

**National Assembly for Wales**  
Health and Social Care Committee

# Access to medical technologies in Wales

December 2014

Cynulliad  
Cenedlaethol  
Cymru

National  
Assembly for  
Wales



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Health and Social Care Committee  
National Assembly for Wales  
Cardiff Bay  
CF99 1NA

Tel: 0300 200 6565

Email: [SeneddHealth@Assembly.Wales](mailto:SeneddHealth@Assembly.Wales)

Twitter: [@SeneddHealth](https://twitter.com/SeneddHealth)

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# Health and Social Care Committee

The Committee was established on 22 June 2011 with a remit to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters encompassing: the physical, mental and public health of the people of Wales, including the social care system.

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## Current Committee membership:



**David Rees (Chair)**  
Welsh Labour  
Aberavon



**Alun Davies**  
Welsh Labour  
Blaenau Gwent



**Janet Finch-Saunders**  
Welsh Conservatives  
Aberconwy



**John Griffiths**  
Welsh Labour  
Newport East



**Elin Jones**  
Plaid Cymru  
Ceredigion



**Darren Millar**  
Welsh Conservatives  
Clwyd West



**Lynne Neagle**  
Welsh Labour  
Torfaen



**Gwyn R Price**  
Welsh Labour  
Islwyn



**Lindsay Whittle**  
Plaid Cymru  
South Wales East



**Kirsty Williams**  
Welsh Liberal Democrats  
Brecon and Radnorshire

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## The following Assembly Members were also members of the Committee during this inquiry:

**Leighton Andrews**, Welsh Labour - Rhondda

**Mick Antoniw**, Welsh Labour - Pontypridd

**Mark Drakeford**, Welsh Labour - Cardiff West

**Rebecca Evans**, Welsh Labour - Mid and West Wales

**Vaughan Gething**, Welsh Labour - Cardiff South and Penarth

**William Graham**, Welsh Conservatives - South Wales East

**Ken Skates**, Welsh Labour - Clwyd South

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## Chair's foreword

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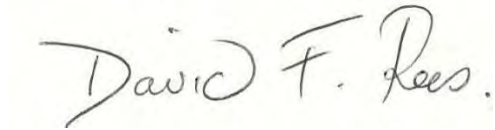
The role new technology has to play in improving the delivery of health and social services is long recognised, with benefits including better outcomes for patients, clinicians, carers, and service commissioners. It is acknowledged that the use of technologies by health and social care providers can lead to more efficient and effective treatment, improved equity of access to services, and delivery of care closer to – or even within – an individual's own home.

Nevertheless, a number of challenges exist in relation to the adoption of medical technologies, many of which are not unique to Wales. A lack of robust evidence about the clinical- and cost-effectiveness of individual technologies can hamper services' confidence to commission them; the pace of technological change can challenge services' ability to keep abreast of an ever-evolving market; and the heavy reliance of many technologies on successful administration by users, whether patient or practitioner, can limit their effectiveness.

Evidence to our inquiry suggests one overarching conclusion: Wales lacks a strategic, coordinated approach to technology evaluation and adoption. In many cases, technologies are introduced due to the enthusiasm of individual clinicians, leading to variable service provision across health boards. To address this, we believe a more robust and transparent appraisal process for new medical technologies is needed. In our view, this will provide the necessary foundation for a more effective and consistent approach to commissioning technologies. To this end, we recommend that the Minister give consideration to the creation of an all-Wales body to appraise and prioritise new technologies.

We welcome the Minister's indication that an all-Wales approach to appraisal is something he will consider seriously. We commend our other recommendations to him as the building blocks for an improved system for adopting medical technologies in Wales.

I would like to thank all of those who have contributed to our inquiry, both in writing and orally. I would also like to express our gratitude to our expert adviser, Dr Alex Faulkner, who has helped us navigate our way through this complex and vast subject area.

A handwritten signature in black ink on a light yellow background. The signature reads "David F. Rees." in a cursive, slightly slanted script.

David Rees AM  
Chair of the Health and Social Care Committee  
December 2014



## The Committee's recommendations

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The Committee's recommendations to the Welsh Government are listed below, in the order that they appear in this Report. Please refer to the relevant pages of the report to see the supporting evidence and conclusions.

The Committee recommends:

**Recommendation 1.** That the Minister for Health and Social Services should, as a matter of priority, identify means by which a more strategic, coordinated and streamlined approach to medical technology adoption will be delivered. This approach should:

- be driven by clinical and population need;
- ensure effective prioritisation of investment in new evidence-based technologies, alongside a programme of disinvestment in out-dated/ineffective equipment;
- provide equity of access to appropriate new treatments for Welsh patients; and
- facilitate the engagement of all stakeholders, including clinicians, patients, industry and research partners. (Page 16)

**Recommendation 2.** That the Minister for Health and Social Services should set out the steps that he will take to ensure that a strategic approach to medical technology development and adoption adequately encompasses the primary and community care voices, and that innovation and best practice in primary and community care settings are identified and shared more widely. (Page 20)

**Recommendation 3.** That the Minister for Health and Social Services, within 12 months of the publication of this report, should develop options for an all-Wales medical technologies appraisal mechanism, to undertake a similar function in respect of medical technologies as the All Wales Medicines Strategy Group (AWMSG) does for medicines. (Page 35)

**Recommendation 4.** That the Minister for Health and Social Services should take steps to ensure that NICE guidance on medical technologies is disseminated within NHS Wales in a timely way and fully taken into account when planning and delivering services. (Page 36)

**Recommendation 5.** That the Minister for Health and Social Services should ensure that the uptake of recommended medical technologies across Wales, including those recommended by NICE, is measured as part of a formal audit process. (Page 36)

**Recommendation 6.** That the Minister for Health and Social Services should develop and establish a more strategic approach to the commissioning of new medical technologies in Wales which must be linked to a robust appraisal and evaluation process. (Page 46)

**Recommendation 7.** That the Minister for Health and Social Services should ensure that a national approach to commissioning is adopted in cases where:

- the budget impact of prospective medical technologies is high;
- wider population needs need to be met;
- services need to be commissioned across health board boundaries; and/or
- there is potential to commission treatment from elsewhere in the UK. (Page 46)

**Recommendation 8.** That the Minister for Health and Social Services should provide details of the actions he will take to further develop the approach to medical technology adoption in Wales. This should include an indication of how the Commissioning through Evaluation project in England, and other options for evaluation, will be explored and adapted to fit the Welsh context. (Page 46)

**Recommendation 9.** That the Minister for Health and Social Services should give consideration to putting mechanisms in place to maximise the benefits of new medical technologies for patients across Wales by ensuring that NHS staff are able to access appropriate training. (Page 50)

**Recommendation 10.** That the Minister for Health and Social Services should outline the steps he will take to facilitate the further development of clinical trials and needs-led research and development in Wales including how this will relate to the medical technology assessment/appraisal process. (Page 54)

**Recommendation 11.** That the Minister for Health and Social Services should ensure that models of appropriate patient and carer representation are considered and put in place in medical and assistive technology research and development, appraisal, and evaluation. (Page 56)

**Recommendation 12.** That the Minister for Health and Social Services should set out the actions that he will take, and associated timescales, to ensure that NHS Wales's financial structures and budgetary processes can effectively support appropriate medical technology adoption. This should include reference to longer-term planning and ensuring closer alignment between capital and revenue funding. (Page 62)

**Recommendation 13.** That the Minister for Health and Social Services should work with local authorities and health boards to share good practice and to explore the development of a funding model based on the patient pathway. (Page 63)

# 1. Introduction

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1. The term “medical technologies” is broad, covering medical devices, surgical procedures and diagnostic techniques. The Medicines and Healthcare products Regulatory Agency (MHRA), which is responsible in the UK for the regulation of medical devices, defines such devices as:

“all products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. The range of products is very wide: it includes contact lenses and condoms; heart valves and hospital beds; resuscitators and radiotherapy machines; surgical instruments and syringes; wheelchairs and walking frames or other assistive technology products – many thousands of items used each and every day by healthcare providers and patients.”<sup>1</sup>

2. The Committee agreed on 20 June 2012 to undertake work on access to medical technologies in Wales.<sup>2</sup> Many future innovations for the provision of health and social care services lie in the field of medical and assistive technologies and yet it remains a subject that rarely receives attention. As a consequence, the Committee wanted to shine a light on the processes that exist in Wales for accessing medical technologies, and to consider what improvements could be made to this important area of development.

3. To inform the Committee’s approach to this work, and in acknowledgement of the complex nature of this topic, a consultation on the inquiry’s scope was launched in August 2012. This consultation sought stakeholders’ views on what the terms of reference should include, and on which aspects of access to medical technologies efforts should be focused. It also sought comments on:

- the uptake of medical technology in Wales, and the possible barriers to effective new (non-drug) treatments being more accessible to patients;
- current appraisal processes for new medical technologies; and

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<sup>1</sup> Medicine and Healthcare Products Regulatory Agency, [What we regulate](#) [accessed 7 November 2014]

<sup>2</sup> The Committee agreed that its inquiry would not include access to medicines.

- the decision-making process in NHS Wales for funding new medical technologies/treatments.

4. In total, 37 responses were received to the consultation on the inquiry's scope.<sup>3</sup> The Committee also held an informal seminar in March 2013, at which it discussed possible areas for inquiry with invited stakeholders.

5. Following the Committee's consideration of the emerging themes of its consultation, it agreed on 6 June 2013 that its inquiry would examine:

- how the NHS assesses the potential benefits of new of alternative medical technologies;
- the need for, and feasibility of, a more joined up approach to commissioning in this area;
- the ways in which NHS Wales engages with those involved in the development/manufacture of new medical technologies; and
- the financial barriers that may prevent the timely adoption of effective new medical technologies, and innovative mechanisms by which these might be overcome.

6. Following the call for written evidence the Committee took oral evidence over a period of 8 months, conducting a total of 20 evidence sessions. The Committee is grateful to all those who contributed. A list of those who gave oral evidence is included at Annex A, and lists of those who responded to the Committee's consultations are attached at Annex B.

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<sup>3</sup> The responses to the Committee's consultation on the scope of this inquiry can be found on the Committee's [website](#). A list is provided in Annex B

## **2. Adoption of medical technologies in Wales**

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### **What is a “medical technology”?**

7. A key theme emerging from the Committee’s inquiry was the lack of a common understanding of what is meant by the term “medical technology”. In many cases, it was assumed that medical technologies meant expensive, “big ticket” items, rather than simpler, less expensive innovations.

8. During the course of the Committee’s inquiry it became clear that “medical technologies” could range from the most basic of bandages to the most complex and innovative radiography machine. It was also emphasised that the use of technology was not the domain of secondary and tertiary care settings alone; community-based care provided by primary and social care practitioners was also drawing – and had much more potential to draw in the future – on the innovations offered by technological advancement.

### **The role of medical technologies in health and social care**

9. Throughout the ages technology has played a significant role in the advancement of medicine and social care. The improved diagnostic and assistive tools delivered as a consequence of technological developments have improved patient outcomes, as have the more targeted and less invasive treatments they have provided. In many cases the introduction of technologies has also enabled the achievement of efficiencies, either by automating processes or allowing other changes in patient pathways. In addition, technological developments have enabled many treatments and care packages to be provided closer to an individual’s home.

10. According to the Welsh Government, the potential benefits of the adoption of medical technologies in Wales include:

- raising the quality of care;
- reducing the cost of care;
- providing more equal access to care across all areas;

- engaging the public and patients in the co-production<sup>4</sup> of health and social care; and
- reducing need and demand, particularly through improved diagnoses and the prevention of illness.<sup>5</sup>

## Challenges

11. Notwithstanding the potential benefits of medical technologies to health and social care services, the Committee was told that a number of challenges to their evaluation and adoption exist in Wales. In particular, evidence suggested strongly that there was a need for a more strategic, coordinated and planned approach to the introduction of technologies in Wales.<sup>6</sup>

12. It was clear from the evidence received by the Committee that challenges to the evaluation and adoption of medical technologies were not unique to Wales. A number of studies and reports have identified barriers to the adoption of new medical technologies across the UK,<sup>7</sup> including:

- inadequate information on the true cost-effectiveness of technologies;
- a “short-term perspective” when it comes to investing in technology;
- inefficient and disparate decision-making processes within the NHS; and
- lack of quality evidence as to the clinical and cost-effectiveness of new medical technologies.

13. In the Welsh context, the following challenges to the adoption of technology were listed in responses to the Committee’s consultation:

- ineffective implementation of National Institute for Health and Care Excellence (NICE) guidance on medical technologies,

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<sup>4</sup> Co-production is the concept of services working in partnership with users and the general public to shape and improve them.

<sup>5</sup> National Assembly for Wales, Health and Social Care Committee, HSC(4)-13-14 Paper 3 Evidence from the Welsh Government, December 2013

<sup>6</sup> Ibid, RoP [para 71, 198] 5 February 2014, RoP [para 148, 152, 234] 19 February 2014, RoP [para 7, 49] 6 March 2014, RoP [para 31, 133, 174, 205] 20 March 2014

<sup>7</sup> Including the 2002 Wanless Report; House of Commons Health Committee’s 2005 report on the use of new medical technologies within the NHS; the Work Foundation’s 2011 report *Adding Value: The economic and societal benefits of medical technology*; and the 2011 Department of Health report *Innovation health and wealth: Accelerating adoption and diffusion in the NHS*.

confusion over its applicability in Wales, and the fact that this guidance is advisory in status only;<sup>8</sup>

- lack of a clear, formal appraisal pathway for new medical technologies in Wales (discussed in more detail in chapter 3);<sup>9</sup> and
- lack of any central, strategic planning or transparent process for decision-making on funding new medical technologies in NHS Wales.<sup>10</sup>

14. As a result of these challenges, a number of consultation respondents said that there was a perceived lack of decisiveness about the adoption of new technologies at a system-level.<sup>11</sup> Dr Molly Price-Jones of Tybio Ltd commented:

“Wales is fortunate in having a thriving medical technology community with many highly innovative SMEs. However, as in all areas of the UK, there are significant barriers to getting a new technology adopted and enabling patients to get access to improved diagnostic techniques.”<sup>12</sup>

15. In particular, the Committee heard that there was a lack of systemic horizon scanning to identify potentially effective, cost-saving new technologies. Instead, evidence suggested that it was often individual clinicians who become aware of new technologies through their professional contacts or networks.<sup>13</sup> Dr Tom Crosby of the Velindre Cancer Centre told the Committee:

“What I think is lacking is some horizon scanning, planning and the strategic planning of services looking forward. Then, I think that there is a problem with the robust and rapid appraisal of technologies and treatments. I think that we have relatively weak commissioning and performance monitoring of the

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<sup>8</sup> National Assembly for Wales, Health and Social Care Committee, Consultation responses MT4 Royal College of Physicians, MT5 Dr Peter Groves, MT10 Chartered Society of Physiotherapy, MT11 NICE, MT23 MediWales, MT25 Urology Trade Association

<sup>9</sup> Ibid, Consultation responses MT12 Association of British Healthcare Industries, MT13 Royal College of Radiologists, MT16 Dr Molly Price-Jones, MT23 MediWales, MT29 AposTherapy

<sup>10</sup> Ibid, Consultation responses MT18 Time for Medicine Ltd, MT23 MediWales, MT28 BMA Cymru Wales, MT32 Dr S Peirce

<sup>11</sup> Ibid, Consultation responses MT18 Time for Medicine Ltd, MT23 MediWales, MT28 BMA Cymru Wales, MT32 Dr S Peirce

<sup>12</sup> Ibid, Consultation response MT16 Dr Molly Price-Jones (Tybio Ltd)

<sup>13</sup> Ibid, Consultation response MT32 Dr S Peirce



services. So, across that, there is a lack of strategic planning in service delivery.”<sup>14</sup>

16. Written evidence received by the Committee suggested that this lack of a strategic approach resulted in Wales being slow to adopt some technologies. It was suggested that, as a result, Welsh patients were unable to access certain treatments available elsewhere in the UK or Europe, for example in the fields of heart surgery, radiotherapy, colorectal surgery, endoscopy and genetics.<sup>15</sup> MediWales, the life science network for Wales, told the Committee:

“Delay[s] in introducing an appropriate system for access to medical technologies in Wales carries the risk of impacting on patient care now and in the foreseeable future.”<sup>16</sup>

17. The Committee also heard that failure to adopt medical technologies had an impact on Wales’ standing as a centre of excellence for research. Professor Peter Barrett-Lee, Consultant Clinical Oncologist and Medical Director, Velindre NHS Trust, told the Committee:

“If you are behind the curve on technology, you are not going to be able to impress the world with your research. It will be a joke, will it not? You will be behind on technology; no-one will be interested in your research on old technology.”<sup>17</sup>

18. In addition to the impact on Wales’ profile as a centre of excellence for research, it was also suggested that slow and/or piecemeal uptake of technology could impact on the nation’s ability to recruit medics and specialists. Dr Martin Rolles of the Royal College of Radiologists Standing Welsh Committee told the Committee:

“For consultant specialties, we are in competition nationally across the UK. [...] One of the things that we can do is make sure that if people are going to come here, they can practise their craft to the best of their ability. One thing that they do not

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<sup>14</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 7], 6 March 2014

<sup>15</sup> Ibid, Consultation responses MT4 Royal College of Physicians, MT13 Royal College of Radiologists Standing Welsh Committee, MT9 Association of Coloproctology of Great Britain & Ireland, MT15 Welsh Association for Gastroenterology and Endoscopy, MT21 Genetic Alliance UK

<sup>16</sup> Ibid, Consultation response MT23 MediWales

<sup>17</sup> Ibid, RoP [para 75], 20 March 2014

want to do is to come to a place and try to work in a department that is technically backwards while feeling that they are not able to practise to the best of their professional ability. [...] We do not want to recruit people who cannot get jobs anywhere else. We need to recruit leaders who will bring the service forward and make it better for Wales.”<sup>18</sup>

### ***The Committee’s view***

19. The Committee’s inquiry covered matters relating to the appraisal, evaluation, commissioning, and financing of medical technologies. It also considered the extent to which services engaged with relevant stakeholders, including clinicians, patients, industry, and research partners. Each of these themes is explored in more detail in subsequent chapters. However, the overarching conclusion emerging from the Committee’s work was the need for a more coordinated and strategic approach to technology evaluation and adoption.

**Recommendation 1: The Committee recommends that the Minister for Health and Social Services should, as a matter of priority, identify means by which a more strategic, coordinated and streamlined approach to medical technology adoption will be delivered. This approach should:**

- **be driven by clinical and population need;**
- **ensure effective prioritisation of investment in new evidence-based technologies, alongside a programme of disinvestment in out-dated/ineffective equipment;**
- **provide equity of access to appropriate new treatments for Welsh patients; and**
- **facilitate the engagement of all stakeholders, including clinicians, patients, industry and research partners.**

### **Medical technologies in primary and social care**

20. Evidence to the Committee’s inquiry indicated that medical technologies could play as important a role in primary and social care as it could in secondary and tertiary settings. The importance of the potential role of technology in the delivery of the Welsh Government’s commitment to providing more care closer to home was emphasised

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<sup>18</sup> National Assembly for Wales. Health and Social Care Committee, RoP [para 39], 20 March 2014

by many witnesses, with the Minister himself highlighting the importance of medical technologies in enabling services to be provided in community settings.<sup>19</sup>

21. It was noted that medical technologies which could be used in primary and social care (such as diagnostics, monitoring or assisted living technologies), had the potential to realise significant benefits for patients and the NHS by moving care from secondary to community settings. MediWales told the Committee:

“If you look at where the potential cost savings are to be gained, primary and social care have a huge role to play. So, characterising medical technology procurement as being something for hospitals would be wrong, because a lot of our members are involved in remote or home diagnostics and assisted living.”<sup>20</sup>

22. Moreover, Dr Grace Carolan-Rees of Cedar (an NHS-academic technology evaluation centre) told the Committee that in her experience of evaluating technologies in the NICE programme, she had noticed:

“very often, what determines that something becomes cost-saving is that very change from treatment that happens in secondary care to something that happens in primary care. So it goes hand in hand that actually being able to move things from secondary to primary care is very often cost-saving, which is a positive benefit.”<sup>21</sup>

23. This point was echoed by Sue Evans of the Association of Directors of Social Services who noted:

“in terms of prudent healthcare or prudent social care, the evidence [...] shows clear financial benefit and qualitative benefit to those individuals in how some of that technology promotes independence and supports people to have a much more fulfilled life—and it is cheaper for the public purse.”<sup>22</sup>

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<sup>19</sup> National Assembly for Wales, Health and Social Care Committee, HSC(4)-13-14 Paper 3 Evidence from the Welsh Government, December 2013

<sup>20</sup> Ibid, RoP [para 240], 6 March 2014

<sup>21</sup> Ibid, RoP [para 41], 5 February 2014

<sup>22</sup> Ibid, RoP [para 173], 18 September 2014

24. However, the evidence received by the Committee also identified a lack of overall leadership in relation to the adoption of medical technologies in primary care. This appeared to result in the adoption of technology on a largely ad hoc basis in individual practices. Representatives of the BMA Cymru Wales noted the ad hoc nature of adoption in primary care was due, at least in part, to the lack of a formal process, pathway or resourcing for developing the use of technologies. They noted that any uptake of medical technology was largely due to:

- the degree of enthusiasm displayed by an individual general practitioner;<sup>23</sup>
- the relative size of the practice (with larger practices being more able to absorb associated costs);<sup>24</sup> and/or
- the influence of newly-created GP clusters, which is encouraging the sharing of good practice between peers.<sup>25</sup>

25. Although pockets of individual good practice were cited,<sup>26</sup> witnesses told the Committee that greater strategic oversight and planning was needed, and that primary care practitioners would welcome a stronger voice in the process of identifying, appraising and evaluating medical technologies.<sup>27</sup>

26. Sue Evans of the Association of Directors of Social Services noted that, in primary and social care, “the potential [of technology] is massive, and I would say that it is untouched or untapped. Certainly, there seems to be much more of a cohesive picture within the social care family than within the healthcare family, purely because, I think, of the complexity of some of the health technologies being both in the community, but also in hospital settings”.<sup>28</sup>

27. The Health and Well-being Best Practice and Innovation Board was established by the Welsh Government in 2012 as a time-limited mechanism. Its purpose was to assist in accelerating the pace of innovation relevant to health, social care and well-being, and support the systematic identification and spread of best practice. The Board’s

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<sup>23</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 81], 18 September 2014

<sup>24</sup> Ibid, RoP [para 41], 18 September 2014

<sup>25</sup> Ibid, RoP [para 28], 18 September 2014

<sup>26</sup> Ibid, RoP [para 17], 18 September 2014

<sup>27</sup> Ibid, RoP [para 230], 20 March 2014

<sup>28</sup> Ibid, RoP [para 173], 18 September 2014

final report found that systems do not exist to support primary care innovation and best practice being identified and shared across both primary care practitioners and the wider health and social care system. It recommended that:

“work be undertaken to focus upon and identify innovation within community settings, and that this work be used as the basis for consideration of the most appropriate model to ensure cross fertilisation across community care services. This work needs to recognise and manage risk and seek to ensure that independent living is protected and supported.”<sup>29</sup>

28. Fiona Jenkins of the Cardiff and Vale University Health Board told the Committee that a lack of coordinated basic IT infrastructure to support communication and referrals between clinicians was a source of frustration, and cited the example of occupational therapists in health, social care and housing, who are unable to make referrals by email.<sup>30</sup> She said that GPs were often “ahead of the curve” in the use of technology, such as e-prescribing, but that they were frustrated by poor interfaces with hospital services.<sup>31</sup>

29. Sally Chisholm of NICE said that there was a need to help those in primary care to better understand the benefits of adopting medical technologies, and to ensure that there are systems in place to facilitate the deployment of new technologies.<sup>32</sup>

30. The Minister said that he anticipated that the Health Technologies and Telehealth Fund would assist in increasing the focus on investment in primary care technology. He said:

“using the fund, having better leadership and making sure that we have got the policy perspective right mean that we are going to be able to make some significant advances in the primary care field over the next year or so.”<sup>33</sup>

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<sup>29</sup> Health and Wellbeing Best Practice and Innovation Board, [Final Report](#), January 2014 [accessed 7 November 2014]

<sup>30</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 135], 19 February 2014

<sup>31</sup> Ibid, RoP [para 140], 19 February 2014

<sup>32</sup> Ibid, RoP [para 45], 5 February 2014

<sup>33</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 118], 8 May 2014

### *The Committee's view*

31. The Committee noted that while there is scope for medical technologies to provide considerable benefits to patients and the NHS in the delivery of primary care services, there seems to be a lack of leadership in this area. Technology adoption appears to be happening largely on an ad hoc basis within individual practices. The Committee agreed that greater strategic oversight and planning is needed. While noting the very different ways in which social care and NHS primary care are organised, the role of assistive technology seemed to be more established in the field of social care, and the Committee would urge primary care practitioners to follow the lead of their counterparts in that sector. Nevertheless, it seemed that more joined-up working could take place between primary and social care.

**Recommendation 2: The Committee recommends that the Minister for Health and Social Services should set out the steps that he will take to ensure that a strategic approach to medical technology development and adoption adequately encompasses the primary and community care voices, and that innovation and best practice in primary and community care settings are identified and shared more widely.**

### 3. Appraisal and evaluation of medical technologies

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#### Challenges to the appraisal and evaluation of medical technologies

32. During the course of the inquiry, a number of challenges to the appraisal and evaluation of medical technologies were highlighted to the Committee. It was emphasised, for example, that the benefits of technologies can be more difficult and complex to appraise than pharmaceuticals. Linked to this, it was also noted that there is no clear infrastructure in place for the appraisal and evaluation of medical technologies; this is in contrast to the clear framework that exists for medicines in Wales. This section explores these themes in more detail.

#### *The differences between medicines and medical technologies*

33. A mechanism already exists in Wales for the appraisal of medicines on a national basis. The All Wales Medicines Strategy Group (AWMSG) evaluates the clinical- and cost-effectiveness of all new medicines that are not included on the NICE appraisal programme, and makes recommendations as to their use within NHS Wales.

34. A number of witnesses emphasised the differences between medicines and technologies, which makes appraisal more complex and a robust assessment of their clinical and cost-effectiveness more difficult to achieve. For example, the available evidence on new technologies is often extremely limited. In contrast to the pharmaceutical industry, manufacturers of medical technologies are frequently small or medium-sized enterprises with limited research budgets and ability to access relevant expertise, such as health economics.<sup>34</sup>

35. Other differences, highlighted by NICE, included the fact that:

- technologies may be modified over time in ways that change their effectiveness;
- the clinical outcomes resulting from the use of technologies often depend on the training, competence and experience of the user;

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<sup>34</sup> National Assembly for Wales, Health and Social Care Committee, Consultation response MT33 Cedar

- the healthcare system benefits of adopting medical technologies often depend on organisational factors, such as the setting in which the technology is used or the staff who use it, in addition to the benefits directly related to the technology;
- when the technology is a diagnostic test, improved clinical outcomes depend on the subsequent delivery of appropriate healthcare interventions;
- costs of medical technologies often comprise both procurement costs (including associated infrastructure) and running costs (including maintenance and consumables);
- a new technology may influence costs by its effect on various aspects of the care pathway, in addition to costs directly related to the use of the technology; and
- in general, medical technology pricing is more dynamic than that of other types of medical interventions.<sup>35</sup>

### ***Horizon scanning***

36. As noted in the previous chapter, evidence to the inquiry highlighted the lack of a consistent, systemic approach to assessing the benefits of new or alternative medical technologies, and a corresponding lack of systemic horizon scanning to identify potentially effective, cost-saving new technologies. Instead, it can often be individual clinicians who become aware of new technologies through their professional contacts or networks.<sup>36</sup>

37. Karen Samuels of the AWMSG told the Committee that one of the best ways to ensure access to up to date technologies is horizon scanning for emerging technologies during the development process.<sup>37</sup> However Dr Tom Crosby of the Velindre Cancer Centre told the Committee that in his experience:

“The third sector quite often comes in to provide things when the NHS is not doing so well. It speaks volumes that the third sector has come in and said ‘Look, we need to horizon scan for

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<sup>35</sup> NICE, [Medical Technologies Evaluation Programme Methods Guide](#), April 2011, pp.7-8 [accessed 7 November 2014]

<sup>36</sup> National Assembly for Wales, Health and Social Care Committee, Consultation response MT32 Dr S Peirce

<sup>37</sup> Ibid, RoP [para 95], 22 January 2014



radiotherapy technologies, looking forward'. I do not think there is any formal horizon scanning and strategic planning."<sup>38</sup>

38. The Committee heard from MediWales that there were organisations in Wales which are regarded as leaders in new technology assessment, but:

“while Wales boasts these exemplar centres of technology evaluation there is no systematic, all Wales, approach to the NHS identifying, evaluating and adopting new technologies, or an entry point for technology providers to submit new technologies for evaluation.”<sup>39</sup>

39. Evidence from the primary care sector reiterated the lack of a structured approach to horizon scanning. Dr Charles Allanby, a general practitioner representing the BMA Cymru Wales, noted that technologies are most often identified by:

“the enthusiasts who might want to meet with individual marketing people to discuss whether that [technology] is something worth experimenting with before it is actually rolled out [...] there is nobody in a co-ordinated role undertaking horizon scanning at the moment.”<sup>40</sup>

40. Charlotte Moar, representing Cardiff and Vale University Health Board, suggested that any future horizon-scanning mechanism should focus on the issues of greatest importance to service planners and providers in order to ensure a focused and coherent approach.<sup>41</sup>

41. Evidence from social care representatives illustrated a more structured approach to horizon scanning, with local authorities employing dedicated “technology brokers” who are experts in the relevant technology available on the market. The Committee was told that the brokers work alongside the social workers who undertake an individual’s needs assessments, and/or the district nurse who

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<sup>38</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 87], 6 March 2014

<sup>39</sup> Ibid, Consultation response MT23 MediWales

<sup>40</sup> Ibid, RoP [para 113], 18 September 2014

<sup>41</sup> Ibid, RoP [para 59], 18 September 2014

conducts the clinical assessment, in order to identify the best support or solution.<sup>42</sup>

42. Nevertheless, Andrew Bell of the Social Services Improvement Agency noted that a more centralised approach to horizon scanning would be helpful in informing local authorities' decisions to commission technologies. He noted that was particularly important given the fast pace of change within the field.<sup>43</sup> Sue Evans from the Association of Directors of Social Services agreed, noting that "the idea of getting an all-Wales evaluation or horizon scanning would probably help all of us, as a bit of a shortcut to trying to find out what is out there".<sup>44</sup> She warned that, in the absence of a system of this kind, practitioners or brokers are often guided by the marketing of the relevant technologies' producers:

"if something is readily available and visible, whether it is to members of the public or to the health or social care practitioners, those are the things that come to light."<sup>45</sup>

### ***The "usability" of medical technologies***

43. The Committee heard that, for the implementation of medical technologies to be successful and to make a difference to patients, it is important that those using and receiving treatment through technologies have the skills and information they need.<sup>46</sup>

44. The benefits that can be realised from a particular technology may be heavily dependent on "usability factors".<sup>47</sup> The Committee heard that the variable effectiveness of medical technologies depending on the way in which they are used has meant that clinicians and commissioners are often keen to test technologies locally, rather than rely on evidence produced elsewhere. However, local pilots and evaluation are frequently informal, and not sufficiently robust.<sup>48</sup>

45. AWMSG told the Committee that usability and user preference were bigger factors in the consideration of medical technologies than

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<sup>42</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 180], 18 September 2014

<sup>43</sup> Ibid, RoP [para 182], 18 September 2014

<sup>44</sup> Ibid, RoP [para 200], 18 September 2014

<sup>45</sup> Ibid, RoP [para 200], 18 September 2014

<sup>46</sup> Ibid, RoP [para 110], 5 February 2014

<sup>47</sup> Ibid, Consultation response MT32 Dr S Peirce

<sup>48</sup> Ibid

medicines, because of the physical involvement users have with medical devices.<sup>49</sup>

46. In response to the Committee's consultation, Cedar was clear that usability should be considered alongside safety, clinical effectiveness and cost effectiveness, but that this is currently not the case either in CE marking<sup>50</sup> or published research studies.<sup>51</sup> Peter Phillips, Director of the Surgical Materials Testing Laboratory, told the Committee that while manufacturers undertake usability testing as part of the development of their devices, it does not always take sufficient account of the "human factor" and the NHS does not always assess usability when adopting new technologies.<sup>52</sup>

47. Social care representatives told the Committee that, in the case of many assistive technologies, "demonstration centres" exist. These centres are used to train staff on the technologies' use and to allow service users to test the technologies' potential.<sup>53</sup>

48. It was emphasised that any new appraisal process for medical technologies must have access to the necessary expertise. It was also noted that any process must take into account the diverse nature of technologies, the weaker evidence base than that which exists for medicines, and factors such as usability and impact on the care pathway.<sup>54</sup>

### **NICE guidance**

49. NICE's Technology Appraisals are recommendations on the use of new and existing medicines and treatments within the NHS. These can be:

- medicines;
- medical devices, such as hearing aids or inhalers;
- diagnostic techniques;

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<sup>49</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 16], 22 January 2014

<sup>50</sup> The CE mark is a mandatory conformity marking for certain products sold within the European Economic Area (EEA). The CE marking is the manufacturer's declaration that the product meets the requirements of the applicable European Commission directives.

<sup>51</sup> National Assembly for Wales, Health and Social Care Committee, Consultation response MT33 Cedar

<sup>52</sup> Ibid, RoP [para 180-1], 19 February 2014

<sup>53</sup> Ibid, RoP [para 176], 18 September 2014

<sup>54</sup> Ibid, RoP [para 110], 5 February 2014, and RoP [paras 49, 333], 6 March 2014

- surgical procedures, such as repairing hernias; and
- health promotion activities such as ways of helping people with diabetes manage their condition.

The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's Technology Appraisals.<sup>55</sup>

50. The Medical Technologies Advisory Committee (MTAC) operates as a standing advisory committee of the Board of NICE. The MTAC advises NICE on:

- the application of criteria to select for evaluation medical devices and diagnostics which hold the potential to drive significant improvements in outcomes, improvements in patient experience (of treatment and recovery), ease of operator use, and/or improvements in the efficient use of resources; and
- the routing of products accepted, for evaluation, through one of the designated evaluation programmes, including MTAC itself.

It is not mandatory for the NHS to apply guidance issued by MTAC.<sup>56</sup>

51. The Welsh Government's Quality Delivery Plan for the NHS in Wales 2012-16<sup>57</sup> highlights NICE's Medical Technologies Evaluation Programme (run by MTAC) as an important source of advice. The *Quality Delivery Plan* states that the NHS will collectively review how well new technology is adopted. It also includes an action plan for health boards and trusts to work together to put effective processes in place to ensure the prompt uptake of evidence-based new technologies which maximise benefit and value.

52. In his written evidence to the Committee, the Minister said:

“The Welsh Government has entered a Service Level Agreement with NICE which includes access to NICE's evaluation of new or innovative medical technologies (including devices and diagnostics). The Welsh Government expects the NHS to take

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<sup>55</sup> National Institute for Health and Care Excellence (NICE), [Nice Technology Appraisal Guidance](#) [accessed 7 November 2014]

<sup>56</sup> Ibid, [Medical Technologies Advisory Committee \(MTAC\)](#) [accessed 7 November 2014]

<sup>57</sup> Welsh Government, [Quality Delivery Plan for the NHS in Wales 2012-16](#) [accessed 7 November 2014]

NICE guidance fully into account when planning and delivering services, as they are based on the best available evidence.”<sup>58</sup>

53. Nevertheless, some respondents to the Committee’s consultation expressed concerns that NICE guidance on medical technologies is not consistently implemented in Wales. They made the point, however, that consistent application of this guidance would not provide a complete solution, as a more proactive approach to assessing medical technologies in Wales was needed.<sup>59</sup> The Committee learned about two tools in use in other parts of the UK to encourage the implementation of NICE Technology Appraisal guidance and MTAC guidance. First, NICE described the role of its “implementation consultants”, a field-based team of eight consultants who work with the NHS, local authorities and other organisations to help to put guidance into practice.<sup>60</sup> Secondly, NICE told the Committee about its Health Technologies Adoption Programme, which is responsible for identifying ways to overcome potential barriers to the implementation of MTAC guidance.<sup>61</sup>

54. On 8 May 2014, the Minister told the Committee “our subscription to NICE, which costs us £1 million a year, gives us full access to everything that it does in this field”.<sup>62</sup> However, the Committee heard that whilst NICE’s team of implementation consultants covers the whole of England and Northern Ireland, there was at present no remit for them to be working with organisations in Wales.<sup>63</sup>

55. The AWMSG noted that there is variable uptake of NICE technology appraisal guidance in Wales, and explained:

“This can result in variation of access to clinically-effective and cost-effective technologies across Wales, or in delays in decision-making, particularly when the initial outlay may be

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<sup>58</sup> National Assembly for Wales, Health and Social Care Committee, HSC(4)-13-14 Paper 3 Evidence from the Welsh Government, December 2013

<sup>59</sup> Ibid, Consultation response MT23 MediWales

<sup>60</sup> Ibid, RoP [para 90], 5 February 2014

<sup>61</sup> Ibid, RoP [para 30-31], 5 February 2014

<sup>62</sup> Ibid, RoP [para 99], 8 May 2014

<sup>63</sup> Ibid, RoP [para 30], 5 February 2014

<sup>63</sup> Ibid, RoP [para 90], 5 February 2014

significant, and the cost benefit to be made occur sometime into the future.”<sup>64</sup>

56. Professor Philip Routledge, Chair of the AWMSG, stated that the implementation of guidance was crucial, saying that his key recommendation for the Committee would be to review the way in which advice, including NICE guidance, was implemented.<sup>65</sup>

57. The Minister told the Committee that he had set up a group to facilitate the dissemination and adoption of NICE guidance in Wales. He said:

“What I hope that group will be able to do is to make sure that senior clinicians in the Welsh NHS get some early indications of work that NICE is doing, so that people can be preparing for it.”<sup>66</sup>

58. Dr Peter Groves, Consultant Cardiologist at Cardiff and Vale University Health Board and Vice-Chair of NICE’s Medical Technology Advisory Committee, argued that NHS Wales could go further than simply seeking early access to forthcoming guidance and implementing it. He expressed the view that more could be done to access and influence NICE’s assessment topics:

“there is the opportunity for us in NHS Wales to potentially be more proactive in setting the agenda for some of the technologies and interventions that could, or should be, on the NICE programme or agenda. There may well be, for example, the opportunity to establish within Wales a committee or a multidisciplinary approach to setting what we see as our own priorities that could then directly link in with NICE and perhaps influence the way in which technologies are looked at and reported at a NICE level.”<sup>67</sup>

59. Since gathering its oral evidence on this inquiry the Committee has noted NICE’s calls for a new approach to managing the entry of “technologies” (that is medicines, medical devices, diagnostic techniques, surgical procedures, and health promotion activities) into

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<sup>64</sup> National Assembly for Wales, Health and Social Care Committee, Consultation response MT38 All Wales Medicines Strategy Group

<sup>65</sup> Ibid, RoP [para 215], 3 April 2014

<sup>66</sup> Ibid, RoP [para 162], 8 May 2014

<sup>67</sup> Ibid, RoP [para 16], 5 February 2014

the NHS. In particular, the Committee has noted NICE's calls for any changes to its methods to be made as part of a wider review of the innovation, evaluation and adoption of new treatments involving patients, people working in or with the NHS, the life sciences industries and health researchers. Alongside any changes to its methods, NICE has proposed:

- an office for innovation inside NICE to provide companies with a "flight path" through the stages of the development, evaluation and adoption of their products into the NHS;
- agreement between NICE, NHS England and the Department of Health, on the NHS's willingness to pay for new treatments, which would take account of any special cases, such as ultra-orphan conditions and cancer; and
- more productive sharing of risk between companies and the NHS.<sup>68</sup>

### **The role of the Welsh Health Specialised Services Committee (WHSSC)**

60. The role of the commissioning body WHSSC in relation to technologies was discussed by a number of witnesses. Some evidence described WHSSC as specialising in "relatively ad hoc" services.<sup>69</sup> It has also been suggested that its work may involve some duplication of the work of the AWMSG and/or NICE in terms of technology assessments.<sup>70</sup>

61. Dr Phil Webb of WHSSC told the Committee that, in the past two years, there had been a relatively small overlap between appraisals undertaken by WHSSC and those undertaken by NICE, representing around 10 per cent of WHSSC's appraisals.<sup>71</sup> WHSSC representatives told the Committee that the NICE MTAC assessments undertaken were largely at the request of manufacturers, whereas WHSSC's appraisal programme tended to be informed from the perspective of those delivering services.<sup>72</sup>

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<sup>68</sup> National Institute for Health and Care Excellence (NICE), [NICE calls for a new approach to managing the entry of drugs into the NHS](#), 18 September 2014 [accessed 7 November 2014]

<sup>69</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 68], 6 March 2014

<sup>70</sup> Ibid, RoP [para 211] 5 February 2014, RoP [para 65,71] 6 March 2014

<sup>71</sup> Ibid, RoP [para 11], 19 February 2014

<sup>72</sup> Ibid, RoP [para 13], 19 February 2014

62. It was acknowledged by a number of witnesses that WHSSC plays an integral part in the appraisal and commissioning of medicines and technologies at present. However, there was less clarity as to the role that WHSSC should fulfil in the future. Jared Torkington, a Consultant Laparoscopic Colorectal Surgeon at Cardiff and Vale University Health Board and representative of the Royal College of Surgeons, told the Committee:

“if WHSSC were a computer programme, it would be ready for an upgrade in terms of moving it on. When it started, it was clearly very important that it represented the LHBs, but we have now reached a stage where we have the health technology fund that provides big capital investment and then we are going to another body to ask for revenue. So the two are disconnected and there needs to be a better working relationship between these bodies.”<sup>73</sup>

63. The recent review of the appraisal of orphan and ultra-orphan medicines in Wales recommended that the role of WHSSC should be amended to enable closer involvement and integration with the appraisal process, to enable the complete patient treatment pathway to be taken into account and considered within the appraisal process.<sup>74</sup>

### **A new appraisal approach for Wales**

64. Jared Torkington, consultant surgeon, told the Committee that there should be flexibility within an appraisal process to avoid duplication. He said:

“We do not need to reinvent the wheel with appraisal: if we have a clinical need for our patients in Wales that has not been looked at by NICE, for example, then we should appraise it. If we have a clinical need, but it has already been appraised by half a dozen other bodies, there is no need for us to appraise it again, and we will just say that we need that service, and then go straight to the commissioning group.”<sup>75</sup>

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<sup>73</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 151], 20 March 2014

<sup>74</sup> Buss, P, Evans, S, Phillips, C, [Review of the appraisal of orphan and ultra-orphan medicines in Wales - Report for the Minister of Health and Social Care](#), October 2013 [accessed 7 November 2014]

<sup>75</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 140], 20 March 2014



65. The Committee heard that the process for the appraisal of medicines by the AWMMSG is well-respected and considered to be successful, and that a similar approach for technologies would be beneficial. When questioned about the capacity and expertise required for a body such as the AWMMSG to undertake appraisals of technologies, Professor Philip Routledge suggested that collaboration with Cedar could provide a solution. He told the Committee that AWMMSG had health economics expertise, and that this could be supplemented by specific technology expertise from Cedar where required.<sup>76</sup>

66. Professor Ceri Phillips, a health economist from Swansea University, told the Committee that there would be significant benefits to a new group being established under the AWMMSG “umbrella”, including making use of its existing infrastructure, processes and clinical engagement methods.<sup>77</sup> He told the Committee:

“I think that AWMMSG has always been seen as the front door in terms of getting medicines appraised. The problem in Wales is that there have been many backdoors as well. What happens is that those backdoors can lead to inconsistency and postcode issues, whereas if it was streamlined and if everything came in through the front door, then, obviously, medicines would go in one direction and other technologies would go in another, and it would all then go back to the AWMMSG committee to make the final recommendation and then to the Minister.”<sup>78</sup>

67. Karen Samuels of the AWMMSG told the Committee that it considered the transparency and inclusivity of its appraisal process for medicines to be important, and outlined the membership of its expert panel, which included “NHS clinicians, pharmacists, academics, health economists, and both industry and patient representatives”.<sup>79</sup> In addition she referred to the need for AWMMSG to provide its advice in a timely way to “expedite access to cost-effective and clinically effective medicines for patients within NHS Wales”.<sup>80</sup>

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<sup>76</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 164], 3 April 2014

<sup>77</sup> Ibid, RoP [para 211], 5 February 2014

<sup>78</sup> Ibid, RoP [para 215], 5 February 2014

<sup>79</sup> Ibid, RoP [para 3], 22 January 2014

<sup>80</sup> Ibid, RoP [para 10], 22 January 2014

68. The Association of the British Pharmaceutical Industry (ABPI) highlighted that it is likely that multiple assessment procedures will be required for medical technologies, depending on the particular technology, but:

“critically, the principles need to be firm and consistent. So, the principles of transparency and robustness, for example, are critical on an ongoing basis. Consistency can be brought through a consistent approach to the principles, not necessarily the specific methodology involved.”<sup>81</sup>

### ***Recognising the link between medicines and medical technologies***

69. The ABPI told the Committee approximately 60 per cent of medicines currently being developed would be termed “speciality medicines”, the majority of which would benefit from associated technologies. This meant that:

“the pharmaceutical industry is heading into an area of medicines development very much aligned with the development of diagnostics and devices, so called ‘companion diagnostics’. It is a critical area for the pharmaceutical industry.”<sup>82</sup>

70. The Committee heard evidence that it was becoming more common for new medicines and new technologies to be linked (for example companion diagnostics). It heard that, as a result of these developments, there was a need for a more joined-up approach to the consideration of related medicines and technologies. The Committee heard that this was likely to become an increasingly important area, particularly in diseases such as cancer,<sup>83</sup> as genetic and genomic research progresses.<sup>84</sup>

71. Karen Samuels of the AWMSG echoed this, saying that there was “potential for significant overlap” between the AWMSG’s existing role in relation to appraising medicines, and a potential future role in also appraising medical technologies. She said that if the AWMSG did not itself assume this role, it would need to develop a close working

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<sup>81</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 180], 22 January 2014

<sup>82</sup> Ibid, RoP [para 148-9], 22 January 2014

<sup>83</sup> Ibid, RoP [para 135], 22 January 2014

<sup>84</sup> Ibid, Consultation response MT21 Genetic Alliance UK

relationship with whatever new body was established to assess medical technologies.<sup>85</sup> The ABPI agreed, saying that ideally companion devices and medicines should be:

“assessed together, in parallel, by, if not the same body, certainly bodies that had close discussions and communications with one another.”<sup>86</sup>

72. The Committee noted the increasing links between new medicines and new technologies and agreed that the appraisal and commissioning processes for medical technologies must take account of this growing area.

### **Post-adoption evaluation of new medical technologies**

73. Some respondents were concerned about whether there is adequate evaluation of the safety and efficacy of new medical technologies.<sup>87</sup> Much of the evidence that the Committee heard related to the evaluation of technologies prior to their adoption and implementation. However, the Committee also heard about the importance of post-adoption evaluation to monitor safety and assist in understanding the clinical- and cost-benefits of new technologies. Pete Phillips of the Surgical Materials Testing Laboratory provided an example:

“We have used cold steel tonsillectomy equipment for 50, 60 or whatever years. There is a new technology called coblation, which was brought on to the market about 10 years ago. Through Public Health Wales’s surveillance mechanism, Alun and people in Public Health Wales have shown that this new technology, which was the new bright hope in the firmament, has not been as safe as the traditional cold steel methods of tonsillectomy. In fact, it has caused more patient problems or safety issues.”<sup>88</sup>

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<sup>85</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 14], 22 January 2014

<sup>86</sup> Ibid, RoP [para 176], 22 January 2014

<sup>87</sup> Ibid, Consultation response MT20 NWSSP Procurement, SMTL, Mr Alun Tomkinson et al

<sup>88</sup> Ibid, RoP [para 168], 19 February 2014

74. It was noted, however, that evaluation of technologies post-adoption is rarely undertaken.<sup>89</sup> Witnesses explained that this is problematic given that the diverse and rapidly-changing nature of technologies can mean that there is frequently limited evidence available to accompany early adoption, meaning that immediate and ongoing evaluation are of particular importance.<sup>90</sup>

75. Dr Grace Carolan-Rees of the Cedar evaluation centre told the Committee that it was important that once taken, decisions should be evaluated to ensure that the expected outcomes are realised. She argued that lessons arising from such evaluations should then be used to inform future appraisals.<sup>91</sup>

76. Professor Carl Heneghan of the Centre for Evidence-based Medicine at Oxford University suggested that in some areas, post-adoption surveillance was carried out effectively, referring to the National Joint Registry and Renal Registry as examples:

“We have very well-functioning registries that come from associations, whether the Royal College of Surgeons or the British Orthopaedic Association, which tend to lead that process. They are probably the best people to lead those processes. Having them strongly in place is very helpful.”<sup>92</sup>

### **The Committee’s view**

77. In the Committee’s view, an improved, robust and transparent process of appraisal for new medical technologies on an all-Wales basis is needed. The evidence that the Committee heard suggested strongly that there could be a role for a national body, similar to the AWMSG, to be established, or for the existing remit of the AWMSG to be expanded.

78. The role, whether carried out by the AWMSG or by a new body, should:

- complement the work of NICE;

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<sup>89</sup> National Assembly for Wales, Health and Social Care Committee, Consultation response MT30 PATH (Pathways to Adoption of Technologies in Healthcare Team)

<sup>90</sup> Ibid, RoP [para 140], 20 March 2014

<sup>91</sup> Ibid, RoP [para 111], 5 February 2014

<sup>92</sup> Ibid, RoP [para 341], 6 March 2014

- include acting as a “front door” to NHS Wales for industry to engage with a clear technology submissions process;
- engage with fora in which Welsh population needs for technologies are identified, promoted and developed with researchers and manufacturers; and
- include proactive horizon scanning.

79. The Committee noted the differences between new medicines and new technologies, and was clear that any new appraisal body or process must have access to the necessary expertise, taking into account:

- the diverse nature of technologies;
- the weaker evidence base than that which exists for medicines; and
- factors such as usability, impact on care pathways and workflows, the frequent modification of devices etc.

80. The successful fulfilment of the appraisal role would not be measurable by the rate of uptake of new medical technologies, but rather by the appropriate and timely adoption of effective, evidence-based technologies that are relevant to Welsh needs. However, the Committee was of the view that more robust data about technology uptake is required to support the assessment of the appraisal process.

**Recommendation 3: The Committee recommends that the Minister for Health and Social Services, within 12 months of the publication of this report, should develop options for an all-Wales medical technologies appraisal mechanism, to undertake a similar function in respect of medical technologies as the All Wales Medicines Strategy Group (AWMSG) does for medicines.**

81. The Committee believes that, in developing an all-Wales appraisal process, consideration must be given to an appropriate notification or referral route for new technologies from manufacturers, clinicians and others, and the scope for instigating Wales-centric appraisals proactively.

82. The Committee was concerned to hear that where NICE guidance in relation to medical technologies exists, there is inconsistency in its dissemination and uptake in Wales. It welcomed the Minister’s evidence that a group had recently been established to address this

issue, and to facilitate NHS Wales' early engagement with the NICE work programme.

**Recommendation 4: The Committee recommends that the Minister for Health and Social Services should take steps to ensure that NICE guidance on medical technologies is disseminated within NHS Wales in a timely way and fully taken into account when planning and delivering services.**

**Recommendation 5: The Committee recommends that the Minister for Health and Social Services should ensure that the uptake of recommended medical technologies across Wales, including those recommended by NICE, is measured as part of a formal audit process.**

83. The Committee also noted the recommendation of the review of the appraisal of orphan and ultra-orphan medicines about the role for WHSSC in the appraisal and commissioning of these medicines. In responding to the Committee's recommendations about improvements to appraisal and commissioning arrangements for medical technologies, the Committee expects that the Minister will also consider and clarify the role of WHSSC.

## 4. Commissioning

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84. The written evidence submitted to the Committee’s inquiry suggested that decision-making processes in relation to the adoption of new medical technologies can be slow, and lacking in clarity, transparency, and consistency across Wales.<sup>93</sup> Concerns were expressed by a number of stakeholders, including Cedar and the WHSSC, that decisions to commission medical technologies are not always evidence-based.<sup>94</sup>

85. The Committee was told that technology adoption currently happens in a number of ways, but is frequently clinician-driven, which can result in the commissioning of technologies with the most vocal or persistent advocates, rather than those with the best case for adoption.<sup>95</sup> Consultation respondents were clear, however, that access to clinical expertise was an important element of the decision-making process.<sup>96</sup> In addition, the importance of recognising patients’ and carers’ perspectives in the commissioning process was emphasised by the Royal College of Radiologists, amongst others.<sup>97</sup>

86. Dr Tom Crosby of the Velindre Cancer Centre told the Committee about his experience of seeking to establish an Intensity Modulated Radiotherapy (“IMRT”) service, describing it as “chaotic”, and saying that there were three different systems for commissioning radiotherapy services, including:

- the Welsh Scientific Advisory Committee’s Clinical Oncology Sub-Committee;
- the Welsh Health Specialised Services Committee; and
- health boards’ own commissioning arrangements.<sup>98</sup>

87. He told the Committee that what clinicians wanted, in relation to technologies, was clarity about the commissioning processes to avoid

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<sup>93</sup> National Assembly for Wales, Health and Social Care Committee, Consultation responses MT13 Royal College of Radiologists, MT31 Cancer Research UK, MT29 AposTherapy

<sup>94</sup> Ibid, Consultation responses MT32 Dr S Peirce, MT33 Cedar, MT23 MediWales

<sup>95</sup> Ibid, Consultation responses MT32 Dr S Peirce, MT33 Cedar

<sup>96</sup> Ibid, Consultation response MT13 Royal College of Radiologists

<sup>97</sup> Ibid

<sup>98</sup> Ibid, RoP [para 13], 6 March 2014

having to “use a scattergun approach with every opportunity to try to drive the technology forward”.<sup>99</sup>

88. An All Wales Prioritisation Framework<sup>100</sup> was developed in 2011 for use by all Health Boards and WHSSC as a tool to aid decision-making on healthcare services, including medicines and medical technologies. The Framework recommended that a formal “prioritisation panel” be established in each Health Board/WHSSC. Cedar’s evidence paper described the work of the prioritisation panel in Cardiff and Vale UHB as a positive example of a systematic approach to decision making, but noted with regret that the panel was no longer meeting. In oral evidence on 5 February however, the witness from Cedar stated that the Cardiff and Vale panel was now meeting again.<sup>101</sup>

89. Dr Susan Peirce, a Clinical Engineer experienced in the evaluation and use of medical technologies, told the Committee that she believed that most hospitals would have examples of technologies which were rarely used, although a “greater culture of gatekeeping, scrutiny and justification in terms of acquiring technology” was developing.<sup>102</sup> Sue Evans for the Association of Directors for Social Services noted that the fast pace of change in the field of medical and assistive technologies meant that “things become out of date pretty quickly”.<sup>103</sup>

90. On 8 May 2014, the Minister highlighted the importance of “technology discard”, referring to the Health and Wellbeing Best Practice and Innovation Board’s Technology Adoption Systems Guidance, issued to health boards in 2013:

“As well as introducing new technologies, a very important part of this field is to stop using technologies that have been superseded by better things. The board’s advice was very clear to local health boards: they needed to look at what they were

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<sup>99</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 31], 6 March 2014

<sup>100</sup> NHS Wales, [All Wales Prioritisation Framework](#), December 2011 [accessed 7 November 2014]

<sup>101</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 96], 5 February 2014

<sup>102</sup> Ibid, RoP [para 146], 5 February 2014

<sup>103</sup> Ibid, RoP [para 164], 18 September 2014



already doing and to stop doing things that were no longer the most current and effective.”<sup>104</sup>

### **National versus local commissioning**

91. Professor John Watkins of the Welsh Scientific Advisory Committee told the Committee that medical technologies fall into three categories: those which contribute to testing and diagnostics; interventional technologies; and “disruptive innovations [...] that change the way that you actually do things”.<sup>105</sup> He said that the evidence-base for the benefits of such “disruptive innovations” could be less clear than for the other categories of technologies.<sup>106</sup>

92. Sally Chisholm of NICE told the Committee that technologies are:

“used in complex care pathways where technologies may provide an opportunity for patients to receive their care in a different setting, or in a different way, at a different time. That needs service redesign and it is really important that the people who are going to be using and receiving that technology are involved and are given the skills and advice to allow them to make that change so that the technology can be most successfully deployed.”<sup>107</sup>

93. The Minister highlighted the impact that the commissioning of new services can have, saying that the introduction of a new technology can require cultural change, and the reengineering of systems and patient pathways.<sup>108</sup>

94. The Committee heard examples of decentralised commissioning which had impacted negatively on the services available to patients in Wales. The Welsh Association of Gastroenterology and Endoscopy (WAGE) provided an example where a decision was taken, against the advice of experts in the field, not to centralise the South Wales endoscopic ultrasound (EUS) service:

“The proposal was discussed at one of the monthly meetings of the Health Board Chief Executives, and the conclusion was that

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<sup>104</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 89], 8 May 2014

<sup>105</sup> Ibid, RoP [para 27], 8 May 2014

<sup>106</sup> Ibid, RoP [para 71], 8 May 2014

<sup>107</sup> Ibid, RoP [para 110], 5 February 2014

<sup>108</sup> Ibid, RoP [para 104], 8 May 2014

it was up to each individual LHB to prioritise investment in this service as they saw fit. This was an unfortunate outcome, which has impeded development of a modern, cost effective EUS service in Wales, and an important opportunity for setting up a viable service with adequate volumes for training (meeting national standards) was missed.”<sup>109</sup>

95. Similarly, Fiona Jenkins of Cardiff and Vale University Health Board described the programme that was ongoing to develop a genomic strategy for Wales. She spoke about the difficulties of commissioning in partnership across health boards, universities, Public Health Wales and WHSSC, and said that if progress was not made to establish a strategy, Wales could lose its current levels of expertise.<sup>110</sup>

96. There was widespread agreement among those who responded to the Committee’s consultation that there was a need for a more strategic, coordinated approach to commissioning new medical technologies. There was support for commissioning to be carried out on an all Wales basis, either in reference to particular areas of practice, more expensive or highly specialised treatments or techniques, or for technologies more generally.<sup>111</sup> The ABPI told the Committee that a national commissioning process “avoids the fragmentation of any local decision making”.<sup>112</sup>

97. Jared Torkington, consultant surgeon representing the Royal College of Surgeons, said that at present, health boards are sometimes unwilling to commission services at a local level because:

- they do not consider there to be sufficient local demand for the service to be financially viable; and
- they do not know which other health boards might also commission the service.<sup>113</sup>

98. He explained how the relationship between a commissioning group and an appraisal group should work:

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<sup>109</sup> National Assembly for Wales, Health and Social Care Committee, Consultation response MT15 Welsh Association for Gastroenterology and Endoscopy

<sup>110</sup> Ibid, RoP [para 54], 19 February 2014

<sup>111</sup> Ibid, Consultation responses MT4 Royal College of Physicians Wales, MT5 Dr Peter Groves, MT10 Chartered Society of Physiotherapy, MT13 Royal College of Radiologists, MT14 Academy of Medical Royal Colleges in Wales

<sup>112</sup> Ibid, RoP [para 160], 22 January 2014

<sup>113</sup> Ibid, RoP [para 131], 20 March 2014

“I feel that we should have a separate commissioning group that says, ‘The appraisal group has said that we need to have an RFA<sup>114</sup> service in Wales’, and the commissioning group then decides how it is going to be commissioned. [...] it is a really good example of a service that is required in Wales and a really good example of why a new, more transparent approach to appraisal and commissioning is desperately required for new technology.”<sup>115</sup>

99. Professor Peter Barrett-Lee of Velindre NHS Trust also described the link between commissioning and a robust appraisal process:

“I think that, first of all, you would have a single body that would do the appraisal. If we all sign up, then we have to agree and abide by the result. That is the first thing. You get a clear result as to whether this is something that we should do in Wales or something that we should not do. Then, I think, there needs to be a link to the commissioning.”<sup>116</sup>

100. Dr Martin Rolles of the Royal College of Radiologists Standing Welsh Committee described how the complexity of commissioning technologies in terms of the equipment, the staff training and knowledge, and the ongoing expertise meant that it was a long process requiring a long term strategic view. He said:

“Really, we have to be thinking five and 10 years into the future, spotting trends and trying to anticipate things, because it is an ongoing process. That really requires central and strategic commissioning.”<sup>117</sup>

101. A number of witnesses described the need for a balance between national and local commissioning. Dr Peter Groves, Consultant Cardiologist at Cardiff and Vale University Health Board and vice-Chair of NICE’s Medical Technology Advisory Committee, told the Committee:

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<sup>114</sup> Radiofrequency ablation (RFA) is a rapidly developing minimally invasive treatment for certain cancers of the lung, liver and kidney. It is also useful in the treatment of certain bone tumours.

<sup>115</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 131], 20 March 2014

<sup>116</sup> Ibid, RoP [para 84], 20 March 2014

<sup>117</sup> Ibid, RoP [para 31], 20 March 2014

“there is, indeed, a place for strategic national commissioning, which should be multidisciplinary and, in my opinion, take advice from clinicians, commissioners, patients and people receiving the services. One could define a structure that allows for a multidisciplinary approach that provides a national strategic framework for this kind of exercise to work in parallel with the local implementation that is, inevitably, very important within our organisations.”<sup>118</sup>

102. The need for such a balance was expanded on by Dr Tom Crosby, who said that health boards were good at commissioning for their own populations, but not so successful at collaborating across health board boundaries to commission jointly:

“Appraisal should be on an all-Wales basis for whatever technology it is and wherever it is being used to ensure that health boards have access to that appraisal evidence that they can use to commission for their population. So, I would say that the appraisal process should be national. As to commissioning, anything that extends across a health board boundary should come into a specialist commissioning group.”<sup>119</sup>

103. With regard to the commissioning of technologies within social care, Sue Evans of the Association of Directors of Social Services warned:

“One danger of commissioning things nationally is that you end up with a storage facility with equipment that is no longer fit for purpose.”<sup>120</sup>

104. She explained that, as a consequence, local authorities commission on the following basis:

“if something is very expensive, and you want to buy it only once, you might want to commission that on a regional or even national basis. However, if it is something that you are buying on a regular basis, and it is very small, it is much easier to try

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<sup>118</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 68], 5 February 2014

<sup>119</sup> Ibid, RoP [para 68], 6 March 2014

<sup>120</sup> Ibid, RoP [para 164], 18 September 2014

to think about commissioning that on a very local basis at a local authority level.”<sup>121</sup>

105. Professor Philip Routledge, Chair of the AWMSG, agreed that the appropriate commissioning level for medical technologies might vary. He suggested that as well as the geographic issues outlined by Dr Crosby, the type and cost of the technology should be taken into account when determining the appropriate commissioning approach. He suggested that individual technologies with significant cost implications, or low cost technologies which would be required in significant volumes, could have a large budgetary impact on the health service in Wales.<sup>122</sup> He proposed that the scale of budgetary impact should be a factor in determining whether a technology should be commissioned centrally or at a more local level.<sup>123</sup>

### **Commissioning through Evaluation**

106. Some witnesses spoke favourably about NHS England’s Commissioning through Evaluation initiative, through which technologies are adopted at an early stage, but subject to immediate and ongoing evaluation. Under this initiative, if technologies do not provide the envisaged benefits, or prove more costly than predicted, adjustments can be made at an early opportunity.<sup>124</sup> Dr Peter Groves, Consultant Cardiologist at Cardiff and Vale University Health Board and vice-Chair of NICE’s Medical Technology Advisory Committee, told the Committee that he would be keen for Wales to participate in the Commissioning through Evaluation programme, noting its strength is the fact that:

“when there may be uncertainties about the evidence of the benefit of a new technology, rather than discard the potential promise, as it were, an approach adopted in England is to have a collaboration between commissioners and providers to deliver the service, but at the same time generate the evidence.”<sup>125</sup>

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<sup>121</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 163], 18 September 2014

<sup>122</sup> Ibid, RoP [para 196], 3 April 2014

<sup>123</sup> Ibid, RoP [para 196], 3 April 2014

<sup>124</sup> Ibid, RoP [para 72], 20 March 2014

<sup>125</sup> Ibid, RoP [para 84], 5 February 2014

107. Similarly, Dr Tom Crosby of the Velindre Cancer Centre told the Committee that Wales must have access to a commissioning through evaluation approach, whether as part of the Commissioning through Evaluation programme developed by NHS England, or as a separate Welsh system.<sup>126</sup>

108. The Minister advised the Committee that Wales will be involved in the Commissioning through Evaluation programme.<sup>127</sup> However, the Minister's official told the Committee that a single programme of that nature can only look at a limited number of technologies. He said that while NICE appraises five or six technologies per year, WHSSC's evidence showed that 500,000 new technologies are used by health services in Europe. He continued:

“What needs to be done, and what the developers and producers of those technologies need, is a way to get that into health settings so that they can be tested as they go along, with evaluation from clinicians and patients to see whether the technology works and how it could be improved.”<sup>128</sup>

### **Individual Patient Funding Request process**

109. Concerns were raised in the evidence received by the Committee about the operation of the Individual Patient Funding Request (IPFR) process in relation to new medical technologies.

110. Fiona Jenkins of Cardiff and Vale University Health Board told the Committee that she was a member of her health board's IPFR panel, and that she had recently attended a meeting of all Welsh IPFR panels, which had discussed the variation in processes across health boards. There had been consensus that assessing 'exceptionality' was problematic, and that the current IPFR process did not take account of “how we best use our funds on the basis of the budget that we have and the remit that we have for the health of the total population”.<sup>129</sup>

111. In its evidence paper to the Committee, WHSSC described the IPFR process as “the lowest grade and quality of appraisal process currently in Wales”. It went on to say that there was significant variation between

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<sup>126</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 93], 6 March 2014

<sup>127</sup> Ibid, RoP [para 122], 8 May 2014

<sup>128</sup> Ibid, RoP [para 125], 8 May 2014

<sup>129</sup> Ibid, RoP [para 70], 19 February 2014

the quality of appraisals undertaken by different health boards, and that “most Panels operate without robust methods of evidence appraisal”.<sup>130</sup>

112. Dr Geoffrey Carroll of WHSSC told the Committee that there could be instances where it was unclear which health board had responsibility for making decisions on a patient’s IPFR, which could result in “annoyance of patients and others”, and that there was uncertainty for clinicians about whether decisions made on one patient’s case created precedent for decisions in relation to another patient.<sup>131</sup>

113. The Minister commissioned a review of the IPFR process in October 2013 and, in April 2014, the review group concluded that the IPFR process can support rational, evidence-based decision making for medicine and non-medicine technologies which are not routinely available in Wales. It made a number of recommendations for the strengthening of the process, including enhanced transparency and inter-panel consistency.

114. The Minister told the Committee that he believed that there should be a “tipping point” at which, instead of making decisions on an individual basis, a national commissioning approach would become appropriate, saying:

“At that point, it ought to move from being an IPFR process to being a WHSSC process, where WHSSC commissions it. That is part of why the report is so clear that better alignment between AWMSG, WHSSC and IPFR is part of what needs to happen.”<sup>132</sup>

115. Since the Committee gathered its evidence on this inquiry the Minister has outlined the steps he will be taking to strengthen the IPFR process in Wales.<sup>133</sup>

### **The Committee’s view**

116. The Committee noted that there was substantial support for an all-Wales commissioning body to help ensure equitable, timely access

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<sup>130</sup> National Assembly for Wales, Health and Social Care Committee, Consultation response MT36 Welsh Health Specialised Services Committee

<sup>131</sup> Ibid, RoP [para 69], 19 February 2014

<sup>132</sup> Ibid, RoP [para 159], 8 May 2014

<sup>133</sup> Welsh Government, [Written statement: Individual Patient Funding Request \(IPFR\) Process – Next steps](#), 5 November 2014 [accessed 7 November 2014]

to treatments for patients across Wales. Nevertheless, the Committee also noted that there was a need to ensure that there is a balance between national and local commissioning, depending on the type and cost of technology being considered, and the level of need across the population. The Committee recognised the points made in evidence about the need for arrangements relating to cross-boundary commissioning – whether health-board boundaries or the Welsh-English boundary – to be given further consideration.

**Recommendation 6: The Committee recommends that the Minister for Health and Social Services should develop and establish a more strategic approach to the commissioning of new medical technologies in Wales which must be linked to a robust appraisal and evaluation process.**

**Recommendation 7: The Committee recommends that the Minister for Health and Social Services should ensure that a national approach to commissioning is adopted in cases where:**

- the budget impact of prospective medical technologies is high;**
- wider population needs need to be met;**
- services need to be commissioned across health board boundaries; and/or**
- there is potential to commission treatment from elsewhere in the UK.**

117. The Committee noted the positive regard in which NHS England's Commissioning through Evaluation programme was held by witnesses, and welcomed the Minister's evidence that Wales will be involved. However, in isolation the Commissioning through Evaluation initiative will not be sufficient. The Committee would seek further details as to how the Minister will develop this approach to technology adoption in Wales.

**Recommendation 8: The Committee recommends that the Minister for Health and Social Services should provide details of the actions he will take to further develop the approach to medical technology adoption in Wales. This should include an indication of how the Commissioning through Evaluation project in England, and other options for evaluation, will be explored and adapted to fit the Welsh context.**



## 5. Early engagement with stakeholders

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118. The importance of ensuring that all relevant stakeholders are involved in the process of appraising, commissioning and evaluating medical technologies was a key theme in this inquiry. Written and oral evidence emphasised the important role clinicians, industry and research partners, and patients have to play in all aspects of the process of adopting medical technologies.

### **Role of clinicians and practitioners**

119. Clinicians and practitioners play a central role in technology adoption, including in the identification of clinical need, horizon scanning for relevant technology, appraisal, service planning and implementation.

120. While there was consensus about the importance of clinical and practitioner involvement in the evaluation of new technologies, views were expressed that clinicians should not have sole responsibility for evaluating technologies, as they may lack some of the skills, time and whole-system view needed to carry out thorough assessments.<sup>134</sup>

121. The Committee also heard that the ability to access effective new treatment is felt to be an important factor in the recruitment and retention of high-calibre staff, and that a lack of availability of leading-edge technology could disadvantage Wales in competing with the other UK nations to recruit the best workforce.<sup>135</sup>

122. Dr Peter Groves, Consultant Cardiologist at Cardiff and Vale University Health Board and Vice-Chair of NICE's Medical Technology Advisory Committee, told the Committee:

“Clinicians would be reassured in their working environment if they knew that processes were in place that would provide them with the opportunity of implementing new technologies within their speciality, within their working environment. That is something that would be an incentive and would absolutely

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<sup>134</sup> National Assembly for Wales, Health and Social Care Committee, Consultation response MT32 Dr S Peirce

<sup>135</sup> Ibid, Consultation response MT13 Royal College of Radiologists

help with recruitment of specialists to come to work or at least to stay in Wales.”<sup>136</sup>

123. Professor Peter Barrett-Lee echoed this, saying that specialists want to work in centres of excellence within their fields, and that:

“If you are not on that map, then there is a struggle, because we are in competition, not just with ourselves in Wales, but with everybody else, even with those in Europe. So it is about retention of staff, but also encouraging staff to come to work.”<sup>137</sup>

124. The Committee was given an example of the benefits to SMEs of engaging with clinicians at an early stage in the development of their technologies. Professor Ceri Phillips said that he had recently been involved in the evaluation of single-use surgical equipment for tonsillectomies which an SME intended to produce. Clinicians raised concerns about the minor variations in single-use instruments, and the risks of contamination of not using single-use instruments were deemed, in the light of advances in cleaning techniques, to be so slight that the use of single-use instruments was not cost-effective. The SME was able to receive advice, therefore, that there was unlikely to be a market for the products early in its development process.<sup>138</sup>

125. Other witnesses considered that there was a need to promote greater engagement with medical technologies amongst General Practitioners. Dr Pushpinder Mangat of Abertawe Bro Morgannwg University Health Board told the Committee that securing clinical engagement among GPs and hospital consultants could be challenging, and that his health board was establishing networks to encourage dissemination of enthusiasm for – and innovation in – the use of medical technologies.<sup>139</sup> While some representatives from general practice noted that no formal forum has existed historically within which primary care can discuss and set priorities for the use of technologies,<sup>140</sup> it was emphasised by others that the newly established

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<sup>136</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 105], 5 February 2014

<sup>137</sup> Ibid, RoP [para 38], 20 March 2014

<sup>138</sup> Ibid, RoP [para 250], 5 February 2014

<sup>139</sup> Ibid, RoP [para 138], 19 February 2014

<sup>140</sup> Ibid, RoP [para 105], 18 September 2014

GP clusters could play an important role in enabling those discussions to take place.<sup>141</sup>

126. In contrast, social care representatives referred to the Assisted Technology Learning and Improvement Network that exists within the sector to share best practice and learning:

“What we have found within the Social Services Improvement Agency is that bringing people together who have a vested interest and a skill set around particular themes can be very useful to take forward agendas. [...] we have brought back what is called the assisted technology learning and improvement network. It is about the key people who work within health and local authorities who work in that field, and trying to pull people together, because what we find is that there is some excellent learning that could be shared by bringing people together. It is also about trying to look at how we can find consistent approaches. By bringing people together, you get an understanding of what the picture is for Wales.”<sup>142</sup>

127. AWMMSG told the Committee that clinicians were represented in its appraisal and decision making processes and it drew on information from clinical networks about emerging medicines to identify the level of clinical interest and inform its work. It said that it would be beneficial for clinicians’ views to be captured in the appraisal of medical technologies, but that there would be challenges in ensuring that manufacturers were aware of the benefits of engaging early with clinicians, appraisers and the NHS.<sup>143</sup>

128. Evidence received by the Committee was clear that the introduction of new technologies must be accompanied by training programmes to ensure that those delivering services have the necessary expertise and optimal use is made of the technology.<sup>144</sup> The Committee heard that there are examples of good practice, such as the Welsh laparoscopic colorectal training scheme which has resulted in an uptake of laparoscopic colorectal surgery in Wales that is

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<sup>141</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 106], 18 September 2014

<sup>142</sup> Ibid, RoP [para 168], 18 September 2014

<sup>143</sup> Ibid, RoP [para 117-21], 22 January 2014

<sup>144</sup> Ibid, RoP [para 57], 8 May 2014

comparable to anywhere else in the world.<sup>145</sup> Torfaen’s medication administration scheme was also cited as an exemplar:

“A GP will prescribe the drug treatment, the pharmacist will advise on a piece of kit that may be useful, the social worker does the assessment, to see whether that individual has the capability or the functional ability to manage that piece of equipment, and the care worker delivering the service is then trained in using that.”<sup>146</sup>

### ***The Committee’s view***

129. The Committee noted the importance of access to new and effective medical technologies in the recruitment and retention of high quality staff, and of training in the use of new technologies to support the development and delivery of effective services.

**Recommendation 9: The Committee recommends that the Minister for Health and Social Services should give consideration to putting mechanisms in place to maximise the benefits of new medical technologies for patients across Wales by ensuring that NHS staff are able to access appropriate training.**

### **Industry and research partners**

130. Respondents to the Committee’s consultation highlighted the need to change the relationship between the NHS and its technology suppliers, and described a lack of clarity about NHS structures and how industry should engage.<sup>147</sup>

131. Dr Tom Crosby of the Velindre Cancer Centre described the difference between the pharmaceutical and medical technologies spheres, saying:

“If clinicians did nothing, the pharmaceutical industry would ensure that its drugs were reviewed in a timely way, and that it had partnerships with appraisers to have patient access

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<sup>145</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 144], 20 March 2014

<sup>146</sup> Ibid, RoP [para 117-21], 22 January 2014

<sup>147</sup> Ibid, Consultation response MT20, NWSSP Procurement, SMTL, Mr Alun Tomkinson et al

schemes. We do not always have that in the technology industry.”<sup>148</sup>

132. This was echoed by Gwyn Tudor of MediWales, who told the Committee that the Association of British Healthcare Industries, which he said regards itself as a lobbying organisation on behalf of the health technology sector, lacked:

“the budget to be as ever-present in all areas as the pharmaceutical industry, and I do not think that it has the same objectives. The development of a medical device is more collaborative and needs based.”<sup>149</sup>

133. Fiona Jenkins of Cardiff and Vale University Health Board said:

“the development and greater use of technologies has to be driven by the needs of the patient and from the clinical base, but we would be foolish to think that industry is not a partner in this. If, by working with industry, we could collaborate better, we would be able to advance the implementation of technologies better. However, it has to be driven by the needs of the patient, with industry as a partner, but not necessarily an equal partner in that respect.”<sup>150</sup>

134. Evidence to the Committee’s inquiry suggested that industry needs to understand better how to engage with NHS Wales at different stages if medical technologies are to be developed and implemented appropriately. This includes awareness of NHS needs, and how to feed products or prototypes into an NHS Wales appraisal system. MediWales told the Committee that industry had no clarity about the “front door” through which they were able to engage with the NHS Wales.<sup>151</sup>

Professor Carl Heneghan of the Centre for Evidence-based Medicine at Oxford University said that most SMEs:

“do not have the skills to develop the evidence, they do not have the academic ability or the cost basis to bring that academic infrastructure, to say what studies they should do and what they should look like. So, what you are really trying to

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<sup>148</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 47], 6 March 2014

<sup>149</sup> Ibid, RoP [para 203-4], 6 March 2014

<sup>150</sup> Ibid, RoP [para 83], 19 February 2014

<sup>151</sup> Ibid, RoP [para 224], 6 March 2014

do is combine two things: academic credibility and evidence bases with companies trying to build effective technologies.”<sup>152</sup>

135. It was also noted that more needs to be done to encourage new entrants to the market in order to increase innovation. The Committee heard that a tendency to retender for products based on existing specifications or historical requirements can restrict the adoption of innovation at a local level.<sup>153</sup>

136. The evidence received suggested that the NHS most commonly interacts with industry at the procurement stage, rather than evaluation, and that the focus tends to be on short term costs rather than the efficacy and longer term benefits of technologies.<sup>154</sup>

MediWales referred to work it had been commissioned to undertake by the National Institute for Social Care and Health Research (NISCHR), during the course of which it had found that the development and adoption of medical technologies in Wales could be improved through access to clinical expertise at a number of stages, one of which was a formal process for the timely evaluation of new technologies as they are brought to market. However, while MediWales felt that many of its recommendations had been well received, there had been limited progress because there was a lack of a clearly identified lead organisation or department.<sup>155</sup>

137. Dr Geoffrey Carroll of WHSSC told the Committee that NICE’s specialised technologies appraisal programme involves the manufacturers of medical technologies to a greater degree than the equivalent AWMSG process. He told the Committee that commercial companies under the NICE programme are very much a “participant at the table”, asked to summarise and discuss medical evidence, research evidence, and the basis on which patients might be treated.<sup>156</sup> He contrasted this with the AWMSG process in which commercial companies may be asked to answer some questions, but do not play as prominent a role in discussions.

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<sup>152</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 294], 6 March 2014

<sup>153</sup> Ibid, Consultation response MT23 MediWales

<sup>154</sup> Ibid, Consultation response MT36 Welsh Health Specialised Services Committee

<sup>155</sup> Ibid, Consultation response, MT23 MediWales

<sup>156</sup> Ibid, RoP [para 82], 19 February 2014

138. The Committee heard that there are few medical technology clinical trials conducted in Wales,<sup>157</sup> but that there is good practice in terms of models of academic health science centres and networks which could improve the integration between academia, industry and the NHS to develop trials of needed technologies.<sup>158</sup> Examples of good practice of engagement between the NHS and the medical technology industry were given, such as the Wales Cancer Bank which allows researchers and manufacturers to access patient samples for testing in a controlled and structured way. It was suggested that this model could be applied to other diseases.<sup>159</sup>

139. Both the South East Wales Academic Health Science Partnership and the West of England Academic Health Science Network provided evidence which highlighted the benefits of such networks in facilitating closer working between the NHS, academia and industry, and improving access to expertise. Dr Corinne Squire of the South East Wales Academic Health Science Partnership said that one of its roles was to make connections with local companies to identify ways for them to engage in clinical trials.<sup>160</sup> However, MediWales, in its written evidence, noted:

“while working closely with industry and academia improves awareness of technological advancements, this spirit of collaboration is not an alternative for a systemic, impartial process of horizon scanning and evaluation.”<sup>161</sup>

140. The recently established Health Research Wales – a publicly-funded body created to facilitate the successful delivery of commercial research in the NHS – was praised by some witnesses as a useful one-stop source of information and support for companies wishing to undertake clinical research in Wales.<sup>162</sup> Gwyn Tudor of MediWales said that manufacturers welcomed the opportunity to “speak to the Welsh NHS as a whole” which Health Research Wales made possible in relation to clinical trials.<sup>163</sup>

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<sup>157</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 79], 20 March 2014

<sup>158</sup> Ibid, RoP [para 193], 5 February 2014

<sup>159</sup> Ibid, Consultation response MT16 Dr Molly Price-Jones (Tybio Ltd)

<sup>160</sup> Ibid, RoP [para 289], 6 March 2014

<sup>161</sup> Ibid, Consultation response MT23 MediWales

<sup>162</sup> Ibid, Consultation response MT37 Welsh NHS Confederation

<sup>163</sup> Ibid, RoP [para 215], 6 March 2014

141. The Minister described the priority and investment given to life sciences as an economic development sector, including for example a life sciences hub, opened in July 2014, with an aim of acting as a “front door” to the health system and the life sciences sector in Wales.<sup>164</sup>

### *The Committee’s view*

142. The Committee recognised the Welsh Government’s investment in and development of the life sciences sector in Wales. The recent establishment of Health Research Wales, and the academic health science network was also welcomed. The Committee believed that this work would facilitate the engagement of industry, academic and NHS partners, and has an important role in the development of clinical trials of technologies that are relevant to Welsh needs. Furthermore, the Committee recognised the important role clinical trials have to play in attracting and retaining high quality clinicians and academics to Wales. The Committee concluded that more could be done to further develop needs-led research and development in Wales.

**Recommendation 10: The Committee recommends that the Minister for Health and Social Services should outline the steps he will take to facilitate the further development of clinical trials and needs-led research and development in Wales including how this will relate to the medical technology assessment/appraisal process.**

### **Involvement of patients**

143. The Committee also heard evidence about the importance of including patients’ perspectives in the evaluation and adoption of technologies, as they, and/or their family members, will be best placed to “value the real-life impact of early diagnosis and subsequent planning for services that can be realised as a result of the timely uptake of new medical technologies”.<sup>165</sup>

144. Bernadette McCarthy of the Velindre Cancer Centre told the Committee that there was not enough involvement of patients in the development and assessment of medical technologies, but recognised

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<sup>164</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 132], 8 May 2014

<sup>165</sup> Ibid, Consultation response MT21 Genetic Alliance UK



it could be difficult to engage people in such a complex area.<sup>166</sup> Emma Greenwood of Cancer Research UK said that patients were interested in being involved in decision-making around the funding of technologies and trials, but the lack of a clear or systematic process for assessing medical technologies made it difficult to identify the appropriate stage for them to do so.<sup>167</sup>

145. The Committee heard oral evidence of good practice in relation to patient involvement in the appraisal, commissioning and evaluation of services. The AWMSG's patient and public involvement group, which feeds information about patient interest in new medicines into its appraisal process, was cited as a possible model for medical technologies to follow.<sup>168</sup> Deborah Evans of the West of England Academic Partnership also referred to work underway by "health integration teams" in England to build in the views of service-users, carers and the public when commissioning services.<sup>169</sup> She explained that these are:

"teams of researchers working with people who commission services and the providers of services. So, the idea of them working together is that you get more relevant research, because it is informed by perspectives about service provision [...] all of those groups that are supported have a criterion that they must have patient and public involvement at the heart of the group. So, it is not just informed by the researchers and the service providers; the whole thing is informed by the service-user perspective. They also have local authority involvement, so that you bridge into the social care and wider aspects. That is a really powerful model."<sup>170</sup>

146. Evidence received from Cwm Taf University Health Board and reiterated by the Welsh NHS Confederation suggested that "patient-led" device development should be adopted. Both the Health Board and the Confederation noted that developing devices that patients consider would be helpful to them, their condition and quality of life at the "idea" stage would be preferable to "NHS professionals and academics

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<sup>166</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 22], 6 March 2014

<sup>167</sup> Ibid, RoP [para 24], 6 March 2014

<sup>168</sup> Ibid, RoP [para 194], 3 April 2014

<sup>169</sup> Ibid, RoP [para 305], 6 March 2014

<sup>170</sup> Ibid, RoP [paras 305-306], 6 March 2014

assuming the position on making the decisions and developing devices on their behalf".<sup>171</sup>

147. The Chartered Society of Physiotherapy's written evidence noted that "often some of the best ideas and innovations come from the clinicians working closely with their patients and devising a solution with them".<sup>172</sup> Furthermore, Professor Colin Gibson, representing the Institute of Physics and Engineering in Medicine, noted that engaging with stakeholders, including patients, was:

"critical to acceptance and rapid adoption, because, often, the devil is in the detail. Local implementation of new technologies [...] can be hampered, if you like, not because there is not good evidence or there is not an awful lot of will to make these things work, but because the devil is in the detail. Particularly when you have to consider the impact on patients and on patient pathways, it is not just right, but actually much more effective to engage with all stakeholders, particularly the users of technology and patients in particular."<sup>173</sup>

### ***The Committee's view***

148. It is clear from the evidence received by the Committee that to overlook the views of patients in the process of appraising and evaluating medical technologies is to pave the way for their likely failure. The Committee noted the importance of user acceptance for the adoption of medical and assistive technologies, and recognised that, in many cases, the user will be a patient or carer rather than a clinician or practitioner.

**Recommendation 11: The Committee recommends that the Minister for Health and Social Services should ensure that models of appropriate patient and carer representation are considered and put in place in medical and assistive technology research and development, appraisal, and evaluation.**

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<sup>171</sup> National Assembly for Wales, Health and Social Care Committee, Consultation responses MT1 Cwm Taf University Health Board, MT37 Welsh NHS Confederation

<sup>172</sup> Ibid, Consultation response MT10 Chartered Society of Physiotherapy

<sup>173</sup> Ibid, RoP [para 125], 5 February 2014

## 6. Financial barriers to adoption

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### Short- and long-term perspectives

149. The Committee heard from witnesses that organisational and budgetary silos (both within and between organisations) can impact on the introduction of new treatments and techniques.<sup>174</sup> It was also noted that a short-term perspective in the procurement of – and investment in – medical technologies also has a detrimental effect.<sup>175</sup>

150. Professor Colin Gibson of the Institute of Physics and Engineering in Medicine told the Committee that he thought that:

“there is a tendency in healthcare to think in terms of silo budgets. So, I may invest in this area, but the financial benefits are seen in another. That in itself is an impediment to that investment because we are all very conscious of the lack of resources available.”<sup>176</sup>

151. This view was echoed by the Association of British Healthcare Industries, which emphasised the need to break down silos, but said that this required “greater collaboration across all parts of the NHS and across care settings”.<sup>177</sup> Professor Stephen Keevil of the Institute of Physics and Engineering in Medicine said that there needed to be recognition of the non-budgetary benefits of technologies as well, such as quality or length of life for patients.<sup>178</sup>

152. Charlotte Moar, Director of Finance for Cardiff and Vale University Health Board, noted that despite the benefits of new technologies being well known, the current financial climate means that it is difficult to prioritise health board resources in their direction.<sup>179</sup> She noted that although an invest to save approach for medical technologies may be beneficial, “the reality is that the pressures to invest things into issues

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<sup>174</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 147], 5 February 2014

<sup>175</sup> Ibid, RoP [para 218], 19 February 2014

<sup>176</sup> Ibid, RoP [para 134], 5 February 2014

<sup>177</sup> Ibid, Consultation response MT12 Association of British Healthcare Industries

<sup>178</sup> Ibid, RoP [para 135], 5 February 2014

<sup>179</sup> Ibid, RoP [para 7], 18 September 2014

that need to be solved now is very great, so there is always a push for the short term rather than the long term”.<sup>180</sup>

153. Witnesses also told the Committee that there can be a disconnect between capital spending, for example the purchase of a new machine, and revenue funding, for example to meet related staffing costs.<sup>181</sup> The Genetic Alliance UK told the Committee that this can impact on the development and sustainability of services.<sup>182</sup> This point was also emphasised by those representing primary care.<sup>183</sup>

154. Sally Chisholm of NICE commented that the need to make short-term financial savings can prevent the fruition of the longer-term benefits investments in medical technologies can bring. She said:

“With regard to cost-effectiveness, for example, or cost-benefit [...], it can often take a long time for those benefits to be realised. In many places, unfortunately, the constraints of finances mean that decisions are made not to adopt technologies that might offer benefits because of the requirement to balance budgets in the short term.”<sup>184</sup>

155. To address this issue, she said that when making decisions in relation to commissioning technologies, decision makers need to take into account who will benefit and how the technology will be used, and to take a long-term view of the potential benefits.<sup>185</sup> Mark Roscrow of the NHS Wales Shared Services Partnership told the Committee that the challenge was to recognise the opportunities for spend in the short term to bring about savings in the longer term, but that “the way that we sometimes do our financial budgeting does not support that kind of thinking”.<sup>186</sup>

156. Fiona Jenkins of Cardiff and Vale University Health Board said that there were mechanisms in place within her health board to make decisions about medical technologies, and to ensure that the appropriate systems and infrastructure was in place to support the deployment of technologies. She said that as health boards were

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<sup>180</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 11], 18 September 2014

<sup>181</sup> Ibid, RoP [para 91], 6 March 2014

<sup>182</sup> Ibid, RoP [para 133], 6 March 2014

<sup>183</sup> Ibid, MT A117 – BMA Cymru Wales, September 2014

<sup>184</sup> Ibid, RoP [para 25], 5 February 2014

<sup>185</sup> Ibid, RoP [para 25], 5 February 2014

<sup>186</sup> Ibid, RoP [para 218], 19 February 2014

funded on a one-health-board basis, it was more difficult to respond to technologies which would be of benefit across different health board areas.<sup>187</sup>

### **Innovative approaches to funding services**

157. The Chartered Society of Physiotherapy told the Committee that local authorities and health boards were collaborating and pooling budgets for community equipment services in Wales, which was enabling improved commissioning, stock management and patient access.<sup>188</sup>

158. The final report of the Health and Well-being Best Practice and Innovation Board recommended that the Welsh Government should consider:

“the incentives that would explore the potential to implement pathway based resourcing across general NHS budgets, initially tested via a prototype model working with, and advised by, NHS Wales Shared Services Partnership. Incentives that operate across sectoral boundaries – such as formal pooled budget arrangements – also need to be reinforced and encouraged in order to ensure partners make the best use of resources and develop robust and sustainable models of care and support.”<sup>189</sup>

159. Dr Susan Peirce, a Clinical Engineer experienced in the evaluation and use of medical technologies, told the Committee that health boards were finding innovative ways to fund new technologies, such as charitable funds, managed services and accessing free capital equipment through spending more on consumables. However she did not think that this was necessarily desirable, as simply accessing additional funds did not necessarily address the underlying issue of silo budgeting.<sup>190</sup>

160. Professor David Cohen, a retired Professor of Health Economics at the University of South Wales, told the Committee that decisions are currently taken on the basis of cost-effectiveness, but that a new

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<sup>187</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 29], 19 February 2014

<sup>188</sup> Ibid, Consultation response MT10 Chartered Society of Physiotherapy

<sup>189</sup> Health and Wellbeing Best Practice and Innovation Board, [Final Report](#), January 2014 [accessed 7 November 2014]

<sup>190</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 147], 5 February 2014

model, “value-based assessment” was being explored. This model takes account of broader benefits, such as people getting back to work, rather than just financial benefits to the NHS or social services.<sup>191</sup>

161. Mark Roscrow of the NHS Wales Shared Services Partnership told the Committee that clinicians were not always aware of alternative technologies which could be more cost-effective than those currently used. He cited the example of the National Joint Registry, which could be used to assist orthopaedic surgeons in taking value for money as well as clinical effectiveness into account when making decisions about particular knees to use.<sup>192</sup>

162. Alun Tomkinson, a surgeon from Cardiff and Vale University Health Board, told the Committee that greater engagement with industry could also assist in addressing financial barriers, as increased understanding by manufacturers of the comparative clinical benefits of different products could assist in negotiating prices for particular technologies or products.<sup>193</sup>

163. Professor Lars Sundstrom of the South West England Academic Health Partnership suggested that budgetary pressures could be alleviated by partnership working with the private sector, and co-creation with business.<sup>194</sup>

### **Health Technologies Fund and the Health Technology and Telehealth Fund**

164. Fiona Jenkins of Cardiff and Vale University Health Board told the Committee that her health board based its decisions on how technologies could improve patient care, while considering how technologies might evolve and be used to the benefit of the population. She said that the Health Technologies Fund assisted her health board in this, saying:

“We see this is a resource that we can access to help drive forward the use of technology. If the health technology fund was not there, I think that we would struggle to find capital to develop some of the emerging technologies. However, some of the constraints with the health technology fund are that it is

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<sup>191</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 207], 5 February 2014

<sup>192</sup> Ibid, RoP [para 214-6], 19 February 2014

<sup>193</sup> Ibid, RoP [para 217], 19 February 2014

<sup>194</sup> Ibid, RoP [para 314], 6 March 2014

just capital and we are still constrained with the resource implications of getting some new technologies in, because it is not just capital.”<sup>195</sup>

165. Representatives of general practice noted that there is no specific pot of money for individual practices to use to invest in technologies; rather, practices have to invest their own money (in equipment and staff resource) in order to use technology. This was described as a “stumbling block” for the adoption of technologies by primary care.<sup>196</sup> It was also cited as a possible source of resentment among GPs who may feel that services previously provided in secondary care are being transferred to primary care without the necessary funding following hand in hand with the new responsibility.<sup>197</sup>

166. Representatives of social care emphasised the positive influence of a specific allocation of funding for assistive technologies some years ago:

“What was useful a few years ago was that the Welsh Government came up with a particular fund for technology and that enabled us to pump prime and test new things out that we had not tried before [...] those sorts of initiatives, if moneys like that become available, really give you an impetus to take a bit more of a risk, possibly, because budgets are so very tight.”<sup>198</sup>

167. The Minister highlighted some of the projects which were being supported through the Health Technologies Fund.<sup>199</sup> Witnesses welcomed the fund as an opportunity to access capital funding for new technologies, but did express concerns about the sustainability of the funding, and the need for a closer alignment between capital and revenue funding to allow new services to be properly established and developed.<sup>200</sup> The Minister told the Committee that a successor fund, the Health Technology and Telehealth Fund had been established in 2014 to invest at least £9.5million in new technology in non-hospital

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<sup>195</sup> National Assembly for Wales, Health and Social Care Committee, RoP [para 28], 19 February 2014

<sup>196</sup> Ibid, RoP [para 152], 18 September 2014

<sup>197</sup> Ibid, RoP [para 15], 18 September 2014

<sup>198</sup> Ibid, RoP [para 165], 18 September 2014

<sup>199</sup> Ibid, HSC(4)-13-14 Paper 3 Evidence from the Welsh Government, December 2013

<sup>200</sup> Ibid, Consultation response MT31 Cancer Research UK

settings, with a focus on supporting the use of digital and telehealth technologies and allowing more scope for innovation.<sup>201</sup>

### **National Health Service Finance (Wales) Act 2014**

168. The NHS Finance (Wales) Act 2014 became law in Wales in January 2014, and places a new legal financial duty on health boards to break even over a rolling three year financial period. The stated intention of this legislation is to allow for better decision making and implementation of optimal solutions in health boards, and remove the incentive for short-term decision making within the previous regime.

169. Mark Roscrow of the NHS Wales Shared Services Partnership told the Committee that he anticipated that the move to three year financial planning would assist in the procurement of medical technologies, but that it would not, in itself, be sufficient.<sup>202</sup>

### **The Committee's view**

170. The Committee noted that organisational and budgetary silos, together with a short-term perspective in relation to investment in new medical technologies, can impact on the introduction of new treatments and techniques. The Committee recognised the evidence that it had heard about the role of the Welsh Government's Health Technologies Fund and Health Technologies and Telehealth Fund in facilitating access to capital funding for new technologies, but was concerned to hear that there are doubts about the sustainability of such funding. It was also concerned to hear about the disconnect between capital and revenue funding, and the impact that this can have on the development and sustainability of services.

**Recommendation 12: The Committee recommends that the Minister for Health and Social Services should set out the actions that he will take, and associated timescales, to ensure that NHS Wales's financial structures and budgetary processes can effectively support appropriate medical technology adoption. This should include reference to longer-term planning and ensuring closer alignment between capital and revenue funding.**

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<sup>201</sup> National Assembly for Wales, Health and Social Care Committee, HSC(4)-13-14 Paper 3 Evidence from the Welsh Government, December 2013

<sup>202</sup> Ibid, RoP [para 220], 19 February 2014



171. The Committee noted the evidence it had received in relation to the benefits which could accrue from collaborative working and pooled budgetary arrangements.

**Recommendation 13: The Committee recommends that the Minister for Health and Social Services should work with local authorities and health boards to share good practice and to explore the development of a funding model based on the patient pathway.**

## Annex A - Witnesses

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The following witnesses provided oral evidence to the Committee on the dates noted below. [Transcripts of all oral evidence sessions](#) can be viewed on the Committee's website.

### 22 January 2014

Karen Samuels	All Wales Medicines Strategy Group
Joanne Ferris	Association of the British Pharmaceutical Industry
Dr Richard Greville	Association of the British Pharmaceutical Industry

### 5 February 2014

Dr Grace Carolan-Rees	Cedar
Sally Chisholm	National Institute for Health and Care Excellence
Dr Peter Groves	Consultant Cardiologist at Cardiff and Vale University Health Board and vice-Chair of NICE's Medical Technology Advisory Committee
Dr Susan Peirce	Clinical Scientist
Professor Colin Gibson	Institute of Physics and Engineering in Medicine
Professor Stephen Keevil	Institute of Physics and Engineering in Medicine
Professor David Cohen	Retired Professor of Health Economics at the University of South Wales
Professor Ceri Phillips	Swansea University

### 19 February 2014

Pushpinder Mangat	Abertawe Bro Morgannwg University Health Board
Fiona Jenkins	Cardiff and Vale University Health Board
Dr Geoffrey Carrol	Welsh Health Specialised Services Committee
Dr Phil Webb	Welsh Health Specialised Services Committee
Alun Tomkinson	Cardiff and Vale University Health Board
Mark Roscrow	NHS Wales Shared Services Partnership
Pete Phillips	Surgical Materials Testing Laboratory

**6 March 2014**

Clare Bath	Cancer Research UK
Emma Greenwood	Cancer Research UK
Dr Tom Crosby	Velindre Cancer Centre and the South Wales Cancer Network
Bernadette McCarthy	Velindre Cancer Centre
Buddug Cope	Genetic Alliance UK
Emma Hughes	Genetic Alliance UK
Hayley Norris	Genetic Alliance UK
Gwyn Tudor	MediWales
Dr Corinne Squire	South East Wales Academic Health Science Partnership
Deborah Evans	West of England Academic Health Science Network
Lars Sundstrom	West of England Academic Health Science Network

**20 March 2014**

Dr Richard Clements	Royal College of Radiologists Standing Welsh Committee
Dr Martin Rolles	Royal College of Radiologists Standing Welsh Committee
Professor Peter Barrett-Lee	Velindre NHS Trust
Dr Alan Rees	Royal College of Physicians
Jared Torkington	Royal College of Surgeons
Dr Miles Allison	Welsh Association for Gastroenterology and Endoscopy
Dr Nazia Hussain	Royal College of General Practitioners Wales

**3 April 2014**

Professor Phil Routledge	All Wales Medicines Strategy Group
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**8 May 2014**

Professor Huw Griffiths	Welsh Scientific Advisory Committee
Professor John Watkins	Welsh Scientific Advisory Committee
Mark Drakeford AM	Minister for Health and Social Services
Ifan Evans	Welsh Government
Christine Morrell	Acting Chief Scientific Adviser (Health)

**18 September 2014**

Dr Anna Kuczynska	GP Locality Director, Cardiff and Vale University Health Board
Charlotte Moar	Director of Finance, Cardiff and Vale University Health Board
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
Sue Evans	Association of Directors of Social Services (ADSS) Cymru
Andrew Bell	Social Services Improvement Agency

## **Annex B - Written evidence**

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The following people and organisations provided written evidence to the Committee between July and October 2013. All [consultation responses](#) can be viewed in full on the Committee's website.

<b>Organisation</b>	<b>Reference</b>
Cwm Taf University Health Board	MT 1
College of Occupational Therapists	MT 2
Royal College of Anaesthetists Advisory Board in Wales / NSAG Anaesthesia	MT 3
Royal College of Physicians (Wales)	MT 4
Dr Peter Groves, Consultant Cardiologist, Cardiff and Vale UHB	MT 5
Royal College of General Practitioners	MT 6
Dr P Connor, Consultant Paediatric Haematologist, Children's Hospital for Wales & Dr J Kell, Consultant Adult Haematologist, Clinical Director of Haematology and Clinical Immunology, University Hospital of Wales	MT 7
Royal College of Nursing	MT 8
Association of Coloproctology of Great Britain & Ireland	MT 9
Chartered Society of Physiotherapy	MT 10
NICE	MT 11
Association of British Healthcare Industries (ABHI)	MT 12
The Royal College of Radiologists Standing Welsh Committee	MT 13
Academy of Medical Royal Colleges in Wales	MT 14
Welsh Association for Gastroenterology and Endoscopy (WAGE)	MT 15
Dr Molly Price-Jones (Tybio Ltd)	MT 16
All Wales Medical Genetic Laboratory	MT 17
Time for Medicine Limited	MT 18
Institute of Physics and Engineering in Medicine (IPEM)	MT 19

NWSSP Procurement, SMTL, Mr Alun Tomkinson	MT 20
Genetic Alliance UK	MT 21
Dr Rebecca Dimond	MT 22
Professor Alison Bullock	
Dr Mark Stacey	
MediWales	MT 23
Westgate Cyber Security Ltd	MT 24
Urology Trade Association	MT 25
Coloplast	MT 26
Genomic Health	MT 27
BMA Cymru Wales	MT 28
Apos Therapy	MT 29
PATH (Pathways to Adoption of Technologies in Healthcare) team	MT 30
Cancer Research UK	MT 31
Dr S Peirce	MT 32
Cedar	MT 33
Prostate Cancer UK	MT 34
Public Health Wales	MT 35
Welsh Health Specialised Services Committee (WHSSC)	MT 36
Welsh NHS Confederation	MT 37
All Wales Medicines Strategy Group	MT 38
ABPI Cymru	MT 39
Welsh Government	MT 40
Cross Party Group on Cancer	MT 41
Professor David Cohen	MT 42
Professor Ceri Phillips	MT 43
South East Wales Academic Health Science Partnership	MT 44
West of England Academic Health Science Network	MT 45
Professor Carl Heneghan	MT 46
Royal College of Surgeons	MT 47

Cardiff and Vale University Health Board	MT 48
Royal College of General Practitioners Wales	MT 49
Welsh NHS Confederation	MT 50
Social Services Improvement Agency	MT 51
ADSS Cymru	MT 52
BMA Cymru Wales	MT 53

Additional written information was received from the following organisations

<b>Organisation</b>	<b>Reference</b>
All Wales Medicines Strategy Group	MT A11
Welsh Health Specialised Services Committee (WHSSC)	MT A12
Cancer Research UK	MT A13
Genetic Alliance UK	MT A14
West of England Academic Health Science Network	MT A15
Royal College of General Practitioners	MT A16
BMA Cymru Wales	MT A17
ADSS Cymru	MT A18

The following organisations responded to the Committee’s [consultation on the scope of the inquiry](#) (conducted August – October 2012)

<b>Organisation</b>	<b>Reference</b>
Academy of Royal Colleges in Wales	MT ToR 1
Phil Fairclough	MT ToR 2
Dr Martyn Read	MT ToR 3
Declan O’Doherty	MT ToR 4
Royal College of Anaesthetists	MT ToR 5
Welsh Association for Gastroenterology and Endoscopy (WAGE)	MT ToR 6
Mr Simon Holt	MT ToR 7
Dr Peter Groves	MT ToR 8
Royal College of General Practitioners Wales	MT ToR 9
Mr Mark Poulden	MT ToR 10
JDRF - Juvenile Diabetes Research Foundation	MT ToR 11
APBI Wales	MT ToR 12
Chartered Society of Physiotherapy	MT ToR 13
Cwm Taf University Health Board	MT ToR 14
Welsh Health Specialised Services Committee (WHSSC)	MT ToR 15
Pete Phillips, June Scott, Alun Tomkinson	MT ToR 16
Institute of Physics and Engineering in Medicine (IPEM)	MT ToR 17
The Society & College of Radiographers	MT ToR 18
Welsh Intensive Care Society (WICS)	MT ToR 19
Royal College of Ophthalmologists	MT ToR 20
Cedar	MT ToR 21
Cancer Research UK	MT ToR 22
Royal Pharmaceutical Society	MT ToR 23
BMA Cymru	MT ToR 24
Royal College of Psychiatrists in Wales	MT ToR 25



Medical Technologies Evaluation Programme (MTEP) at NICE	MT ToR 26
Urology Trade Association	MT ToR 27
Betsi Cadwaladr University Health Board	MT ToR 28
DTR Medical	MT ToR 29
Andrea Hague (Velindre Cancer Centre)	MT ToR 30
ESRC Centre for the Economic And Social Aspects of Genomics	MT ToR 31
Westgate Cyber Security Ltd	MT ToR 32
British Pain Society	MT ToR 33
MS Society Cymru	MT ToR 34
MediWales	MT ToR 35
Genetic Alliance UK	MT ToR 36
Alex Powell	MT ToR 37