



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

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

**Dydd Iau, 3 Ebrill 2014
Thursday, 3 April 2014**

**Cynnwys
Contents**

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

Gofal Heb ei Drefnu—Bod yn Barod ar gyfer Gaeaf 2013-14: Sesiwn Ddilynol i Graffu ar
Waith y Gweinidog
Unscheduled Care—Preparedness for Winter 2013-14: Ministerial Scrutiny Session Follow
up

Cynnig i Benderfynu i Wahardd y Cyhoedd o'r Cyfarfod, o dan Reol Sefydlog 17.42(vi) ar
gyfer Eitem 4, a Reol Sefydlog 17.42(ix) ar gyfer Eitem 5
Motion to Exclude the Public from the Meeting, under Standing Order 17.42(vi) for Item 4,
and Standing Order 17.42(ix) for Item 5

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

Papurau i'w Nodi
Papers to Note

Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod ar 30
Ebrill 2014
Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from the Meeting on
30 April

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Mark Drakeford	Aelod Cynulliad, Llafur, Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol Assembly Member, Labour, the Minister for Health and Social Services
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol a Integreiddiad Director of Social Services & Integration
Dr Ruth Hussey	Prif Swyddog Meddygol Chief Medical Officer
Dr Grant Robinson	Arweinydd Clinigol Gofal heb ei Drefnu Clinical Lead for Unscheduled Care
Yr Athro/Professor Phil Routledge	Cadeirydd, Grŵp Strategaeth Feddyginiaethau Cymru Gyfan Chair, All Wales Medicines Strategy Group
Gwenda Thomas	Aelod Cynulliad, Llafur, y Dirprwy Weinidog Gwasanaethau Cymdeithasol Assembly Member, Labour, the Deputy Minister for Social Services

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

Chloe Davies	Dirprwy Glerc Deputy Clerk
Sarah Hatherley	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk

Dechreuodd y cyfarfod am 09:29.
The meeting began at 09:29.

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome everyone to this morning's meeting of the Health and Social Care Committee. In this morning's session, we will start to look at unscheduled care and preparedness for winter 2013-14. Before we start, I remind Members that the meeting is bilingual. Headphones can be used for simultaneous translation, on channel 1, or for amplification of discussions in the room, on channel 0. I remind Members to turn off their phones or any other electronic equipment that may interfere with the broadcasting equipment. There is no scheduled fire alarm today, so if the alarm does go off, please follow the directions of the ushers. We have received apologies from Kirsty Williams and Darren Millar, and no substitutes have been identified.

09:30

Gofal Heb ei Drefnu—Bod yn Barod ar gyfer Gaeaf 2013-14: Sesiwn Ddilynol i Graffu ar Waith y Gweinidog Unscheduled Care—Preparedness for Winter 2013-14: Ministerial Scrutiny Session Follow-up

[2] **David Rees:** I welcome the Minister for Health and Social Services, Mark Drakeford, and the Deputy Minister for Social Services, Gwenda Thomas. Minister, would you like to introduce your officials?

[3] **The Minister for Health and Social Services (Mark Drakeford):** Thank you, Chair. I have with me Dr Ruth Hussey, the Chief Medical Officer for Wales, and Dr Grant Robinson, who is the national clinical lead for unscheduled care.

[4] **The Deputy Minister for Social Services (Gwenda Thomas):** I have Albert Heaney, director of social services and integration for the Welsh Government.

[5] **David Rees:** Thank you, Minister and Deputy Minister. Thank you for your written evidence as well, and for the letter that was submitted to all Members this week from you, Minister, in relation to the unscheduled care activities over the winter period. If it is okay with you, we will go straight into questions this morning. I will start with Gwyn Price.

[6] **Gwyn R. Price:** Deputy Minister, the Welsh NHS has continued to see many pressures facing unscheduled care services. How well prepared was the Welsh NHS and social services for the winter of 2013-14?

[7] **Gwenda Thomas:** I think that we have a success story to report with regard to the integration agenda. Local authorities and the NHS have been working together over the winter to ensure that they provide the best possible care for patients. We have had weekly winter planning conference calls, and I think that they have been successful. The improved integrated planning process has clearly resulted in an increased resilience over the whole system, compared with last year. Following agreement with Plaid Cymru and the Liberal Democrats, we also have the intermediate care fund of £50 million. That will allow us to prepare even better.

[8] We have some good news with regard to the intermediate care fund. We had very last minute information with regard to last night's development. I will ask Albert Heaney to inform the committee as to exactly where we are. We have had the bids in, and I believe that this morning we can issue the grant letters.

[9] **Mr Heaney:** Good morning. Thank you, Deputy Minister. I can confirm that the intermediate care fund has been managed on behalf of Ministers during the winter. Proposals were received by the Welsh Government. Those proposals have been analysed by a panel to assess recommendations to Ministers, and Ministers have approved, this week, all of the intermediate care fund proposals for Wales. As of yesterday, all grant offer letters have been issued by the Welsh Government.

[10] **Gwyn R. Price:** Minister, it has been a relatively mild winter this year compared with last year. What are your views on how we have coped with the winter, and whether the NHS is a better place as a result of that?

[11] **Mark Drakeford:** Thank you, Gwyn. I believe, as I have said before, that the NHS went into this winter better planned, better prepared and better led to meet the challenges of the winter. Nevertheless, the pressures in the system have been real, and there have been difficult days over the winter period. However, if you look across the whole range of indicators—four-hour waits in accident and emergency departments, 12-hour waits in A&E departments, ambulance response times, handover times for ambulances and delayed transfers of care figures—there is a very consistent pattern across all of those things, which is that despite the challenges and despite the fact that there is still a lot of ground to be gained and a lot more that we need to do, the NHS in this winter outperformed the position it was in last winter.

[12] You rightly point to the fact that it was not as cold a winter this winter. Nevertheless, there were weather challenges. In Wales, prolonged periods of mild wet weather lead to acute exacerbations of chronic conditions, particularly in people who suffer from chest problems. In our valley communities there are very large numbers of elderly people in that position. Sometimes, mild wet weather, with a lot of circulation of those sorts of conditions, brings its challenges. We also continue to face this winter the rising number of very elderly people in the community. The number of people going to A&E departments in Wales this winter is slightly down compared to last year, but the reduction has come in minor injury units. The number of people going into major A&E departments has not gone down very much and there has been a 3.5% increase in admission to hospital from major A&E departments, particularly for people aged over 85.

[13] So, as I am sure that we will hear in more detail during the morning, I think that the performance of the NHS over this winter has been better. It has been more resilient, it has overcome the difficult days when those difficult days have occurred, but there remains an underlying set of challenges that we can continue to do better on as we learn from this year's experience.

[14] **David Rees:** Deputy Minister, you highlighted the integrated care fund and the proposal for next year, and, in the letter from the Minister, he indicated the improved relationships with social care to ensure a better flow of patients. Do you have any examples of good practice to show how—. The integrated care fund is next year, and I want to see how we have learned from this year and how that can benefit us with the integrated care fund.

[15] **Gwenda Thomas:** Yes, indeed. I think there has been remarkable co-operation by the directors of social services, coordinated by the Association of Directors of Social Services Cymru. Albert Heaney has led on that for the Welsh Government. I believe that there is a genuine will to move towards more integrated working and joint commissioning and I think that we have seen examples of that. I have provided the committee with examples of projects that are happening right across Wales. It is important to recognise the need for local knowledge in developing what is needed for particular areas. We have mentioned the intermediate care fund; local authorities have led on that and have moved very quickly to get

to where we are now, but also there are the principles of joint working, pooled budgets, integrated working, integrated planning, and the new assessments for the over 65s that we published in December. That is a statutory requirement and we are seeing the benefits of that. We have seen those benefits over last winter, I believe, and that will now move not only into winter planning, but into permanent thinking on the way that we have to transform services. Of course, you will know through the Social Services and Well-being (Wales) Bill and 'Sustainable Social Services for Wales' that that is the way that we will be moving with social services.

[16] **David Rees:** Okay. Thank you. Lynne is next.

[17] **Lynne Neagle:** I have a question for Gwenda, and some general questions. Shall I just ask my question to Gwenda now?

[18] **David Rees:** Please.

[19] **Lynne Neagle:** It is just about the pressure on care home beds, which I know you are well aware of, in places like Gwent, where there have been relatively sudden closures of care homes, which has, obviously, caused pressure within the service. Do you have any comments on how that situation has been managed and whether it has had any impact on the number of delayed transfers of care?

[20] **Gwenda Thomas:** Spot purchase of residential care by local health boards is not new; it has been around for a very long time. I am not aware of any capacity issues in residential care. There are issues that arise when we have situations such as you have had in your constituency. On a longer term basis, we are dealing with that through the regulation and inspection Bill and the White Paper that has been published. You will know that we will require information from providers and that that will be published. That is a proposal within the Bill. They will have to make public their viability to carry on as providers. In the shorter term, we are working with the Social Services Improvement Agency towards a market analysis. This will look at residential care, domiciliary care and other services. We are hoping for an analysis of those this year.

[21] **David Rees:** Do you want to continue, Lynne?

[22] **Lynne Neagle:** Okay. First, I wanted to ask about the flu vaccine, please. We have had some figures for the take-up among two and three-year-olds, which I think were a bit disappointing. Are you planning on doing any sort of work on that? Could you provide an update on the take-up for year 7 pupils as well?

[23] **Mark Drakeford:** I will probably ask the chief medical officer to answer the detailed question. It is important to remember that, for two and three-year-olds, it is the first year of it. There were some initial problems of supply of the vaccine from the manufacturers, because they were not able to manufacture it quickly enough. There is a job of work to be done with the public in general about persuading them that flu is a serious illness and that protecting children against it is an important thing that they can do. We will continue with vaccinations for two and three-year-olds next winter and we will add four-year-olds into the programme as well, in the hope that we will begin to normalise this with parents, so that it just becomes part of what they do every winter to protect their families and others. I will ask Ruth to give you the figures on the year 7 pupils.

[24] **Dr Hussey:** I think that it is important to note that the figures are being updated all the time. We will lock down, if you like, the final seasonal picture in some weeks' time. Data are still coming through from various sources. The current figure that I have for year 7 is 68.7%, which I think, for the very first time, for a new concept and a new programme of

work—although I am not complacent—is a strong basis to build on. I think we also have to set that against a continuing push on the other flu vaccination programmes. We have delivered hundreds of thousands of vaccinations in a very short space of time, if you look across the whole programme. What is reassuring for me is that we have already started next season's planning. The Minister met stakeholders this week. So, work has started even earlier, to make sure that we are building everything we can and putting everything in place to really build on that programme of work.

[25] **David Rees:** Lindsay, do you have a question on the flu?

[26] **Lindsay Whittle:** I noticed that the take-up in the health and social care workforce of the flu vaccine has been roughly the same as last year, which is slightly disappointing. Do you have any ideas about how we can increase those figures for next year?

[27] **Dr Hussey:** I think it is encouraging, in one sense, that the staff vaccination figures have been coming up year on year. We are pleased that we have made quite good progress on the current figure, which is about 41.4%. Our challenge is to keep on building that momentum. I know, from the meeting with stakeholders, that there is a real positive sense of, 'We can do this, it is improving year on year' and really wanting to work with us on pushing towards a higher target. So, I am encouraged and pleased by the amount of people who have come forward this year, bearing in mind that this was a low flu season and that the context was not strongly prompting people to go and do this. Yet, on most of the measures, we have seen progress. So, it tells me that the systems underneath this are now promoting uptake in a better way. I am not complacent, however; there is more work to do.

[28] **David Rees:** Has any analysis been undertaken as to why people have not taken up the opportunity to have the flu vaccination? You say that you have hit 40%; that means that 60% have not taken the opportunity.

[29] **Dr Hussey:** I could pick that up in general terms. People have looked into the barriers, if you like, and the reasons why people choose not to be vaccinated. There is a mixture, as you would expect. This is general research that has happened, because this has been an issue that has been explored over the years. Reasons include not being clear about the purpose of the vaccine or the value of it, and not understanding the evidence base. There is a little bit of that. Sometimes it is about convenience, having it in the right place at the right time. Those are the sorts of factors that you need to consider. What is really shifting, I think, is an understanding of the importance of protecting oneself, but also supporting the cessation of the spread of the virus in the community. So, it is mixture of things. You cannot pinpoint one thing specifically.

[30] **David Rees:** Will there be a more concerted campaign to encourage more people, from an early point, to actually take it up next year?

09:45

[31] **Mark Drakeford:** If I may pick that point up, I think that Lindsay's question is a very important question, and the headline figure disguises some very real variations among different staff groups in health and social care. So, our target is 50%, which we will not have reached this year, although we will have seen a 6% rise this year, and saw a 5% rise the year before. So, there has been quite a rapid progress there. However, among professions allied to medicine—physiotherapists, occupational therapists and radiographers—it is way over 50% already. Among doctors, we are practically at the 50% level. We are not doing as well as we would like to among nurses. Obviously, there are very large numbers of nurses, and, therefore, proportionately, that brings the overall figure down. We are not doing as well as we would like to among social care workers, both domiciliary care workers and residential staff.

[32] So, there are two things that we will try to do for next winter that are additional to what we have done this year. I want to work more closely with the royal colleges. I think that Leighton made these points the last time we discussed this: it is a matter of professional obligation on people who work in these services to take up the flu vaccination in order to protect themselves and to protect the vulnerable people whom they work with. So, I want the royal colleges to do more, and I think that they are very willing to do more in communicating that professional message to their members and in trying to make an extra push on that front.

[33] We are also going to work more closely with Care Forum Wales, the representative organisation of the social care sector, which, again, is very keen, in a leadership way, to get the message out to its members. For the forum, this is a business issue. It is running businesses, and it needs its staff to be in work. For relatively modest sums of money, they can ensure business continuity and they can do more to help themselves as well as helping us.

[34] **Rebecca Evans:** Do you think that there is a specific piece of work that could be done around pregnant women and the flu vaccine? I see that the figure went down from only 43% last year to 40% this year, which is disappointing, given the high level of contact that pregnant women will have with the health service.

[35] **Dr Hussey:** If I could just pick up on the figures, they are a moving picture. The latest figure that I have been given is 43.1%. So, we are butting up to a similar picture to last year, but we will publish the final figures later on in the season.

[36] **Mark Drakeford:** I agree that there is more that we can do. It is a UK-wide phenomenon, and we actually do quite a bit better than England in terms of persuading people in pregnancy to take flu vaccinations¹.

[37] In the end, flu vaccination is a voluntary matter, and it is a matter of education and persuasion. We know that some of those arguments that persuade other people not to take up a flu vaccine include a fear that it makes you ill—we know that it does not but people think that it does—a fear that it is not effective, although we know that this year's flu vaccine was very effective against the relatively low level flu that was circulating, and the fear that it can have other effects on you. People in pregnancy are anxious about the health of the baby as well as their health. However, we need the people who work face to face with people during pregnancy to overcome some of those myths, and, therefore, to persuade more people to take the vaccine.

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

[39] **Janet Finch-Saunders:** My question is in relation to disruption to NHS services when things can go wrong in terms of infection control. I am aware that, in north Wales, we have had some wards closed over the winter as a result of infection. Do you feel that we are winning the battle as regards hospital infections? In particular, my question is: what level of disruption has there been to NHS services, patients and carers, as a result of these infections where you see wards closed? That must have an impact, especially over the winter.

[40] **Mark Drakeford:** I will ask Ruth to give you the figures, because there are some interesting and useful figures on reductions in hospital-acquired infections. However, the general point is an important one, and it is not just infections of this sort, but norovirus and

¹ The Government wishes to note that, 'The four UK countries take different approaches to the measurement of flu vaccination uptake in pregnant women so direct comparison between figures is not possible, but we are working on this.'

other things that circulate during the winter. We have had some health boards that have had difficult weeks, when wards have had to be closed for that reason. There are things that hospitals can do to try to bear down on it, but, often, people are bringing these infections with them on admission.

[41] **Dr Hussey:** You will appreciate that infection in healthcare settings has been a real focus for us, particularly *C. difficile*. We have had a programme of work across the NHS in Wales, supported by Public Health Wales, to drive down some of those figures. For example, on *C. difficile*, comparing 2012 to 2011-12, there was a 15% reduction in in-patients aged over 65; from April 2013 to February 2014, there was an 18.2% reduction. Therefore, there is a real sense that people are getting on top of this.

[42] **Janet Finch-Saunders:** What about norovirus?

[43] **Dr Hussey:** I do not have figures for norovirus, but we can get the figures on that. We do not routinely collect numbers of beds affected on a day-to-day basis and look at them in that way.

[44] **Janet Finch-Saunders:** May I just ask why that—

[45] **David Rees:** Give her a chance to finish. Have you finished, Ruth?

[46] **Dr Hussey:** The operational management looks at what is happening on a day-to-day basis; Grant might want to comment on that. The ones that we closely monitor are healthcare-acquired infections. The emphasis that we have had is on ensuring that we are not acquiring *C. difficile* or MRSA and that we are driving down the impact of that on patients. We are seeing a really strong drive on that. The added benefit is that infection control, more generally, in a hospital setting is getting a real focus, with strengthened teams and a real push. There are added benefits around that. I do not know whether Grant, from the operational management side, wants to comment about the impact of norovirus.

[47] **Dr Robinson:** The weekly conference calls have already been mentioned. There are weekly conference calls that the director general has held with chief executives, but there are also operational calls that happen not just weekly, but daily during times of pressure. I have been involved in both sets of calls at various times—more in the weekly calls. Those beds that are out to norovirus or other infection-control problems are discussed each time that we have a call. We know, for instance, that in Cardiff there were some beds out due to norovirus about a month ago. That has improved now. My sense, over the winter, having been involved in those calls two years in a row, was that there was a lot less disruption this winter. As Ruth said, there has been a really strong emphasis generally on infection control, and we know that these things are linked. If you can bear down on the factors that will help you to control the spread of one infection—hand-washing and hygiene measures—that will have a beneficial effect in more than one area. There is no doubt that awareness and operational response is at a higher level than it was last year or the year before.

[48] **Janet Finch-Saunders:** I am a little alarmed to learn that you do not monitor norovirus and the impact that it has. Are you likely to review that? It can be quite debilitating and can close wards.

[49] **Dr Hussey:** We know about the impact, because of all the calls, daily counting of how many wards are affected, capacity issues and so on. What I do not have is a count of the number of cases, because norovirus is present in the wider community. It is a much more ubiquitous infection. In terms of the impact, absolutely, people look at the capacity and what is happening on a day-to-day basis throughout the winter and take account of what is happening. I just wanted to differentiate between those two points.

[50] **David Rees:** Minister, in a previous meeting, you mentioned the surge capacity that would be available. In instances where we have ward closures due to norovirus, do you have an analysis as to the effectiveness of the surge capacity in dealing with those situations?

[51] **Mark Drakeford:** Yes, we have a sense of the way in which surge capacity has been used across the NHS this winter. We know that the NHS deployed between 450 and 500 extra beds—or had at its disposal between 450 and 500 bed or bed equivalents—in order to deal with the sorts of circumstances that Janet described, either where there is a sudden rise in admissions to hospitals and you need more beds or where capacity has had to be closed in order to deal with infection control. We have been monitoring it. There is an interesting discussion to be had sometime during the morning as to whether surge capacity—in other words, adding more capacity—has been a more effective solution to winter pressures than improving flow through hospitals—in other words, making better use of the capacity that is there already. A bit of a natural experiment has gone on in Wales over this winter, because some health boards have concentrated on flow and just making better use of the beds that they have already and others have concentrated more on being able to increase capacity to deal with times of pressure. We could tell you a bit about that if Members were interested.

[52] **David Rees:** I am sure that somebody will take you up on your offer, Minister. Leighton and Rebecca have supplementary questions.

[53] **Leighton Andrews:** I wanted to ask about flow and where you saw that. You were saying that health boards adopt a different strategy, so I wonder whether you could just elaborate on who adopted what and what worked.

[54] **Mark Drakeford:** I will just give you the headline and then ask Dr Robinson to give you the details of how it has happened. Looking at the data, my conclusion from them is that improving flow and getting patients through the system and making better use of the beds that are already there has been a more successful strategy in dealing with winter pressures than simply trying to turn on the tap and create more beds in order to deal with it. I am sure that there is a combination of both—they are not either/or—but, on the whole, we believe that the big lesson to be learned from this winter, for the whole system, is that the LHBs that have improved their flow through the system have coped with those pressures in a more resilient way than those that have had to rely on trying to bring extra capacity on stream. Grant can give you the specifics.

[55] **Dr Robinson:** Sure. There is a formal sense in which we planned for the winter, which we might talk about a little more as we go through this meeting. Health boards, of course, were bringing their plans. We had an increased level of scrutiny and we have continued that through the winter, so we have fairly good vision of what has gone on in each health board area and we have been able to see how they have moved through the winter.

[56] As the Minister says, it is not as if you either look at capacity or you look at flow. You look at both, of course, but you do have some choices regarding where you put the emphasis. In a nutshell, the flow approach is focused on reducing waiting for things to happen—what we would call ‘lead time’ when we are talking about the operational management of flow. So, wherever you spot someone waiting for something to happen, you bear down on that and then you put a co-ordinated set of actions in place to remove the waiting. You have a choice regarding how much you focus on that and how much energy you put into that.

[57] Broadly speaking, the health boards that put more energy into that did better over the course of the winter. As we were sharing that approach as much as we could and we had a formal programme, which the 1000 Lives team facilitated for us—the patient flow

programme that allowed people to come together alongside the formal planning process to share what was working, what was not working and to exchange ideas; that is running as a formal collaborative now inside the health service in Wales—health boards were able to change their emphasis as they went through the winter. So, some health boards that started the winter more focused on capacity focused more on flow and saw the benefit of that as they went through the winter.

[58] Leighton will probably know that the health board in his area, Cwm Taf, started the winter with a strong emphasis on flow and that worked well for it, actually. We saw some dramatic improvements, so if you go back a year ago and the year before that, there were waits either in the accident and emergency department or in ambulances outside of the accident and emergency departments. By taking a flow approach, Cwm Taf health board was able to reduce those waits substantially. So, those are now rare events in that health board. Other health boards have seen similar improvements, but I would pick Cwm Taf out as being an area where that worked particularly well.

[59] So, we are about recognising what works, but also—and this is important—taking that and spreading it out as quickly as we can through the health service. We had some success in doing that this year, which we would aim to build on in the future.

[60] **Mark Drakeford:** I wonder whether I could just give a couple of specific figures, because they quite dramatically illustrate the success that Cwm Taf has had by focusing on flow. In March last year, when I went out and made some visits to A&E departments in Cwm Taf, it was undoubtedly struggling to deal with the level of demand that it was facing. In March last year, 242 ambulance handover times took more than an hour in that month. In the last nine months in Cwm Taf, there have been 45 examples of an ambulance handover taking more than an hour. In February last year, 100 ambulance handovers took more than an hour in Cwm Taf, and in February this year there were four. I think that those are pretty dramatic turnaround figures, and they are achieved by having the emphasis on getting people flowing through the system as quickly as possible and bearing down on delay points in any part of that process.

10:00

[61] **Rebecca Evans:** For those health boards that reduced the amount of elective orthopaedic surgery that was going to take place in order to increase that capacity, are you satisfied with the amount of elective surgery that did take place over the winter? Do you have any concerns about the knock-on effect on waiting times for surgery?

[62] **Mark Drakeford:** I will begin, perhaps, and then see whether colleagues wish to join in. As I am sure that Members recognise, there is a judgment call that all health boards have to make in trying to gear their capacity to deal with the weight of emergency work that they know that they will face over the winter and the amount of elective activity that they are able to undertake. Some health boards over this winter—Hywel Dda Local Health Board did it in the most upfront way—decided that they would reduce the amount of planned activity in order to be sure that they could deal with the higher levels of emergency activity that they faced. The upside of that is that they cancelled very few operations, compared to the previous winter. Members around the table will have examples in other parts of Wales where people have been called in for operations to find them cancelled on repeated occasions. That has not happened in Hywel Dda over this winter. In fact, there is a 48% reduction in cancelled operations in the Welsh NHS in December and January of this winter, compared to the previous winter.

[63] The downside of it is that that means that there will be some people waiting longer for their planned operation than they otherwise might have been—we cannot say ‘would have

been' because they may have been in the category of people who were called in and then sent home again. I think that the experience of this winter suggests a better balance. Not trying to over-programme your planned activity allows the system in the round to respond better to the level of demand that it will face. What we have said to the health service is that, as we pull out of winter, particularly as we have been relatively fortunate this year to pull out of winter a bit earlier, we expect it to move the balance back in the opposite direction. I am quietly confident that, when we see the figures for February and into March, we will see a bearing down on the number of people who have been waiting for planned operations as health boards have switched the balance back in favour of planned activity because the nature of this winter has allowed them to do that.

[64] **Rebecca Evans:** I met last week with Hywel Dda health board, and I was told about some patients who have musculoskeletal conditions who did not have surgery over the winter but were put on different care pathways, had their condition treated with medication and with exercise, and no longer need surgery. Are we too quick to put people on waiting lists for surgery?

[65] **Mark Drakeford:** I will ask Ruth to answer, but from a prudent healthcare perspective, which I talk a lot about now, I think that that is a very interesting potential finding, and we will really want to look, with Hywel Dda, at whether there were people who, in the normal course of events, would have had a surgical procedure but now turn out not to have needed that procedure because of the alternative pathways that Hywel Dda concentrated on over that period. There is evidence—I do not want to over-emphasise it, and we are working with a group of clinicians specifically in the orthopaedic area—that we move some people too fast to the surgical end of service, where those people's conditions could have been equally successfully managed by other less intrusive forms of intervention, which means that, when people do end up having to have a hip or knee replacement a bit further down the line, you can also have an impact on the need for further surgery much later on again when people are a good deal frailer and less able to cope with that. There is international evidence that suggests that you can slow down the rate of surgical interventions to the benefit of patients. There may be some evidence from the Hywel Dda experiment over the winter that will cast some light on that.

[66] **Dr Hussey:** Just to expand on the work that we are doing to test out some of these ideas in Wales, one of the areas that we are focusing on is orthopaedics. Taking the principles of prudent healthcare, we are looking at what sort of things would come into play to change the pathways that we would offer patients. That work is ongoing. We expect it to conclude in the summer. It is very much driven by health boards, Public Health Wales and clinicians talking through the ideas behind the evidence that suggests that there are alternative pathways. We know that, if you are fit going into an operation, you are likely to get a better outcome. So, there are benefits—even if it involves looking at things like weight management and smoking. The Cardiff work on optimising outcomes is also something to take into account. So, there are some real choices. Are there alternatives at the outset? Are there different pathways? Then, as people progress through their illness, whatever that chronic illness might be, and come to a view that surgery might be necessary, going into that operation as fit as possible gives them the best result afterwards as well. So, there is a whole set of things that we need to build into the care process to make sure that we are getting the right outcomes for people. The concept of prudent healthcare is what is best to help the person live their life the way they want it to be. We have got to try to reshape how we offer things and take people through that in a joint decision-making process.

[67] **David Rees:** I am conscious that we have taken the theme away from Lynne's questions and that we need to come back to questions from her, but, Elin, do you have a question on capacity?

[68] **Elin Jones:** Yes, I have a question on surge capacity and flow. I want to understand something from your letter to us dated 3 February where you outline the surge capacity beds that various health boards had. What has been the use of that surge capacity number of beds? Do you have any feel for—. It says that Aneurin Bevan has 102 surge beds—‘capacity now open’. Were they all utilised to their maximum, given the fact that we did not have two weeks of snow on top of that? I am assuming that they were not used to their maximum because we did not have two weeks of snow, but that may be incorrect.

[69] **Dr Robinson:** We did not have snow, that is quite right, and there is no doubt that that has helped. However, the underlying drive for emergency care, particularly for older people, is strong. Despite the fact that there was no snow, we saw a 3.5% increase in admissions through emergency departments, and these are emergency departments that continue to work under pressure and that will be looking at every opportunity not to admit. So, those were needed admissions, by and large. Was there less pressure because there was less snow? Probably not, actually. There was probably a little bit more pressure on beds this winter compared with last winter, but the point about flow is really important, because it is about what use you make of those beds and how you make sure that people are not waiting for things to happen, so that we are getting the most value out of the beds we have.

[70] Did people use their surge capacity? Yes, by and large, they did. There were some rare instances when people were not able to use all of their surge capacity. The one health board where that was an issue was Betsi Cadwaladr, where they had some problems with staffing it. However, all health boards were able to open surge capacity as they had planned, and that surge capacity was, by and large, used. However, the point about using that in combination with an approach around flow is very important because, as we moved through the winter, that was not the only tool that health boards were using. They were also refocusing on flow to take down the lead times, to take down the waiting times, for people.

[71] **Elin Jones:** What is the balance in terms of cost-benefit of flow versus extra beds? What is the cost implication of the improved flow that you described earlier?

[72] **Dr Robinson:** I think that there are big advantages, in terms of cost, to focusing on flow, because, by taking that approach, you are taking the waste out of the system. We know that we have to make sure that the beds that we have are properly staffed and that they are safe, caring environments, but resource is limited and will continue to be limited across the whole of the United Kingdom for healthcare, so we have to make sure that that is working as well as it can.

[73] To do that, we have to stop people waiting for things to happen. Broadly speaking, the things for which they will wait to happen—this is not just in Wales, but everywhere that you look at it—include a senior opinion, and the senior opinion to decide what happens to them may need a diagnostic test to have been done, so you take out the waiting for that. Waiting for therapies input is really important, and it is particularly important for older people, so we have to make sure that we have physiotherapists and occupational therapists deployed effectively across the ward, and then, as Albert and Gwenda will know, it is about making sure that we have got the hook-up—and we have really focused on this—with social care services, so that people are not waiting. You do not get them medically fit and then try to get their social input, you run those things on a twin track, so that you are focusing on their social needs alongside their healthcare needs and getting them ready to get back to where they want to be as soon as possible. All of those things have to happen, and there is still room to improve on that, and that takes us into things like making sure that that happens across the seven days in the week, because, of course, people do not just come in with their problems on Monday to Friday. They come in across the whole seven days of the week, and getting that resource evenly distributed across the week and across the working day is part of that. So, it is not just one thing, it is quite a large bit of work to do.

[74] **Mr Heaney:** Chair, if I may add to Dr Robinson's comments, it really was and is about the whole system working together. In terms of the demand coming in, there was not a period over the last six to seven months when we could say that demand eased. It did not ease for the social care sector. Demand was very high. What took place was much more working together through the whole system and understanding the whole system, so also helping citizens who could be pulled away from having to go to hospital by pulling them away, but, more importantly, dealing with those who were in the hospital and helping them, through reablement culture, to help them be more enabled to move back into their homes. What we saw in the social care sector was quite a high demand, but a regular meeting of that need. During the winter, we actually ended up in a situation where, during the last three months, from December to February, despite the fact that we had high demand, we had 6% fewer delayed transfers of care overall than in that period the year before. In December, for the first time in our record of looking at the data over the last 10 years, we ended up with below 400 DToCs, which was the lowest point that we have ever achieved.

[75] **Elin Jones:** May I just ask a question on the issue around a 24/7 hospital service with social care and social workers able to assess and discharge on a Saturday evening, thereby improving flow, as you have described it? Is the health board that has done this reasonably successfully this year, Cwm Taf, close to being a 24/7 hospital—it is one hospital, is it not, or is it two in that board?

[76] **Dr Robinson:** There are two acute hospitals, yes. I cannot answer for it, but what I think that it would say is that it is still a distance away from where it would want to be. There is still room to get the service right. It is an old saying—I grew up with it and the chief medical officer will have as well: we have to get the right treatment to the right patient in the right place at the right time. That means that you try not to keep them waiting. A little bit of waiting is inevitable for some things, but it is about minimising that and being ambitious about what you want to drive it down to. There are opportunities to do that. There have been fantastic bits of pilot work going on, and what we are about is spreading that so that people can see what is going on in other parts of Wales and across the wider United Kingdom and do that. So, is Cwm Taf where it wants to be yet? It is in a better place than it was and this has not been quick or easy work. The people who have done it say, 'It was quite hard work to do this, but we're really glad that we did, and we don't want to go back'. However, they would also say, 'We've got a way to go yet'.

[77] **Elin Jones:** So, Minister, is it your ambition that we have a 24/7 hospital service with admittance, discharge and treatment within that? Is it an ambition that you have as a Government to get to that point and do you have a timetable for getting to that point?

10:15

[78] **Mark Drakeford:** It is clearly an ambition for the Welsh health service, as it is for others, to try to get our system working on a seven-day-a-week, through the week sort of basis. There are real challenges in doing so. One of the challenges that we undoubtedly face in Wales is, if you want to do that, you cannot go on doing everything that we try to do in all of the places that we try to do it. You can achieve seven-day, 24-hour services if you concentrate the expertise and the staff that you have around a service in a particular place. That is a particular challenge in Wales because of the nature of our geography and because, as we know, of the attachment that people have to the services that they have there at the moment. The challenges in achieving 24/7 are not simply in terms of the way that the service itself can be provided, but is in persuading people of the things that you need to do if you are to be able to do that.

[79] There are good examples in the specific area that Elin has mentioned. Betsi struggled

over the winter with some of its surge capacity, but it achieved something pretty good, given the number of different local authorities that it has within its boundary, to have a common approach in which social workers were available, not just in the week, but at weekends as well. Another important change this winter was, in social services departments, having people available during that Christmas and new year fortnight when, if you look at previous winters, a big backlog developed with people staying in hospital because social services were often not working over that period. Betsi worked really hard with its local authorities and persuaded them all to make sure that they had staff available right over that Christmas period, so we did not start back in January not only having to deal with the January surge, which we know we have to expect, but with a built-up backlog of people waiting for discharge. So, even with the constraints that we face, there are some really good examples, as Grant said, and we want to try to make sure that others learn from those for next year.

[80] **Gwenda Thomas:** As part of that, there has clearly been a much earlier identification of people ready for discharge within the system as well.

[81] **David Rees:** Lynne, you have a couple of questions.

[82] **Lynne Neagle:** I had a couple of questions on the ambulance service. The Minister's letter of 3 February highlights the very positive progress that has been made in terms of filling vacancies, and I wondered whether there was any further update on that. I also wanted to ask about the effectiveness of the specialist emergency medicine doctors, and what evaluation there has been of their role, and how that has impacted on the pressures within the system.

[83] **Mark Drakeford:** In my letter, I said to the committee that the Welsh Ambulance Services NHS Trust intended to recruit 82 new full-time members of staff this winter, and it has recruited to all of those posts, so it had 82 more people at the front line over this winter than it otherwise would have done. I know that Mick Giannasi, the new and now confirmed chair of the Welsh ambulance service trust, is particularly keen to shift some of the previous patterns, which have seen a high reliance on overtime within the ambulance service. He wants to shift some of that expenditure into full-time appointments of permanent staff. That does depend on having more people in training, and we have more people training to be paramedics and advanced paramedics in Wales, but on top of the 82 new staff who have been recruited over this winter, there are now plans for a further expansion of their permanent establishment by redeploying the budgets away from overtime and into permanent members of staff.

[84] Lynne referred to the fact that there were two emergency doctors employed by the trust for the first time over this winter. The effectiveness of that is being reviewed by the Wales Deanery and WAST together, to look at what impact they had on the service. The emerging data are encouraging. It looks as though they show that 50% of the people who were seen by those doctors were treated at home, and did not need to be taken by an ambulance into hospital. If that is borne out in the detailed work, then I know that the Welsh Ambulance Services NHS Trust intends to try to reinforce that workforce further with another two appointments—not necessarily exactly the same, but alongside those people—for the coming year.

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

[86] **Rebecca Evans:** Yes, it is still on this point. Minister, in your letter to Assembly Members on 1 April, you said that the eight-minute target has, at best, a weak clinical evidence base. You also said that it is your intention to develop and introduce a series of new patient-focused outcome measures. Could you expand on your comment about the weak evidence base and update us on that piece of work?

[87] **Mark Drakeford:** The source for the weak evidence base for the eight-minute target comes from the McClelland review. Professor McClelland's report says absolutely clearly that a focus on getting an ambulance to every category A call in eight minutes makes very little difference to outcomes for patients. We will continue to report the eight-minute target figures, as we do with the nine-minute target and the 10-minute target, and so on, in future, but alongside that, we want to work up a new set of indicators that measure the ambulance trust against the things that it does that actually do make a difference to patient outcomes.

[88] So, you will know that, a week ago, we talked a bit about these experiments. They will be in relation to three conditions where we know that getting a quick ambulance service, and getting things to happen in the ambulance, makes a difference to the outcome for patients, namely cardiac, stroke and fractured neck or femur—so, broken hips among older people—where you need to get the ambulance there quickly. It is not just about getting the ambulance there quickly. The emphasis in the McClelland review was to try to shift the ambulance service in public perception, and in the way that it operates, away from being a transport service to being an emergency medical service, using the skills of paramedics to the maximum. So, with those three conditions, it is not simply a matter of getting the ambulance there quickly, which is very important, it is then about what goes on in the ambulance while you are taking the person to the emergency department, so treatment has already started. Where treatment has already started by paramedics in those conditions, quickly, we know that the final outcome for patients is likely to be improved. So, we want to report on that, because, there, we think that the target does make a difference.

[89] **David Rees:** Okay. Lindsay is next and then Leighton.

[90] **Lindsay Whittle:** My question is on that issue of somebody, when you dial 999, coming through your front door—if the accident is at home—and you look for assistance. Personally, if I have a minor injury, I do not care whether the ambulance takes eight minutes or half an hour, but if I am having a heart attack, I want someone there as quickly as possible. Could we save more lives by using senior paramedics on motorbikes, who can get through traffic far more quickly than an ambulance at, perhaps, peak school times?

[91] **Elin Jones:** Do not ring for an ambulance if you have a minor injury.

[92] **Leighton Andrews:** Quite right. *[Laughter.]*

[93] **Lindsay Whittle:** When I say 'minor injury', I mean, for example, if I have fallen down the stairs and cannot move, then somebody might want to call.

[94] **David Rees:** Let us go back to the original question.

[95] **Mark Drakeford:** Lindsay's original proposition is exactly the one that we are trying to pursue. I will ask Dr Robinson to speak about the specific idea of motorcycles. Quite certainly, the eight-minute target was first devised in 1974 and road conditions, in terms of the volume of traffic and your ability to get around urban and other areas quickly, are hugely different 40 years later than they were then.

[96] **Dr Robinson:** The simple problem with a motorbike is that it is quite hard to get all of the gear on to it. One of the pleasures of doing the job I do now is that I get to go out with the ambulance service, either in an ambulance or in one of the rapid-response vehicles, or, occasionally, if I am very lucky, in a helicopter. The rapid-response vehicles are, I think, closest to what is in your mind, so that is somebody who gets there with kit at an early stage. That is definitely a part of the ambulance service's strategy. It does deploy rapid-response vehicles and they can be a really useful initial part of the service. Sometimes, the skilled paramedics in those vehicles will be able to sort the situation out and will not need to get an

ambulance in. Sometimes, there is no alternative and you have to get an ambulance there as well. So, they will usually get an RRV away and the ambulance will be following on because the RRV can often get there a bit quicker.

[97] To go back to the earlier question, what you can do when you get to the scene, whether it is a specialist doctor or a trained paramedic, is really important, because if we focus on that, that 'see and treat' approach is definitely part of the ambulance service's clinical work that we have been developing with it going forward. There are lots of problems you can resolve with people there, and even if you cannot resolve the problem, there are early steps that the paramedic can take, such as getting an electrocardiography for someone who has chest pain, giving the early stages of therapy or giving immediate pain relief to someone who has broken their hip. That will change outcomes significantly, whether that is survival outcomes or the experience of it. These are examples of the sorts of areas that we want to explore with new measures for unscheduled care. The timeliness is really important, but it is not just about the timeliness.

[98] **Leighton Andrews:** I want to ask Mark a little more on the ambulance side about recruitment, because you mentioned that it has recruited 80 or so people in the last winter. However, you said that there were further posts to be recruited to. Can you say a word about that?

[99] **Mark Drakeford:** Thank you. Eighty two extra people have been recruited to front-line services over this winter. We have put an extra £0.25 million from central funds, in a way that we have not in the past, into providing extra training places for people who are—I have to make sure that I get the terminology right—technicians, and who do a one-year course to be upgraded to paramedics, or paramedics who can become advanced paramedics with extra training. I want to take very seriously the recommendation in the McClelland review about the way that we re-model the workforce to make sure that it is better able to do the job that we want it to do, and then that the protocols that the ambulance service uses allow those people to use their skills to the maximum. We have gone a fair way in one year on that, but there is more to go.

[100] This coming summer, we will have extra people graduating from Swansea particularly, where the main course is run. The discussions that I have been having with Mick Giannasi around the way that he wants to take things forward are about being able to take those people into full-time permanent posts by re-engineering the way in which the ambulance service uses its staffing budgets now. The ambulance service has had its full share of the extra money that the Welsh Government made available in the last financial year. That money will re-occur in this financial year as well, so it has the certainty to be able to plan for that. I know that as chair of the board, and working with his senior executives, he is very keen to do that re-modelling, to change the nature of the way that they provide these services.

[101] **Leighton Andrews:** Can we get an update on the percentage shift towards advanced paramedics, because paramedics do say to me that that was one of the things they would like to see more of—those training opportunities and so on?

[102] **Mark Drakeford:** I would be very happy to provide a note that sets out what has happened so far in the plans.

[103] **David Rees:** Do we have an indication of how many advanced paramedics are in operation today?

[104] **Mark Drakeford:** I have seen the figure; I am sorry that I do not have it in my head. However, in the note, we can give you those figures and reflect the increase in those posts as well.

[105] **Gwyn R. Price:** Minister, can you give me an update on the discussions, if you have had any, with Baroness Finlay on how services in Wales can best meet the needs of an ageing population?

[106] **Mark Drakeford:** Thank you, Gwyn. I last met Baroness Finlay on this issue on 6 March. Her first report is almost completed and she is working on some final bits of that. She will make a fairly wide-ranging set of observations about services for people who are not in the end-of-life pathway, which is where her main work has been in the past, but who are coming towards the end of very long lives. She will talk a lot about the way that primary care services provide for people. She will also, I think—I am anticipating this here because I have not seen the final report—talk a bit about the way that when people of that age, and of that frailty, get drawn into hospital, we need to speed up their exit from hospital.

10:30

[107] I have a bit of a fear that, once you are in the hospital system, it hangs on to you for quite a long time, that you get passed from one sub-specialty to the other, tested to destruction and told, two weeks later, that there is an awful lot wrong with you, but not a lot that can be done about it. At that point, you may be a lot less able to go back to living where you were and where you have managed, one way or another, for maybe over 85 years.

[108] So Ilora, I think, is just trying to make some comments about the way that the system responds to people at that point in their lives. She will pick up the Greenaway review about the need for a new generation of generalists to be trained, who have a general understanding of gerontology, as well as the particular speciality that they may want to concentrate on. I know that what she wants to do with her report is to get it discussed as widely as possible. I think that she would say, it is fair to say, that her discussions so far have tended to be with people whose job it is to provide these services, and with those organisations that have a representative history of reflecting the views of older people, but she has not necessarily talked directly to members of the public in the wider sense. She is keen to use her report to try to generate that slightly wider discussion in Wales about the way that care for people at that point in their lives is provided. I am very keen to encourage her to use both the platform that she will have because of her own authority and the work that she has done to have that sort of wider conversation.

[109] **Lindsay Whittle:** We did not have snow, we did not have influenza and the good old Welsh rain kept the Sahara sands away, so that is positive. However, if all of those had occurred, our hospitals would have been inundated and the unscheduled care plan would have kicked in. I visited a hospital recently and staff morale is very low. I think that, sometimes, it can be unfair. I know of examples of staff, both in hospitals and care, who have, in the past, walked miles through snow to deliver a service. This might be another opportunity for round two of a fight somewhere else, but there is unnecessary criticism sometimes of our staff and that does have an effect on your planning. I am wondering what you are doing for the morale of the staff, the vast majority of whom, we all know around this table, are very dedicated people indeed.

[110] **Mark Drakeford:** I completely agree that, when what goes wrong in the health service is always so prominently reported in the media—that is not at all to say that when things go wrong we do not need to shine a light on that; of course we must do all of that—and when the exceptional is portrayed as though it were the typical, it does have a corrosive effect on the morale of the people who are trying to provide services every single day. I will just give one example in return. I went to the Welsh Ambulance Services NHS Trust headquarters in north Wales towards the end of February, just at the tail end of all the very bad weather in terms of very high winds, very heavy rain and flooding and everything like that. People told

me, not in the sense of trying to make an impression or anything, but in a really matter-of-fact way, about the incredible efforts that they personally had made to get themselves into work on those days, so that they could go out and provide a service to people who they knew would be relying on it.

[111] The extra that people in our health service provide, to go on providing the service that they do, is enormous, and when they feel that that is somehow not being recognised or being written off, it has an effect on the way that they feel about the job. The good news is that they still go on doing it because their dedication and their sense of public service remain undimmed. What really matters to them is what they hear directly from the patients that they work with, because they know, and people tell them all the time, just how much what they do is appreciated. So, they do counterbalance the headline stuff and all of that with the lived experience of what patients say to them every day. We are doing more to collect that sort of information on a routine basis.

[112] So, in the Princess of Wales Hospital in south Wales, where you know that there have been some difficult headlines, over this last winter, the health board has been routinely collecting friends and family information, asking 'Would you recommend care in this hospital to one of your friends or family?' In huge numbers, the answers that have come back are enormously positive. Sharing that information with staff, ward by ward, and letting them know what people say about the care that they provide, has the opposite effect and boosts morale again.

[113] Certainly, wherever I go, I try to meet staff, and I try to be as positive as I can with them. It is a job that we can all contribute to, not shying away from things when they go wrong, being prepared to take that seriously, but, at the same time, making it completely clear to staff how much they are appreciated, and how much we know that the job they do is valued by patients.

[114] **Gwenda Thomas:** I would like to extend that to staff in residential care and domiciliary care, where we have seen people walking long distances to people's homes, and also to recognise the role of the voluntary sector in the way that it backs all of this up. Altogether, I think that it was a remarkable effort this year again, and I was pleased to write to directors and other organisations to say thank you.

[115] **Lindsay Whittle:** That is all positive news.

[116] **David Rees:** Elin is next.

[117] **Elin Jones:** Hoffwn droi yn ôl at le ddechreuom ni bore yma, gyda'r *integrated care fund*. Hoffwn ddiolch i'r Gweinidog a'r Dirprwy Weinidog am yr adroddiad ar hynny. Fodd bynnag, a gaf ofyn i chi wneud y wybodaeth honno ar gael yn gyhoeddus: y dosraniad arian ar gyfer awdurdodau lleol a'r cynlluniau y mae'r awdurdodau lleol a'r byrddau iechyd wedi eu cymeradwyo o ran y gweithgaredd y byddant yn ei wneud yn eu hardaloedd? A wnewch chi wneud hynny ar gael yn gyhoeddus?

Elin Jones: I would like to go back to where we started this morning, with the integrated care fund. I would like to thank the Minister and the Deputy Minister for the report on that. However, may I ask you to make that information public: the allocation for local authorities and the plans that local authorities and health boards have approved in terms of the activity they will be undertaking in their areas? Will you make that public?

[118] Yn ogystal, mae gen i rywfaint o gwestiynau ynghylch argaeledd data i ni gael deall y pictiwr yn llawn, fel rydych chi'n ei

In addition, I have some questions about the availability of data for us to understand the full picture, as you understand it. May I ask

ddeall. A gaf ofyn yn benodol ynghylch llawdriniaethau wedi eu gohirio? Rydych chi wedi rhoi ffigur i ni o 48%, sydd yn ffigur arwyddocaol. A ydych chi'n cadw data am *activity levels of elective surgery*, a llawdriniaethau orthopaedig yn bennaf, i ni gael pictiwr dros flwyddyn o'r nifer o lawdriniaethau sydd yn digwydd yn y gwahanol fisoedd yn y gwahanol ysbysai? Credaf fyddai hynny'n ffordd arall o roi pictiwr llawn i ni o sut mae'r gwasanaeth yn cael ei gynllunio. Felly, yn ogystal â gohirio triniaethau, byddai'n rhoi pictiwr i ni o faint o driniaethau sydd wedi cymryd lle.

[119] Yn gyffredinol, mae'r *dashboard* o wybodaeth rydych chi'n ei gyhoeddi yn weddol anodd i'w ddadansoddi. Tro diwethaf wnaethoch chi adroddiad i ni cyn y gaeaf, rhoddoch chi lot o ystadegau, sy'n amlwg gyda chi, i ni, ond nid ydym wedi cael y cyfle i'w cael nhw yn yr un ffordd heddiw. Tybed a fydddech chi'n gallu roi dadansoddiad clir i ni o'r ystadegau dros y gaeaf, fel gallwn ni fod rhywfaint yn gliriach ynghylch patrymau sydd yn datblygu.

[120] Yn olaf, yn sgil y cwestiwn gwnaeth Lindsay ei ofyn am y gaeaf, fel y bu i chi ei ddisgrifio, nid oes llawer o eira na thywydd oer wedi bod. Mae rhywbeth yn digwydd, onid oes, pan mae hi'n *below 4 degrees centigrade*? Nid oes cymaint o hynny wedi bod ag arfer. Nid yw'r fflw yn y gymuned, fel rydych chi ei ddisgrifio, wedi bod mor wael a bu hi yn y gorffennol. Felly, i ryw raddau, y cwestiwn yr wyf eisiau ei ofyn yw: a oedd y fath beth ag *winter pressure* eleni?

[121] Roeddwn i eisiau tynnu eich sylw chi at ystadegau ynglŷn ag *attendance at major A&E*. Gwnaethoch sôn rhywfaint am y gwahaniaeth rhwng y gaeaf llynedd a'r gaeaf eleni ac ei bod wedi mynd i lawr. Fodd bynnag, os rwy'n edrych ar y ffigurau, er enghraifft, roedd *major A&E attendance* ym mis Gorffennaf llynedd yn 72,000 o bobl ac roedd *major A&E attendance* ym mis Chwefror eleni—yng nghanol y gaeaf pan roedd y glaw ar ei waethaf—yn 56,000. Felly, roedd tipyn yn llai yn y gaeaf nag yr oedd yn yr haf. Felly, rwy'n stryffaglian tamed bach wedyn deall beth yw'r cysyniad hwn o *winter pressure*. Rwy'n ei ddeall mewn cyfnodau o oerfel ond nid wyf yn siŵr

specifically about surgery that has been postponed? You have given us a figure of 48%, which is a significant figure. Do you keep data on activity levels of elective surgery, and orthopaedic surgery specifically, for us to see the picture over a period of a year of the number of operations that are undertaken during those months in various hospitals? I think that would be another way of giving us a full picture of how the service is planned. Therefore, as well as delayed treatment, it would give us a picture of how many treatments have been undertaken.

Generally, the dashboard of information that you publish is quite difficult to analyse. The last time that you reported to us before the winter, you provided us with a lot of statistics, which you obviously have, but we have not had the opportunity to have them in the same form today. I wonder whether you could give us a clear analysis of the statistics over the winter period, so that we can be a bit clearer about the patterns that are emerging.

Finally, in light of the question that Lindsay asked about the winter, as you have described it, there has not been a lot of snow or harsh weather conditions. Something happens, does it not, below 4 degrees centigrade? There has not been as much of that as usual. The flu in the community, as you have described, has not been as bad as it has been in the past. So, to an extent, the question I want to ask is: was there such a thing as winter pressure this year?

I want to draw your attention to the statistics on attendance at major A&E departments. You mentioned the difference between the winter of last year and the winter of this year and that that had reduced. However, if I look at the figures, for example, major A&E attendance in July of last year was 72,000 people and major A&E attendance in February of this year—in the middle of the winter when the rain was at its worst—was 56,000. So, it was substantially less in the winter than in the summer. So, I struggle a little to understand this concept of winter pressure. I understand it in periods of cold but I am not sure whether I understand it in a winter such as the one we have just

fy mod yn ei ddeall mewn gaeaf fel yr un yr experienced.
ydym wedi ei gael.

[122] **Gwenda Thomas:** Yr ateb yw: yn bendant, byddwn. Byddwn yn cyhoeddi manylion y cynigion rhanbarthol a hefyd yr ariannu a byddwn yn rhannu'r gwersi o'r broses hefyd o bob sector: gwasanaethau cymdeithasol, iechyd, y sector dai, y sector wirfoddol a'r sector annibynnol. Fy mwriad i yw cyhoeddi wrth inni fynd ymlaen a rhannu gyda chi fel gwrthbleidiau hefyd.

Gwenda Thomas: The response is that yes, we definitely will. We will publish details of the proposals on a regional basis and also the funding and we will share the lessons from the process from all sectors: social services, health, housing, the voluntary sector and the independent sector. My intention is to publish that as we go along and to share that information with you, as opposition parties.

[123] **Mark Drakeford:** I droi at y data, rydym yn casglu data ar lawdriniaeth. Nid wyf yn siŵr os yw'r mynd i lawr i faint sy'n driniaeth orthopedig a faint sy'n bethau eraill, ond mae'n bosibl fod y wybodaeth honno ar gael. Gallwn ofyn i'r CMO i weld beth yr ydym yn gallu ei gyhoeddi. Rydym yn dal i gasglu rhywfaint o ddata o'r gaeaf; nid yw popeth wedi dod trwyddo eto. Rydym yn mynd i edrych ar y *dashboard*. Ar hyn o bryd, mae'r *dashboard* yn rhywbeth mewnol ac mae'n dibynnu ar *management data*. Mae'n bwysig inni fod yn glir gyda'r cyhoedd ar beth yw'r data sy'n dod mas yn swyddogol gyda phopeth sy'n mynd i mewn i'r *official statistics* a beth sydd gennym fel data yr ydym yn ei ddefnyddio bob dydd. Mae'r prawf o beth sy'n *official* a beth sy'n ddata sy'n cael ei ddefnyddio yn rhywbeth gwahanol. Fodd bynnag, rwyf eisiau defnyddio mwy o'r data sydd gennym yn y *dashboard* a chyhoeddi'r data hwnnw. Mae'n un peth, fel rydym wedi dweud nifer o weithiau yn y man hwn, i roi'r data ond mae'n rhywbeth arall i esbonio'r data. Nid wyf eisiau dim ond rhoi'r data mas heb gael esboniad a dadansoddiad gyda'r data sydd gennym.

Mark Drakeford: Turning to the data, we do collect data on surgery. I do not know whether that goes down to the detail of how much is orthopaedic treatment and how much is other things, but that information may be available. We can ask the CMO to see what we are able to publish. We are still collecting some data from the winter; not everything has come through yet. We are going to look at the dashboard. At present, the dashboard is something internal and it depends on management data. It is important for us to be clear with the public on what are the data that come out officially with everything that goes into the official statistics and what we have as data that we use on a day-to-day basis. The test of what is official and what are data that are just used is something different. However, I want to use more of the data that we have in the dashboard and to publish that data. It is one thing, as we have said many times in this place, to provide the data but it is another thing to explain the data. I do not want just to provide the data without having that explanation and analysis of the data.

[124] Were there winter pressures this year? I think that there were very real winter pressures, because it is not simply about numbers, it is also nature. It is the nature of what comes through the door as well as the number of people who come through the door. Public Health Wales will, I am sure, do an analysis of this winter as it did with last winter. I think that I rehearsed this briefly once before in front of the committee. When Public Health Wales looked at last year's winter pressures, it asked whether the weather make a difference: yes, it did. It looked at what else was bringing people through the door: it is the ageing nature of the population and, a year later, that has ratcheted up a little bit compared to the year before. It is also the complexity of cases. These are not simply people who are older: they come into A&E departments now with very complex comorbidities, which have been managed in the community in a way that would not have been the case even just a few years ago. However, most of all, Public Health Wales said that, over last winter, what was bringing people into A&E departments and tipping them from managing into not managing was the impact of

poverty on the lives of so many of our older people. When you have real cutbacks in benefit levels and other things for people who are just on the edge of managing, the choice between heating and eating is a real one for people. It is not a fiction. It is a choice that people make all the time and when people are faced with less and less to manage on and more and more demands as prices go up and so on—. Public Health Wales believes that, of all of the factors that it looked at, that was the most significant one. That will have been even more true this winter, as those cuts began to bite even more, than it was in 2012-13. So, they are winter pressures and it is in the nature of the cases as well as their numbers. Grant will probably say more.

10:45

[125] **Dr Robinson:** Sure. When we talk to a committee like this, or make a report, we tend to give a percentage or a number at a particular time. It is always helpful to look at what the chart is doing over a period of time. There are two big flows of patients—we have been talking a bit about flow today—that go through emergency departments. There is a flow of minor cases, which is always higher in the summer. There are a number of things that drive that. There will be, particularly in your constituency, summer visitors coming for their holidays, which will drive it up. Even where there are not large numbers of summer visitors, there is a higher incidence of minor conditions presenting through A&E departments over the summer period.

[126] In the winter period, the pattern is reversed and we get fewer of the minor attendances, but the major attendances go up. These are people who may well need to come into hospital. We know that, if we look at this year compared to last year, there was a small reduction in the number of minor attendances over the winter period, but there was a small increase in the number of people we can see being admitted through emergency departments.

[127] Underneath that headline figure of 3.5% that I think the Minister quoted, there were substantial increases. Some health boards—Cwm Taf, for example—saw, I think, nearly a 10% increase in admissions through its emergency departments and it was able to cope with that because it focused on flows, so it was able to efficiently deal with the people who were coming in. It was not the only health board that saw an increase. So, it differs a little bit from area to area. One of the lessons of the flow programme is that you have to have a proper understanding of what is going on in your own patch, because the precise measures that you need to put in place will vary a little bit depending on exactly what the experience of the patients who come to you are. However, keeping in your mind the different flows is helpful when you are designing those services.

[128] **Elin Jones:** Your statistics show that attendance at major A&E for July last year was 72,000. In August, the figure was 67,000, but, in January this year, it was only 60,000 and, in February, it was 56,000. So, even for major A&E work, there seems to be a summer emphasis there rather than a winter emphasis.

[129] **Dr Hussey:** May I perhaps add a comment? I think that what we are talking about is the complex juggling that the healthcare system does on a day-to-day basis, and, indeed, the social care system, to match changing factors, some of which are more long-term social factors and some of which are environmental and more immediate, if you like. You will remember that, last summer, we had a spell of prolonged hot weather. We know, and you will know from coverage at the time, that that actually has adverse effects on people's chronic health problems as well. So, not only do you have the short-term minor things of people going out and getting sunburned and having accidents, because they are doing things that they do not normally do, and a flow of visitors, but, actually, every degree the temperature rises, it starts to precipitate poor health in vulnerable people. So, the challenge for the health service is—

[130] **Elin Jones:** So, do you have surge capacity in the summer?

[131] **Dr Hussey:** Yes. We have to be flexible the whole time. We know that, in winter, we generally have more types of environmental factors such as cold weather. We do not often have very hot weather in the summer, but extremes of temperature bring the same thing. So, the challenge for the health system is to be able, on a daily and weekly basis, to know how to quickly flex all of its abilities and all of its resources to try to get that system to flow well every day, on the button.

[132] I think that that was the period that we are talking about. I would have to check on that, but I just wanted to draw the point that while, generally, we talk about winter pressures and we always have done, perhaps we should talk about seasonal pressures and the different types and mix of services that we need to have available at different times. Some of it you just cannot predict on a month by month basis, because some of them are less common, like very hot weather.

[133] **Elin Jones:** The statistics that I have from June through to late September are much higher than the winter attendance. So, there was something happening there, which is partly explained by hot weather in July. I can see that. In terms of the whole concept, I like the fact that, at some point, we should not really be discussing winter pressure; we should not have plans for every winter that change from year to year because this should be 365-day seamless work for the NHS. There should not be such a thing as winter pressure.

[134] **David Rees:** I now call Lynne.

[135] **Lynne Neagle:** I just wanted to ask about going forward. Clearly, we have had an unprecedented level of planning for this winter, which is very welcome. Dr Robinson mentioned how you would be trying to take what worked in particular areas and ensuring that that good practice is spread. Could you just tell us what the process will be now of learning from the experience this winter and how that will feed into the planning for next year?

[136] **Dr Robinson:** Do you want me to start?

[137] **Mark Drakeford:** Yes, please.

[138] **Dr Robinson:** As I said before, there are sort of two processes running alongside each other. There is a formal process of seasonal winter unscheduled care planning that goes on between Welsh Government officials and health boards, and running alongside that is a supporting process to help people who are working on the ground to exchange what works best. The seasonal planning process, as the Minister has explained, is tighter and involves more parties than it has previously done. As the Minister said, I think, we last met on 6 March. We are meeting again in June to go over seasonal plans with health boards. We will be meeting again with them in September, and we would expect them to have published their plans to see us over the winter period, taking Elin's comments about planning across the whole year into account. However, we anticipate that they will be out before the end of October. There will be a much tighter process around reviewing those. It was tighter this year, but we are going to try to keep that pressure on to make sure that that is there in the public domain.

[139] The sharing that we did in terms of planning between the health service, local authorities and the ambulance service worked well, and we want to build on that experience. There are the exciting integration pilots that Albert and the Deputy Minister have already mentioned, and we will be interested to see how we can feed that into the process as we move forward. So, there is that formal process. Alongside that is the 1000 Lives patient-flow

programme, which has been meeting alongside that formal process. That is an opportunity for people to have a bit more of a real conversation about what is really working and what is not working for them, to share in a slightly less formal way. However, it still involves storyboards. We bring people together and we also bring them together through web exchanges and telephone calls in between those meetings. We have another collaborative meeting again in June. We have been having them over the course of the winter, and that is a programme that will be here to stay with us now. So, we have those two things running in parallel.

[140] **Lynne Neagle:** Thank you.

[141] **David Rees:** In light of those points, clearly, reconfiguration will have an impact upon some of the planning, I would think, particularly as the south Wales programme has now been completed. In respect of the strategic review of the ambulance service, some of the reforms have been enacted as of yesterday. I assume that you are taking those into your consideration of your planning as a consequence of everything that has gone on.

[142] **Dr Robinson:** I shall start on that. As the Minister has said, in a sense, some of these are different perspectives on the same problem because you cannot consider flows without getting fairly quickly into a conversation about where you do what. For some activities, it is simply not possible to do everything everywhere. At the same time, we have to balance that against the need to provide services as locally as possible when that is important. The main pressure—the story that we are telling about the pressure on unscheduled care—does rotate very much around older people. We have to hold in our minds the need to get the services for older people as good as they can be. There is always a need to balance priorities. If an older person had a heart attack or stroke, we would aim to give them the same quality of care as a younger person. That might mean moving them further than they would previously have gone, to get to a place where that care is available 24/7; so, they will get the intervention that they need straight away, rather than waiting until the next day as they might have done previously. However, at the same time, we know that taking an older person away from their social support and their family set-up also has an effect on the outcome. The older you get, the more comorbidities you have, and the more that is an issue for you. So, those are the kinds of things that we need to balance as we move forward.

[143] We have been through a very careful process of consulting with clinical colleagues about the degree of centralisation that we think is achievable and necessary in future as we move this forward. However, it is important also to bear in mind that this is not for all services. Some services will be kept local, and it is particularly important to keep the focus on how we are providing services for older people. As we do this, we want to move them around the system as little as possible, whether that is between wards inside a hospital or from hospital to hospital. However, sometimes, those moves will be necessary to make sure that they are on the most effective care pathway for them.

[144] **Mark Drakeford:** Chair, just to pick up the point you made about some very significant changes that came into effect on 1 April, as you know, we have remodelled the way in which ambulance services in Wales are to be planned and provided. We extracted that responsibility from WHSSC and regulations went through the Assembly recently to set up a free-standing emergency ambulance committee, which will be made up of all the chief executives in Wales, to plan and commission the service for the future. I was very keen that that committee should be independently chaired. That post was advertised and recruited and, not to be outdone by the Deputy Minister, I am making an announcement in front of the committee, and I can announce this morning that Professor Siobhan McClelland put her name forward for that post and has been appointed, so she will chair that committee for the foreseeable future.

[145] **David Rees:** Thank you for that, Minister. Do colleagues have any further questions? Deputy Minister, do you want to say something?

[146] **Gwenda Thomas:** I want to say that we have published the integration framework for older people. That is in the public domain. Within that, there is a requirement for LHBs and partners, including local authorities, to produce statements of intent. Those were received in draft in January, and we are looking at those with a view to finalising the statements. We will be very pleased to share those.

[147] **David Rees:** I think that we are probably at our last question. We have not touched on primary care at all this morning and, clearly, it is a big question. One of your focuses was to reduce the number of people going into hospital in the first instance. Have you done any analysis as to whether that has been successful? You have talked about a 3.5% increase. Has there been a reduction because of the primary care services, so that people have not had to go in to hospital unnecessarily?

[148] **Mark Drakeford:** There are very good data from the ambulance service on the care pathways it has agreed with secondary and primary care in relation to people who have had a fall or people who have epilepsy. It is able to demonstrate that that extra work is diverting about 1,000 patients every week who would otherwise have gone into an A&E department and who are now not going in because ambulance personnel are able to deal with those conditions in situ. With one minute to go, I might ask Ruth whether she can encapsulate what has gone on in primary care towards helping that as well.

[149] **Dr Hussey:** As you know, we have been focusing very much on improving access, and there has been quite substantial progress with regard to access. There is more work to do, but it is very much in our sights. There is also work on supporting self-care and the development of a framework for self-care. You will be aware of the recent Wales Audit Office report on the management of chronic conditions, which highlights some of the good work that has been going on, in better managing people with chronic health problems. Obviously, there will be a response in due course to the detailed findings, but that focus on trying to manage people better in the community is starting to show signs of some promise.

[150] **David Rees:** Thank you for that, and I thank you for your attendance today and for the evidence you have given. You will receive a copy of the transcript to check for factual accuracy. Once again, thank you very much.

[151] **Mark Drakeford:** Thank you.

10:59

**Cynnig i Benderfynu i Wahardd y Cyhoedd o'r Cyfarfod, o dan Reol Sefydlog
17.42(vi) ar gyfer Eitem 4, a Reol Sefydlog 17.42(ix) ar gyfer Eitem 5
Motion to Exclude the Public from the Meeting, under Standing Order 17.42(vi)
for Item 4, and Standing Order 17.42(ix) for Item 5**

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

the committee resolves to exclude the public from the meeting for item 4 in accordance with Standing Order 17.42(vi) and for item 5 in accordance with Standing Order 17.42(ix).

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

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:59
The public part of the meeting ended at 10:59

Ailymgynullodd y pwyllgor yn gyhoeddus am 13:03.
The committee reconvened in public at 13:03.

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

[154] **David Rees:** May I welcome Members back to the committee's afternoon session? We have Professor Phil Routledge with us. The intention this afternoon is to test some of the themes that have been emerging from the inquiry into medical technologies regarding an improved, robust and transparent process for the appraisal of new technologies, and some of the evidence that we received focused on the possibility of the All Wales Medicines Strategy Group being a vehicle for that. May I welcome Professor Routledge, who is chair of the All Wales Medicines Strategy Group? Thank you for your willingness to come this afternoon; we heard from AWMSG at an earlier point in this inquiry, but thank you very much for coming back to go through some of the issues that have come through as a consequence of our work. So, Gwyn, will you start the questions?

[155] **Gwyn R. Price:** Yes; thank you, Chairman. Good afternoon and welcome. In relation to medicines, what benefits have there been from the establishment of AWMSG and, in your view, is there a need for an all-Wales approach to the appraisal of new medical technologies?

[156] **Professor Routledge:** Thank you. In my view, AWMSG and the development of the National Institute for Health and Care Excellence in England and Wales have been a real benefit in relation to early access to medicines that are effective. I chaired a medicines and therapeutics committee at regional level—I think it was Bro Taf medicines and therapeutics committee—for about 10 years. During that time, one of the frustrations was often that the committee might feel that a drug would be effective, and a cost-effective use of resources, but it was not using mechanisms to then get that drug available to patients, and so there were often long delays. Part of the reason for that was that, at that stage, we had not really understood the value of health economics in deciding on the cost-effectiveness, as well as the clinical effectiveness, of a medicine. So, the introduction of NICE and, subsequently, AWMSG has resulted in there being a transparent mechanism by which the benefits, risks and, therefore, the clinical effectiveness of the drug can be balanced against its cost-effectiveness, so that the health service is receiving value for money for the technology or in the case of AWMSG and NICE, largely but not exclusively, drugs.

[157] **Gwyn R. Price:** Do you think that there is a need for an all-Wales approach then?

[158] **Professor Routledge:** I believe that there is, yes. I have made soundings with lots of colleagues. I do believe that the fact that NICE has guidance through its technologies evaluation programme is a very positive thing, and I would say that the first thing that needs to be done is for us to ensure that we have processes to ensure that we get the greatest benefit from that process that already exists. It is largely for a small number of medicines. We have the deputy chair of that committee working in Wales, so we have expertise locally, and I think it is very important that there are mechanisms for that advice to be considered very carefully, because it has the potential to help to ensure equity across Wales.

[159] **Rebecca Evans:** Do you have a view on the relatively low threshold of evidence that

is required for technologies as opposed to medicines?

[160] **Professor Routledge:** Yes, it is not ideal, but it is the best that we have, and I think that any evidence base is better than none. I think that perhaps in the past what we suffered from was no evidence base at all. At least now we have an evidence base and, therefore, I believe that we can work with it. You are quite right that it is not as good as for medicines. Many of these companies are much smaller, and the cost and time of doing the studies is perhaps very difficult for them, and therefore we often may not have what we would see as the gold standard of cost-utility analysis for the medicines. Nevertheless, cost-consequences analysis is important in determining whether the outlay for a particular technology is worth while. I would say that, in addition to the work of NICE, which looks at a relatively small number of technologies, there are specific technologies that do not come under the aegis of NICE, and it is very difficult then for individual clinicians who believe that that technology is good for patients to get it to patients without the mechanisms in place. So, I think that there is a need for further options, just as we complement the work of NICE, but do not reproduce it. We look at all the medicines that are not on the NICE programme, and that way we get the benefit of putting all our resources into the ones that would fall out of the net.

[161] **Rebecca Evans:** One of the strongest themes that has come through in this inquiry is the need for an all-Wales approach. Several witnesses have suggested that there should be a technologies sub-group or sister group within AWMSG. What would be your response to that?

[162] **Professor Routledge:** That would certainly be one model, and it is a similar model to NICE. That would be an approach that, I believe, would be workable. As you probably know from my colleague Karen Samuels, we already have sub-groups of NICE, such as the new medicines group. We also have a group that looks at therapeutics and medicines management issues across Wales, called the all-Wales prescribing advisory group. So, we use that process, and then AWMSG acts as the strategic committee that will endorse any recommendations from those sub-groups. So, we have the advantage then of a committee that is geographically representative of Wales, and representative of the professions, so it is multidisciplinary, but also has input from lay individuals, so that we engage with the public and carers to ensure that the decisions have the widest possible input.

[163] **Rebecca Evans:** Do you have the capacity in terms of knowledge, contacts and so on, within AWMSG, to expand to look further at technologies?

[164] **Professor Routledge:** That is a very important question. I think that the answer is that we have some of the expertise. We have the health economic expertise. My background is as a clinician, a general physician at Llandough, since 1981. So, the clinical assessment of technologies is something that many of us do have expertise for. However, I think that there are specific areas where we would need to draw on expertise from elsewhere. We have had conversations with our colleagues in Cedar, particularly Dr Carolan-Rees, who has shared her thoughts with us and has indicated that we could collaborate. We work in the same health board, and within the same clinical board within that health board, and I think that our areas of expertise would complement each other.

[165] **Elin Jones:** In your answer to Rebecca, you said that you could see that what Rebecca mentioned in relation to the idea of a sub-group or sister group within AWMSG would be a workable model. Do you have any other models that you think would lend themselves well to an all-Wales approach that would be an improved and more efficient way of assessing than is the case currently?

[166] **Professor Routledge:** I think, to be honest, that the most cost-effective model would be to have a sub-group that would report to the main group. The general principles of health

technology appraisal are similar. The approaches and the mechanisms used might differ, but I think that the people who have the expertise in making difficult decisions, and who have had a lot of experience of working in the health service, are the same people who could make the decisions, given sufficient evidence from a sub-committee that had the expertise that was needed. I think that the sub-committee would, as our new medicines group already does, look very carefully at the clinical effectiveness and, where possible, the cost-effectiveness, and then the main committee would make the judgments on whether that was right for Wales.

[167] **David Rees:** May I clarify something? Whereas the medicines group involves one set of procedures and roles, clearly technology would require additional consideration, particularly for the workforce, usability training and maybe even the changing of care pathways. Do you think that you have the experience and expertise in the procedures to address those issues as well?

[168] **Professor Routledge:** I believe that we would, yes. As I said earlier, we have the benefits of several medical practitioners and many pharmacists who have an enormous range of skills that are available and also health economic expertise. Clearly, it is an area that would need a different approach and a broader approach, but I believe that we do have the expertise to consider taking on that role—just as NICE has done that from the very beginning. However, NICE has a separate committee, and so I think that there is a message there that there are sufficient differences that they need to be addressed perhaps by a different sub-committee. However, I believe that the expertise is available.

[169] **Leighton Andrews:** Are there any difficulties at present where, say, a technology has been approved for use by NICE's sub-committee in terms of you then passporting its use in Wales?

[170] **Professor Routledge:** Due to the fact that we are not involved in medical technologies, no, but of course we have had issues in relation to medicines, where we perhaps have had a preliminary assessment in Wales that is then looked at by NICE and our view is that we accept the NICE recommendation. Very rarely has that been different from any preliminary assessment within Wales. So, I think that, provided that you have robust methodologies in place, generally, there is close concordance not only between those recommendations, but with the recommendations of the Scottish Medicines Consortium.

[171] The issue with health technology appraisals is broader than just the issue of the appraisal. First, there are the issues around horizon scanning to find out what is coming. We have that well developed for medicines, but I think that it needs to be developed more with health technologies.

13:15

[172] Then, after the appraisal, you have issues around implementation, and we are working hard with medicines to ensure that those drugs that have been approved by NICE or AWMSG are implemented. That is very important, but I think, in the case of medical technologies, because of the weaker evidence base, you do have to have systems for evaluation.

[173] **Leighton Andrews:** Do we need a separate system from NICE?

[174] **Professor Routledge:** We have always taken a view in Wales that if NICE was to look at all medicines, there would be no need for AWMSG to look at any medicines. However, that has proved impossible because of the volume. In terms of medical technologies, the same situation exists, where there are technologies that have not gone through the NICE process, but on which clinicians in Wales want an independent, evidence-based decision, to inform their judgments about whether it should be taken up. So, while that

situation exists, we do need to consider alternative mechanisms. Clearly, if NICE was to expand to look at all technologies, that would no longer be the case. AWMSG's role, for instance, is as much about making sure that we use the technologies that are available effectively, as it is about approving technologies.

[175] In the same way, that would be true of medical technologies other than medicines, in that there is a real need to monitor implementation and also, in certain cases, to try to ensure that there is evaluation because, if the evidence is insufficient, the only way to get it is when you take up the technology to make sure that you are collecting data.

[176] **Rebecca Evans:** Medicines often need technologies as a means of delivering them to the patient. Are you aware of any cases where a medicine has been approved but the delivery mechanism of the technology has not, or is the system quite well joined up in that regard?

[177] **Professor Routledge:** It is a very important issue, and it is getting increasingly important, as you say. I am not aware of any instances where that has happened. Certainly, when we look at a medicine with an associated diagnostic technology, we clearly think carefully about the implications of the diagnostic technology. I think that is going to be increasingly true, as you say, as we move towards personalised medicines. However, I am not aware that that has been an issue to date. To the limits of my knowledge, I do not think that it is a particular issue.

[178] **Elin Jones:** On the issue of commissioning through evaluation, you have mentioned several times that the approach to appraisal for medicines would be very different to the approach to medical technologies, because you get a lot of evidence from pharmaceutical companies whose medicines are well developed before you do the appraisal. However, very often that is not the case for medical technologies. So, it is a very different discipline of appraisal, and a very different culture of appraising something and almost taking a certain degree of risk in appraising, commissioning and then evaluating over three or five years. Do you think that there is the acceptability or the capacity to do that work because the NHS and the public sector in general can be quite poor at evaluating expenditure on anything? So, I wonder how robust you think that the system of commissioning through evaluation can be.

[179] **Professor Routledge:** I will be careful to say that the resources would have to be available to make that happen, but, if those were available, it is not very dissimilar to some of the situations with regard to orphan, and ultra-orphan, drugs, where we make decisions based on very small amounts of evidence, sometimes on surrogate end points, but we ensure that patients are enrolled on a registry in order for that information to be collected. We then ensure that, for all medicines, the appraisal is reviewed in three years and, if necessary, further evidence is gleaned to ensure that the decision was an appropriate one. So, with medicines for which the evidence is relatively small in scale, we are already taking that approach. However, I agree with you that it is essential that you have an evaluation process to inform your commissioning.

[180] **David Rees:** Lindsay, do you want to continue with the appraisal theme?

[181] **Lindsay Whittle:** I just wanted to ask about this all-Wales approach to appraisal and whether we should look at every single item of technology or whether you would just target specific items of technology to, perhaps, address Welsh Government targets and help most people, but, to play devil's advocate—not that I am advocating this—not everybody, because of tight financial resources.

[182] **Professor Routledge:** You are right. I think that the number of medical technologies that are coming into the arena every year are such that it would be impossible to look at all technologies. You could talk about, you know, x number of laryngoscopes coming to put an

airway into a patient. Of course, the numbers and design of those means that you have a large number of issues.

[183] What I believe is that you would have to prioritise. We already deal with medicines. If the service feels that there is a particular medicine that might have a major impact in Wales, then we are prepared to appraise that medicine at an early stage, even if it is on the NICE work programme. Accepting that, if NICE's judgment was subsequently different, we would follow NICE's guidance. We did that with the drug abiraterone for prostate cancer, so that the drug was available four months earlier in Wales than it was generally available in England.

[184] So, I think that prioritisation is absolutely essential and that is where you need the expertise. What you need really is the expertise of the clinicians. What we have realised over the last 12 years of AWMSG is that the most crucial thing is to have the ownership of the process by the clinical networks, so that our clinicians are our source of information, not only for horizon scanning, but for prioritisation as well. So, we rely heavily on the clinical networks to say, 'This particular agent is the one that we really need for patients in Wales', and then that gets priority.

[185] **Lindsay Whittle:** It is no good buying the best technology in the world if you have nobody who knows how to use it, of course, so training is also essential.

[186] **Professor Routledge:** Absolutely. I think that Dr Carolan-Rees makes the point, and she may have made it to this committee, that usability is a very important issue in relation to medical technologies. With a medicine, you may swallow it as a tablet, or you can give it intravenously, but with a technology, if it is not usable, then it is not often used, or if it is used, it is used wrongly. So, I think that those are factors that are in addition to what you would expect for a medicine.

[187] **David Rees:** Rebecca is next.

[188] **Rebecca Evans:** When you prioritise medicines for appraisal, what role does cost savings to the NHS play in those decisions in terms of finding a drug that is cheaper but does the same thing as what is currently being used?

[189] **Professor Routledge:** I have to say that, in my experience, that is not a major issue in relation to decisions. The decisions are largely around the effectiveness of the agent and issues around equity. So, those issues drive the decision-making process. That is not to say that cost savings are not important. Half of the work of AWMSG is to look for prudent prescribing opportunities in order that we can save the money that could be invested in newer technologies, including medicines.

[190] So, when it comes to the cost-effectiveness issues, that is an important part of the appraisal, but it is not necessarily that we want something that is cost saving—we want the best technology and we have to then work hard to try to identify areas where the health service can disinvest in order that it can invest in the best technologies. That is difficult, but it is paramount, because you cannot just keep on spending from a limited budget unless you are also efficient.

[191] **David Rees:** You identified in an earlier answer that you look at cost consequence analysis. Clearly, there is an issue of cost-effectiveness and cost benefits. However, what are you looking for particularly in cost consequences?

[192] **Professor Routledge:** Clearly, the outcomes to the patient. Sometimes, they can be very clear, measurable end points, such as reduction in mortality, but with cost-utility analysis you are looking at a much broader aspect, including the quality of life of the patient.

Therefore, that is why it is the gold standard—it is not only the duration of extra life, but the quality of that life. That is ideal, but it is not always available, and therefore you have to look at whatever consequence you can measure that will allow you to make a judgment as to whether the cost that is required to obtain that consequence is adequate. I personally have not had any experience of cost-consequence analysis, but our health economists clearly will have.

[193] **Lindsay Whittle:** What is the patient involvement in looking at new technology?

[194] **Professor Routledge:** In terms of the sub-group, called the new medicines group, as I mentioned, we have lay input into that. We also have the main AWMSG, where we have lay input—a lay member. The lay member concentrates on the submissions from the patient interest groups and relays those to the committee. We are also now developing its role much more broadly—a patient and public interest group, which I think is vital. That may not necessarily be on an individual technology, but the lay members on each of the committees have input to the decision and vote with everyone else as to whether this technology should be adopted or not. I think that it is vital that we do have lay input at all stages of the process. We have a strategy to try to improve that engagement. One of the frustrations, when we are looking at medicines, is that we do not always manage to get groups to give evidence. I think that that, in a sense, is to the detriment of the process. I would prefer that we always have at least one, but often more than one, representation from patient interest groups. I think that we are working hard to try to ensure that the patient interest groups, the representatives of the patients or carers, feel that their voice is making a difference. I think that that is our role and responsibility, not theirs.

[195] **David Rees:** Elin asked earlier the question about commissioning by evaluation. Commissioning models are probably an important area. We have had this raised by other witnesses. Do you believe that the current approach to commissioning is appropriate to technologies? Should we be looking at some commissioning at a national level, mixed with the board level, or should it all be at a national level? What approach, do you think, is appropriate in commissioning new technologies?

[196] **Professor Routledge:** Given that technologies are so broad in their range from diagnostic technologies through to therapies—and some people within technologies would have interventional procedures, for instance, as part of them—it is very hard to be specific that all of those should be assessed at a single level. When it comes to what they call the big ticket items—things that are going to have a major impact on the health service—I think that it is important that there is a national view. It may also be important to look at those areas where there are large volumes, and therefore a large budget impact to the health service. I think that budget impact is a factor that might determine whether you would need to look at something centrally rather than regionally. I am not sure that one-size-fits-all would necessarily be the approach, but I think that it would require some discussion.

[197] **David Rees:** The recent review on the orphan and ultra-orphan drugs also highlighted better collaboration between Welsh Health Specialised Services Committee and AWMSG. Where do you see the role of WHSSC in commissioning and technologies?

[198] **Professor Routledge:** Clearly, it has an enormously important role in commissioning technologies. I am pleased to say that we have had a close relationship with WHSSC and its predecessor organisations for the last 10 years or so. That relationship has got better because we now have WHSSC representation on the new medicines group, and on AWMSG, as well as on the steering group of AWMSG. I think that it must be embedded in any processes because, as I have mentioned, implementation has to be an important part of that, and you have to have a commissioning body to ensure that that implementation happens.

[199] **David Rees:** Rebecca is next.

[200] **Rebecca Evans:** We have heard some suggestions that there should be an audit of uptake of medical technologies because, at the moment, the systems do not really exist to know who is using what and where. What would be the best way of doing that audit, and who should lead on it?

13:30

[201] **Professor Routledge:** Clearly, we would have to work with local health boards to try to ensure that that information was available. Sometimes, it is best to concentrate on, say, a representative example of a particular type of technology and then engage with the local expertise of a specialist group. So, for instance, when we have required information, when we have required audits, we have often approached small groups of specialists who know what the important questions are and, with their help, we have collected information that has allowed us to look at the implementation of medicines. I think that that model is one that could translate to health technologies. So, again, it comes down to the clinicians. I am a general physician and I therefore have a broad interest, but I think that, when it comes to specialist areas, you have to have the people who are doing this day in, day out.

[202] **Rebecca Evans:** You have a GP background; in a recent evidence session, a GP came to us and said that there might be ways of GPs reporting more easily what they are using in the feedback and information that you give routinely. Could it be expanded to include technologies?

[203] **Professor Routledge:** I am actually a general physician in a hospital—

[204] **Rebecca Evans:** Oh, sorry—

[205] **Professor Routledge:** —but I work closely with GPs, and 90% of our prescribing is conducted by GPs, so they are a fundamental part of the healthcare process. Did you mean the reporting of concerns or adverse events or more broadly the benefits of a particular medicine?

[206] **Rebecca Evans:** I was referring to reporting on their use because we do not know which GPs are using which new technologies. It would just be a simple audit, really, of what GPs are adopting locally.

[207] **Professor Routledge:** I think that, again, we have good representation of general practice in the committee but also good links with the appropriate organisations to ensure that GPs would engage in a review. Again, it would be relevant to the technology that a GP might use, which is likely to be very different from the kind of things used in hospitals. So, you are right that we would have to engage across primary as well as secondary care because medical technologies are not limited to secondary care.

[208] **David Rees:** You mentioned horizon scanning earlier on this afternoon, but, clearly, it has been brought to our attention that it is an important element to start looking at what technologies are coming down the line and their usefulness. Do you do much horizon scanning as part of AWMSG now, because it is slightly different? Given that it is clinician-led, and we have been told that a lot of the technology adoption is clinician-led, how do you see that approach working in an all-Wales strategy?

[209] **Professor Routledge:** We are certainly involved in the horizon scanning. I have to say that the development of horizon scanning has been a very positive event over the past decade, and, now, the processes that we used to use and develop have been superseded by an all-UK approach, involving the industry as well as the service to obtain that information. That really has been a plus in terms of progress because I think that we get a much broader picture

and good engagement with the industry. So, I think that, if you are doing horizon scanning, you need a multifactorial approach. You need the clinicians to say what they feel is going to make a difference to patients, but you also need input from the manufacturers and the commissioning groups. So, horizon scanning requires a very broad approach that does not rely on any one particular group of individuals. I think that it is broadly analogous to the horizon scanning approach for medicines—it is just not as well developed. For instance, Cedar will provide horizon scanning information to NICE and NICE collates that, and I think that there are three other similar centres to Cedar, so, presumably, they will provide similar evidence. However, it could be developed much more broadly in Wales because there may be other technologies, as I say, that are not necessarily being flagged in the systems that are in place now.

[210] **David Rees:** As it is clinician-led an awful lot, if it is an all-Wales strategy, will clinicians have the confidence that it will not be too bureaucratic, for example, and, therefore, that there will still be an opportunity to drive forward what they want to try to use?

[211] **Professor Routledge:** It is very important to ensure that your processes are as efficient as possible, because you are right that, if someone has to fill in a long form of 10 pages, that is likely to deter them; they have patients to see. So what we did, right at the beginning, was to go to Scotland, which had set up the Scottish Medicines Consortium, and we shared their processes and their paperwork. Since that time, we have developed it further, but the accent has always been on timeliness, because I think that, if a process is not timely, it is not fit for purpose. So, we have shortened the timescale for our appraisals. I think that we have to have a process that does not bog people down in bureaucracy. It has to be responsive to the needs of the clinician. I believe that that is possible. Clearly, one would have to ask clinicians about what they feel about the work of AWMSG, rather than me, having been involved in it for the last eight years, but I believe that we have seen that as a priority: you must ensure that you do not end up hitting people with reams of paper. This is about patients; it is not about paperwork.

[212] **David Rees:** This afternoon, we have asked you many questions about whether you think that AWMSG could be the body to do this work on an all-Wales strategy. Are there any barriers that you foresee to being able to achieve that?

[213] **Professor Routledge:** Clearly, resources are an issue, and one has to invest in processes in order to ensure that the capacity is there to do the work. I would say that AWMSG is a committee, rather than an organisation. I chair it, and I step down in September and hope that there will be a new chair of the committee, but underpinning the committee is an organisation called the All Wales Therapeutics and Toxicology Centre, which is a group of health professionals, doctors, pharmacists and life scientists, and that is the professional support arm for AWMSG. So, AWTTTC is really where the initial work and engagement occurs. AWMSG is where the decisions are made. So, I think that the organisation is there; there are organisations in Scotland, as I said, that are similar, but they certainly do not look at health technologies at the present time.

[214] **David Rees:** Okay, thank you. Do any other Members have any other questions? They do not. My normal standard question at the end of a session is to ask whether there is one thing that you think that we should be looking at or recommending. In your view, what should that be?

[215] **Professor Routledge:** I would recommend that we have a very close look at the way that advice is implemented, wherever it comes from, and that would include the advice of NICE.

[216] **David Rees:** Thank you very much and thank you for coming in this afternoon. We

are very grateful to you for giving of your time. You will receive a copy of the transcript for factual corrections, if there are any.

13:38

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

[217] **David Rees:** Can we note the minutes of our previous two meetings of 28 March 2014 and 26 March 2014? Thank you. We also have correspondence from Healthcare Inspectorate Wales identifying the publication of its operational plan for 2014-15. I wish to draw your attention to the fact that the Wales Audit Office, as part of its recently published briefing to the Public Accounts Committee on its value-for-money programme, has noted that the auditor general will consider a request from the chief executive of HIW to undertake a review of the overall effectiveness of HIW and delivery against its 2014-15 operational plan. So, that is going ahead.

13:39

**Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o'r
Cyfarfod ar 30 Ebrill 2014**

**Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from
the Meeting on 30 April**

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

the committee resolves to exclude the public from the meeting on 30 April in accordance with Standing Order 17.42(vi).

[219] This is to participate in a professional development programme for in-year financial scrutiny and to consider the draft report for the inquiry into the availability of bariatric services. Are all Members content? I see that Members are in agreement. Thank you very much.

*Derbyniwyd y cynnig.
Motion agreed.*

[220] **David Rees:** Therefore, I now wish you a very merry Easter. Have a good break and come back to the Assembly reinvigorated, because I know that we will all be working hard in the three weeks in between.

*Daeth y cyfarfod i ben am 13:40.
The meeting ended at 13:40.*