to manage risk of 'what might happen'.

Patient views and needs are also beginning to be recognised in that the UK Government Health Bill makes provision for taking forward pilots of direct payments for medical technology – such as insulin pumps, to be used to help manage medical conditions. This follows on from the use of personal budgets in social care, which have been received positively by the UK government. Expanded use of direct payments and a duty on local authorities to encourage and develop alternative models of care are a feature of the Social Care and Wellbeing Act in Wales that give a similar opportunity to bring supportive medical technology into the community level to support individuals to minimise hospital visits and remain at home.

Both UK and Wales Governments have recognised the need to encourage innovation and new development through having open awards processes. The Department of Health as a £20 million innovation prize budget and MediWales – funded through Wales Government - has operated innovation awards in Wales for Welsh companies over the past seven years.

It would therefore be *useful to confirm that funding for innovation will continue* at similar levels as now, or greater, to support Welsh based technology organisations. That funding should include partnership working as a core requirement for new proposals. An example of how this principle can be applied was the changed remit of the Health Technology Fund to be a Health Technology and Telehealth Fund (HTTF). It was a positive change for 2014/15 and has helped foster greater collaboration across Health Boards in Wales and with social

care partners. Examples would be the sharing of ideas across the three Health Boards in SE Wales – Cardiff & Vale UHB, Cwm Taff LHB and Aneurin Bevan UHB ahead of bid applications, and the multi disciplinary panel approach in ABUHB that included social care partners.

3. Inquiry Themes

i. To examine how the NHS assesses the potential benefits of new or alternative medical technologies.

This does seem to vary across Health Boards, with little or no national strategy that is very evident. Take up does seem to be driven by local champions often working within specific disciplines. It may be useful to develop a *network of champions as a practice group*, supported by Wales Government, to be a *sounding board for new innovations* and to undertake clinical trials. To some extent this exists with the Life Science Expert Advisory Group – but their remit should be open and include patient perspectives, as well as opportunity for social care input.

It would also be helpful to have *a strong policy statement* – akin to the Department of Health '3 million lives' campaign aims – from Wales Government to show that there is *commitment to developing and using technology to support* patient care.

Consideration of *extending direct payments for patient take up of medical technology* could also be considered – so that there is a user driver for change as well as a clinical driver.

ii. To examine the need for, and feasibility of, a more joined up approach to commissioning in this area.

The current commissioning process for new technologies is not completely obvious as there are different strands and different organisations that have a part in the process. The overarching body covering medical technologies and agreeing their use is NICE (National Institute for Health and Clinical Excellence) and their Medical Technologies Evaluation Programme. They will use accredited health organisations to undertake evaluation work – including the Cedar Evaluation centre within Cardiff and the Vale University Health Board.

There are a number of other organisations that undertake appraisal of technologies, including the NHS Wales Informatics Research Laboratories. It may therefore be helpful to have a clear mapping of what is done where so that ideas and designs can be submitted to the right place – depending on whether it is a direct patient used aid, a medical procedure, a new type of treatment, etc. The operational perspective and patient 'receiver' perspective should be included right at the design stage – so that the right solutions are commissioned for the right issues. The aim should be for a *clear development pathway that ensures designers and developers have access to the right clinical forums* for their type of product, as well as access to 'expert' patients who can give the user perspective, and the inclusion of

social care and third sector partners to look at the best ways to commission, with agreement as to desired outcomes.

There should be learning from the ways that assistive technology has developed in the UK – both successes and failures – so that best practice is followed, with good governance arrangements allied to a patient centred approach. This should be explored in terms of supporting better access to medical technologies, learning from telehealth experience in Carmarthenshire/Hywel Dda and in North Wales, working with Betsi Cadwallader LHB.

iii. To examine the ways in which NHS Wales engages with those involved in the development /manufacture of new medical technologies

This might seem to be predominantly for discussion by NHS organisations rather than local authorities, but social care is well placed to see the 'end user' impact of medical treatments as people are supported to live at home and in the community. It is also the case that local authorities can be a 'critical friend' in taking a community and social perspective to balance a medical model perspective. Some general observations might be:

* *Ensuring that Wales companies are given priority consideration so as to support the Welsh economy*

* *An open and transparent decision process using a panel that fully represents the whole of Wales and different arms of health care and social care.*

* *Support to range of technologies – including home based technology to support patients at home and not just technology in secondary care. This would have to consider integration and interoperability with Telecare/Telehealth that is already deployed. Existing collaboratives and partnerships should be utilised so that there is shared learning and avoidance of duplication*

* *Supporting a strong patient panel to ensure that the patient/user experience of medical technology is heard and informs forward development*

* *Learn from the positive and negative experiences of the 3 million lives campaign*

* *Take full account of the learning and experience of Telecare and Telehealth in Wales, including the person centred approach to risk management and accessibility. Telecare monitoring centres can provide some support to roll out of assistive technology for health needs, as an existing resource in place - there have been examples of a combined approach in North Wales, and an integrated approach is certainly supported by the newly reformed All Wales Assistive Technology LIN.*

iv. To examine the financial barriers that may present the timely adoption of effective new medical technologies, and innovative mechanisms by which these may be overcome.

The first point is that with more partnership approaches to identify, commission and assess new medical technologies then the more scope to pool some funding to take effective new solutions forward.

The second point is draw upon research facilities to support the trial and testing of new technology, with developer funding to take this forward being an important part of business planning to give greater new product assurance. The experience from Telecare and Telehealth has been an over reliance on supplier innovation and solutions and a failure to always have good 'field testing' before products come to market.

A third point is to use end user/patient and operational views to identify those technologies with best development potential – in other words to understand the market place for the particular technology. This will vary from highly sophisticated devices that may be at the level of one per LHB in Wales to simpler technologies that support a wide range of conditions.

A fourth consideration is to look at scope for small scale business investment in innovative solutions – 'crowd funding' approaches have been taken forward in the US to develop good ideas through to marketable products, from mobile phone apps to telecare solutions for older people.

Finally it may be worth thinking about enabling mechanisms for the public to purchase more health and social care technology for themselves by making "accredited" devices available on the high street. There may be scope for an all Wales (or regional) approach to develop a social enterprise to either manufacture or warehouse and sell direct to public, using skills from Economic Development in Wales Government or in local authorities.

4. Summary Points – Ten Point Plan

i. Presenting a clear definition of medical technology and specific elements under this term (and what is not) so there is clarity with other terms such as telemedicine.

ii. Confirmation of continued investment in Wales at same or increased levels, with partnership and integration as key investment criteria

iii. Clarity as to network of champions – practice group and patients – with defined role

iv. Presentation of a strong, high level policy statement from Wales Government indicating commitment to technology to support patient care.

v. Consideration of direct payments options for patients to use useful home based technology to support their self management of health

vi. A clear development pathway for designers to reach the right clinical forums and access to expert patients and social care partners

vii. Ensuring that Wales companies are given priority consideration so as to support the Welsh economy

viii. An open and transparent decision process using a panel that fully represents the whole of Wales and different arms of health care.

ix. Support to range of technologies – including home based technology to support patients at home and not just technology in secondary care

x. Supporting a strong patient panel to ensure that the patient experience of medical technology is heard and informs forward development

5. Concluding remarks

We believe that a partnership approach should underpin the development of medical technologies in Wales as a fundamental means of ensuring access to the right technology at the right time and in the right place. The greater the awareness of what technology can do and what the areas of need are, then the greater the potential to firstly identify solutions and then deploy them to best affect.

Gio Isingrini
President
ADSS Cymru
14th August 2014

Agenda Item 9

Document is Restricted

SCRUTINY SESSION WITH THE HEALTH AND SOCIAL CARE COMMITTEE – 18 SEPTEMBER 2014.

NATIONAL ASSEMBLY FOR WALES: HEALTH AND SOCIAL CARE COMMITTEE

Date: 18 September 2014
Venue: Senedd, National Assembly for Wales
Title: General Scrutiny Session (Part 1)

Purpose

1. This paper provides an update on key priorities and issues across the Health and Social Services Ministerial portfolio, as requested by the Committee Chair in his letter of 9 July 2014. A separate paper (Part 2) covers our response on financial matters, which includes specific reference to those areas of interest identified by the Committee in Annex A of their letter dated 15 May 2014.

Overview of recent progress and achievements, and portfolio priorities

2. Since my last attendance at the Committee's general scrutiny session on 18th July 2013, continued progress has been made in taking forward the Health and Social Services contribution to the ***Programme for Government***, the Welsh Government's plan of action for delivering high quality public services and improving the lives of people in Wales. This progress is outlined in the June 2014 Summary Progress Report.

3. ***Together for Health***, our five-year vision for the NHS in Wales, sets an ambitious agenda for service improvements, to assist in improving the health of everyone in Wales and reduce health inequalities. We are now just over half way through this programme and on 18th December 2013, I provided the Assembly with the latest progress update. While there is still much to do, progress is being made in implementing the commitments we set out in 2011. For example, we have published detailed delivery plans for each of the major services identified, with many having already provided their first annual reports, charting their progress.

4. The challenges that the NHS in Wales continues to face are real and significant. The recent **Nuffield Trust** report recognised these challenges, including rising costs; increasing demand; an ageing population; and a growth in the number of people experiencing chronic conditions – the same challenges every healthcare system in the world faces in this age of austerity. The report predicted that there could be a £2.5 billion funding gap in Wales in the next 10 years, on the basis that funding is held flat in real terms and if productivity gains cannot continue to be gathered. The Trust, however, recognised how we have already responded to the challenges identified, through a range of measures. These include improvements in efficiency and productivity, reductions in length of stay in hospital and hospital admissions, and remodelled services for people with chronic conditions, as well as identifying further potential for additional long-term savings, which the NHS can make if it continues to reform and reshape services. I have been working with the Finance Minister over the summer to establish what more

we can do to support new models of service delivery, to strengthen the care and support provided in local communities, and respond to the challenges identified in this report.

5. As part of our continued response to the challenges facing the NHS and Social Services. Work is taking place to develop, codify and embed **prudent healthcare** principles into health services across Wales. In my address to the NHS Confederation Annual Conference in January, I set out my intention to shift the focus of the health services we deliver to ensure that they fit the needs and circumstances of patients and actively avoid wasteful care that is not to the patients' benefit. This is an ethical approach to treating patients in which clinical need and clinical prioritisation determine how services are provided, concentrates efforts on the things that make a real difference and make the most effective use of resources. In doing so, a renewed effort is needed to embrace a preventative, primary and community care-led NHS which is **integrated with social care,** and delivers as much care as possible closer to patients' homes, shifting the balance between Primary and Secondary care. This approach complements the principle of coproduction, in which patients are encouraged to take greater responsibility for maintaining their own health and well being, by selecting the most appropriate and proportionate NHS service for their needs.

6. Trust in our NHS and the regard in which it is held remains important. We are committed to providing consistent, **high quality care** for everyone in Wales, and the ***Quality Delivery Plan*** sets out how we aim to achieve this through training, monitoring and reporting. The vast majority of people in Wales receive good, safe care, and we know from recent surveys including the *National Survey for Wales* that people in Wales are generally satisfied with the health services being delivered. However, that strong general picture must be reinforced by a determination to take fast effective action when things do go wrong.

7. I am also pleased that we continue to make good progress in delivering on the Health and Social Services portfolio contribution to the Welsh Government's **legislative programme**. The *'Listening to you – Your health matters'* Public Health White Paper is clear evidence of our commitment to preventing the fundamental causes of ill health rather than simply treating people when they fall ill. *The Organ Donation Act,* which received Royal Assent on 10 September 2013, also demonstrates our ambition for Wales to be a UK leader by taking bold decisions when we believe lives can be saved. The Food Hygiene Act is both a practical and popular success. The implementation of the flagship *Social Services and Well-being Act* will prove to be a ground-breaking change in policy, as it lays the foundations for modernising the care of some of our most vulnerable citizens, giving them a much more active involvement in the services they receive.

Session 1: General Scrutiny Issues

TOGETHER FOR HEALTH

8. *Together for Health* sets out our commitments to improve health services for everyone, improving access and patient experience, ensuring better service safety and quality to improve health outcomes, and ensuring services meet patients' needs and expectations. Our collective aim must be to support a modern NHS which consistently delivers high quality care, while meeting the considerable challenges it faces with confidence. The interlocking reforms detailed in *Together for Health* are essential to improve quality of life for all and make the NHS in Wales consistently safe, effective, more integrated, sustainable and resilient.

9. We also recognise that in order to reinforce patient confidence in the services we deliver, we must be transparent with regard to performance and to identify not only good performance, but also areas we know are in need of improvement.

Delivery Plans

10. *Together for Health* committed us to develop and publish a range of delivery plans for major services. Good progress is being made in implementing them.

11. Delivery Plans for Cancer, Mental Health and Stroke were published in 2012, and Plans covering Respiratory Health, Oral Health, Eye Health, Heart Disease, Diabetes, Neurological Conditions, End of Life Care and Care for the Critically Ill have been published within the last 18 months. A delivery plan for Liver Disease is currently being developed with Public Health Wales, and will be published for public consultation this autumn.

12. National Clinical Lead posts have been established for diabetes, stroke, end of life, unscheduled and planned care.

13. In June 2011, the National Unscheduled Care Programme Board published the "Ten High Impact Steps to Transform Unscheduled Care". This document provided a strategic framework, around which health boards could build an unscheduled care transformation strategy, and was informed by the issues identified within the Wales Audit Office 'Unscheduled Care: developing a whole systems approach' report (2009). In April 2013, I provided the Assembly with an update on the Programme and in August, Dr Grant Robinson was appointed as National Clinical Lead. Following the implementation of the Programme, performance levels improved with reductions in 12 hour waits, reduced ambulance handover delay, improved category A response times and A&E four hour performance.

14. In December 2013, a National Planned Care Programme was announced to replicate the model introduced for Unscheduled Care. The Programme includes a number of work streams: better managing capacity and demand, ensuring appropriate thresholds for treatment, optimising workforce contributions, and

ensuring sustainable delivery arrangements. In August, I announced Mr Peter Lewis as the Clinical Lead for this Programme, whose role will be to work with the Welsh Government and NHS Wales to take forward planned care and the co-ordination of primary and hospital services to ensure a safe system of care.

Mental Health Strategy

15. *Together for Mental Health - A Mental Health and Wellbeing Strategy for Wales* was launched in October 2012, setting out the Welsh Government's 10-year strategy for improving the lives of people using mental health services, their carers and their families. All Health Boards, Trusts and the Welsh Government are required to produce annual reports on their progress in implementing the strategy. The first set of reports, published in December 2013, set out the progress made in the first 12 months in delivering against the commitments.

16. Under the Strategy we have established a national Service User and Carer Forum which is bringing together individuals from across Wales, providing them with a strong voice to influence planning and provision at both local and national levels. We are rolling out a national core mental health data set at a service user level, which enables us to better understand the needs and outcomes of individuals using those services. Policy Implementation Guidance has been issued on veterans in prisons and offender mental health across the justice system, with specific guidance on young people who offend due to be issued shortly.

17. *Time to Change Wales* is the first national campaign seeking to end the stigma and discrimination faced by people with experience of mental health problems in Wales. The central aim of the campaign is to change negative attitudes and behaviour towards mental illness. In 2013, the Welsh Government signed the *Time to Change Wales* organisational pledge, showing how the Welsh Government, as an organisation, is committed to reducing and tackling mental health stigma and discrimination. The Welsh Government has agreed to provide £67,500 additional funding to extend the campaign until October 2014. This additional funding will help the campaign to extend its reach with organisations and people in Wales to engage with the campaign.

<u>CAMHS</u>

18. A Service Improvement Group supported by service change support, funded by Welsh Government has been established to oversee a wide ranging CAMHS improvement plan developed by the Welsh Government during 2013. This plan takes account of the WAO/HIW December 2013 report recommendations and is supported in its work by the all-Wales CAMHS and Eating Disorder Planning Network.

<u>Mental Health (Wales) Measure (2010)</u>

19. An interim report reviewing the implementation of our landmark legislation, the Mental Health (Wales) Measure 2010, showed that service users broadly felt this

had made a real difference to their care. More than 33,000 people have had an assessment of their mental health within primary care in the last 12 months and have been provided with information, advice and intervention as needed. Of those receiving secondary mental health services, over 90 per cent now have a Care and Treatment Plan. Independent Mental Health Advocacy services have been extended, and service users and staff have reported positive outcomes. In continuing to evaluate and monitor the Measure using independent research, satisfaction surveys and performance data, our ongoing emphasis will be on further improvements in the quality of the care provided and ensuring this good practice is shared.

Mental Health Ring-fence

20. Mental health accounts for the largest single area of health expenditure in Wales. Our continued commitment to mental health is demonstrated by ring-fenced funding (which has increased from £387.5 million in 2008-09 to £587 million in 2014-15. We have committed to review the effectiveness of the Mental Health Ring-fence in our *Together for Mental Health* Strategy and this has been brought forward to commence this year.

Psychological Therapies

21. A further £650k funding boost to improve access to psychological therapies for people with mental health problems was announced in June, building on the £200k also made available in 2013/14. The funding will support the delivery of psychological therapies for people of all ages, and will include psychological therapies for armed forces veterans with post traumatic stress disorder.

Dementia

22. The Welsh Government is committed to improving services and support for people with dementia and their families. *Together for Mental Health* identifies our priorities now and in the future.

23. The Living Well with Dementia Information Pack, funded by the Welsh Government and developed and distributed by the Alzheimer's Society, is a UK first. A source of invaluable advice, the pack has been welcomed by professionals and patients, their families and carers. The infrastructure is in place to provide every individual diagnosed with dementia this year with their own pack. We are continuing to fund the 24/7 bilingual Wales Dementia Helpline. *Book Prescription Wales* includes four publications on dementia which are available in every public library in Wales.

24. In January, I was able to help launch the Alzheimer's Society's *Dementia Ffrindiau* (*Dementia Friends*) initiative. Funded by Welsh Government, it is designed to increase wider understanding, augment advocacy services and roll-out training for those delivering care. The roll-out of the Welsh Government-funded primary care training module was developed in conjunction with the Alzheimer's Society. Launched in November 2013, it is designed for delivery to entire primary care teams (GPs, nurses, practice managers and receptionists)

through the Directed Enhanced Service. This will not only aid more timely diagnoses, but ensure primary care in Wales is better equipped to understand the needs of those with dementia and their carers. 106 practices, over 25% of practices in Wales, have completed this training module in the first year of the 3 year Direct Enhanced service.

25. On 19th June the Welsh Government, along with the other UK nations, signed the Blackfriars Consensus. This states 'that action to tackle smoking, drinking, sedentary behaviour and poor diet could reduce the risk of dementia in later life as well as other conditions such as heart disease, stroke and many cancers'. We will continue to work with local stakeholders, as well as the UK Health Forum and other UK nations, to develop a new dementia prevention approach. We will then use this new approach within our update of the *'Dementia – How to reduce your risk'* guidance and will develop a communication plan to disseminate any new messages and guidance.

26. Building our evidence base is crucial if we are to better grasp the causes and effects of dementia and, in turn, improve the quality of care and patient prognoses. Wales is at the forefront of global research, an international collaboration led by Cardiff University recently identifying 11 previously unknown genes that increase the risk of developing dementia.

27. It was announced early this year that Cardiff University will lead the Medical Research Council's new UK Dementias Research Platform (UKDP), which will initiate new approaches in the detection, treatment and prevention of dementia. Dr John Gallacher, from the University's School of Medicine, will be directing this multi-million pound programme, which will ensure that Wales remains as a World-leading nation in the field of dementia research.

28. Researchers at Bangor University have been awarded £4 million for the IDEAL project, designed to improve the experiences of those living with dementia. Both awards demonstrate Wales continues to make a significant contribution to ground-breaking research.

Quality and Safety

29. Our vision is one of a Welsh NHS which is safe and compassionate. We want to build on all the progress we have made and ensure our system is:

- Providing the highest possible quality and excellent patient experience;
- Improving health outcomes and helping reduce inequalities;
- Getting high quality from all our services.

30. The consistent delivery of safe and high quality care relies on contributions from a wide range of organisations. This is described in *Safe Care, Compassionate Care – A National Governance* Framework to enable high quality care in NHS Wales issued in January 2013.

Independent external reviews

31. Where improvements are needed, or issues arise which require investigation, action has been taken, drawing on external advice and expertise:

- In November 2013, an independent external review was commissioned into aspects of the care practice at the Princess of Wales Hospital and Neath Port Talbot Hospital within Abertawe Bro Morgannwg University Health Board. The review team, led by Professor June Andrews and Mr Mark Butler published their report *Trusted to Care* on 13 May 2014. The report makes 18 recommendations, four for the Welsh Government and offers wider learning for the whole of the NHS in Wales. I gave all Health Boards four weeks to consider the report and its implications for them. They have all since published their responses. To seek assurance that issues identified in the report in relation to the fundamentals of care were not widespread I have instigated a programme of unannounced spot checks in all district general hospitals in Wales. These are underway. The Chief Medical and Chief Nursing Officers jointly chair a steering group to take forward the implementation of the reports recommendations. Regular reports on progress are being provided.

- On 10 February 2014, I announced an external review of how concerns (complaints) are handled in NHS Wales. This work has been led by Mr Keith Evans, recently retired Chief Executive and Managing Director of Panasonic UK and Ireland, assisted by Andrew Goodall, then Chief Executive of Aneurin Bevan UHB. This is now complete. A period of engagement has been taking place over the summer to seek wider views on the proposals.

- On 21 March, a review of the way in which mortality measures are collected and used was instigated. The review has been undertaken by Professor Stephen Palmer of Cardiff University with an initial focus on six hospitals with a Welsh Risk Adjusted Mortality Index (RAMI) score of more than 100 in the data published on Friday 21 March 2014. Professor Palmer's review has now been completed and the report was published on 16 July Professor Palmer concluded that RAMI is not a meaningful measure of quality, but he supports the mortality case review process, which is in place for all deaths in Welsh hospitals, and is an area in which Wales leads the UK. He also recommended that the Welsh Government and NHS Wales must ensure meaningful and useful information in captured to measure and describe quality care in hospitals. The Chief Medical Officer for Wales has written to all clinicians in NHS Wales to reinforce their responsibilities about medical records, which is a patient safety matter, but which is also important to ensure clinical coding is optimised. I intend to report more extensively on the use of mortality case note reviews later this month.

- On 4 June, I accepted a recommendation of this Committee that a review should be undertaken of Healthcare Inspectorate Wales (HIW). Ruth Marks, the former Older People's Commissioner for Wales has been appointed and is providing external scrutiny and expertise. . The review will be carried out with a view to strengthen the role of HIW. Following the review, the Welsh

Government will publish a Green Paper, outlining proposals for new legislation to secure a strengthened, independent inspection and regulatory remit for HIW before the end of the Assembly term in 2016. It is proposed that an NHS Quality Bill will be introduced early in the next Assembly to streamline and strengthen existing legislation regarding the quality of healthcare in Wales. This will include the roles and responsibilities of HIW.

Patient Experience

32. Improving the patient's experience of care is a key priority for NHS Wales was issued. In May 2013, the Framework for Assuring Service User Experience which identifies core principles to underpin patient experience work and recommends a four quadrant model to build on existing expertise and resources.

33. In July 2013, the Chief Nursing Officer, issued core service user experience questions to achieve the 'real time' quadrant of the Framework. These were developed by the National Service User Experience (NSUE) Group to be used across all care settings, to ensure a consistent approach to determining service user experience across Wales.

1000 Lives improvement programme

34. The 1000 Lives improvement programme demonstrates the commitment NHS Wales has to continuous improvement. It has shown that previously accepted outcomes for patients, when challenged, can be improved. For example, preventing pressure ulcers and ventilator-associated pneumonia in our Intensive Care Units.

35. The current focus is the Flow and Unscheduled Care programme to ensure we improve our systems to meet current increased demand and ensure the right person is treated in the right place at the right time.

36. More than 8000 NHS Wales staff have completed the first level of the national quality improvement learning programme, *Improving Quality Together*. The programme provides a common and consistent approach to improving the quality of services that will help improvements take place much more quickly and spread effectively throughout NHS Wales. This forms part of the commitment set out in our Quality Delivery Plan to develop local capacity and capability to drive continuous quality improvement.

Fundamentals of Care National Audit 2013

37. The Fundamentals of Care Audit system was completely reviewed prior to the 2013 national audit which was completed during October and November 2013. In light of the significant revisions made to the format, number and types of questions included in this year's audit, no direct comparison can be drawn between the 2013 and previous annual audits. It is also important to note that the operational audit, patient experience and staff survey questions have been reviewed independently and not combined as in previous audits. It is intended that the 2013 audit will form a baseline for the 2014 and subsequent audits.

38. The results show:

- 94% of patients were satisfied with the overall care they received;
- 97% always or usually felt they were treated with dignity and respect;
- 98% agreed the clinical area was kept clean, tidy and uncluttered;
- 96% agreed they were given help to maintain their independence; and
- 93% agreed that when they asked for help they received it promptly.

Annual Quality Statements

39. All NHS Health Boards and Trusts in Wales published their 2012-13 Annual Quality Statements in September last year.

40. A peer review exercise led by Professor Rosemary Kennedy, Chair of Velindre NHS Trust took place in December last year to learn from the process with the aim of making improvements to 2013-14 Statements. This was achieved through a multi-disciplinary 'Quality Round Table' visit to each organisation.

41. Revised guidance was issued to all NHS Health Boards and Trusts in May. Organisations are required to publish their 2013-14 Statements by no later than 30 September 2014.

Improving NHS Performance

42. Performance targets remain an important tool in measuring and improving performance, but they are not always closely enough aligned to measuring clinical benefit. This view is informed not only by clinicians' views, but, was a key conclusion of the Mid Staffs inquiry where Robert Francis attributed aspects of the failure of care to target driven systems producing behaviours, which did not match the best interests of the patient.

43. I am determined to explore new outcome indicators that will result in better outcomes to all patients. We need to develop measures and outcome indicators that measure clinical benefit and outcomes for patients, and we need to communicate these better to the public.

44. We will continue to retain existing targets and our focus will continue to be to improve performance against these targets whilst we determine the new outcome indicators.

45. Current performance against these existing targets is set out below:

Ambulance

46. The key elements of the McClelland review have now been put in place, Welsh Government investment has allowed the ambulance fleet to be up-graded, and in this financial year, an extra £7.5m has been agreed, which will allow the recruitment of more than 100 frontline staff. It is now for the Welsh Ambulance Service to turn all this into the required standard of performance.

47. In July, All-Wales delivery of the eight minute category A target was 58.3%, against a target of 65%. Delivery of the WAST eight minute measure continues to be a challenge. Health Boards have been tasked to support the delivery of this target in conjunction with WAST. More clinically focused measures around the clinical care delivered by WAST have been introduced and are being published on *My Local Health Service* from June. These are around pain relief for patients with fractured neck or femur, early assessment of patients with a potential stroke, and achievement of early thrombolysis for patients with a heart attack.

Waiting times

48. In June, All-Wales RTT delivery was 87.3%, against a target of 95%. As part of 2014/15 trajectories all Health Boards have indicated plans to remove all 36 week breaches by end of March 2015 at the latest and bring delivery back to 95%. The July data will be published on 11 September 2014 – a verbal update will be provided at the meeting.

Unscheduled care

49. In June, All-Wales 4 hour delivery was 87.7%, against a target of 95%. As part of 2014/15 Health Boards have plans and trajectories to improve delivery to achieve the target by March 2015. These are being performance managed throughout the year.

Cancer

50. In June, all Wales 31 day delivery was 97.6%, against a target of 98%; and 62 day delivery was 84.3%, against a target of 95%. As part of 2014/15 Health Boards have plans and trajectories to improve delivery to achieve the target by March 2015 at the latest. Again, these are being performance managed throughout the year.

Cardiac surgery waiting times

51. Over the past nine months, concerns have been raised with regard to waiting times for cardiac surgery.

52. The Welsh Government and WHSSC have been working with affected Health Boards to support them in actively managing and reducing waiting times for cardiac surgery in order to meet current and future demand.

53. Health Boards have put in place additional short-term capacity for heart surgery, through a variety of internal arrangements and temporary outsourcing of patients

to hospitals in England. They have also been working to increase cardiac surgery capacity in the medium to long-term.

Hywel Dda University Health Board

54. In October 2013, the Royal College of Physicians (RCP) was invited to review the quality and safety of cardiology services within the Hywel Dda University Health Board, in response to concerns raised with the Welsh Government regarding the care of patients with acute cardiological problems. Their final report was published in January 2014, with key proposals to address these concerns, including retaining some services across all hospitals and developing a centralised 'hub' service, most likely based at Glangwili Hospital, Carmarthen.

55. A report on the options for a future model for cardiac services and an action plan were developed in response to the external review, and these were considered and fully supported by the health board at their meeting on 22 May. Work on fully implementing the action plan has been initiated.

56. An updated report will be provided to the health board's public board meeting in November 2014 for approval, recommending the final model for cardiology services for implementation across the health board.

Cardiff and Vale University Health Board

57. In response to a visit by the Royal College of Surgeons in April 2013, Cardiff and Vale University Health Board plans to invest £2.4 million in tackling surgical waiting lists, part of an ambitious plan to dramatically cut the time people wait for planned surgery. As part of the long-term plan, the Health Board has been negotiating through WHSSC a business case to increase capacity for major cardiac surgery from a baseline of 800 cases per annum, to 900 cases per annum, which it is proposed will commence on 1st April 2015. The proposal is that this will initially be commissioned by WHSSC for a minimum of 2 years. The business case is due to be considered by the Joint Committee on the 16th September.

58. In addition to the longer term plan, the Health Board has also taken a number of immediate actions to see those heart patients in most need. They have included recruiting extra medical and nursing staff, introducing weekend working, ring-fencing surgical beds, investing £1.5 million of Welsh Government funding in 2013-14 to replace critical cardiac theatre equipment and using services elsewhere to tackle long waiting lists for heart surgery.

59. Following a return visit in April, the RCS praised the progress in improving surgical services since concerns were raised 12 months previously, and stated that they were encouraged to note that there was both documentary and verbal evidence to demonstrate that the Health Board had taken their concerns seriously and that they had initiated a clear programme of work to address these issues. They said there was substantial work to do but that improvements had already been made.

60. Over the last 12 months the Health Board has seen a 25% drop in the number of people waiting 36 weeks for surgery. Last year, the number of operations delayed due to a lack of beds in January was 547. This year that figure was reduced 40.

Cardiac Surgery in Mid, West and South East Wales – improving outcomes and waiting times project

61. Health Boards in Mid, West and South East Wales, working with the WHSSC, have initiated a multi-faceted project to improve outcomes and waiting times for cardiac surgery. Waiting times have improved since January, particularly in South East Wales where during this period the number of patients waiting greater than 36 weeks has almost halved and there are also reductions in the number waiting greater than 26 weeks.

62. Outsourcing initially concentrated on South East Wales has achieved the levels needed to ensure the region will achieve its referral to treatment time targets. WHSSC is attempting to accelerate the number of patients in Mid and West Wales being outsourced to address the waiting times challenge there in the same way.

Implementing a new approach to waiting times

63. The Heart Disease Implementation Group has agreed that the development of a clinically led pathway based on clinically agreed component waits would focus performance on these areas most in need. A small sub group has been established and they will seek to pilot this component based pathway in the coming months, before making recommendations on the way forward.

Developing Primary and Community Care

64. The Welsh Government's strategic aim is for as much healthcare to be planned and delivered at, or as close to, home as possible through highly organised multi disciplinary primary and community care services designed around the individual, integrated with secondary care and social care. In January 2014, I reiterated to the NHS that it must embark on a sustained shift in leadership focus and resources invested in primary and community care.

65. I am developing a national plan for October to make more rapid and systematic progress with improving population health and local integrated healthcare services. The development of the 64 "clusters" of GP practices offers a real opportunity for a collaborative approach between general practices to improving their services for local communities. These clusters are producing formal action plans by end September.

66. The national plan will reaffirm our commitment to collaboration, through what we call 'locality networks', between those responsible for planning and securing local care and those who provide services. This commitment to collaboration at community level draws in all available financial, workforce and other resources and promotes a community focused and owned approach to health and

wellbeing.

67. Increasingly, collaboration to plan and coordinate local healthcare for small communities of between 25,000 and 100,000, which international evidence suggests is most effective at this local level, will increasingly inform and shape health board three year Integrated Medium Term Plans.

68. I wrote to AMs in July to announce the provision of an additional £3.5m for primary and community care in 2014-15. This funding is focused on tackling the inverse care law, building the skills of multi disciplinary primary and community care teams and delivering more follow up eye care closer to home. We are developing a national plan for the autumn to guide and direct action by Health Boards to improve local population health and to meet people's needs.

69. Our aim is to provide care at, or as close to home as possible and medical and dental education programmes need to reflect this change of emphasis. New programmes such as the C21 programme at Cardiff have been developed and aim to increase the time students spend in GP practices and other care settings and gaining greater contact time with patients. Other existing programmes are changing to adopt this approach. This approach will result in less hospital based training.

70. On 1st August, I agreed that £0.349m be moved from the hospital based clinical placement allocation to increase the support for GP placements, further strengthening the GP workforce of the future.

GP opening hours

71. We continue to work closely with Health Boards on their plans to improve access to high quality, safe and sustainable multi-disciplinary primary and community care services at or as close to home as possible.

72. Access to GP services is a key Welsh Government commitment. Published statistics for 2013 indicate that access to services with core hours continues to improve. 76% of GP practices are now open for daily core hours or within one hour of daily core hours, an improvement of 16 percentage points from 2011; 95% of GP practices now offer appointments between 5.00pm and 6.30pm at least two week nights per week, an improvement of 3 percentage points from 2011, and the number of GP practices which are closed for half a day on one week day has reduced from 19% in 2011 to 6% in 2013.

73. Approximately 70% of GP practices in Wales, involving 35,000 patients, have signed up to *My Health Online.* In order that working people have a wider choice to access GP services more conveniently during the day/late evening proposals are also being developed to pilot an out of area non registered day patient scheme in Wales which should be in place in the autumn.

74. Access to GP services after 6.30pm, however, has remained stable at 11%. I have asked that Health Boards to confirm that all GP practices have undertaken an assessment of the need for access to GP services, in particular, access to

services after 6.30pm, and that where a reasonable need has been identified, how this access is being provided or planned to be met.

75. Over the coming months a new pilot scheme will be introduced for improving access to GP services for working people who live outside their GP practice area and who wish to have a consultation with a participating practice, but remain registered with their current GP practice. The pilot scheme, which is anticipated to include a small number of GP practices in Swansea, Cardiff, Newport and Wrexham, will run for a period of 12 months.

76. As part of the work to develop a 111 service for Wales a sustainable model for primary care out of hours is also being planned from October 2015.

Health Board Acute Services Reconfiguration Plans

77. The first phase of service reconfiguration in NHS Wales is now complete, and the changes being made will ensure that services are safe, sustainable, meet relevant standards, and provide patients with the best possible outcomes.

78. The legal challenges brought against my determinations of changes to emergency care services at Prince Philip Hospital (Llanelli) and neonatal services in the Hywel Dda region were heard by the Court 24–26 June 2014. On 10 July, the Judge issued his ruling which confirmed that my determinations were “fair and lawful”.

79. Hywel Dda University Health Board is continuing to implement the service changes and the new midwife led units at Withybush and Glangwili Hospitals opened on 4 August. The new paediatric high dependency unit will open in Glangwili in October, with Withybush providing a 12-hour paediatric day assessment service (which will cover the majority of children’s health needs) on a 7 day basis.

80. In North Wales, the next phase of the reconfiguration programme is in progress, taking account of the First Minister support for Ysbyty Glan Clwyd to be the site of the Sub Regional Neonatal Care Centre. Betsi Cadwaladr University Health Board is currently developing an acute services review framework document.

81. For South Wales, all Health Boards and Community Health Council have agreed that consultant led emergency, neonatal and children’s services will in future be concentrated at five hospitals in the region, instead of the current eight. The longer term intention is to move to three acute Health Care Alliances, located at the Specialist Critical Care Centre in Cwmbran (once built), UHW (Cardiff) and Morriston Hospital (Swansea).

<u>Lessons Learned Review</u>

82. A Lessons Learned Review has been commissioned on the engagement and consultation exercises conducted by Health Boards on the first phase of changes to health services. Mrs Ann Lloyd is leading the Review, and will be supported by a small reference group with experience of major service change in the NHS.

83. The Review will provide an assessment of the effectiveness of current service change guidance, and what improvements may be necessary. It will also assess the role of CHCs in the whole process and provide advice on both the part they are asked to play in the consultation and referral processes; and their ability to discharge these responsibilities effectively. I expect to receive the review team's interim report, including findings and any recommendations, on 12 September. Mrs Lloyd's findings will feed into work already underway on potential changes to the CHC Regulations following the recommendations of Professor Marcus Longley and others into the role and functions of CHCs.

Workforce and Organisational Development

Working differently - Working together

84. Published in 2012, the *Working differently - Working together* framework for workforce and organisational development provides a five-year vision for the NHS workforce in Wales, which focuses on the vital role that all staff play in delivering safe and effective care for the people of Wales, supporting the development of the right staffing models needed to continue the transformation of how healthcare is delivered.

85. A number of programmes have been developed under the framework, aimed at delivering evidence-based workforce and organisational development interventions, which support change at an organisational wide or individual level. These include:

- The commissioning and undertaking of the *2013 NHS Wales Staff Survey*. The Welsh Government is now working with the NHS to consider proposals for a follow up survey.

- Establishing the *All Wales Health and Wellbeing Charter*, the *All Wales Health and Wellbeing Network* and ensuring that all Health Boards and Trusts inform and promote health and wellbeing related policies to all staff.

- Improving benchmarking through the development of a *Workforce Interactive Tool* that allows easily available comparison between NHS Wales organisations across a range of workforce data.

- Supporting managers to get the maximum from the existing contracts - in terms of productivity and efficiency of the workforce - has been provided through the publication of the *Optimal Application of Provisions of the NHS Terms and Conditions Handbook.*

Developing the Workforce Elements of Integrated Plans guidance

86. We published guidance in January 2014, which focusses on the three-year medium term planning process, introduced as a result of the NHS Finance (Wales) Act 2014 and highlights the elements that should be considered in the development of a workforce plan, as well as providing tools and information that

could assist in the process. The Welsh Government is currently working with Workforce Directors, and the Education and Development Service (WEDS) to review the workforce information requested as part of the wider refresh of the NHS planning framework ahead of the next round of plans being commissioned in October.

Recruitment

- Nurse Staffing Levels

87. Since 2012, the Welsh Government has worked with NHS organisations on ensuring appropriate nursing establishments on adult acute medical and surgical wards. A national set of principles has been used while an acuity and dependency tool was chosen; this was implemented in April 2014. The introduction of the national principles has led to an improving picture for nurse staffing levels across adult acute in-patient wards in NHS Wales. The principles included a requirement of a1:7 nurses to patient ratio; the majority of areas now comply with this. The Welsh national principles also included a ratio of 1.1 WTE nurse/nursing assistant per bed and again the majority of wards now comply with this requirement.

88. In response to the Francis Inquiry, £10 million funding (recurring) was introduced in the 2013/14 financial year to support Health Boards as they ensure they have the right nurse staffing levels in hospital settings.

89. The issue of nurse staffing levels is complex. It has to encompass skill levels, skill mix and patient acuity, as well as raw numbers. What is important is that Health Boards get nurse staffing levels that are appropriate to patient needs, which is why we have supported them to use a triangulated approach that includes use of an acuity tool, professional judgement and nurse sensitive patient outcome indicators.

90. Our engagement continues in other clinical settings with groups established to review evidence based tools in District Nurse community lead teams, Health Visiting teams and mental health in-patient settings.

- GP Recruitment

91. The Welsh Government wants to move towards a preventative, primary and community care led NHS. This means the development of highly organised, multi- disciplinary primary and community care teams, integrated with secondary and social care. As GP cluster level needs assessment and service as workforce planning matures, this will increasingly inform and support Health Board level plans. The changes to the GP contract for 2014/15 strengthens local collaborative working between GP practices, linking with community nursing teams and social care partners to provide more care in the community and / or closer to home. From 2014, GP practices are required to undertake a review of local need and to develop priorities for action to inform the production of a Practice Development Plan. In addition, GP practices are also required to produce a GP Cluster Network Action Plan which includes addressing access

arrangements; actions to foster greater integration of health and social services; and consideration of how new approaches to the delivery of primary care can aid delivery and sustainability of local services.

92. GPs play a key and integral role within the planning and delivery of multi-disciplinary primary and community care. Recent workforce data relating to GPs in Wales indicates that whilst the number of GP practitioners has risen by 11.2% since 2003, the number of GPs aged over 55 years has risen over the same period. This has prompted concerns about an ageing workforce. In addition, there are also specific challenges relating to GP recruitment in rural areas of Wales.

93. These concerns are not unique to Wales. The GP workforce in Scotland, Northern Ireland and England have similar age profiles and all countries find it harder to recruit in rural areas. Feedback from trainees and new GPs indicate they find the current contractor model to be unattractive, particularly in relation to the need to secure and maintain premises in an environment where these are no longer considered an investment. In addition, students and GPs are increasingly considering the work life balance associated with careers in medicine and demanding a wider variety of opportunities become wider in research and teaching. The extent to which this is present in the student population in Wales is currently being explored.

94. The Chief Medical Officer is leading work with Health Boards and others to review and develop national programmes to improve the supply and retention of GPs in Wales, including making the GP Training Programmes more attractive for young medics in rural areas of Wales and to support the retention of older and/or part time GPs. We will simplify the regulations in relation to the GP Performers List to make it easier for GPs, in particular locum GPs, to work across Wales. Health Boards are considering new contractor models where GP practices can work together and share resources and also a GP salaried workforce may better meet the primary care needs of the people in their area of operation.

95. The Welsh Government and Health Boards also continue to work closely with GPC Wales, Wales Deanery and the Royal College of General Practitioners (RCGP) and others to develop new and innovative ways of providing integrated primary, community social care services in future.

- <u>Medical Recruitment Campaign (Recruitment Strategy)</u>

96. The *Work for Wales* campaign has, to date, focussed on the strategic promotion of Wales as a good place to develop a medical career. So far, it has successfully established a champion network to act as ambassadors for Wales, along with a medical career website and has been a continued presence at relevant conferences and events at key dates in the medical calendar.

97. The purpose of the campaign has been to promote Wales and to increase general awareness of the opportunities to work and practice in Wales. Its aim is

not to fill specific vacancies on a locality or specialism basis, and it remains the responsibility of Health Boards and Trusts to fill individual vacancies.

98. It is clear that *since the campaign was launched, vacancy levels for medical and dental staff have fallen and* now compare favourably with other professions and NHS organisations in the UK. For example, published data for medical and dental staff between 2012 and 2013 (in terms of whole time equivalents) has increased by 162 (2.8%) to 6,073.

99. Proposals are currently being developed for a further phase of the campaign to address any requirement to re-model the NHS medical workforce to focus on the delivery of future services. The integrated plans are key to this. The most recent updates to these plans will be scrutinised to ascertain priority areas of recruitment which need to be featured in the campaign.

- Public Appointments

100. Work is underway to review the approach to making public appointments to Local Health Boards and Trusts within the overall framework provided by the Commissioner for Public Appointments. Recruitment to the WAST Board recently provided an opportunity to pilot new thinking on our approach. The arrangements were founded on a more rigorous three-stage approach comprising detailed sifting of applications, an assessment centre and then an interview panel.

101. This has resulted in a diverse and more appropriate balance of skills and attributes that reflects relevant experience. A mentoring scheme has been developed with two strong, but unsuccessful candidates from under-represented groups, having access to additional development in understanding the role and the opportunity to be mentored by a non-executive member. The pilot undertaken in WAST is being reviewed alongside other examples of best practice to enhance the selection process for future appointments.

NHS Pay and Terms and Conditions of Service

- DDRB Recommendations - Pay Award 2014-15

102. I published a Written Statement in March, confirming that the Welsh Government remains committed to the preservation of jobs within the Welsh NHS to enable the provision of high standards of patient care.

103. For non-consultant salaried doctors, it was confirmed that in Wales we will make an award based on the same quantum as the Department of Health (DoH), equivalent to the cost of implementing the DoH proposals in Wales. For consultants, an award will be made based on the same quantum as England, equivalent to the cost of implementing the DoH proposals in Wales.

104. In July I announced that speciality and associate specialist (SAS) doctors and doctors in training at the top of their pay scale would receive a 1% non-consolidated award. Consultants at the top of their commitment award scale will also receive a 1% non-consolidated payment.

105. The pay scales for new doctors in training will be harmonised the pay scale in England. The pay award is effective from 1 September 2014. The pay award regarding salaried GP's for 2014/15 is yet to be agreed.

- Agenda for Change (AfC) staff and the Welsh Consultant Contract

106. The consultation and ballot on proposed changes to AfC terms and conditions, as implemented in England, concluded at the end of April. A majority voted in favour of acceptance of the proposed changes to the contract. Implementation is contingent on the staff side seeing clear and unequivocal action in respect of the medical staff. However, the BMA have not been prepared to negotiate prior to considering proposals drafted by employers. That position remains.

107. I confirmed in a written statement on July 9th the intentions for the distribution of the pay award for 2014/15 for staff covered by AfC arrangements, excluding very senior managers, will seek to achieve two main aims: a flat cash payment of £160 and implementing the living wage in the NHS in Wales. The cost of these new arrangements exceeds the equivalent quantity provided for AfC staff in England but reflects the financial pressures remaining for NHS Wales. The pay award is subject to ongoing discussions between NHS employers and the AfC trade unions.

108. In the absence of a negotiated solution, I have concluded there is no prospect of maintaining a separate Welsh consultant contract. I have, therefore, asked my officials to ensure Wales formally join the England and Northern Ireland negotiations on the consultant contract.

Training

- Health Professional Education Investment Review

109. We invest more than £350m each year supporting 15,000+ students and trainees across Wales undertaking health-related programmes including undergraduate, postgraduate and continuing professional education. I want to make sure that arrangements underpinning this investment support the workforce changes required to deliver sustainable services in the future. I have, therefore, appointed a panel to review Wales' investment in health professional education.

110. The review, which will report on its findings by the end of the calendar year, will consider a number of issues, including:

- The nature of the current investment in health professional education i.e. what we are funding and whether this delivers what is required to support and sustain the healthcare workforce in Wales;

- The return on this investment, in terms of staff retained within the Welsh NHS;

- The current arrangements in place for medium and longer term planning within the NHS and whether they facilitate multi professional working;

- How the healthcare agenda informs planning, role design and education commissioning;

- How incentives could be used to support the education and training agenda.

Digital Health and Care

eHealth and Care Strategy

111. A work programme is underway with key stakeholders in health and social care to refresh the eHealth and Care strategy. Further public engagement is being planned. The work on the strategy does not involve any pause or delay in ongoing work.

My Health Online

112. We continue to make progress with *My Health Online*, the bi-lingual NHS Wales website that allows patients to use the internet to book or cancel appointments with their GP and request repeat prescriptions. *My Health Online* is live in 340 practices across Wales.

Informing Healthcare Programme

113. The Informing Healthcare Programme continues to roll out and has delivered some of the key foundations on which to build and operate our services, including;

- more than half of all patient referrals by GPs for specialist hospital care are now sent electronically and the number is increasing each month;
- through the Individual Health Record, 91 per cent of GP records are available for use in GP out-of-hours services; and
- a single all-Wales Laboratory Information Management System (LIMS) is being implemented in pathology for recording and exchanging information such as blood test results which will allow health professionals to see all previous tests conducted for a patient, and request new tests.

Community Care Information System

114. NHS Wales and a number of Local Authorities have been working in partnership to jointly procure the Community Care Information System. The proposed system will meet the requirements of both social care and community health services (including mental health) and will enable a person-centred record that can be shared between health and social care, to support the increasing need for care delivered in the home. The benefits of this programme will include the support for effective information sharing and multi-disciplinary team working.

Health Technology and Telehealth Fund

115. The Health Technology and Telehealth Fund is a £9.5 million fund which is being delivered in 2014/15, made up of £5 million held back from the Health Technology Fund for technology providing benefits in community and primary care settings and £4.5 million allocated for Telehealth from the draft Budget in October 2013. The Fund received 43 applications, of which 18 were approved. The supported projects cover four priority themes:

- Connecting primary care [£2.33m] - projects supporting e-referrals, discharge and data sharing, covering pharmacy, dentistry and optometry;
- Hub and spoke models [£0.53m] – enabling pre- and post- operative care to be delivered without visiting a hospital;

- Telemedicine [£2.87m] – remote devices to connect clinicians and patients, and connecting community based staff, care homes and nursing homes using telecare and telemedicine technologies;

- Enabling infrastructure [£3.92m] – core infrastructure implemented on a 'once-for-wales' principle, providing a national platform for telemedicine and for connecting point-of-care testing devices.

116. The Fund also has a network element to it which includes membership from all projects and the innovation leads of all NHS organisations. Subject to securing external sponsorship to cover the network's costs, it will meet twice within the year to share learning and best practice and identify opportunities for wider roll-out of projects which prove to be a success in individual areas.

Research and Development and Innovation

Research and Development

117. The importance of research and development (R&D) to improving health and wellbeing, effectiveness of services and wealth generation in Wales is well recognised. Many effective interventions that have resulted in major health and wellbeing gains for the population of Wales are only available as a result of R&D.

118. The National Institute for Social Care and Health Research (NISCHR) develops policy on research and development to drive health and social care improvement consistent with prudent healthcare principles and the creation of economic value. NISCHR has established a robust and effective infrastructure to stimulate and support high-quality research together with a range of research funding schemes, including involvement in UK programmes. With much of the NISCHR infrastructure funded until March 2015, a review was undertaken at the end of 2013, along with the development of restructuring proposals, through engagement with public representatives and stakeholders. NISCHR's restructuring proposals, which are now being implemented, support the development of a world-leading health and social care research endeavour that is responsive to the needs of Wales, highlights the benefits that research can offer, effectively translates new discoveries into improved care and has a strong ethos of public/community engagement and co-production.

Research and Innovation

119. The wider benefits of R&D include impact on policy, improved health and social care services, and the creation of economic value in Wales.

120. The NISCHR *Industry Engagement in Wales* plan (2013) includes a range of activities designed to further engagement and collaboration with industry. One such activity is *Health Research Wales*, a sign-posting and facilitation service that helps industry identify suitable NHS and academic collaborators, providing access to world-leading researchers and facilities.

121. The current Research Excellence Framework assessment will measure the impact of R&D conducted by Universities. Recent University designation of Health Boards in Wales shows that our health system is pursuing the same aims of securing greater impact from research.

122. The Welsh Government is supporting research and innovation in life sciences and health, which is one of three priority areas in the *Science for Wales* and *Innovation Wales* strategies. I work closely with the Minister for Economy, Science and Transport to ensure a joined-up approach between our portfolios.

Health and Wealth: Innovation

123. The Health and Wealth approach seeks to realise the potential of our healthcare system to drive health improvement and to grow the economy more quickly and productively in Wales. It builds on the value of our comparatively compact, integrated, and accessible system and our planned approach to service delivery and prudent healthcare. This approach aims to create a platform for partnership between clinicians, academia and industry to develop, demonstrate and adopt new products and services that are more efficient and effective, in ways that deliver shared value.

124. In December 2013, Assembly Members were provided with a copy of the '*Recommendations on Health and Wealth'* report produced by the Health and Wellbeing Best Practice and Innovation Board. The report proposes a more systematic approach to securing health and wealth benefits from applied research and innovation. The recommendations in the report have informed a new delivery plan and we are currently exploring potential funding routes.

Engagement with academic, business and clinical stakeholders

125. The Welsh Government will continue to invest in creating strong links with our partners in this area. Last year, for example, I visited the WIMAT surgical training centre based at the Medicentre within the University Hospital of Wales which is the leading laparoscopic training centre in the UK. The Welsh Government has funded the development of a business plan for its future expansion and development, the outcome of which is expected very soon.

126. I also recently opened the Mapleson Centre for Innovation in Mountain Ash, which is a partnership between academia (Cardiff University), industry (Flexicare Medical) and clinical practice, particularly training and simulation. And this month, the launch of the Life Sciences Hub will take place. It is set to be the national focus for the whole of the Life Sciences sector including the academic, business and clinical communities alongside funding organisations.

127. September sees the opening of the joint Welsh Government/NHS Wales funded Welsh Wound Innovation Centre which will link research to training and knowledge transfer activity, supporting service improvement and economic development. Meetings also take place regularly with global companies such as GSK and Novartis and with industry representatives (e.g. ABPI) to discuss a range of issues including applied research and innovation.

SUSTAINABLE SOCIAL SERVICES

128. The Welsh Government's role in social services is to set the legislative framework; work in partnership with service users, Local Authorities, the third sector, the independent sector and other partners to monitor system performance and, in extreme cases, intervene; co-produce a strategic direction for the sector in Wales; and foster and accelerate transformational change, as set out in *Sustainable Social Services for Wales: A Framework for Action*.

129. Social services support approximately 80,000 adults, providing statutory care for people with mental health problems, physical and learning disabilities and frail older people. Nearly 40,000 children in Wales were referred to social services last year. Child protection registers record 3,000 cases of neglect, emotional, physical and/or sexual abuse. There are 5795 looked-after children in Wales.

130. Gross public expenditure on social care was over £1.8 billion in 2012-13, with £0.3 billion raised in fees as many adult social services are means-tested. Demographic pressures through increasing life expectancy, both for older people and the severely disabled, together with a growth in demand for children's services has lead to a near doubling in social services expenditure since 2001-02.

131. Local Authorities have the statutory duty to deliver social services and provision is a mix of direct delivery and commissioned services from independent providers. As demand and service user expectation increases, and budgets fall, the current approach to social services is not sustainable.

132. The Welsh Government's principles and priorities for the delivery of social services in Wales are set out in *Sustainable Social Services for Wales: A Framework for Action*.

A New Accord (Leadership) for Social Services

133. A New Accord for Social Services is developing a new approach to collaborative leadership throughout the social care sector to improve efficiency and effectiveness and support transformational change. It is being promoted through two key groups: the Deputy Minister's National Partnership Forum, which brings together the key political leaders from local government, together with leaders from health, the voluntary sector, the independent sector and the Care Council for Wales; and the Leadership Group of chief executives and senior professionals across health and social care. This structure is supported by the National Citizen Panel to ensure that the citizen is at the heart of policy development, which was set up, piloted in 2013 and consolidated with refreshed membership in January 2014.

A New Improvement Framework

134. Our new improvement framework for Social Services will introduce a National Outcomes Framework for social care providers. To help deliver this aim, a Well-

being statement and Outcomes Framework was launched in April 2013, and the new Outcome Frameworks for the NHS and for Social Services, was launched on 26 June.

A Strong Voice & Real Control for Citizens

135. Our approach to change in social services is to give a stronger voice and real control for citizens, putting them at the heart of their care and support, and promotes control through a reform of core processes to ensure that frontline services are coproduced with citizens.

136. We are delivering a new approach to: information, advice and assistance; eligibility and assessment; direct payments; and changing the way people pay for care. Technical Groups have been established to provide advice to Welsh Government on how the new approach underpinning the Social Services and Well-being (Wales) Act will operate. These work-streams will look to develop draft regulations and a Code of Practice, or in certain cases Code of Practice alone, by Autumn 2014 in readiness for a public consultation exercise over the Winter. The Eligibility Framework has led the development programme and three engagement events were held across Wales in May/June 2014.

A Strong & Professional Delivery Team

137. We are investing over £8m in the Welsh social care workforce to build confidence and competence, and further professionalise the sector and ensure that people are prepared for new models of care and support following the Social Services and Well-being (Wales) Act. We are working with the social care employers to ensure that this sector plays a full and active role in the economy of Wales, e.g. contributing to the Welsh Government's LIFT programme for creating employment opportunities in Communities First areas.

A Stronger Framework for Safeguarding

138. We are strengthening the safeguarding of people in Wales and improving arrangements to ensure citizens remain free from exploitation and abuse. Most Adult Safeguarding Boards and Children Safeguarding Boards are making the transition from local to regional arrangements. We are monitoring the ongoing developments. Through the Social Services and Well-being (Wales) Act 2014 we are strengthening the protection of vulnerable adults particularly through the introduction of new duties to enquire; to establish Adult Safeguarding Boards and the introduction of Adult Protection Support Orders.

Integrated Services

139. The Integrated Services Project is driving forward collaborative approaches between Local Authorities, and across Local Authorities and other partners, in particular the NHS. Our *Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs* was published on 19 March and local authorities and LHBs should have published their statements of on their website The *National Framework for Continuing NHS Healthcare (CHC) in Wales*

consultation closed on 13 March; and the refreshed CHC Framework was published on the 30th June. The Framework emphases the importance of CHC as an entitlement for those eligible to receive it and eligibility is to be determined by health need and not financial considerations.

140. The £50 million Intermediate Care Fund (ICF) is being used to support older people to maintain their independence and prevent unnecessary hospital admission and delayed discharges. A new Integrated Family Support Service (IFSS) was rolled out across Wales at the end of April and is now fully operational, providing joined up support to families with some of the most complex needs.

141. Work to establish the National Adoption Service is proceeding to time, with the ministerial launch due to take place on 5 November as part of Adoption Week 2014. Suzanne Griffiths has provisionally been offered the role of Director of Operations, subject to DBS [Disclosure and Barring Service, formerly CRB] checks, and all the Regional Collaboratives will be up and running in time for the launch.

142. The Wales Adoption Register was launched on 4 June; and the new national adoption Performance Management System is now in place and has been run successfully, to produce data from across Wales for the first quarter of the financial year. The research we commissioned from the universities of Cardiff and Bristol (regarding adoption support and adoption disruption) has been published and the findings are being used to shape the National Adoption Service.

143. Work is proceeding at a pace to ensure that we issue directions to local government using our powers under Section 170 of the Social Services and Wellbeing (Wales) Act 2014, thereby delivering on our commitment during scrutiny to do so.

Social Services Expenditure

144. The latest published figures on Local Authority budgeted expenditure for the current financial year show a slight decrease in overall spending compared with 2013-14. This reflects a significant reduction in the core settlement of 3.5% offset by increases in specific grants, council tax and a drawing of funding from reserves.

145. It is important to recognise these figures are budget estimates and will be subject to change. Previous experience suggests Local Authorities overestimate the amount they draw from reserves as a result of actual specific grant funding being higher than anticipated.

146. The data show the continued prioritisation of spending on social services. Spending on social services is budgeted to increase by 2.2% reflecting the continued pressure on social services budgets as a result of demographic changes.

147. Providing the majority of funding for Local Goverment through the Settlement in the form of unhypothecated funding provides Local Authorities with the flexibility to deliver resources in the way that best meets the needs of that authority and minimises grant administrative costs. To maintain that flexibility, authorities have responsibility to demonstrate the delivery of shared outcomes.

LEGISLATIVE PROGRAMME

148. We have continued to make good progress in delivering DHSS's contribution to the Welsh Government legislative programme, and have had a number of successes in the past year in bringing forward innovative primary legislation.

Public Health White Paper

149. The Public Health White Paper was published on 2 April and outlined a number of radical proposals for addressing specific public health concerns. The proposals seek to continue Wales's strong tradition of radicalism when it comes to protecting the nation's health. The overall aim is for the proposals to make a cumulative, positive impact on health and wellbeing in Wales.

150. In developing the proposals in the White Paper, we sought to build upon the positive response received to the previous Public Health Green Paper, which was consulted upon in late 2012. That exercise showed support for two distinct approaches to public health legislation: one for an overarching approach requiring organisations to address health across their functions (i.e. a 'Health in All Policies' approach); and the other for legislation to address specific public health concerns. The concept of 'Health in All Policies' is now being taken forward through the Well-being of Future Generations (Wales) Bill , and the focus of the Public Health White Paper is on providing a series of practical legislative actions in a number of different areas.

151. All of the proposals in the White Paper follow a preventative approach by seeking to intervene at points which have most potential for long-term benefits, both in the health of individuals and in helping avoid higher long-term societal and financial costs associated with avoidable ill-health. The proposals have stimulated lively debate on a number of important issues, with particular debate regarding the proposals to limit the use of electronic cigarettes in enclosed public places, introduce a Minimum Unit Price for alcohol, and improve provision and access to toilets for public use.

152. The consultation on the White Paper closed on 24 June, and attracted a high level of interest from inside and outside Wales. As part of the consultation exercise, a series of engagement events were held, both with members of the public and groups of key stakeholders. Over 700 responses were received, from a broad range of stakeholders and individual members of the public. Detailed consideration of responses has been taking place over the summer, and a consultation summary report will be published in the autumn.

Regulation and Inspection Bill

153. The Regulation and Inspection Project is delivering a new framework for regulation and inspection of care and support in Wales. The Bill is designed to support the regulators to carry out their duties and to deliver the Welsh Government's expectations of securing the well-being of citizens and to improve the quality of care and support within an ever changing environment where new models of service are developing that are not easily definable within the classifications of the current regulatory and inspection regime.

154. Following the Deputy Minister's launch of *The Future of Regulation and Inspection of Care and Support in Wales* White Paper on 30 September 2013, work is in hand to introduce the Bill at the beginning of 2015.

155. Consultation on the White Paper was held between 30 September 2013 and the 6 January 2014. It received 99 responses from a wide range of stakeholder groups including regulators, Local Authorities, service providers, the third sector and service users. A consultation summary report and each of the responses received was published on the Welsh Government website in May 2014.

Human Transplantation (Wales) Act

156. The Human Transplantation (Wales) Act received Royal Assent in September 2013. The new law will introduce a soft opt-out (or "deemed consent") system for consent to donation in Wales from 1 December 2015. A two-year public awareness and engagement campaign has now started to ensure people are aware of the new law and their choices under it.

157. The latest phase of the communications work began at the end of June and includes TV, radio and outdoor advertising. Work is also well underway on the redevelopment of the Organ Donor Register to enable it to record opt-out decisions, on the supporting regulations and training for staff. In addition, we will evaluate the impact of the new legislation.

158. We will be consulting on three sets of regulations in the autumn of this year – these will cover "novel" forms of transplantation which will be excluded from deemed consent; appointed representatives; and living donors who lack capacity to consent to donation. These regulations, together with the Human Tissue Authority Code of Practice will be put before the Assembly for approval in early September 2015.

Food Hygiene Rating (Wales) Act

159. The Food Hygiene Rating (Wales) Act 2013 was given Royal Assent on 4 March 2013. The Act makes Wales the first country in the UK to adopt a mandatory food hygiene rating scheme. Food businesses inspected from 28 November 2013 are required to display their food hygiene rating sticker in a prominent position at their establishment, enabling the people of Wales to make informed choices of where to eat or shop for food. There are clear indications that existing food businesses are improving their food hygiene ratings.

160. Food businesses receiving “5” (very good) ratings increased from 2012 to 2014 by nearly 17% from 33.2% to 50.1%. The percentage of food businesses receiving ratings requiring improvement fell by 9.7% between 2012 and 2014 from 19.2% to 9.5%. It is considered that the requirement to display the rating is a major motivation in this respect.

161. I agreed to develop further regulations to require certain food businesses to include a statement on their hard copy publicity materials that will assist consumers to find out their food hygiene rating. These regulations are currently the subject of a public consultation, which will run until 24 October 2014. Trade to trade food businesses will be included in the mandatory scheme from November 2014.

Social Services & Well-being (Wales) Act 2014 - Implementation

162. The Social Services and Well-being (Wales) Act, which secured Royal Assent on 1 May 2014, is the largest piece of legislation delivered by the National Assembly for Wales to date. It provides the legal framework to deliver citizen-centred services, with a focus on early intervention, integration and well-being.

163. Work is underway to develop the regulations and codes of practice that will support implementation of the Act. This work will culminate in two consultations on draft regulations under the Act, one in the autumn of 2014 and one in the summer of 2015, after which the regulations and codes of practice will be laid before the National Assembly. The target date for implementation of the new legal framework is April 2016.

164. Successful implementation will require enhancing strong regional and local leadership bringing health, Local Authorities, the third sector and private providers together to co-deliver transformational change. To support this, the Deputy Minister has made it clear that she expects to see the national engagement structures she has put in place replicated at regional level. To assist this, and the wider work on implementation, a £1.5 million grant has been made available to local authorities and their regional partners in 2014-15, building on that made available in 2013-14.

OTHER PORTFOLIO ISSUES

Public Health

165. The health of the population of Wales is continuing to improve. However, we know that improvements are not currently being shared equally. Tackling the inequalities gap requires concerted long-term action across the breadth of society, not just by what we immediately think of as the 'health system.' Elimination and prevention of health inequalities can only be achieved when linked to the underlying inequalities of income, wealth and power across society.

166. Action to tackle health inequalities forms a central part of the Welsh Government's work and is embedded across a range of strategic policies and programmes. A broad range of action is taken forward through our *Tackling Poverty Action Plan* and *Fairer Health Outcomes For All*. Action is also embedded across flagship programmes such as *Flying Start*. We remain fully committed to tackling health inequalities and working to ensure everyone in Wales has a fair opportunity to have good health.

167. We are also taking steps to empower people to take responsibility for their own health and wellbeing, through health monitoring and early preventative action.

Add to Your Life

168. Following a period of field testing, the *Add to Your Life* online health and wellbeing assessment for people aged over 50 is now being rolled out nationally, led by Public Health Wales. This service provides individuals with information and

advice on a range of issues relevant to their overall health and wellbeing, as well as facilitating access to relevant services and sources of support. It provides a valuable opportunity for individuals to become better informed about their health and wellbeing.

169. The online assessment is supplemented by telephone support and targeted community support through Communities First and Age Cymru networks, which will help ensure a range of people are supported to access the programme. A national communications programme is also being put in place to raise awareness of the programme and encourage individuals to access it during its first year.

Immunisation and Vaccination

170. Vaccination uptake rates for routine childhood immunisations continue to improve. A key achievement saw the *Programme for Government* commitment to achieve 95% uptake of one dose of MMR vaccine in children by two years of age exceeded during 2013/14, reaching 96.5% across Wales, up from 94.6% in 2012/13. Uptake of two doses of MMR by age five years also continues an upward trend increasing to 92.6% from 89.6% in 2012/13. These are the highest recorded annual uptake figures for MMR. The improvement is a considerable achievement and reflects the efforts invested by Health Boards and GPs to increase MMR uptake in light of the measles outbreak and an increased awareness by parents of the risks associated with measles.

171. The proportion of children who are up to date with their routine immunisations by four years of age has also increased to from 82.4% in 2012/13 to 87.9%, with improvement seen in all health board areas. Since 2008, girls in school year 8 have been offered three doses of the Human Papillomavirus vaccine (HPV), which protects against one of the main causes of cervical cancer. The latest available data shows uptake of 86% for the complete three dose course.

172. Despite low levels of flu circulating over the winter, uptake of the seasonal flu vaccination in those aged 65 years and over; those under 65 years in risk groups and pregnant women, also continued a gradual upward trend, reflecting ongoing work to protect more vulnerable individuals each winter. However, we are still not achieving the uptake targets which would help to reduce the serious effects of flu on vulnerable people and relieve the pressures on NHS services.

173. Flu vaccine uptake in Health Board employed health care workers increased to 41.7% from 35.5% in 2012/13 representing over 24,000 staff with direct patient contact in the NHS who received a flu vaccination during the season. In the NHS as a whole, over 34,000 staff received a flu vaccination. This significant improvement demonstrates that the additional emphasis and effort directed towards staff vaccination is continuing to have an impact. It is important that we continue to build on this progress in the coming season to protect those most at risk of flu and its complications.

Maternal health and early years

174. The latest available data from Public Health Wales shows progress in moving towards achieving the low birth target, though the gaps between the most deprived fifth and the middle fifth and between the most and least deprived fifths have not significantly changed. Public Health Wales has been reviewing the evidence on the causes of low birth weight and these will be used to refine and develop activity aimed at its reduction.

175. Four Health Boards have piloted work on increasing the uptake of smoking cessation services by pregnant women. This work is being led by Public Health Wales with the expectation that best practice will be shared and rolled out, if these pilot projects are shown to be cost effective, and subject to budgets being identified.

176. We are also setting up focus groups in Communities First areas to discuss how maternity services could engage better with pregnant women and considering how Communities First initiatives could support pregnant women in developing healthy lifestyles.

177. The rollout of a consistent all-Wales approach to assess the health, development and wellbeing of all children in Wales in the early years, so that problems are identified early and the necessary support given will be completed by January 2015.

Substance Misuse

178. The Welsh Government continues to invest almost £50 million annually to tackle drug and alcohol related harm in Wales. This funding has supported the implementation of a range of actions and we are making good progress in delivering the commitments in the Substance Misuse Delivery Plan 2013-15. The latest Working Together to Reduce Harm Substance Misuse Strategy Annual Report, which was published in October 2013, set out progress against the Delivery Plan, which included:

- Publishing a health and well-being compendium for a range of practitioners to help reduce substance misuse harm;

- Issuing guidance to improve access to substance misuse services for veterans; and

- Publishing a new Recovery Framework designed to embed the recovery approach into all substance misuse services from referral through to aftercare.

179. New guidance for Substance Misuse Area Planning Boards to review fatal and non fatal drug poisoning was issued in July 2014 and is now being implemented regionally by substance misuse commissioners and providers.

180. Formal 12-week consultations have also been completed on a number of guidance documents, including the refreshed service user involvement

framework, and guidance to improve access to substance misuse treatment for older people. The Service User Involvement Framework will be published later this month.

181. The time that people have had to wait between referral and the start of treatment has continued to improve. In 2012/13, 85.5% of all clients commenced their treatment within the KPI target of 20 working days, an increase of 3% on 2011/12 figures.

182. Given the increasing levels of alcohol related harm we are strengthening our response, using those policy levers available to us. We are continuing to tackle alcohol misuse through our Change4Life campaign *Don't let drink sneak up on you;* our *Have a word* alcohol brief intervention training and have also included a proposal in the Public Health White Paper *Listening to You: Your Health Matters* published on 2 April, to introduce a Minimum Unit Price for Alcohol of 50p per unit. The consultation closed on 24 June and consultation responses are now being analysed.

Improving Access to Medicines

Review of Appraisal Process of Orphan and Ultra-Orphan Medicines

183. In May 2013, a review was commissioned of the All Wales Medicines Strategy Group (AWMSG) appraisal process for orphan and ultra-orphan medicines. The purpose of the review was to explore how orphan and ultra-orphan medicines should be appraised to ensure patients with rare diseases have fair and equitable access to appropriate, evidence based treatments.

184. The review group's report was published for consultation in November 2013. The report sought to extend the role of AWMSG to appraise orphan and ultra-orphan medicines, including the development of a more appropriate methodology.

185. AWMSG have been asked to scope the work required to develop and implement the proposed new approach for the appraisal or orphan and ultra-orphan medicines.

IPFR Review

186. A review of the IPFR process was commissioned to consider how the current process could be improved with a particular emphasis on transparency and consistency of decision-making between IPFR panels. The review group completed its work and the report was published on 30 April 2014 for an eight week consultation ending 25 June 2014.

187. The review group have concluded the IPFR process supports rational, evidence-based decision-making to access medicine and non-medicine technologies that are not routinely available in Wales. The group identified that inappropriate use of the IPFR process and a lack of central, expert co-ordination

were contributing to a perception the process is inconsistent, and have made a number of recommendations to strengthen the IPFR process.

188. The review group explored the issue of moving to a single All-Wales IPFR Panel, but concluded it would be logistically impractical. They have, however, suggested joint meetings between neighbouring panels should be considered once the whole system has been further standardised. The consultation responses are being analysed and an announcement will be made shortly.

WAO Update Report on the Management of Chronic Conditions

189. I was pleased the Wales Audit Office' report, *The Management of Chronic Conditions in Wales: An Update*, published in March 2014, recognised the improvements achieved in recent years. In particular, it noted the sustained reduction in the number of emergency hospital admissions and re-admissions within a year for a basket of chronic conditions.

190. The report identified scope for further improvement, particularly in terms of planning, co-ordination of care and shared information, and modern IT systems. The Permanent Secretary has written to the Chair of the Public Accounts Committee, setting out the Welsh Government's formal response to each of the recommendations, and the Acting Chief Executive of NHS Wales wrote to the Health Boards asking them to factor appropriate action in to their plans and programmes of work for chronic conditions. We will monitor this action through our regular dialogue with each of the Health Boards' Directors of Primary and Community Care and Mental Health.

191. Agreeing individual care, goals and action, proportionate to need, with each person living with long-term conditions is key to success. To promote the use of care plans, we published our *Framework for Agreeing Individual Care with People who have Long Term Conditions* on 28 May. This offers a practical guide to the creation of a care plan. For some, it might be a simple verbal agreement and for others, with more complex needs, it might be a formal written document. A care plan must reflect individual need and preferences.

192. Much of the care of people with long-term conditions can be planned and delivered at, or close to, home by primary and community care services, integrated with secondary care and social care. The NHS must embark on a sustained shift in leadership focus and resources invested in primary and community care. Development of the 64 "clusters" of GP practices offers a real opportunity for a breakthrough in locally led service planning and delivery. These clusters, as they mature over time, create small and locally sensitive planning mechanisms and opportunities for bold professional leadership, innovation and better ways of working. This year's GP contract helps incentivise this shift.

193. The current round of Health Board three-year Integrated Medium Term Plans recognises the need to rebalance the health system in varying degrees in their narrative. Increasingly, the cluster-level action plans, the first versions of which

are due in September 2014, will help drive improved service and workforce planning further and faster.

194. Through the new Outcome Frameworks for the NHS and for Social Services, which was launched on 26 June, the Welsh Government will continue to measure the reduction in the number of emergency hospital admissions for people with chronic conditions as a result of effective and integrated primary, community and social care. We will use the *National Survey for Wales* to ask people with long-term conditions if they feel well-informed and supported in managing their health and wellbeing.

Travelling to Better Health – Guidance for Healthcare Practitioners on working effectively with Gypsies and Travellers

195. Research and evidence shows that Gypsies and Travellers suffer disproportionately when compared with the general population in relation to health status and access to healthcare.

196. To address this, the Welsh Government has issued for public consultation a guidance document for healthcare practitioners on working effectively with Gypsies and Travellers. It is titled *Travelling to Better Health* and responds to the four health objectives contained in the Welsh Government's overall strategy for Gypsies and Travellers titled *Travelling to a Better Future*.

197. The guidance is presented in three main parts: advice on cultural awareness for the benefit of practitioners; advice on practice which could encourage greater participation in health and health services; and a summary analysis of the available research and evidence base which provides the rationale for the guidance.

198. Published alongside the guidance is a Bibliography of research and evidence, a list of Useful Contacts and Resources and a series of Annexes designed to support the implementation of the guidance including a health needs assessment tool. The consultation closes on October 30th and the guidance is due to be published in early 2015.

Preparations for NATO Summit

199. The NATO Summit taking place on 4-5 September is expected to have in attendance representatives from over 60 countries. The Summit is expected to attract many thousands of protesters, up to 1500 of the world's media and will have thousands of extra police in attendance.

200. The NHS has been heavily involved in developing its planning for the Summit, working very closely with partner agencies. The aim has been to ensure health provision for the population is maintained, as far as possible, and that the potential for a range of emergency situations that require an NHS response were fully addressed.

201. There has been a need to enhance health arrangements through creating additional services at the venue site to provide healthcare for delegates, support staff and residents within the security cordon and by having additional emergency and minor injury services, to cover Newport and Cardiff. These services will provide the NHS with the capability to assess and treat minor injuries and mitigate the need for people having to attend an emergency department thus impacting on normal A&E business.

202. These health facilities form part of the multi agency security and resilience plans and provide options for the NHS in managing any possible injured demonstrators, police, media or security staff that require treatment as a result of an accident or injury. Welsh Ambulance Services will have resources deployed at the various locations with the other emergency services and will have specialist trained and equipped staff available for responding to an incident.

203. Ambulance planning has also focussed on maintaining business continuity for the public through the Summit period. A review of hospital security has also been undertaken and enhancements are being made to protect both infrastructure and facilities at University Hospital Wales and Royal Gwent Hospital. This capital investment has longer term advantages in improving hospital security and are not only for NATO.

Part 2: FINANCIAL SCRUTINY SESSION

2013-14 FINANCIAL YEAR

2013-14 – End of Year Financial Position

1. The 2013-14 year-end revenue position of each Health Board in relation to their statutory duty is shown below:

Local Health Board	2013/14 Resource Limit	Net Expenditure	Surplus / (Deficit)	Statutory Duty Achieved
	£m	£m	£m	
Abertawe Bro Morgannwg	941.2	941.1	0.1	Yes
Aneurin Bevan	1,002.8	1002.7	0.1	Yes
Betsi Cadwaladr	1,229.2	1229.2	0.0	Yes
Cardiff & Vale	776.9	796.0	(19.2)	No
Cwm Taf	563.2	563.2	0.0	Yes
Hywel Dda	683.3	702.5	(19.2)	No
Powys	241.0	260.3	(19.3)	No

2. Three Health Boards failed to achieve their statutory resource duty, Cardiff & Vale, Hywel Dda and Powys. Consequently, the Auditor General for Wales has placed a qualified regularity audit opinion on the statutory accounts of these entities.

3. Two Health Boards received repayable brokerage provided by the Welsh Government. Cwm Taf received £3.9m and Betsi Cadwaladr received £2.250m. Both organisations will be required to repay this resource in future years.

£50 million Contingency Reserve

4. An additional £50 million was provided non-recurrently to the DHSS MEG in the final supplementary budget motion in March 2014. The additional funding was provided in recognition of the high level of forecast year-end deficits being predicted by NHS organisations at that time.

5. The actual year end deficits of Cardiff & Vale, Hywel Dda and Powys turned out to be over £57 million and consequently, only by driving out further savings from programmes managed centrally was the Department able to outturn within its overall Departmental Expenditure Limit. The additional funding of £50 million provided to the Department from Welsh Government reserves was retained centrally, with no element allocated to NHS organisations.

6. As a result of no further allocations to the NHS, three Health Boards (Cardiff & Vale, Hywel Dda and Powys) failed to meet their statutory financial duties and consequently their accounts were qualified. The decision not to allocate further funding to the Health Boards was based on the following rationale:

- It supports and sends out a strong message in support of the new Financial regime and is consistent with the recommendations made by the Health and Finance Committee as well as the Public Accounts Committee;

- It would assist in ensuring that the key service issues are addressed in relation to the three Health Boards through the development of robust plans;

- The £50m as in previous years is non recurrent funding and non-recurrent funding should not be used to support long term deficits;

- By allocating the £50m in the budget already allowed the Health Department to draw down cash and make "cash only allocations" to Health Boards. This was key in ensuring that appropriate action was taken to ensure that staff and suppliers continued to be paid during March.

Additional Funding Provided to Health Boards following the Final Supplementary Budget

7. Additional funding provided to Health Boards for 2013-14 since the final supplementary budget in March 2014 is shown in the table below:

Health Boards	**Abertawe Bro Morgannwg**	**Aneurin Bevan**	**Betsi Cadwaladr**	**Cardiff & Vale**	**Cwm Taf**	**Hywel Dda**	**Powys**	**Total**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Funding to cover technical accounting treatment*	-9.5	-1.4	-3.5	-5.1	-0.4	-8.8	0.2	**-28.6**
Other Routine Allocations **	0.5	3.2	-0.4	1.0	0.0	0.1	0.5	**4.9**
2013/14 Brokerage allocated repayable in future years	0.0	0.0	2.2	0.0	3.9	0.0	0.0	**6.1**
Allocations made from 11 March 2014 to year end	**-9.0**	**1.8**	**-1.7**	**-4.1**	**3.5**	**-8.7**	**0.7**	**-17.6**

Notes

**Funding for technical accounting treatment includes items such as depreciation and impairment charges, on reconciliation of asset registers and final receipt of valuation reports, a number of returns of technical funding items were made. This is typical for this period of the financial year.*

***Other routine allocations include items such as year-end recharges, clinical excellence allowances and awards, NHS Redress funding, and Referral to Treatment funding.*

8. Based on information submitted by Local Health Boards the performance against planned savings in 2013-14 for each Health Board, including the amount of savings achieved and a breakdown of recurrent/non-recurrent savings is set out below:

Organisation	Annual Savings					
	Plan	Actual	Over / -Under achievement		Recurring	Non Recurring
	£m	£m	£m	%	£m	£m
Abertawe Bro Morgannwg	28.8	26.8	-2.0	-7.0%	16.0	10.8
Aneurin Bevan	20.0	16.6	-3.4	-17.0%	14.8	1.8
Betsi Cadwaladr	40.5	40.0	-0.5	-1.3%	29.6	10.3
Cardiff & Vale	56.7	45.6	-11.1	-19.6%	38.4	7.2
Cwm Taf	15.0	10.5	-4.5	-29.9%	9.2	1.3
Hywel Dda	28.5	23.5	-5.0	-17.4%	23.5	0
Powys	9.5	5.8	-3.7	-39.0%	5.5	0.3
Public Health Wales	1.3	1.3	-	2.4%	1.3	0.1
Velindre	11.4	11.4	-	0.5%	9.1	2.3
Welsh Ambulance	13.7	3.3	-10.4	-76.0%	3.3	0
NHS Wales	**225.4**	**184.8**	**-40.6**	**-18.0%**	**150.7**	**34.1**
					81.5%	**18.5%**

9. Information regarding how the additional £150 million funding provided in the supplementary budget 2013-14 was spent by Health Boards is given in the table below:

Health Board	Nurse Staffing	Unscheduled Care	Immunisation	VER Funding	Total
	£m	£m	£m	£m	£m
Abertawe Bro Morgannwg	1.8	21.8	1.3	0.7	**25.6**
Aneurin Bevan	1.9	23.9	1.3	0.1	**27.2**
Betsi Cadwaladr	2.2	26.6	1.6	0.5	**30.9**
Cardiff & Vale	1.4	17.1	1.0	2.6	**22.2**
Cwm Taf	1.1	13.4	0.7	1.7	**16.9**
Hywel Dda	1.3	15.5	0.9	1.3	**19.0**
Powys	0.4	5.2	0.3	0.1	**5.9**
	10.1	**123.5**	**7.0**	**7.0**	**147.6**

10. Of the £150 million allocation made in the Supplementary budget £2.4m related to allocations for Kalydeco drug funding, Central Programmes or NHS Trusts.

11. While work has been undertaken to identify how Health Boards have used the money in some areas e.g. nurse recruitment and VER, the allocation made it clear that the £150m was an allocation to recognise a range of general and specific service and cost pressures in the general context of the Francis Report. The additional £150m has, therefore, enabled Health Boards to maintain performance in delivering high quality and safe services, particularly whilst addressing the demands within unscheduled care services.

2014-15 FINANCIAL YEAR

Implementation of NHS Finance (Wales) Act 2014

Progress on agreeing the remaining three-year plans for Health Boards and Trusts

12. The NHS Finance (Wales) Act and supporting Planning Framework sets out a clear ambition for a stronger, more rigorous and better integrated planning system in NHS Wales. Under this new regime, Integrated Medium Term Plans (IMTPs) are subject to my formal approval.

13. The increased demands of the planning regime, coupled with a variation in organisational planning experience, culture, capacity and capability have predictably resulted in a gradual transition into the medium term planning regime.

14. I made it clear throughout the passage of the Bill that plans would not be approved unless they met the required standards.

15. Following a robust assessment of Integrated Medium Term Plans in April 2014:

- I was able to confirm, in a written statement on 7 May, approval of Integrated Medium Term Plans for Cardiff and Vale University Health Board, Cwm Taf University Health Board and Velindre NHS Trust.

- Two organisations were asked to resubmit their improved Integrated Medium Term Plans by 30 May 2014 - Aneurin Bevan University Health Board and Abertawe Bro Morgannwg University Health Board

- Following further assessment I was able to confirm approval of Abertawe Bro Morgannwg University Health Boards three year plan. However Aneurin Bevan University Health Board concluded that the organisation needed more time to strengthen its financial and service planning work and consequently wished to submit an annual plan for this year before submitting a three year Integrated Medium Term Plan in January 2015.

- The remaining health boards and NHS trusts were told to prepare one year plans (Hywel Dda Local Health Board, Powys Teaching Health Board, Betsi Cadwaladr University Health Board and WAST). Due to a range of mitigating factors such as significant Board member changes, the link to external reviews such as the Mid Wales Healthcare Study and the need to conclude certain reconfiguration planning work.

16. In the absence of an agreed three-year plan, each organisation has received more detailed accountability letters from the Interim Chief Executive of NHS Wales setting out their performance and delivery expectations for 2014/15, while the Welsh Government continues to work with the organisations on the further development of their robust plans.

The scrutiny process to which the statement refers for signing off the new plans

17. The scrutiny process has been robust and it has been quality assured by the Good Governance Institute, and it has also been scrutinised and recognised by Welsh Government Internal Audit Services and the Wales Audit Office as being clear and rigorous.

18. The Internal Audit Review in May provided a 'Substantial Assurance' of the NHS Planning process and work invested across the Department in setting up a clear planning cycle, with rigorous assessment. The recommendations, particularly those with a significant classification, are already being acted upon.

Arrangements in place for Ministerial oversight in identifying whether Health Boards and Trusts are likely to overspend against plans in the first year

19. In addition to the formal process of reviewing and approving plans, the existing performance management arrangements have been reviewed and enhanced to establish more integrated performance management arrangements. This holistic approach will assess plan delivery against all elements of the integrated plans, not just finance. This will build on the existing well established and robust financial monitoring returns arrangements and will be integrated with the existing performance and quality monitoring arrangements. Accordingly, the integrated monthly performance management arrangements will, in future, identify the in-month and forecast outturn performance on activity, finance and other domains.

Details of the governance arrangements in place to deal with significant variance from plans

20. Performance will be monitored against required deliverables and will be tracked through the integrated performance management arrangements, including the various monitoring returns, Quality, Safety and Delivery meetings; and Joint Executive Team meetings, Chief Executive and Chair bilateral discussions.

21. Where there is an unacceptable level of variance from the agreed plan, including plan profile, an organisation will be subject to increased monitoring and challenge, support and escalation arrangements and may lose the advantages associated with being part of the Medium Term Planning Regime. These arrangements were set out in the Delivery Framework and they were enhanced by the NHS Wales Escalation and Intervention Arrangements published in March 2014.

22. In addition, where organisations will operate within the annual planning regime for 2014/15, they will require a more intensive period of monitoring and support over

the next 6 – 12 months both to performance manage against 2014/15 deliverables, and to support them in developing a sustainable and balanced Integrated Medium Term Plans for 2015/16 to 2017/18.

23. The Welsh Government is committed to supporting all organisations to succeed in the planning and delivery of sustainable high quality services for their populations. This includes supporting the ongoing maturation of their planning processes, culture, planning and delivery outputs so that they are afforded a realistic opportunity of entering the medium term planning regime in the coming years.

Follow-up from the Committee's scrutiny of the draft budget for 2014-15

Work being undertaken in relation to the resource allocation formula

24. I recently met officials to discuss the progress that has been made in this area. The project has looked at international and UK research to identify the key issues to be addressed as part of the Resource Allocation Review Programme.

25. While the early work has identified a number of areas where we need to make improvements, it has also confirmed that there are many issues of good practice that are already included within the current "Townsend" allocation basis.

26. The allocation formula needs to be kept under constant review and some changes may take some time to implement. However, in light of the clear recognised demographic changes, over the last few years, and those projected going forward, I have agreed with officials a number of short term goals and improvements that must be prioritised to maximise benefits and to help achieve sustainable services in the short term. These include:

- Reviewing and fine tuning the weaknesses and limitations in collection of information and applications of the current direct needs formula e.g. information collected through the Welsh Survey;

- Aligning allocations and the formula around the key strategic objective to shift resources in line with the prudent healthcare agenda and towards earlier prevention and treatment;

- Addressing problems in funding flows between NHS organisations and communities;

- A review of continued ring-fencing of allocations within integrated health organisations; and

- To develop other funding mechanisms and incentives to ensure that the transfer of care to appropriate primary and community services is achieved.

- To develop an on going Resource Allocation Review programme to maintain, update and further develop the formula to reflect latest evidence, population needs, financial and allocation data.

Work underway to provide more transparent, accessible and comparable financial information, including an update on implementing common templates for the publication of information across Health Boards

27. There is already a significant amount of published information through the published budgets and accounts.

28. Since the establishment of a Financial Information Strategy (FIS) Board, which went on to publish the strategy "Spending by Design" at the end of 2005, the Welsh Government and the NHS have worked closely together to improve the consistency and standardisation of published financial information. The improvements in the monitoring and reporting arrangements have already been recognised by the Wales Audit Office in their NHS Finances Report.

29. There is a range of further developments being taken forward e.g. the Welsh Government has supported the NHS in creating and promoting the work of a Financial Information and Costing Group (FIaC). This group has developed common templates and costing guidance for NHS organisations to complete and there are standard benchmarking arrangements that are being taken forward but the added value of any development has to be carefully considered.

30. The existing extensive monthly monitoring arrangements are being reviewed to make further improvements that are appropriate to cover improvements that have been suggested by PAC and other NAfW Committees. This is currently being considered as outlined earlier in the context of the enhanced performance management arrangements created by the introduction of integrated service plans.

Capital and Infrastructure Investment

31. NHS Bodies, as part of their Integrated Medium Term Plans, have revisited and updated their capital requirements to deliver both service transformation and to support the modernisation and replacement of existing infrastructure. Work is ongoing to review the NHS Wales Capital Programme to ensure that allocations are targeted at securing improved health outcomes for patients, and facilitating the long term clinical and financial sustainability of the NHS in Wales. The focus of investment going forward will be prioritised to deliver the following investment objectives:

    - Support changes to streamlining and transforming healthcare provision, with a focus on prevention and supported self management, the provision of care closer to home, and the integration and coordination of service delivery with partners;

    - Promote the maximum efficient utilisation of assets and to improve asset condition and performance;

- Promote the use of innovation to improve the quality of care, to reduce costs and to deliver the necessary service change.

32. In terms of the capital schemes arising from the completed consultation exercises, these are already being given priority in terms of funding support to ensure they are delivered at the earliest opportunity. For example, funding of £5 million was announced in May 2014 for a new integrated primary care centre in Llangollen.

Innovative Financing

33. In May, the Finance Minister announced that a new specialist cancer care centre at Velindre Hospital will be progressed using innovative investment funding models. The capital cost of the new centre is estimated to be £210 million and will facilitate access to high quality cancer services, comparable with the best in the world. The Strategic Outline Programme for the scheme is being developed by Velindre NHS Trust and it is anticipated that this will be completed in the autumn. While a number of funding vehicles are being considered, the non profit distributing (NPD) model has been identified at an early stage as a possible mechanism to deliver the scheme. This will be examined and confirmed as the scheme progresses through the business case process.

34. A number of other potential investment areas in the Welsh NHS are also being considered in relation to innovative financing. These are currently being scoped, but include the possible development of a primary and community care programme and an energy efficiency programme. Funding vehicles could include the introduction of a financing hub initiative, which is designed to bring together Health Boards, Local Authorities, police, and fire and rescue services and other public bodies, together with a private sector development partner.

35. In terms of the requirement for legislative changes, this will need to be assessed as the potential investment programmes are developed. For example, in relation to the proposed development at Velindre, it should be noted that NHS Trusts in Wales currently have the ability to borrow. However, for this and other programmes, we will need to take account of a wide range of factors, including statutory powers, to determine how the investment vehicles are to be developed and structured to deliver schemes at best value.

Alignment of the budget with the Programme for Government

36. The current budget allocation was agreed by the National Assembly for Wales in December 2014. The allocation was approved on the basis of a clear alignment with the Welsh Government's priorities as set out in the Programme for Government.

37. A series of examples of the alignment of the budget with the Programme for Government priorities can be found in the paper provided to Members for general scrutiny purposes.

Further detail on how the £25 million contingency around legislation implementation will be spent

38. The implementation of the NHS Finance (Wales) Act provides a basis for more flexible planning over the medium term and at the same time moving the statutory duty to breakeven over a 12 month period to a duty to breakeven over a period of three years. The £25 million contingency fund will be used to support the more flexible planning regime, by providing access to repayable funds to 'smooth' the financial pressures between years and/or for upfront investment purposes.

Intermediate Care Fund

39. The Welsh Government's Final Budget for 2014-15 included proposals to establish an Intermediate Care Fund. The Fund includes £35 million revenue (of which £5m relates to the existing Regional Collaboration Fund) and £15 million capital funding. This Fund was a result of the Budget Agreement between the Welsh Government, Plaid Cymru and the Welsh Liberal Democrats. Revenue funding lies in the Local Government MEG and capital is to be found in the Housing and Regeneration MEG.

40. Ministers issued a Written Statement formally to announce the regional funding. This noted proposals submitted by each of the six regions - Cardiff and the Vale, Cwm Taf, Mid and West, North Wales, Western Bay and Gwent. These have been assessed, against broad criteria areas relating to integration, transformation, new/additional, benefits, and strategic importance and governance arrangements. Consequently, these proposals were informed of their approval for funding in April.

41. It is too early to analyse the extent of progress within each proposal at this point, though officials will continue to monitor activity closely and meet with regional leads. The complexity of the schemes also makes it difficult to define any expenditure from the Fund based solely on health provisions. The Fund does, however, build on existing good practice and provides for more integrated services across Wales. It can for example, allow for pump-priming of funding to assist transformation and change, to test out new models of delivery, remove barriers, such as the need to secure start-up funding, and commitments from a number of organisations.

Supplementary Budget 2014-15

42. The only changes being actioned in the first supplementary budget for 2014-15 to the DHSS MEG, are changes to the Annually Managed Expenditure (AME) budgets. Local Health Boards and NHS Trusts are required to provide regular forecasts of their AME funding requirements.

- **Impairments – increase £4.605 million**
  Funding requirements for impairments vary reflecting the timing of capital scheme completions and related valuations, and changes in valuation indices.

- **Provisions – increase £10.000 million**

Provisions funding relates to the forward forecast provision requirements for the Welsh Risk Pool, assessed from the claims database maintained by NHS Wales Shared Services Partnership (NWSSP) Welsh Risk Pool Services. (*NB: This increase has no impact on the Welsh Risk Pool expenditure charged to the Department's DEL Budget)*

The revised figures reflect the most recent forecasts obtained and reported as part of the UK Estimates process to HMT.

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref LF/MD/0711/14

David Rees AM
Chair of the Health and Social Care Committee
HSCCommittee@wales.gov.uk

4 September 2014

Dear David,

Supplementary Legislative Consent Motion (LCM) for the Criminal Justice and Courts Bill – offence of Wilful Neglect or Ill-treatment

Thank you for the letter addressed to Gwenda Thomas AM regarding clarification on issues relating to the supplementary LCM. As I will be leading the debate I thought it appropriate to respond to your queries.

Since I laid the LCM on 24th June 2014, the First Minister outlined the legislative priorities for the Assembly over the next year. Within this announcement, on 15th July, the First Minister announced a Bill to develop the regulatory and inspection regime to protect and promote the wellbeing of people in Wales in most need of care and support.

The issue of the overlap between the subject matter of these offences and the forthcoming Regulation and Inspection Bill was not covered in the Legislative Consent Memorandum and I hope it will assist the committee to outline the view which the Deputy Minister for Social Services and I have taken.

As far as social care workers are concerned, provision for an offence of this nature would be within the scope of the forthcoming Regulation and Inspection Bill. The Bill is concerned with the regulation of social care providers and the social care workforce. It is limited solely to social care; the offence created in the UK Government's Bill applies to both health and social care.

There is no opportunity to legislate in relation to healthcare workers in this Assembly term. Even if such an opportunity arises in the next Assembly is even less certain and in any event it would mean that the creation of the offence in relation to healthcare workers would be several years away. Additionally, if the offences were to be created in two separate bills – one for health and one for social care – there is no guarantee that the offences would be created in identical terms.

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For these reasons the Deputy Minister and I consider it is right for the provisions in the UK Bill creating these offences to apply to Wales as well as England, subject to the Assembly's agreement. I have therefore laid a LCM before the Assembly, requesting its consent to the creation of the offence in relation to both healthcare workers and social care workers through the UK Government's Criminal Justice and Courts Bill.

In response to your other queries:

Delivering Safe Care, Compassionate Care sets out the Welsh Government's response to the Robert Francis report into the events in the Mid Staffordshire NHS Foundation Trust. It demonstrates our commitment to deliver safe and compassionate care to all who use our services. The Welsh Government aims to ensure we have a culture which focuses, at all times, on the needs and rights of patients. *Delivering Safe Care, Compassionate Care* talks about the need to develop an intolerance of unacceptable care. Creating an offence of this kind therefore complements Welsh Government policy.

In *Sustainable Social Services*, published in 2011, the Deputy Minister for Social Services set out the principles for social care going forward. A key principle was safety, articulated as: "We all, whether young or older, have a right to be protected from avoidable harm and from neglect."

The creation of this offence will contribute to meeting this principle, and the underlying policy aims that flow from it, by making it clear that wilful neglect will not be tolerated in our social care system. It will form part of a wider legislative framework that protects citizens from abuse and neglect in social care. In both health and social care it will send out a message and will provide a deterrent to those working in health and social care that they can be held to account through a criminal process.

The Department of Health consultation on behalf of England and Wales drew out the fact that care workers in excluded health care settings will still be subject to section 1 of the Children and Young Persons Act 1933. This section makes it a criminal offence for any person who has responsibility for any child or young person under 16, to wilfully assault, ill-treat, neglect, abandon, or expose that child in a manner likely to cause the child unnecessary suffering or injury to health.

The Department of Education (England) took the view that it was unnecessary to extend the scope of the offence beyond formal healthcare settings as a care worker providing healthcare in one of the excluded children's services and settings could be held to account in the event of them ill-treating or wilfully neglecting their patient, as the potential application was limited and there are already adequate safeguards in those circumstances.

The exclusion of local authorities from the scope of the care provider offence is not a blanket exclusion, but only in relation to the exercise of their education functions, their function of securing sufficient childcare in their area under part 2 of the Childcare Act 2006, or in relation to the exercise of their social services functions as regards children. This includes where services that could amount to healthcare are included as part of an integrated package of services set up by the local authority or its agent, tailored to the needs of a particular child.

This exclusion is included at the request of the Department of Education (England), in order to provide consistency with regard to children's non-health settings and services and to exclude liability in circumstances where there is merely an element of healthcare in arrangements made by a local authority in the exercise of its social services functions. A local authority can however be liable under the care provider offence in relation to the exercise of its functions regarding adult social care, safeguarding vulnerable adults, etc.

I trust this clarifies the important points you have raised.

Best wishes

Mark Drakeford.

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

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