



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

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

**Dydd Iau, 18 Medi 2014
Thursday, 18 September 2014**

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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

Mohammad Asghar	Ceidwadwyr Cymreig (yn dirprwyo ar ran Janet Finch-Saunders)
Alun Davies	Welsh Conservatives (substitute for Janet Finch-Saunders) Llafur (yn dirprwyo ar ran Rebecca Evans)
Andrew R.T. Davies	Labour (substitute for Rebecca Evans) Ceidwadwyr Cymreig (yn dirprwyo ar ran Darren Millar yn y bore)
Paul Davies	Welsh Conservatives (substitute for Darren Millar in the morning) Ceidwadwyr Cymreig (yn dirprwyo ar ran Darren Millar yn y prynhawn)
John Griffiths	Welsh Conservatives (substitute for Darren Millar in the afternoon) Llafur (yn dirprwyo ar ran Leighton Andrews)
Elin Jones	Labour (substitute for Leighton Andrews) Plaid Cymru
Lynne Neagle	The Party of Wales Llafur
Gwyn R. Price	Labour Llafur
David Rees	Labour Llafur (Cadeirydd y Pwyllgor)
Kirsty Williams	Labour (Committee Chair) Democratiaid Rhyddfrydol Cymru
	Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Charles Allanby	Cymdeithas Feddygol Prydain Cymru British Medical Association Cymru Wales
Andrew Bell	Yr Asiantaeth Gwellu Gwasanaethau Cymdeithasol Social Services Improvement Agency
Mark Drakeford	Aelod Cynulliad, Llafur (Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (The Minister for Health and Social Services)
Sue Evans	Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru Association of Directors of Social Services Cymru
Dr Andrew Goodall	Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director General, Health and Social Services, Welsh Government
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol ac Integreiddio, Llywodraeth Cymru Director of Social Services and Integration, Welsh Government
Dr Peter Horvath-Howard	Cymdeithas Feddygol Prydain Cymru British Medical Association Cymru Wales

Dr Nazia Hussain	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners Wales
Dr Ruth Hussey	Prif Swyddog Meddygol, Llywodraeth Cymru Chief Medical Officer, Welsh Government
Dr Anna Kuczynska	Cyfarwyddwr Ardal Meddygon Teulu, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro GP Locality Director, Cardiff and Vale University Local Health Board
Charlotte Moar	Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Director of Finance, Cardiff and Vale University Local Health Board
Martin Sollis	Cyfarwyddwr Cyllid, Llywodraeth Cymru Director of Finance, Welsh Government
Dr Mark Vaughan	Coleg Brenhinol yr Ymarferwyr Cyffredinol Cymru Royal College of General Practitioners Wales

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

Amy Clifton	Gwasanaeth Ymchwil Research Service
Helen Finlayson	Ail Glerc Second Clerk
Sian Giddins	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Joanest Varney-Jackson	Cynghorydd Cyfreithiol Legal Adviser
Philippa Watkins	Gwasanaeth Ymchwil Research Service

Dechreuodd rhan gyhoeddus y cyfarfod am 10:16.
The public part of the meeting began at 10:16.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning and I welcome Members to the committee following the summer recess and to the start of a new term of the Health and Social Care Committee. I remind Members that the meeting is bilingual. Headphones can be used for simultaneous translation from Welsh to English on channel 1, and for amplification if you want it on channel 0. We do not have any scheduled fire alarms, so if any fire alarms do go off, please follow the directions of the ushers. I remind people to turn off their mobile phones or any other equipment that may interfere with the broadcasting equipment. We have received apologies this morning from Rebecca Evans, Leighton Andrews, Darren Millar, Janet Finch-Saunders and Lindsay Whittle. We have John Griffiths, Mohammad Asghar and Andrew R.T. Davies acting as substitutes this morning. I welcome you all. At this point, I put on record our thanks to Leighton Andrews for his work on the committee; as he is now a member of the Welsh Government, he will no longer be part of this committee. I think we should record our thanks for his involvement in the inquiries and his incisive questioning while he was with us.

10:17

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

[2] **David Rees:** We have several papers to note that are in your pack of papers. Can we note the minutes of the meeting on 16 July 2014 and correspondence received from the Minister for Health and Social Services regarding Healthcare Inspectorate Wales, the health professional education investment review, the Welsh Government cancer delivery plan and the national clinical lead for stroke services? Are you happy to note those? I see that you are. Thank you.

10:18

**Ymchwiliad i Fynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn
Dystiolaeth 17
Inquiry into Access to Medical Technologies in Wales: Evidence Session 17**

[3] **David Rees:** We now move on to the purpose of this morning's session, which is an evidence session in our continuing inquiry into the access to medical technologies in Wales. I remind Members that this is a continuation and that this session was specifically requested by Members on the primary care sector in this inquiry, because we felt that we needed more information to come from the primary care sector and the social services sector with regard to how they perceived the issues relating to new technologies, access to technologies and whether those technologies work, and so on, in relation to that. So, that is the area that we will be going into.

[4] I therefore welcome our first two witnesses, Dr Anna Kuczynska from Cardiff and Vale University Local Health Board, and Charlotte Moar, also from Cardiff and Vale health board. Thank you for your written evidence, which the committee has received. As you are aware, when we get the written evidence we tend to ask questions as a consequence of that, so those questions will be forthcoming from Members. I will start, if that is okay. What engagement does the primary care sector have in horizon scanning or looking at new technologies and their effectiveness for patient care?

[5] **Ms Moar:** I will start with the overall university health board framework then perhaps Anna would like to give some real examples from her work as a general practitioner. In Cardiff and Vale UHB we have very strong primary care provision. It is very well developed and we are well resourced in terms of primary care contractors. They are absolutely integral to our management structure; they are one of the key corporate divisions. So, primary care is absolutely at the heart of our decision-making processes and is therefore incredibly involved in terms of the prioritisation of technologies.

[6] As a UHB, we absolutely recognise the benefits of technologies in terms of transforming patient care, whether that is actually enabling local care by getting access to specialist expertise that might be somewhere else, whether it is to do with patients having the convenience of booking appointments online, or accessing their own healthcare records, whether it is savings in administrative processes by doing things electronically, or whether it is to do with joining up our care with social services, so that, from a patient's point of view, they only see it once. So, we are absolutely committed to the benefits of new technologies.

[7] The reality is, however, that we are in a very challenging financial position, both in terms of revenue and capital. There is a whole range of things that we need to do to improve our services, so the prioritisation process is quite difficult. I think, as a UHB, we have had

some really big success in terms of investment in primary care technology and Anna can give you some live examples of those. They have come from the grass roots and have been supported by the UHB team. However, I would say that where we are still is that it is patchy, it is not moving at a sufficient pace and it is nowhere near where patients, who are increasingly used to technology, would expect us to be.

[8] **David Rees:** You say that it comes from the grass roots up. Is the process, therefore, that GPs or GP practices identify technologies or approaches that they wish to look at and maybe use, and then they work it up through the health board for support?

[9] **Ms Moar:** Yes, our annual business planning process is top-down, so we look at the Welsh Government targets, at regulatory standards and local delivery plans and we set our prioritisation framework around what we need to achieve as the UHB. Then, through our individual clinical boards, which then engage with contractors, they look at where they are in terms of the local services, the neighbourhoods and clusters and what the needs are and we bring that together. So, we have those routes of bringing together the priorities. As I say, the difficulty is that the prioritisation process is very tight and very difficult. So, absolutely not everybody gets everything that they think they should have. However, I would be interested to know how it feels from Anna's point of view as opposed to—[*Laughter.*]

[10] **John Griffiths:** I have a question on this point. It is difficult, obviously, with the budgets and finances at the moment, but I wonder whether there is any element of an invest-to-save approach to all of this, whereby money invested now in new technologies and better ways of doing things, as well as producing better services and better care and treatment, might also be financially productive, even if it is a little way down the line in terms of timing.

[11] **Ms Moar:** Yes. You are absolutely right and we do invest to save. We tend to invest to save over a two to three-year time horizon, because that is both the period of our three-year plan and also the payback period that things like the health technologies fund and the Welsh Government invest-to-save fund are generally looking for. I think that there would be merit in, and there is a great opportunity with, the refresh of the Welsh Government's informatics strategy, in particular, which will look ahead to the next 10 years. It is a great opportunity to look at benefits over a 10-year horizon, as well as over the shorter term. So, we do invest to save, but the reality is that the pressures to invest things into issues that need to be solved now is very great, so there is always a push for the short term rather than the long term.

[12] I can give you an example of that that is linked to technology. If you take cardiac, the Welsh Government has produced a local delivery plan—sorry, not 'produced'; we fully support the Welsh Government local delivery plan—around cardiac care. That sets out the care you need if you go to see your GP with high blood pressure, chest pain or whatever it may be, if you need to see a cardiology consultant and you go in and have your diagnostic, or if you need to have a heart transplant and you go to a cardiac surgeon. In terms of patient care, clearly you want to support patients at the earliest point possible, because nobody wants to have cardiac surgery if they do not have to and, you know, it costs £150 to go to see Anna and it costs £17,000 to have a cardiac surgery operation. If you take that one, because of the high profile of the length of time that cardiac surgery patients have been waiting, quite rightly, we have had a huge amount of investment in this year into treating cardiac surgery patients, a bit into cardiology, and very, very little into primary care. So, we are sort of not quite prioritising the prevention as well as the endpoint. That is not an example about technology exactly, but the same could be said of technology. We have pressure from ourselves and pressure from you to focus on the high-profile problems rather than what happens really early on.

[13] **Dr Kuczyńska:** It does come into technology because one of the big things in practice, which is supported by NICE, is ambulatory blood pressure monitoring, which is

mentioned in the paper. It is for better diagnosis of people with high blood pressure. You reduce the number of people who have been diagnosed who do not actually have it, and you can then make sure that the people who need treatment get it based on a solid diagnosis. Practices that have that technology in their practice have invested themselves. That has come from their money—their prescribing money. Other practices that have other pressures on their prescribing moneys or on their investments in their patients might choose to do it in extra nursing time, new couches or curtains. It can be very basic. That is why it is sporadic. An intervention such as that, which costs perhaps £1,000 in a practice to have one piece of kit, is not across the board because different practices will prioritise differently, although there is solid clinical evidence for it. We have asked the health board whether it can support it, but it does not have the money. It is real grass-roots stuff: to make sure that the right people get the right treatment at the right time.

[14] **David Rees:** May I ask the question, then—you have highlighted a point there—as to whether there is a difference in practices and the ability of those practices to actually look at new technologies or new approaches based upon their location within communities? Are those in more deprived areas therefore tackling the issues about medication and nursing more than having to look at the ability to introduce new technologies or address some of the issues because their budgets are actually going in different directions?

[15] **Dr Kuczynska:** I think that it is a bit of both. There is also perhaps a bit of fear of new technology among some GPs. They have done it the old way and there is perhaps a little bit of reluctance about new stuff that they are not aware of. I am not sure whether it is politically correct to say so, but there is a little bit of resentment that GPs are being asked to put funds into something that has good clinical grounds but was a service originally provided by secondary care—cardiologists used to do this, and that service has been withdrawn from cardiology. GPs are expected to do it and perhaps cannot because their priorities lie elsewhere. So, I think that there are different barriers to it, whether it is knowledge, confidence or choosing to invest elsewhere in patient care.

[16] **Ms Moar:** I was just going to say that we are well resourced in primary care already as a UHB, but our three-year financial plan does shift money out of hospitals into primary care. So, it feels like quite a small amount—a 2% increase year on year—but it is quite a big deal. However, what actually practically happens in practice is that a lot of that money goes into primary care prescribing and continuing healthcare growth, so, on the ground, people do not necessarily feel that there is additional investment. I think that part of the discussion that we need to have within primary care, and with ourselves, is how we absolutely make sure that we evaluate the benefits. I do not know that we really know that increasing primary care prescribing year on year is genuinely giving us benefits, but because it is sort of the norm, that is what keeps happening. It is inexorable. So, we need to find a different way to have the conversation about what we are actually going to prioritise—the extra money that we are putting into primary care—in a really positive way. One of the things around that—and Anna has illustrated this exactly—is that it does not need to be a huge new big IT system or huge new big expensive kit. We actually have fantastic infrastructure; it might be quite ageing, but we have had a mental health and community system for 10 years at Cardiff and Vale UHB. Someone in the UHB and Welsh Government made a really bold decision 10 years ago to invest in it because these were totally unknown beasts then; you had to go to Northern Ireland to see one. Now, actually, Hywel Dda, ABMU and Aneurin Bevan LHBs all want one and they are all visiting us, and we are leading the all-Wales procurement for this system. So, we have this great platform, but we are missing the little bit of money to develop the software system to get them to talk to each other, the bits of kit, so that we can move from 60% of practices having something to 100%, and the training and support to work with GPs who do not necessarily want to move on to something new to help work through the barriers and understand what it is that is difficult. So, we have the platform, but we need to move to complete roll-out and that requires quite a lot of detailed work and support.

10:30

[17] **Dr Kuczynska:** The other thing that is going on is little, tiny pockets of absolute brilliance and disseminating that brilliance from those more proactive practices that have made investments in IT themselves. I was talking to a colleague and they said that they have put a computer into a nursing home with a printer—a very simple procedure—so that they can do timely note keeping and prescribing on the spot, avoiding medication errors and note-keeping errors. However, that is a single-practice initiative. With the cluster work and single-practice initiatives like that, which are perhaps affordable—and prescribing incentive moneys can be used to fund them—perhaps the message will get out better. There is a real opportunity for sharing those little pockets of brilliance at no great cost.

[18] **David Rees:** Andrew, do you have a question?

[19] **Andrew R.T. Davies:** Yes. Thanks for the opening remarks. Anna, you touched on something when you said that there was resentment in some practices of being told to do something or being encouraged to do something. I was just wondering how the process actually works. If a new technology comes through and the health board has determined that it is happy to fund it, then, ultimately, if the GP says ‘no’, does it mean that it does not happen in that particular surgery? Obviously, they are autonomous and, as long as they are providing the level of care that the LHB wishes them to do, they do not necessarily have to embrace that new technology. So, how does the process work if there is this tension between what the GP wants to do and perhaps what the health board believes needs to be done to hit the national targets about which we as AMs very often get lambasted?

[20] **Dr Kuczynska:** The resentment can—. You might get a better insight from my BMA colleague who is coming in later, because that is perhaps a more political slant on it, but it is fatigue. It is fatigue in terms of, ‘Here’s another thing we’ve got to do that is coming out of secondary care, without anything to back it up and without the support or the infrastructure or the transfer of funds’. That is the perception. So, for example, in relation to the blood pressure stuff that I was talking about, that is a piece of kit that was being provided for in secondary care. It is perfectly well placed in primary care, but it requires the kit, the appointment to set it up, the appointment to take it off, and time to interpret the result. So, while £1,000 might not be much, it needs all the other stuff that comes with it. When you are packing that into a 12 or 14-hour day, it is that, ‘Oh, my word, how am I supposed to do this? Yes, it’s a good idea, but when on earth will I find the time to do this?’ Good patient care is being compromised by time and so I think that that resentment is perhaps, ‘They’re asking me to do something. I know it’s good, but how on earth do they really expect me to do it?’

[21] **Ms Moar:** Anna and I were talking about this before because I think this is the next absolute key development. The example that we were using was that about 60% of referrals into the hospital at the moment are electronic and about 40% come in on paper. There are all sorts of benefits of everything being electronic, which I am sure every GP practice and every GP would sign up to—it is real time, it lands there and does not get lost, you can link it into electronic patient booking. So, we were talking about what it is going to take us to get the extra 40% on, because it is only when we have that 40% on that we will make savings in terms of administrative time. There were a couple of things. It is partly about help and support. So, NWIS is really good at supporting us in rolling out computer systems, but it does not have the resource to help us get the benefits out. We need to prioritise that resource as well, but I think that it would help if it did too. Secondly, we need things aligned, but, for example, the primary care plan, which is out for consultation at the moment, does not mention technology at all. So, there is something out for consultation that is a key next direction for primary care and it does not talk about technology, which is not very joined up. The third key thing is the GMS contract and what we ask our contractors to prioritise. So, if we really

believe that uptake in technology is something that, for the long-term, we need people to do—we need to shift care from secondary care to primary care—then we need to build that in through the contract and recognise that, sometimes, it will take more time and, actually, sometimes, when you have got through the initial period, it will take less time. You know, GPs need to recognise that as well, but we need to help them get that time benefit. So, I think that we can do a lot of stuff locally, but there are infrastructure and policy frameworks that Welsh Government can support us with as well.

[22] **Andrew R.T. Davies:** May I just ask a quick supplementary on that, just so that I am clear in my own mind? From what I understand, if the GP says ‘no’, it does not happen. Is it as simple as that? You touched on the contract at point 3, and I take that point. Obviously, if it is not in the contract; the GP has a huge amount of discretion to determine whether they are going to take it on board or not. Despite what maybe the Welsh Government would want or what the health board would want, ultimately, the GP says yay or nay to it actually happening in that particular surgery. That is what it boils down to.

[23] **Dr Kuczynska:** Yes. The reason for that position though, I think, is the feeling that more and more is being shifted from secondary care, and rightly so—it can be perfectly well delivered in the community—but something has to come with it, not just the expectation that this service can be delivered.

[24] **Andrew R.T. Davies:** It sounds like the devolution settlement.

[25] **Ms Moar:** I suppose, contractually, that is the position, but nobody ever won anything by changing the contract, did they? If you spend your whole time flashing the contract at GPs, you have lost. So, it would help if the GMS contract framework was more refined, but actually this is about hearts and minds, with a bit of a sword within the hearts and minds, saying, ‘Actually, we do need to find a way to work with you so that this works for you, but it is not okay for your patients and it is not okay for you as a taxpayer not to come on board and get to a stage where you can refer electronically’. However, I do not think that we are just going to say, ‘Right, it’s in the contract now; you have to do it’. We have long-term relationships with GPs; we need to work together.

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

[27] **Lynne Neagle:** I am just wondering how you are doing that at the moment then. How do you try to drive those changes in primary care at the moment with all the constraints that you face?

[28] **Dr Kuczynska:** Peer pressure is a very useful tool and very small gains are made within the group of the new cluster working. I must admit that I have had this role of community director in the health board for two or three years, and this is the first year that I have felt very optimistic, because we sit at a table and we have to get around it every few weeks, there are ideas going left, right and centre and there is a bit of peer pressure. Somebody who is doing an intervention will say, ‘Come on, actually, it is a piece of cake; go for it, give it a go.’ It can be a very simple, joined-up thinking. Last time I met with my cluster, it was something around antibiotic prescribing. It was like: ‘Look, give it a go. Listen to our experience; it works’. Public Health Wales was concerned that some of the practices are not signed up to SAIL, which is an anonymised database of population and health. On the basis of a conversation around the table a couple of weeks ago, all but one of my practices are signed up to it, with confidence from peers that it works, and it is helpful and not as scary or intrusive as it felt. So, peer pressure is a very positive influence.

[29] **Ms Moar:** Also, I would say that we need to offer something back. GPs can access hospital systems in terms of test results and so on, but, as I have said before, we have an

absolutely fantastic community and mental health system, which is better than anything I have worked with in England. We have 700 patient contacts a day and the information going straight into the system. All our district nurses have mobile devices; it really works fantastically. What GPs really want is access to that system—at the moment, it is quite limited—because it is absolutely crucial to them to know whether somebody saw a district nurse and what happened. So, part of it can be, ‘Look, you do the extra around the e-referrals, but we’ll actually prioritise then making the community system available on your desktop or we’ll put the extra bit of kit in.’ So, we need to get to a position across the longer term.

[30] **Lynne Neagle:** Do you feel that you are adequately resourced to do that at the moment?

[31] **Ms Moar:** I think that we have worked very hard within the UHB, so we have dedicated IT and information resources, which only work with primary, mental health and community care. I think that that makes a big difference because we have people who are just there for them and who do not get pulled in to hospital things.

[32] **Dr Kuczynska:** There are tiny little links missing, are there not?

[33] **Ms Moar:** Yes.

[34] **Dr Kuczynska:** These are tiny little things. So the district nursing system and mental health system, their input is into one IT system, to which I have no direct access. I rely on a piece of paper, a printed version of this electronic information, which I can seek out and it gets copied on to my patient notes. It works, but it is a bit daft that it cannot just be directly accessed.

[35] **Ms Moar:** That is what I was going to say. I do not think that we have sufficient resource. I do not think that we need huge resource, but the difficulty is, if you look at our capital situation, we have a 50-year old hospital; we have got a great IT infrastructure, but it is very old, and we have got a very old medical equipment infrastructure. We have MRI scanners that are 11 or 12 years old and normally you would replace them after five to seven years. We have obviously just put our 10-year capital plan to Welsh Government. I know everybody else has, as well. I know that this looks really difficult, and I do not underestimate the difficulties, but the problem is that, when we prioritise, we have to prioritise statutory compliance. We have to prioritise asbestos, fire and legionella, and we have to prioritise keeping what we have already got going, and that does mean that we are really squeezed for very small bits of money. However, I will say that this is where things like the health technologies fund and the invest-to-save fund do really help, because they are a ring-fenced pot that does not get pulled into this massive thing, which is our backlog of maintenance.

[36] **John Griffiths:** I wonder to what extent the size of GP practices is relevant here and if GPs are feeling, to some extent, put upon by this movement from the secondary sector to primary. Presumably the larger practices with more capacity and practice managers who can look at the team of health professionals and ancillary staff might feel in a better position to cope with that. I also wonder whether there is any element of patients voting with their feet in terms of adding to the peer pressure that exists for GP practices to adopt better practices and to be seen to be at the forefront of necessary change and development. I notice that, in my local paper today, the local health board was talking about 80% of GP practices meeting certain requirements on availability and ease of appointments and that sort of thing. You think to yourself, do people in the other 20% start to look at these articles and wonder whether their practices are in that 80% of good practices? If not, do they think about perhaps transferring to another practice?

[37] **Dr Kuczynska:** I think that patients do march with their feet. I think that access is the

biggest issue, to be honest with you. In our cluster, there were concerns that one practice was struggling to keep patients, and we were all very aware of that because they were coming from around Barry for different care, but I think that access is probably a big issue and patients' perceptions of their needs—what a patient wants is not always what they need. So, not getting antibiotics when they want antibiotics, for example—very simple things like that. In our cluster, we have decided that, over the next three months, we will ask new patients very discreetly and anonymously why they are moving, just so that we can feed to each what the issues are and why patients move. So, I cannot answer you exactly now. I can tell you my perception, but in a few months' time, we might actually have some answers.

[38] **Elin Jones:** Can I ask for clarity on that?

[39] **David Rees:** Just let John finish.

[40] **John Griffiths:** Just in terms of the capacity and size of GP practices, what are the issues there?

[41] **Dr Kuczynska:** I think that the bigger practices do manage to take these things on board quicker. It is about economies of scale, is it not? If you are buying a piece of kit that costs £1,000 plus appointments, you can absorb that much better into a 12,000-patient practice than you can into one with 3,500 patients. Some of the very big ones will have business managers specifically to look at these things—whether it is buying in IT equipment or buying bulk equipment or doing deals on a bigger scale. One of our practices is quite large, and it does have a business manager, and I am hopeful that, with the cluster work, I can try to convince him to share a bit of his expertise, particularly among the smaller practices that simply have not got it. They are on a much simpler level.

[42] **Elin Jones:** I just do not know what you mean by access.

[43] **Dr Kuczynska:** It is purely anecdotal.

[44] **Elin Jones:** Do you mean the appointments process?

[45] **Ms Moar:** Yes, opening hours.

[46] **Dr Kuczynska:** It is purely anecdotal, but, yes, it is on getting to see a GP.

[47] **Elin Jones:** So it is not about how far someone is from a practice, but about the appointments process.

[48] **Dr Kuczynska:** Yes.

[49] **Mohammad Asghar:** The fact is that I go to the doctor and the doctor gets instructions from a machine these days. Under the old system, the doctor used to look at the person and would diagnose them by looking at their throat. These days, they put some gadget on your finger and doctors get instructions from machines.

10:45

[50] I personally think that it is like they are seeing their patients on a conveyor belt—they have to keep going. There is no question that this technology is great, but that personal touch of a doctor and a patient is not there. These patients keep coming and coming, and there is no wonder that there is a long waiting list, and all the rest of it, in the health service. My point is, these new gadgets are coming thick and fast, and some of the doctors cannot even cope with it. So, with these sorts of developments in the technological field, what are your steps to

upgrade the doctors who have only learned medicine by pen and paper all their lives, and who suddenly get bogged down with all these gadgets? They are not technically qualified in IT systems, and to put them in a place where they have to use these systems is not helpful to the patients. So, where is your guidance, advice and training for the doctors? First should come the patients, and then the machines, but it is not happening. You said that the ratio was 40:60. It should be 80% in favour of patients and 20% in favour of something else. That should be the thing.

[51] **David Rees:** I think the question is, as GP clusters and GP practices, how do you ensure that GPs actually keep themselves up to date, and that they are enabled to ensure that, as new technologies come through, they are able to use that new technology? I think that is what we are trying to find out. New technologies have an impact, and part of the impact is having training to be able to deliver that new technology. How will GPs find themselves able to keep up with that?

[52] **Dr Kuczynska:** Some of it will be self-led. So, you identify an unmet need, and do the learning and the investment around it. Most of the stuff on your average GP's desk, whether it is a SATS monitor, which it looked like you were indicating, or an electronic blood pressure machine, is there to support GPs' clinical acumen. They are not there instead of GPs' clinical acumen. In the case of GPs, your training should have provided you with adequate acumen to add to that. If I take somebody's blood pressure and the device shows the pulse on it, I will take their pulse as well, because I cannot tell it all from a machine. So, it is very much a personal responsibility to keep up to date. If you are using technology that you do not know how to interpret, you should not be using it. So, if you are having lung function tests, for example—spirometry—your nurses are highly trained, and they should not be using it until they can be confident that they can put it on properly, take it off properly, and then interpret the results.

[53] **Mohammad Asghar:** The fact is I agree with you, on the one hand, but they are inundated with seeing patients, so where do they get the time to get training for themselves?

[54] **Dr Kuczynska:** I do it in my private time and annual leave.

[55] **David Rees:** I think that is fair enough. I will ask a question. You said that sometimes it is self-taught or based on personal interest. Is the decision to look at new technologies a consequence of someone taking that interest, as an individual, and managing to perhaps update themselves and keep up to date with records and journals? If they suddenly see something, how does that person then pursue that avenue? If they were to say, 'I have seen something, I want to take it on board, and I want to use it', how does he pursue that avenue? What is the process, as far as you are aware?

[56] **Dr Kuczynska:** It will vary from practice to practice and from person to person. Take, for example, minor surgery. We have a piece of equipment for cautery that is outdated now, so it would be up to me to find out from colleagues what is the best piece of kit. Then, I would go on a course, or go and mirror or shadow somebody to find out how to use it, to make sure that when I use it, I am fully trained to do it appropriately. GPs have appraisals, so at the end of each appraisal year you will have targets for learning. Whether that is to conduct a purely academic paper exercise on a particular condition, or whether it is learning to do a joint injection, that is very much GP-led, in discussion with your appraiser.

[57] **David Rees:** With the introduction of clusters, for example, is that going to improve the opportunities for people to have the confidence of doing that, or should there be a national approach to looking at how we can support GPs to introduce new technology?

[58] **Dr Kuczynska:** I think that it has to be both, has it not? While, as Charlotte said, it is

driven from the ground, it has to be a two-way process, really. Stuff will come from NICE that we should look at, evaluate, and see whether we can deliver, and then hopefully we get support from somebody to be able to do that. There are loads of tiny things on the ground that would really help if they were across the board, as they could really deliver a difference to patient care. They are small things, like finger-prick testing. There are certain blood tests that can be done on a finger prick, which could make a difference to patient admissions, the control of their diabetes, deciding whether to use antibiotics and so on. They are just tiny little things that make a difference, but at a single practice level, you would find it difficult to deliver them.

[59] **Ms Moar:** I think I mentioned before that the primary care plan, which is out to consultation at the moment, does not mention technology. I think that these things do need to be linked. One of the interesting things or proposals, if you like, is for the Welsh Government, in the same way as is done with drugs, to do horizon scanning and produce a list of things you should do. I suppose that we do not need any more lists of things that we should do, because we have masses and masses of lists of things that we should do already. What would be incredibly helpful is to work together when there is something that we are all grappling with—and a really important one for Wales is that the population in rural areas needs the same access to services as people in the middle of Cardiff. However, actually, if you live in a rural area, you cannot have that. You cannot have specialist consultants in every individual GP practice or local hospital, because, first, there are not enough and, secondly, you cannot have them. So, let us assume that the starting point is somebody who lives in, I do not know, the Rhondda valley, who needs exactly the same level of expertise as those in urban areas, what are the technical things out there that people are using to enable that? Is it Skypeing with hospital consultants? Is it out-patient clinics? Is it texting results? What is it? What would be really helpful is if we could have people who horizon and evidence-scanned around the particular issues that we are all grappling with, so that we can build them in as part of the solution. Otherwise, what we have to do all the time is take all the lists from the royal colleges, the local delivery plans, the primary care strategies and the IT strategies, and we have to work out something coherent. Sometimes, we could have help with that coherence, in bringing it together.

[60] **Elin Jones:** We have a paper in front of us today from the NHS Confederation, and one of its main recommendations is that there should be a transfer of ownership of the patient record to the patient, and online records to help with access to patients' records by other parts of the NHS, social services, the ambulance service and all of that. So, what I would see as useful information would be available wherever the patient accesses the services. From your experience, how far away are we from that? As GPs in primary care, because you hold the record at this point, how do you think that that would benefit the system—or do you think that at all?

[61] **Dr Kuczynska:** I was talking to one of my colleagues earlier, and part of the cluster work, for example, involves sharing expertise across practices. The example that we were talking about was inserting Mirena coils for contraception. Some practices may not have the expertise to do it, but, within the cluster, there are GPs who do. The hesitation from the GPs who do is to do with how to know the rest of the story. The worry is that you carry out an inappropriate procedure without being fully informed about it. One of the main providers, Vision, can, apparently, at the press of a button and at no cost, allow temporary access to notes across practices. When I work out of hours, it is very much hit and miss how much access I can get to patient information, and that is a worry, because you do not get the whole story. You do not even get the whole story from somebody sitting in front of you.

[62] **Elin Jones:** We do not, as AMs, when people come to see us. It is the same for GPs, I am sure.

[63] **Dr Kuczynska:** For example, I met with a young man last week who has quite a serious drug habit. I took his story at face value and started working him up toward treatment, but I had no access to the rest of his history, until I went into another system and asked secondary care centrally, which had access to prison information and this gentleman's whole history. So, while patient confidentiality is really important, it can be quite a dangerous barrier. The person could get the wrong treatment at the wrong time with, hopefully, not bad outcomes, just inappropriate outcomes.

[64] **Elin Jones:** So, on the whole, you favour moving towards that kind of ability to share patient records online between various providers of services, but it feels as if you are quite a long way away from doing that.

[65] **Dr Kuczynska:** It feels like it to me, as a patient and a doctor; I am a patient as well as a doctor.

[66] **Elin Jones:** We did a community pharmacy review in this committee quite a while ago. They had done some work in Gwent, I think it was—they usually do most of the work in Gwent. They did work with patients on patient records and confidentiality issues, and in the survey work that they had done, the result was that patients thought that everybody in the NHS shared their record anyway and had access to it, whether it was an ambulance or a hospital, they thought that they all see the record. Patients are not as worked up and exercised about confidentiality as, maybe, some of us think they would be, or we would be.

[67] **Ms Moar:** Relatively in Wales, and compared to England, our systems talk well to each other. So, if a patient turns up in A&E, you will get an alert to say if they are a mental health patient or which services they are known to, including paediatric services. However, for GPs, it is quite hard to look into mental health and community records, apart from in Flying Start, where social care and health records are entirely shared; we do not share records with social services. So, we are in a strong position compared to England and we are probably nowhere near where we need to be. That needs to be a priority. Rather than getting more systems, it is about making the systems that we have talk to each other through clinical portals and so on.

[68] In terms of patient access to records, we are a very long way off. They get copies of out-patient letters and maternity patients hold their records, but, in terms of real ownership of my care, we are not there at all, systematically.

[69] **David Rees:** Kirsty will ask the last question.

[70] **Kirsty Williams:** Given the challenges in rural areas, in recruiting and retaining GPs full stop, whether they use technology or not, and given the very small nature, usually, of some of those practices, is there a halfway house of utilising the network of community hospitals that still exist in rural areas as diagnostic and treatment centres? Or, should we just bypass that and try to encourage GPs to take up the technology on a practice-by-practice basis?

[71] **Dr Kuczynska:** I work in Barry. For my local population—GPs and patients—the dream would be that you could put local services, including good diagnostics, in the community, particularly as it is a relatively deprived community, which also serves Western Vale, which is a long old slog from Cardiff, if you do not have transport. Barry is two buses to the Heath as it is. So, to have diagnostics on the spot, whether it is ultrasound, up to date x-ray machines that do not pack up, ECG interpretation or echocardiography, would be dreamy. When we discuss it with colleagues in secondary care, it seems that it is not efficient to do it. If they can centralise the expertise in one hospital, they will do that—I get that, as they can get more people through the door—but then the population is having to move to where the

service is, and the service is not necessarily being offered to a population that has difficult access.

[72] The other problem in Western Vale is the cross-border issue. They have an additional challenge in terms of sharing information and access, where they are using two health boards.

[73] **Ms Moar:** I just wanted to come back to the issue of capital, because the capital position across Wales is tight. We have a lot of estate; it is not necessarily well used. Hospital care tends to be used 24/7, but GP surgeries and community hospitals are not. In capital terms, if we can find ways of using IT to provide more care in people's homes than in GP surgeries, and do not have to keep investing in expensive buildings, it is more likely to stack up. So, we need to be estate light and IT rich, but, in a way where people feel cared for locally; that does not necessarily mean a huge hospital building. Local care is not about buildings; it is about local care.

[74] **David Rees:** Kirsty, is that okay?

[75] **Kirsty Williams:** Yes, thank you.

[76] **David Rees:** Our time is up. I thank you both for your evidence this morning. It is very much appreciated. You will receive a copy of the transcript to check for any factual inaccuracies; please let us know if you find any. Once again, thank you very much.

11:00

Ymchwiliad i Fynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn Dystiolaeth 18 Inquiry into Access to Medical Technologies in Wales: Evidence Session 18

[77] **David Rees:** We are going to move on to the next session straight away, because our time is scarce. We are running a bit late. So, we will change witnesses. The next session will be with witnesses from the Royal College of General Practitioners and the British Medical Association.

[78] Good morning. I am sorry for the delay, but we are running a bit late at the moment. I welcome Dr Nazia Hussain back to the committee—you were here earlier this year—Dr Charles Allanby, Dr Peter Horvath-Howard and Dr Mark Vaughan, from the Royal College of GPs and the BMA. Thank you very much for attending this morning. I also thank you for the written evidence that we have received from both organisations. Clearly, once you write evidence, there are opportunities to ask questions based upon that, so we have some questions as a consequence, and we are focusing on the technology and access to technology in primary care settings.

[79] **Andrew R.T. Davies:** I asked the previous set of witnesses about the process of introducing new technologies into GP surgeries and primary medicine, and a lot of it seemed to revolve around the contract, the discussions that go on in the local health board and some of the aspirations that the Welsh Government has about what it wants to see going on in primary medicine. Could you give me your opinions as to the discussions that you would have in primary medicine around the introduction of new technologies and, in particular, the strength of the answer from the previous witnesses that if the GP does not want to do it, basically, they do not have to do it? Would that be a fair reflection?

[80] **Dr Horvath-Howard:** It depends. I think that, to take this discussion forward, we have to split clinical software systems, which are moving ahead really well in Wales for most

of the population, from other bits of technology; we would talk about pulse oximeters, ECG machines and things like that. Clinical systems in Wales are well centralised, well negotiated now that we have got down to two, the funding is clear and the resourcing is clear, and we are way ahead of the rest of the UK, probably, in a lot of different ways. We have just had our upgrade. I think that there are issues in the fact that lots of different people and lots of different crafts are using different systems, so they are siloed. If you want to look at personal computer technology and clinical systems, I think that they run well in Wales. The only proviso is that the border areas do not get considered in time, and they are always put in as an afterthought. So, those of us, including myself, who refer out of the country, do not have the same benefits.

[81] If you then look at pieces of kit, there is no formal process, pathway or resourcing for that kind of development, so that is done on an ad-hoc basis and, depending on the degree of enthusiasm—

[82] **Andrew R.T. Davies:** Should that be formalised or does it work because of the very different nature of primary medicine? You touched on the border example.

[83] **Dr Vaughan:** Yes. I approach it in a different way, because the inference in the way that the question was phrased was about these things that you ought to be doing and these are the structures that you have to put in place to ensure that you deliver them. What you expect of good-quality family practice—and that probably is what you see in most of Wales—is the need to innovate and the desire to change. What is important about that is to ensure that the actual ownership of all those ideas rests with the people who are going to use new technologies and new kit. I kind of look at it through the other end of the telescope, really, and say that what is really important is to ensure that there is enough flexibility in the arcane way that funding and resources are allocated and that the systems to allow for the strength of innovation and the strength of enthusiasm actually shine through. Now, not everyone will deliver the newest and latest, and not everyone will have those ideas immediately. However, there will be enthusiasts, there will be leaders, and other people will follow after that. So, rather than invent a structure that is designed to deliver, it might be better to deliver a structure that enables delivery of the best use of technology. So I suppose that I look at it in a slightly different way and think that we should make sure that primary care and general practice in primary care have ownership of the processes and ownership of some of the resourcing and are able to make the best use of it.

[84] **Elin Jones:** Does that enabling process exist now?

[85] **Dr Vaughan:** My view, sitting in my chair in the surgery, is that it probably does not and that things are a little bit stifled, and that we are a little bit stifled by process. That is not to say that people do not have the right meaning in what they are doing; it is just that we are in a very difficult, tight environment and we are going through a process of transition.

[86] **Dr Allanby:** I think that my colleague has touched on this. Basically, you either drive something upwards through an enthusiastic approach via individual practice or practices or you have a top-down approach where the LHB says, 'We want this delivered'. I think that there has to be some recognition that we must have a happy medium. If you tell GPs what to do, they may say, 'Well, why do I have to do it when I am too busy trying to deal with all the access problems that I am constantly being bombarded with?' So we have to work out what is best for the patient and what is best for the community. The advent of clusters, which are now being progressed in this current financial year, where GPs and localities are working together, might be a way of the LHBs saying, 'Well, what can you provide in your local area and what help do you need to be able to provide that?' If you have a care-homes predominance in a particular area, we need to ask 'What technology would you be able to use to be able to look after those patients better and keep them out of hospital?' It cannot always be done on an

individual basis. There has to be a cohort approach, perhaps, to deliver something better for the community. If the LHB said, 'Look, we would like to reconfigure our services. What's the spin-off? What can we give you to help you, rather than telling you what you've got to be doing?', I think that GPs would feel more enthusiastic about it.

[87] **Kirsty Williams:** Dr Horvath-Howard, GPs in your area have always practised above and beyond traditional surgery. Recently, I know that you have been involved in trying to deliver more and more care in the community. Have you been stifled in your attempts to do that by a lack of technology? What more could you do if there was more help available to develop that work?

[88] **Dr Horvath-Howard:** In my area, the locality development that Charles has just been talking about is well developed and working well. So, for us, I think that that would be a reasonable level at which to pitch that compromise that I was talking about earlier, and that Mark was talking about, between giving some autonomy and having some process and some identified resourcing. It does not always have to be money. It can be people—it can be an IT lead who goes around one or more practices or that kind of thing. In Powys, obviously, the challenge is the geography. Yes, you are right that the health board has funded a hospital-at-home continual care service, what we call our community resource team, where we set aside a morning for a GP to go out and team-work with the district nurses and social services to try to keep people at home. The kind of thing that we have talked about that would be useful there would be the iPad and that kind of thing. There is an almost inverse law that the areas that need that kind of input most do not have the broadband, the wavelengths or the phone connections to actually do it. So, the areas where we really could do with remote access to either talk with, see or dial in with back at home are the ones where you do not have even a good mobile phone signal. A lot of my patch is dead. Powys health board is aware of that and it has a good IT component and we are working on solutions for that. It is difficult to find companies to engage with that have solutions, such as a device like this where, when you walk back into the surgery, it would download the data back onto your centralised system.

[89] The other issue that we have is that all of the teams are working on different systems. So, the nursing team is working on the system that the hierarchy dictates that it should use and we are working on the GP systems, so there is a lot of duplication for the nursing staff. I think that we should all be writing on the same clinical system, but that view is not shared by everybody.

[90] However, yes, remoteness brings its own challenges. The health board is trying to do some work, but there are issues. One could look, in rural areas, at some kind of enhanced service for technology. I am on the General Practitioners Committee Wales's negotiating team and we are sitting down at the moment to try to see whether we can look at a rural enhanced service that might take in some of these issues. Does that answer it?

[91] **Kirsty Williams:** Yes, thanks.

[92] **David Rees:** Before I bring Andrew back in, you mentioned different systems. Does it deter the primary sector from looking at new technologies if it thinks that there are limitations in the systems that communicate with one another?

[93] **Dr Horvath-Howard:** I think that GPs, and GPs as a breed, really, have embraced computer systems. We have always been and still are well ahead of secondary care. A lot of that was way before there was funding from health boards. On the issue that care workers have to write on one system and district nurses have to write on another, ministerially, there has been an objective for a long time now to have a combined assessment for vulnerable referrals, and one has to ask whose system that would sit on. Naturally, we would probably say ours. We have a very open approach to saying that anyone who comes to see our patients,

either at the surgery, in the community and in any way integrates professionally with us, can put the clinical details on the system. You can set up levels at which they can see the past history and that kind of thing. Personally, I think that that is the biggest loophole in child and adult protection: if you have people writing on lots of different systems, people are going to fall between the paving cracks.

[94] **Dr Allanby:** If you are talking about a technological system, it needs to be able to communicate with our system. Say you have an ECG machine or a spirometer, you need that to be able to electronically link with whatever system we have. It also has to link with the hospital system if you want to make a referral. There is no point having an ECG machine, a separate computer and a separate hospital system if the three cannot communicate with each other. So, there has to be some dialogue as to what technology might be appropriate and what could link with each other. Obviously, nowadays, you can have wireless links between your telephone and laptop. That is acceptable, but whether we can have an ECG machine or a spirometer that can electronically link with our database and similarly link with a hospital database is crucial. Otherwise, you have information that you cannot share with colleagues.

[95] **Dr Hussain:** I think that would be an ideal end—to have unity between all of the computer systems—but I do not think that that should stifle innovation with regard to other technologies in the meantime, such as introducing other machinery like ultrasound or ECG monitoring.

[96] **Dr Vaughan:** I was going to make roughly the same point. I think that the important thing is to unpick. This is what we are talking about here: separating the issues about IT from the issues about new technologies. IT in general practices is generally regarded as being quite strong. The issue is the interface and, actually, it has been very well supported by the NHS Wales Informatics Service. If you look at the introduction of new technologies, what is really happening there is an incredible pace of development. You have kit that would have cost thousands of pounds 10 years ago that costs a few pounds now. You have the clinical algorithm change that goes with that and how best you can use things, and then there is the focus of care that changes with that as well.

[97] To pick up on the example that we talked about earlier, I bought a pulse oximeter for our practice about 20 years ago. It was the size of a brick and it cost £2,000. We bought 10 of them from Williams Medical Supplies Ltd last year for £500, so they are now £50 each. You can buy them on Amazon for £18.95. So, what that has meant is that technology has changed very quickly. It is just as accurate, more durable and much easier to use and, actually, the focus of care has gone from secondary care through primary care and general practitioners and out to the patient.

11:15

[98] The issue, really, is about how fast these things are changing, how different things could look, and the impact that it will have on the care of patients. If you look at ultrasound, for example, if you look at the cost of some of the kit—and it is not something that I have personal experience of—it would have cost £0.5 million 10 years ago. You can get better kit for £20,000 now that is very much better and much more portable, but the issue around that, because it is a bigger piece of kit, is about the training, the delivery of care, how it would fit in, how best you would see that you did not duplicate a system that is already available somewhere else, and how best you make sure that the people who are delivering it, in primary care for example, were doing their best with it. The World Health Organization is already saying that that is probably one of the best technologies that you could think about introducing in low-cost environments now. So, there are huge changes and huge challenges, and some of them are about the kind of equipment and the speed at which it is becoming available.

[99] The other bit is about the way that the clinical algorithm—the way in which you would best deliver quality of care—changes with the equipment. I think that you just need to think about these things separately. The IT issue we have very much got right, or are getting right. How we are going to use new smart technologies is something quite different; we are only just beginning to get our heads around it. What we really need to do best with that is very flexible commissioning.

[100] **David Rees:** You are right to point out the separation. What we want to try to find out is what issues you are facing in identifying and accessing those new technologies, and the barriers that you may face in implementing those new technologies.

[101] **Dr Vaughan:** Above that, the first thing is pace of change. That is very difficult to keep up with for anyone. The clinical algorithm is a very big issue, because, if you suddenly have more information at the point of care, somehow you have to decide what you are going to do with that information. We have not really begun to have those debates yet. It is all very well to have a guideline, for example, that assumes that a test is available only in a hospital, but, if that test suddenly becomes available on your desktop with the patient, it changes the way in which care needs to be delivered. I think that we need to have some high-level clinical debates about how things are going to be delivered for some of those issues, and, for others, you just have to go with the flow because they are pretty obvious and they are fairly cheap. Having the flexibility to do that is a very difficult management issue for local health boards. Hopefully, it is not beyond the wit of the Assembly to put the right structure in place to make it possible.

[102] **David Rees:** Andrew, do you want to come back on this point?

[103] **Andrew R.T. Davies:** I just want to follow up on the question that I put. From what I can hear, and obviously from the subsequent evidence to follow-up questions, the commissioning process does not seem to be fit for purpose when you talk about new technologies. We have heard that perhaps you get talked to, rather than listened to, and in particular—and I think that we all suffer with this—the speed of technology is so great that, in something as big as the NHS where you have such diverse sectors, it is difficult to keep the structures up with the technology. Would it be fair to say that the commissioning process is not fit for purpose for new technologies in primary medicine? Is it as simple as that?

[104] **Dr Vaughan:** ‘It has not quite caught up with things’, I think, would be a better description rather than ‘totally unfit for purpose’. There are issues about—

[105] **Dr Allanby:** In the LHB in Cardiff, where I work, we have lots of different clinical divisions—medicine, surgery, children’s health, gynaecology and mental health. With the support of their managers, they can all put together a bid to the board and say, ‘Look, we need this new piece of equipment’, or ‘We need to expand our workforce and appoint a new consultant’, or what have you. In primary care, as you know, we are all individual practices and individual contractors. There is no forum for having a debate and setting the priorities for what may be an appropriate new way of working that can help to deliver care to patients’ homes and keep them out of hospital. That forum does not exist.

[106] As I said before, clusters may be a way of developing that, but they are brand new and no-one has quite worked out how they will work. So, there is no bidding process. We cannot put a bid into the local health board in a structured way like a hospital does. If you want a new A&E department or you want to expand it, you put together a bid, you have managers to support you and that is how the process works through. There is no similar process in primary care; we are a little bit too disparate. That is not something that should be seen as negative, but it is something that is perhaps stifling the commissioning process.

[107] **Dr Horvath-Howard:** May I work you through an example quickly, which should explain what Charles has just been saying? NICE guidance suggests that ambulatory home monitoring is a good thing to do to measure somebody's blood pressure continually, and that doing that will save a lot of people who do not need medication from having potentially harmful medication. Resources will be saved, et cetera. A 24-hour blood pressure machine probably costs about £2,500 to £3,000 for a good one. We are a split site, so we would probably need two. You would need somebody to call the patient in, put the thing on and counsel them as to how to use it. The following morning that patient would have to come back to have the thing taken off.

[108] The point that I would make to Mark is that integration is important because that 24-hour blood pressure machine has to be able to talk to my software, otherwise it is of no use to me at all. We cannot have lots of individual bits of software on one system; it has to be able to talk to EMIS and upload the data, otherwise it is not integrated. So, somebody has to get that up and running, and somebody has to pay for that and for the staff. General practice, as you know, is full already. People are struggling to deal with the sick people and to meet the requirements that they have now. So, if you were in a practice meeting with me trying to work out where to go next, I think that that would probably give you a flavour of the issues: who pays for that machine? Who employs the healthcare technician? Who trains her? Who maintains it? Who updates it? The list goes on. So, that is how it feels on the ground.

[109] **Andrew R.T. Davies:** So, it is about the package.

[110] **Dr Horvath-Howard:** The package, yes.

[111] **David Rees:** John is next and then Elin.

[112] **John Griffiths:** In terms of the pace of change, we are all familiar with the incredible pace of technological change in all aspects of life, and it obviously very much applies to medical technology too. Do you see a need for what was described to us in previous evidence as horizon scanning? Is there a need for some central mechanism or body or group of people in Wales to do horizon scanning to look at evidence of what works? If there is a need for such a mechanism, which would suggest what medical technologies should be rolled out in primary and community settings, would there be a need for GP practices and clusters to have a role in that and look at whether it would work in practical terms? Do you see the need for those sorts of systems? Is there anything like that at the moment in your view, or is there a real gap?

[113] **Dr Allanby:** There is nothing like that at the moment. It is up to the enthusiasts who might want to meet with individual marketing people to discuss whether that is something worth experimenting with before it is actually rolled out. That is the poor structure that we have alluded to already, which is that there is nobody in a co-ordinated role undertaking horizon scanning at the moment that I am aware of. However, we do not want it to be top-down either. We do not want somebody to say, 'That is the piece of equipment that you are going to use', and, in fact, it is not user-friendly when you actually put it on the desktop. So, there has to be some dialogue at some stage to say, 'Yes, this is the range of equipment that we can have', and it would then be up to you to say which one would be more appropriate in your situation, depending on the volume of patients that you have—you may have a small practice that may see only 10 or 15 patients a year for that particular piece of equipment, whereas in an inner-city environment where you have 15,000 patients, it may be used every day of the week. So, different systems may not be appropriate in general practice as a whole.

[114] **Dr Hussain:** I think that the cluster issue should generally concentrate on the higher scale, more expensive technologies to try to balance need and delivery. With my experience

in London, I know that some GP clusters have been set up in the area and they are arguing about the smaller technologies, for example those for calling patients up on a sign and those that allow patients to enter in their own details about smoking history and ethnicity, so that the healthcare assistant is freed up from filling in those sorts of details. There have been arguments about who is receiving funding for that because some practices have self-funded that, so they have, effectively, lost out because the commissioning groups are funding to bring other practices that are not at the same level up to that same level. So, in effect, the practices that have been forward-thinking have lost out in that process. So, I think that it should definitely concentrate on the more expensive technologies as that is where the most benefit would come from the cluster set-up.

[115] **David Rees:** Dr Allenby, you mentioned clusters earlier on. Do you see this as a good opportunity and something that clusters can take forward?

[116] **Dr Allanby:** I think that that is the direction in which the Welsh Government would like to see it being taken. Unfortunately, at the moment, there does not seem to be the facility for the local health boards to direct funding to support that. They may be able to give us managers to help to run a cluster, but that is not actually developing a clinical service. If you would like to say to us, 'We would like you to manage anticoagulation better in your community; what do you need?', I do not need a manager; I need a nurse or healthcare assistant who can actually deliver that service, so that I can take it into a nursing home and can work in conjunction with other practices to deliver that service. So, just saying that LHBs are going to fund this is of concern to us, because they are just doing a management funding as opposed to clinically resourcing the staff to run the service, and that is different.

[117] **Elin Jones:** I want to develop this by going back to something that you said earlier about the relationship and leadership of a cluster, the introduction of new technology and how that could work in practice. You used the example of the 24-hour monitoring of blood pressure. My GP practice has that service and a nurse does that work. In a cluster setting, if that service is set up with one GP practice, are you suggesting that what could happen in the future is that other GP practices that have not yet funded that service, or even accessed the technologies for ultrasound, for example, would be cross-referring?

[118] **Dr Allanby:** That is perfectly acceptable and it could be done if the LHB chooses to do it. There are the facilities, the mechanisms and the infrastructure to allow that to happen. It is up to the LHB to set a priority as to whether it wishes to do it.

[119] **Elin Jones:** So, I am hearing from the royal college and the BMA about that kind of cross-referring to another GP practice, where you are saying to me as a patient, 'We haven't got this in this practice, but I can get you an appointment in the practice down the road in Aberystwyth'. That is a way that you could see the system developing.

[120] **Dr Allanby:** That would not be threatening, and that would help to keep patients out of hospital; I think we would support that.

[121] **Dr Horvath-Howard:** In rural areas such as ours with community hospitals and day hospitals, there are lots of options for that.

[122] **David Rees:** Is that going to help the access to technologies? Is it going to encourage more usage of new technologies as a consequence? Should there be a better commissioning type of approach because you are looking at, perhaps, not a practice any more, but more of a cluster using these technologies?

[123] **Dr Horvath-Howard:** Yes, because it is going to vary from region to region. I was saying to these two that I went into a branch of John Bell and Croyden in the middle of

London to have a look at their 24-hour blood pressure monitor, just to see how the prices had changed. A guy came and had a chat with me and asked, 'What do you want it for?' and I said, 'I'm a GP'. He said, 'You don't need a 24-hour blood pressure monitoring machine, because the patients go to the hospital'. So, in London, that is what happens. Where I work in Powys, the district general hospital is 26 miles either way, so the impetus to develop that service or to develop near patient testing is different. So, you need an approach that is locally sensitive.

[124] **Dr Allanby:** We do not work in hospitals, so I do not know how they work properly. If you accept that hospitals have 24-hour blood pressure monitoring machines, how have they got them? What process have they been through to select one that is appropriate for their use for patients? If we could be allowed to have the same access to that approach to deciding what is appropriate, that would be a way forward. If they want new machinery in a hospital, they have to go through a process. That process is not available to us in primary care to understand how the bidding process or how the selection process works. I think that we must have that type of dialogue in the first instance.

[125] **Mohammad Asghar:** It is very interesting that GP practices are developing, you know, primary care, and all these gadgets and everything. I need to know one thing very clearly. These are all developments with electronic stuff. Your professional qualification is based on books, papers, pens and bodies. Does it really help to rely too much on machines rather than on human hands? That is one question. The second is regarding the gadgets you get. Are they really paid for from your surgery funds or does it come from the LHB, so that sort of thing, either you are not going through, you know, certain equipment that is more relevant to you, rather than saving money? So, there are a lot of questions, but those two are good enough for you.

[126] **Dr Allanby:** When I went to medical school, there were no computers and no mobile phones; we have had to adapt.

11:30

[127] **Mohammad Asghar:** Wonderful.

[128] **Dr Allanby:** Yet, we still want to see the patient face to face where we can and when it is appropriate. We have not yet touched on remote consultations with a video link or skypeing and things like that. There has been some debate as to how valid they are and whether they actually generate more workload at the end of the day. There are different ways of seeing your patient and they do not have to be face to face, but where seeing the patient, touching them and examining them is appropriate, I think that we would want to preserve that. However, there are technologies that can do just as good a job. You have digital thermometers that you put in a patient's ear to record their temperature; we used to use a thing called mercury, but we are not allowed to use that anymore, so technology has advanced to no detriment to the patient. So, I think that we have to be prepared to accept that technology is there and we should use it where it is appropriate.

[129] The second part of your question was: is it going to take us away from the patient? I do not think that it is. I cannot remember the third part of your question.

[130] **Mohammad Asghar:** The funding.

[131] **Dr Allanby:** The funding is variable; that is the problem. It is not standardised. The enthusiasts may introduce it because they want to do that in their practice and get some experience. The other practices may wait until the LHB or the commissioning team funds it, so it is not standardised and that is what upsets people. Some people may say, 'Well, I'm not

going to do it until the LHB gives me the funding to do it.' Other practices may say, 'I'm going to do it' and, from an altruistic point of view, say, 'I'm going to develop a good service for my patients, but I'm not going to let anybody else do it'. However, if a cluster said, 'We're going to provide one ambulatory monitor in this community and we'll let all the practices access it' then that would be a separate way forward. So, it seems to be a different approach in different areas and there is a lack of standard conformity as to how it is being delivered.

[132] **David Rees:** Okay. Are there any other questions from Members?

[133] **Andrew R.T. Davies:** May I ask another question?

[134] **David Rees:** Of course you can.

[135] **Andrew R.T. Davies:** In the last evidence-gathering session, there was this talk of patient transfer between practices. Most of the gripes that I get are that people cannot get on lists because lists are full in certain practices. I also have a perception, rightly or wrongly, that, a bit like the banks, once they have got you, there is very little transfer between practices. Certainly, one of the previous witnesses said that patients will march with their feet. I wrote that down and spent a bit of time talking about transfer rates. In your experience—in rural areas, I appreciate that it is harder for transfers to happen—is there quite a high turnover of patients between practices, because it is most probably about the only way that patients can express their frustration at the service they are getting?

[136] **Dr Vaughan:** Figures would be available for Wales, but in most areas of Wales, outside the urban centres, it is about 10% turnover and most of that is driven by actual demographic change or a change in the structure of local services, such as if a practice closes if people retire. So, there is not a huge amount of patient transfer. Part of that is, okay, you may have a good service and there is a lot of loyalty, but the other part is simply inertia—'This is where I am registered, where I have always been registered and I have not needed to access healthcare for 30 years, and I only find on the next day that I need to access it and then I am registered'. So, inertia is the thing that probably helps that.

[137] **Dr Allanby:** You have hit the nail on the head. In a rural area, it just cannot take place because there is no choice. However, I think that working in Cardiff, there is a high turnover of patients, either because new patients are coming into Cardiff and they are leaving, or patients are literally saying, 'I'm fed up of not being able to get an appointment with the doctor across the road; I'm registering with you.' Previously, under the old contract arrangements before 2004, one could refuse to take that patient on. Now, we have to take any patient who wishes to register with us. There are advantages and disadvantages with that. If somebody is grumpy with one doctor, they are probably going to be grumpy with you, but time will tell.

[138] **Andrew R.T. Davies:** Thank you very much. *[Laughter.]*

[139] **Dr Allanby:** Access is driving patient registration, so if you are known as being easily available, patients may register with you. The Welsh Assembly Government is actually delivering a new programme, which is about to start, where patients living in Swansea can see a doctor in Cardiff. That is going to be available very shortly and I am sure that there will be some publicity about that. So, patients will be able to register, not on a temporary patient basis, in one place and live somewhere else. It will be piloted in Cardiff to see whether they can register to be seen in the daytime.

[140] **David Rees:** It could be near to a place of work.

[141] **Dr Allanby:** That is a different thing. However, I think that what you are trying to ask us is if I had an ambulatory blood pressure monitoring machine, and other practices wish to use it, there should be no barriers to other patients having that, but they would still stay with the original practice. There should be encouragement for patients to be able to use common services, if they are located in the same community.

[142] **Dr Horvath-Howard:** However, may I just add that that needs to be resourced somehow? Charles is not saying that that practice could just take that workload on as well as its own.

[143] **Andrew R.T. Davies:** I presume that you would just invoice the practice that you are doing the work for.

[144] **Dr Horvath-Howard:** No, it is not like that. The idea would be that the locality or the cluster would sit down and work out how it works, depending on what is at its disposal. Where we are, we would use the community hospitals probably because it makes sense. I do not know how it would work in a city practice, but at the moment, we do not cross-exchange. Hopefully that is not going to happen like it is happening in England.

[145] **David Rees:** Elin, you wanted to come in.

[146] **Elin Jones:** Yes, I just wanted to ask about patient records on the information technology side of what we are discussing here. On the whole, you have been quite positive about the integration of information systems. The Welsh NHS Confederation, in its evidence to us, said that there is a need to look at moving to online patient records that are available to every aspect of the NHS wherever you access it, whether through an ambulance service, a GP out-of-hours service, a GP set-up itself or at a hospital. Have you any thoughts about how far away we are from that and whether it is the right direction of travel to focus any effort on having that full integration, and with social services of course?

[147] **Dr Vaughan:** There are two underlying themes there. One is the underlining theme of access to clinical information being available day in and day out, at any time of the day, during any situation, and the other is the patient confidentiality aspect of this. I think that the way forward is probably about developing different views and different permissions, and ensuring that not only does the primary care system work, but that the information is also viewable in social care and in secondary care as well. At the moment, we are not really there. Although the Welsh clinical portal is quite good for seeing bits of information about a patient, so, for example, that would allow you to see an x-ray or a blood test or whatever had been done elsewhere, but that is ad hoc and separate from the whole patient record that is held together. I sit on the GMS information management and technology committee. My feeling is that we are quite a long way from having an integrated system across Wales and the two issues then need to be solved. The one is about patients giving their permission for their information to be available in all of these different places and the other is about the integration of two systems and also about allowing the correct set of views because it may not be appropriate for some bits of information to be viewed by some people.

[148] **David Rees:** Dr Howard, do you want to come in?

[149] **Dr Horvath-Howard:** I came into general practice 20 years ago and everybody worked out of the practice site and the team was far more integrated than it is now. My view is that the biggest challenge is the development of siloed management streams and siloed budgets, which is frustrating the whole teamwork ethic, particularly in rural areas, where you need that. What has come with that is a plethora of different IT systems that people have to use to write on. I think that that is a big risk factor for the country and I like to think that Wales may be able to dare to be different and say, 'No, we're going to have one unified

system'. You have managed to get all of the different GP IT systems down to two. Yes, we have grumbled, but we have gone with it and we are working with it. I do not see why that cannot apply to district nursing and all the teams, including health visitors. It is ridiculous that everyone is writing on different bits of electronic paper and that is where your critical incidents are going to happen because you have not got the continuity.

[150] **David Rees:** One final question from me is: you obviously represent the RCGP and the BMA, so do you have any experience of any primary care practices in Wales that have been involved in pilot schemes for new technologies for evaluation purposes?

[151] **Dr Vaughan:** I think that people just do things and see how it goes. My experience is that we bought a 24-hour ECG monitor—not looking at blood pressure, but looking for arrhythmias—and it just changed the way in which we delivered that chunk of care. I do not think that anyone really noticed apart from the patients and us. Maybe the people in the hospital saw a slight reduction in the work they had, but it is the availability of the kit that changed everything. Certainly, we were able to diagnose a few things that we otherwise would not have and, on the other hand, we were able to reassure a few people who would not have been able to go through the formal system in the past. So, I think it depends on enthusiasts at the moment, rather than—.

[152] **Dr Allanby:** What we have not touched on is that, if you are in the radiology department of the Heath hospital or Swansea or somewhere, you probably have an equipment budget every year; it may be an amount of money, it may be a rolling amount of money, it may be capital funding, but you have access to a certain budget for replacing x-ray machines and replacing technology. That sort of concept does not exist in primary care. That is where the stumbling block is. There is no defined equipment budget. That may be something we need to focus on. We did not put it in our submission, but it has just crossed my mind. If you work in cardiology, you are putting stents in, you are doing lots of things, so you must have an equipment budget every year, which you can use or prioritise. We do not have that in primary care. It is very much ad hoc—do I say that I want a new healthcare assistant or do I order a fancy piece of equipment? That is not fair to the patient.

[153] **Dr Horvath-Howard:** It is not fair to the practices either. We have paid for all of ours over the years. I have to say to you that the tone from my partners is very much that that is not something that we will be continuing to do in light of the way things are heading, which is a shame, actually.

[154] **David Rees:** Dr Vaughan, you mentioned what you were doing. Did you share that good practice with others?

[155] **Dr Vaughan:** Yes, in the sense of talking about having one and that we were enjoying using it and that sort of thing. However, as the people in the BMA say, in order to get that piece of equipment we had to spend £1,000 of our own money and get £1,000 from a charity. So, that is actually quite a lot of money. There are steps.

[156] **David Rees:** Okay. Time is against us. Thank you all for coming in this morning to give evidence. You will receive a copy of the transcript; if you identify any factual inaccuracies, please let us know. Again, thank you very much for your time.

11:40

**Ymchwiliad i Fynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn
Dystiolaeth 19**
Inquiry into Access to Medical Technologies in Wales: Evidence Session 19

[157] **David Rees:** We will move straight on, once the witnesses have changed over, to the third and final session this morning on this inquiry.

[158] This next session is with a representative of the Social Services Improvement Agency and someone from the Association of Directors of Social Services. This final session is about the social services and social care issues that we wanted to address as to whether there are aspects in social care that look at alternative approaches to technologies to help and assist in the care of individuals.

[159] Thank you for coming. I remind you that there is simultaneous translation on the headphones from Welsh to English if you wish on channel 1 and amplification on channel 0. There is no fire alarm scheduled, so if one goes off please follow the ushers. Please turn off all mobile phones or other electronic devices that may interfere with the equipment.

[160] I thank you very much for your written evidence. In this morning's final session we have Sue Evans from the Association of Directors of Social Services and Andrew Bell from the Social Services Improvement Agency. Thank you very much for the written evidence we have received. We just want to ask a few other questions in relation to the technologies and access to technologies that may help with the social care side of issues, because we are looking at primary care and that includes the social care aspects and the care plans for individuals.

11:45

[161] **Andrew R.T. Davies:** I want to ask a similar sort of question to that which I have asked the other witnesses, albeit it that they were predominantly looking at GP practices. A lot of the care that you undertake, and the profession that you represent, is community based—in people's homes, et cetera. Do you think that the commissioning process is fit for purpose when you are looking at new technologies to be delivered in that community setting? Certainly, the previous evidence indicated that it was not. Ultimately, there was no dedicated funding for the commissioning of such technology.

[162] **Ms Evans:** I will start to answer that one, and I am sure that Andrew will come in as well. From a local authority perspective, the commissioning of alternative technologies is seen as part of commissioning services for a package of support. So, it is never taken in isolation; we take a strategic approach, based on what that individual needs and what could help them with their mobility, their independence or monitoring their wellbeing. So, it is very much from the individual user point of view.

[163] We realise that, when commissioning, you need to look at how many people would require that type of equipment and whether we can purchase that on a regional or national basis. We use the concept of high cost, low volume. So, if something is very expensive, and you want to buy it only once, you might want to commission that on a regional or even national basis. However, if it is something that you are buying on a regular basis, and it is very small, it is much easier to try to think about commissioning that on a very local basis at a local authority level.

[164] Very often, with technology, things become out of date pretty quickly. One danger of commissioning things nationally is that you end up with a storage facility with equipment that

is no longer fit for purpose. If it is seen as the totality of a support package, it is much better—I feel, and other directors would say the same—that you are thinking about it in terms of the whole support package for that individual.

[165] In terms of funding, obviously, everyone is under incredible pressure in terms of their budgets. However, by considering it as part of the package, we consider it as part of the total budget, if you like, for adult services or children's services, say. We do not necessarily differentiate. What was useful a few years ago was that the Welsh Government came up with a particular fund for technology and that enabled us to pump prime and test new things out that we had not tried before. So, I think that those sorts of initiatives, if moneys like that become available, really give you an impetus to take a bit more of a risk, possibly, because budgets are so very tight.

[166] **Andrew R.T. Davies:** I know that Andrew wants to say something, but what you have said is that you are confident that the structures that you have in social services—because they are within the local authorities, obviously—are more robust than the ones that exist in local health boards to deliver that new technology in the community setting.

[167] **Ms Evans:** That would be my perception. I spent 20 years in the NHS before I moved into local government, so I have a bit of experience as a commissioner in the NHS. I think that what local government has managed to do, prompted by that fund, is to aggregate some of the intelligence. Andrew will talk about the learning and improvement network—the LIN—where we bring that expertise, knowledge and sharing of best practice together. Do you want to say something about that, Andrew?

[168] **Mr Bell:** Yes, certainly. What we have found within the Social Services Improvement Agency is that bringing people together who have a vested interest and a skill set around particular themes can be very useful to take forward agendas. Working collaboratively with the directors of social services and the Care Council for Wales, we have brought back what is called the assisted technology learning and improvement network. It is about the key people who work within health and local authorities who work in that field, and trying to pull people together, because what we find is that there is some excellent learning that could be shared by bringing people together. It is also about trying to look at how we can find consistent approaches. By bringing people together, you get an understanding of what the picture is for Wales.

[169] This is slightly off brief, for the moment, but it does make sense. We carried out for reablement, which is about that early intervention, position statements to understand what the position is in Wales. We are looking, with assisted technologies, to get that understanding as well. We need to get a good picture of what the current provision is like, and we can then build on that and use it as a basis.

[170] Leading back to the commissioning point, I think that, for me, what is important with assisted technology is that some of the solutions are very low cost. Certainly, when I have gone out to authorities and spoken to service users—I have put some case studies in my evidence—the evidence has shown that very small interventions, if that is the right word, have a massive impact on people's lives. Some of those smaller costs could potentially be self-funded. I am not saying that that is necessarily the route, but that could be an opportunity, where people—certainly as mobile devices are evolving at an incredible pace, with apps and the new Apple watch that does all of the health checks—there are routes out there that can really help to impact on people's lives. It is about making people remain independent and safe at home. The idea of people being supported, I guess, is key to it.

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

[172] **Kirsty Williams:** What do you, as professionals, feel that the scope is for using technology to make social services more sustainable as we go forward, as well as promoting independence? What is the ultimate potential for this, and where do you think we are on that journey? Are we half way there or are we just starting at a very low base at the moment? So, what is the overall potential and where do you think we are on the journey?

[173] **Ms Evans:** I would say that the potential is massive, and I would say that it is untouched or untapped. Certainly, there seems to be much more of a cohesive picture within the social care family than within the healthcare family, purely because, I think, of the complexity of some of the health technologies being both in the community, but also in hospital settings. If you try to bring all of that together under one learning framework, that would be pretty challenging. So I think, if we focused on what can be done in people's own homes, there is certainly merit in looking much closer at the health and social care learning on that. I think Andrew gave an example—sorry, it was in the paper that the Association of Directors of Social Services presented—where we looked at Germany, and the relative difference in the way pacemakers are fitted in Germany and in the UK. So, we know that there is a way to go, but, in terms of prudent healthcare or prudent social care, the evidence that the SSIA has presented shows clear financial benefit and qualitative benefit to those individuals in how some of that technology promotes independence and supports people to have a much more fulfilled life—and it is cheaper for the public purse.

[174] **Mr Bell:** I think that the potential is absolutely huge, but I think that there is a way to go to get to that point. It is important that it is not considered in isolation, and that it is thought about almost as a component within a range of approaches or resources that could be put in to support people. Thinking of it on that scale, I think, could have incredible implications for people.

[175] **Kirsty Williams:** Obviously, the technology is only as good as the individual's engagement with it. I know of lots of examples of elderly constituents who have a pendant that sits in the drawer rather than being worn around their neck, or even a person who was told that the way to combat his isolation was to go to an old-fashioned day centre, at which he was miserable and grumpy and disruptive, when the answer was really to give him a computer to allow him to interact with people he really wanted to interact with, not the people at the day centre. So, how do we get to a situation where we can really individualise and empower people, both on the professional side to make solutions fit for individuals, but also engage individuals so that they have technology that is useful to them, rather than being told by the social services department, 'This is what you need'.

[176] **Mr Bell:** I think that the Social Services and Well-being (Wales) Act 2014 takes us in that direction, does it not? It is about looking at people's wellbeing, keeping people's independence, and putting the person in the centre. I think that is an incredible driver to take us towards that kind of vision, personally. It then links into training staff and practitioners, whether they are health practitioners or local authority practitioners, who work with those individuals. It is about ensuring that they are skilled and trained and aware. There are some excellent examples of demonstration centres—if that is the right name for them—where some local authorities have these rooms set up with all of this equipment, where they bring staff in, and they can bring service users and people in, to see the potential of what it can offer. I think that is quite important. If people understand its position and its role, then, hopefully, it is more likely to be used.

[177] **Ms Evans:** To make it live for the committee, I will give you two specific examples from Torfaen, which is the area in which I work. We have a smart house in Torfaen, which is exactly the sort of set-up that Andrew is describing. It is a dedicated flat where people can stay overnight and test out a whole range of services. Already we are using it to enable people to come out of hospital sooner. They can test things out in a different way, and try out

different pieces of kit. It is not just with the individual but with their family as well. Often, it is the family member who is more nervous than the individual. So, I think that that is a key one.

[178] The other one that I thought would be a useful example to share with you is the Torfaen medication administration scheme. That is real evidence of health and social care working closely. A GP will prescribe the drug treatment, the pharmacist will advise on a piece of kit that may be useful, the social worker does the assessment, to see whether that individual has the capability or the functional ability to manage that piece of equipment, and the care worker delivering the service is then trained in using that. However, it is all done with the service user and their family members to give them that very confidence that you are talking about. So, that is a real good example of health and social care coming together to use a whole range of skills, from the GP to the front-line healthcare worker, to try to use everybody's resource and expertise in the best way possible. That is now being rolled out, using the intermediate care fund that we have recently had, across the other parts of the greater Gwent area, and other parts of Wales will have similar schemes.

[179] **David Rees:** Who decides what technology and equipment goes into those houses? Who does the assessment? That is one of the questions that we are trying to find out the answer to, about the access to medical technologies. So, who is making the decisions as to what technology goes in for consideration?

[180] **Ms Evans:** We have an assistant technology broker; other local authorities will have the same. They are the people who will be experts in finding out what is available. They work with the social workers who do the professional assessment of somebody's needs, or with the district nurse who does the clinical assessment. Through that three-way combination of expertise, they will find a solution that best suits that individual. If that does not work, we will look at something else as an alternative.

[181] **John Griffiths:** I wonder whether you see any need for horizon scanning, as it is termed, and whether there should be some centralised horizon scanning in Wales, of looking at evidence of what works to inform those people making the decisions at a local authority level. Is there a need for something at the higher level, do you think, or not?

[182] **Mr Bell:** I think that that would be of real value, because technology is advancing at an incredible rate, and being aware of where that might be moving towards, and informing the right people of what approaches could be used would be an important step to take.

[183] **Ms Evans:** We could build on the LIN, which started off as a local authority learning and improvement network, but we now have health service colleagues in there, as well. So, there is a real opportunity there to use that. If we could expand that, perhaps to give it some academic rigour and some evaluation, there is real potential there—on an all-Wales basis—for doing more of that learning and, as you say, that evaluation, particularly looking at the question of whether it improves people's lives and whether it is value for money. Those are the two aspects.

[184] **Lynne Neagle:** I want to ask about the health technologies and telehealth fund. In your experience, how well has that promoted partnership working between health and social care?

[185] **Ms Evans:** We have given evidence in our paper, and I would see that as being real evidence. We do not always see it across health and social care at a strategic level, where health boards and their partner local authorities really get together in the same room to prioritise what proposals come forward to try to provide that joined-up approach. In that way, it is not dominated by a clinical view or a social care view, but there is a genuine joining-up

on the question of what is the best way to try to maximise the use of that fund. We saw that evident across Wales, which I think was very welcome.

[186] **Lynne Neagle:** I also wanted to ask Sue about the comment in the ADSS paper about the 3millionlives campaign in England. The paper says that we should look to learn from the positives and negatives of that campaign. Are you able to expand on that a bit for the committee?

[187] **Ms Evans:** Not directly. I would like to go away and have a look at that in a bit more detail. My colleague, David Williams, wrote that paper for me. So, I can come back to the committee with a written response to that.

[188] **Mohammad Asghar:** My question follows on from Lynne's. Where technology was introduced, was real value for money achieved? That is one question. My second question is: what can we learn from the development of community equipment services in Wales?

12:00

[189] **Ms Evans:** I can give you my personal experience of both of those. In the SSIA case studies, I think that you have some real concrete examples of what a difference it makes to individuals and how it saves the public purse. One of the case studies that Andrew and I were talking about earlier was about the young woman who was trying to be independent, but needed prompting for medication et cetera. That was originally an hourly call. By putting in some technology to give her a little bit of a warning—an alarm going off—she was able to manage her own medication and not have interference from other people. That is a real practical example, I think, of how it can transform people's lives. Obviously, it is much cheaper to put a piece of equipment in than to have an individual practitioner going in to somebody's home, which could also potentially be an invasion of their privacy, so there are benefits on both sides. If you multiply that up—that is one individual case—and think that we are trying to do that with everybody in the community across health and social care, the economic impact of that must be significant, if you aggregate it up.

[190] In terms of community equipment services, the Welsh Government developed a capital equipment fund, probably about seven or eight years ago now, which gave a really good pump-priming experience for health and social care to work together, to try to pool our resources and come up with a combined community equipment service. All parts of Wales now have those developed. Again, in the greater Gwent area, we have started to bring in alternative technology and purchase that sort of kit under the umbrella of our community equipment service. Other areas are looking at the same approach.

[191] From that commissioning aspect, you start to get the benefits of economies of scale and you start to aggregate some of the intelligence about what works, what does not work and what is no longer fit for purpose. The days of, say, 10 plus years ago, when you had equipment kept in storage that was obsolete and a waste of money, have gone. We have really sharpened up on delivering equipment to people's homes much quicker, getting it returned, recycled and cleaned, and getting the efficiency out of purchasing on a collaborative basis. So, I think that we can evidence both value for money and an improved service.

[192] More people are now being helped to live at home in their own communities, and people are living longer with long-term conditions and chronic illnesses. That is where we need to focus those resources. The trick for all of us is how we unlock some of that capacity and those resources that are tied up in very acute hospitals and institutions. People want to be at home, and 90% of their healthcare is delivered at home, but the acute sector sucks in a lot of money. It is such an expensive part of the system that it is a challenge to transfer some of those resources out into primary care, social care and community health services, but I think

that that is the challenge for all of us.

[193] **Mr Bell:** Yes, in connection to the value-for-money problem, for myself, I think that there is value for money and there is evidence to show that that is clear, but it is about the improved outcomes for the individual. That is the important thing to us: to keep connected with that and to think about it as people's lives being significantly improved. That is quite an important aspect to keep attached to the money element.

[194] **David Rees:** The question that we have as well is this: you mentioned that you are working closely with the health sector and clearly, that is an important aspect here, but are you in discussions with the health sector when patients come back into the care community, to discuss their particular needs and look at what new technologies might assist those individuals in both a health and a social care sense? What types of discussions go on with that sector?

[195] **Ms Evans:** We do that on a daily basis. Most parts of Wales have intermediate care services, particularly looking at older people or frail younger adults, where their hospitalisation sometimes makes them even more dependent. That hospitalisation is a necessary part of their clinical care, but you want them in there for the shortest time possible, because sometimes their functioning might have deteriorated, so you are trying to bring them out as quickly as possible, using intermediate care and reablement services. So, there is a high-level package of health and social care support, which may be for six weeks. So, it is a big package of support, with health workers, social workers and care providers working collectively. The idea is to step down that high package of care once that person has relearned those skills, or we have given them equipment or facilities that enable them to use alternative technology, where, perhaps, a function has gone—a sensory impairment, or a mobility issue. So, you are trying to replace maybe a function that has been lost with a piece of kit or technology. Trying to maximise that independence, I think, is the key, and that is happening on a daily basis. Every time there is a discussion about somebody being ready to come home, it is about the preparation of the home—is the house suitable or does it need to be adapted? We work with our housing colleagues or Care and Repair and other third sector agencies to try to help in terms of the package at home. Assistive technology would be a part of that discussion.

[196] **David Rees:** In your answer to John Griffiths you indicated that you would like to do horizon scanning. You think that it is a good idea.

[197] **Ms Evans:** Yes.

[198] **Mr Bell:** Yes.

[199] **David Rees:** Do I therefore take it that, for the bulk of the technologies that would be employed in this sector, you are basically looking at what is in the marketplace more than what is coming onto the marketplace?

[200] **Ms Evans:** Our practitioners will be looking at both, but, obviously, one thing that I think we mentioned in our evidence is that, very often, the producers of the technology are promoting it. They have far more resources, if you like, to market their equipment, so it is like any part of a system—if something is readily available and visible, whether it is to members of the public or to health or social care practitioners, those are the things that come to light. However, certainly, we sometimes see service users who are much more clued-up. They will be looking on the internet, and they will be seeing things and coming to practitioners saying, 'I've seen this' or 'They're doing this in the States' or in Europe. 'Do we have any of that here?' 'Can we look at it?' However, I think that the idea of getting an all-Wales evaluation or horizon scanning would probably help all of us, as a bit of a shortcut to trying to find out

what is out there.

[201] **David Rees:** So, if a user currently comes to you to say, 'I've seen this piece of equipment', how is that evaluated? Is it done on an ad hoc basis in individual authorities?

[202] **Ms Evans:** It is at the moment, I think, left to the individual. What we try to do is look at the outcome for the individual, what the package of support is, which would include a technology, and how well that has worked. One way we could certainly improve on using the learning and improvement network is by aggregating some of that intelligence. So, we might hold it at a local authority level or even within a team, but there is scope to certainly aggregate some of that so that we can start to gather and share the things that work well and the things that do not work well, and why.

[203] **David Rees:** So, you are actually looking to start to share best practice now.

[204] **Ms Evans:** Yes, we are.

[205] **Mr Bell:** Yes, it is certainly the role of the LIN to take that forward.

[206] **David Rees:** Do any other Members have any questions? No. It seems that you have answered all of my colleagues' questions. I thank you for your evidence. It has been very helpful for us to look at this sector in particular and at the interrelationship that you have with the health sector.

[207] You will get a copy of the transcript to check for any factual inaccuracies. Please let us know if there are any. Thank you once again for attending today.

[208] That was the last evidence session for this morning.

12:08

**Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i Benderfynu Gwahardd y
Cyhoedd o'r Cyfarfod ar gyfer Eitemau 8, 10 ac 11
Motion under Standing Orders 17.42(vi) and (ix) to Resolve to Exclude the
Public from Items 8, 10 and 11**

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

the committee resolves to exclude the public from items 8, 10 and 11 of the meeting in accordance with Standing Order 17.42(vi) and (ix).

[210] Is everyone content with that? I see that the committee is in agreement, so we will go into private session. For those members of the public watching, I should say that the meeting will recommence in public at 1.30 pm for the ministerial scrutiny session.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 12:08.
The public part of the meeting ended at 12:08.*

*Ailymgynullodd y pwyllgor yn gyhoeddus am 13:32.
The committee reconvened in public at 13:32.*

**Craffu ar Waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r
Dirprwy Weinidog Iechyd: Craffu Cyffredinol ac Ariannol
Scrutiny of the Minister for Health and Social Services and the Deputy Minister
for Health: General and Financial Scrutiny**

[211] **David Rees:** May I welcome Members back to this afternoon's session of the Health and Social Care Committee? May I welcome Paul Davies, who is substituting for Darren Millar this afternoon, and Alun Davies, who is substituting for Rebecca Evans this afternoon? May I also welcome the Minister and his officials to this afternoon's session? This afternoon, we are looking at general and financial scrutiny of the health budget. I intend to split the session. The first hour will be general scrutiny, we will have a five-minute break, and then the second half hour will be for the financial aspects. Minister, would you like to introduce yourself and your team?

[212] **The Minister for Health and Social Services (Mark Drakeford):** Chair, thank you very much. I am Mark Drakeford, the Minister for Health and Social Services in the Welsh Government. With me this afternoon I have Albert Heaney, who is head of social services in the Welsh Government, Dr Andrew Goodall, who is the chief executive of NHS Wales and the director general for health and social services, Dr Ruth Hussey, who is the chief medical officer, and Martin Sollis, who will primarily, probably, take part in the financial part of the scrutiny as head of the NHS finances in the Welsh Government. May I begin by formally putting on record apologies from the newly appointed Deputy Minister in the department, Vaughan Gething, who is still on paternity leave?

[213] **David Rees:** Thank you for that. May I welcome Andrew Goodall in his new role?

[214] **Dr Goodall:** Diolch. Thank you.

[215] **David Rees:** Welcome to the committee. We will go straight into questions, if that is okay, and we will start with Gwyn Price.

[216] **Gwyn R. Price:** Good afternoon, everybody. What action is the Welsh Government taking to improve information sharing and information technology systems for the management of chronic conditions, and what plans does the Welsh Government have to progress a national specified chronic conditions community pharmacy service?

[217] **Mark Drakeford:** I thank Gwyn for both those questions. Obviously, the management of chronic conditions in the community is an essential part of the way that we want to plan our health services for the future. We have some success that we can report in that area, because emergency admissions and readmissions to hospital for people with chronic conditions have been falling month on month in the Welsh NHS over a sustained two-year period. We will probably refer to the Nuffield report a number of times this afternoon, but it is one of the things that Nuffield highlights as having made a significant contribution to closing any funding issues that we may have in the Welsh NHS.

[218] Specifically in relation to how we are deploying IT resources to support that agenda, I think that there are three or four different things that we could look at. We have succeeded over the period of devolution in reducing the number of GP IT systems that we have in Wales. I think that, at the start of devolution, we were almost in double figures in terms of the number of different IT systems that different practices used. We are now down to just two. So, there are very common systems across Wales, which we are better able to support.

[219] GPs are able to identify now, through their registers, people with chronic conditions. They are able to use the electronic way of recording these things to, for example, flag up

automatic recalls for people who need blood tests or further routine monitoring of their conditions. We have the individual health record, which has been a major project in the Welsh NHS. So, out-of-hours doctors, now almost universally across Wales, are able to have access to the individual patient record in out-of-hours consultations, helping to prevent acute exacerbation of chronic conditions turning into hospital admissions.

[220] I know that the committee is aware of the development that we hope to bring about in diabetes care, which is obviously a major chronic condition. The Scottish Government has offered us, free of charge, the electronic system that it has developed for diabetes care. We have to customise it for Wales. Although the basic system is free, it is not cost-free completely because our system is not identical with theirs; we have to fine tune it to allow us to use it. However, when we have it, it will allow individual patients to be tracked right across primary and secondary care, and again to try to move care closer to home.

[221] We have made a substantial investment from the health technologies fund this year in connectivity between optometrists, dentists and community pharmacists with the primary care record again, and between primary and secondary care, again to try to promote the ability to manage chronic conditions closer to home.

[222] Finally, as a sort of specific example, but potentially a very important one, all 22 local authorities in Wales have signed up to the development of a new framework contract for community care information systems. One of the things that we really struggle with is the interface between health records and social services records. Social services records are, in an IT sense, held differently right across Wales, depending on the local authority you are in. All 22 local authorities have signed up to a new framework contract. That framework contract will be available, we hope, from January 2015, and then we will have to work closely with our colleagues in local government to try to persuade as many local authorities as possible to take the contract from the framework because then health records and social services records will be able to talk to one another much more easily, which will help again in quite a major way with the management of people's conditions in the community, in their own homes, and out of hospital.

[223] **Gwyn R. Price:** Minister, would that include the community pharmacy services?

[224] **Mark Drakeford:** Well, we already have a common ailments experiment going on in Wales in community pharmacies. Members here might recall that we have 32 pharmacies in north Wales and Cwm Taf that are involved in a pilot called Choose Pharmacy, where the aim is—and there is an agreed list of conditions, which has been agreed between the doctors and the pharmacists—that if you phone up the doctor and say, 'I want to have an appointment to have my verruca seen to', for example, the doctors' surgery is meant to say, 'We don't do that here now. You can have that done at your pharmacy', because those are all pharmacists who can prescribe, and they are all pharmacists who have the ability to register the treatment that they provide on the GP record in real time. The idea is to try to displace activity that need not happen in hard-pressed GP surgeries into community pharmacies. There is, Chair, as you will know, a very long history in health and welfare services that when you provide something to be instead of something it ends up being as well as, not instead of, it. In these hard times we cannot afford to have new services that just become another place where you can go, so we are evaluating and monitoring that new service very closely. If it turns out, as we hope, that it is displacing activity from the GP service into community pharmacy, we will want to take it further.

[225] **David Rees:** We will continue our discussion of community pharmacy next week, Minister, in another session.

[226] **Mark Drakeford:** Indeed.

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

[228] **Elin Jones:** Minister, you have come in front of us today, the day after the BMA said that the NHS in Wales was in meltdown, and the day after, apparently, a 70-year-old woman died in an ambulance outside Morriston Hospital queuing to get into A&E. Very much, the pressure that you have identified in the NHS during your time as Minister has been on unscheduled care and the ambulance service. You have put in place several measures and put different people to work on improving the service. I do not expect you to make any comment about any individual circumstance, but it does not seem, from people I speak to in the NHS and from people who are representing staff in the NHS, that matters are improving at all in the NHS. So, I want to hear your reflection at this point on the pressures and on how the improvements you put in place are having any real outcomes for the service and the experience of people in the NHS. I have two other questions on more specific issues.

[229] **David Rees:** Lynne wants to come in on the ambulance service, I think, so, if you answer the question, Minister, and Lynne will come in on that as well.

[230] **Mark Drakeford:** Okay. Thank you, Chair. It is a very globally expressed question so I will attempt a beginning answer and then, of course, I will be happy to take any supplementary questions on it. The NHS in Wales, as in all other parts of the United Kingdom, is a system under pressure. The age of austerity is absolutely real in it. Demand goes up; our ability to meet the demand by matching it with resource is compromised by cuts in budgets that we face. Nevertheless, the big picture story is of a remarkably resilient service that provides for the needs of the Welsh people in planned and unplanned care on a huge scale. There are 19 million appointments every year with GPs alone. There are another 7 million appointments with practice nurses. There are 25 million planned contacts in primary care alone and 1 million contacts through A&E departments. Thousands and thousands of operations are planned and delivered. There is a standard waiting time of 10 weeks from the moment that you are diagnosed to the moment that your treatment is complete.

[231] Does this mean that there are not real pressure points in the system? Absolutely not. There are, and the ambulance service, certainly, is one of those places where performance has not been what we would want it to be. However, we have a new set of arrangements that the Assembly has extensively debated. We have Professor Siobhan McClelland leading that for health boards. We have a new national ambulance commissioner appointed. Performance in the ambulance service does have to improve. From the Welsh Government's point of view, it has more money this year and it knew that from the beginning of the year. It has a recruitment plan that will lead to 100 new people being recruited into the service. We have major investment in vehicles, so that it has the best equipment it needs to do the job. It has to be able to demonstrate that it uses all those contributions that are being made to turn that into performance on the ground. Performance is not where we would like it to be, but there are some modestly encouraging signs of improvement.

[232] **David Rees:** Elin, do you want to come back in quickly?

[233] **Elin Jones:** Yes. Just on ambulances, your analysis of where we are with ambulance performance is that it is now clearly on performance within the ambulance service and not on resource availability, given the resources you say you have made available at the start of the financial year.

[234] **Mark Drakeford:** I believe that we have done a pretty good job in very constrained circumstances to give it £7.5 million extra in its budget this year. It has, I think, credible plans for how it will invest that money in staff to provide the emergency medical service that we want it to provide. That sits in a wider plan that involves the disaggregation of patient

transport services to allow the Welsh Ambulance Services NHS Trust to focus on the things that we want it to do. The focus has to be on performance.

13:45

[235] **Elin Jones:** Very quickly, on that point, although you may not be able to supply it now, I would like to ask for further information regarding the 100 extra paramedics. I understand from the ambulance trust that some eight of those are meant to be in my area, for example. Are we able to have a note on progress made on staffing and on where it is with regard to that appointment and recruitment process?

[236] **Mark Drakeford:** We can certainly let you have a note of the plans that WAST has for recruitment.

[237] **David Rees:** I call Lynne on ambulances.

[238] **Lynne Neagle:** Thanks, Chair. I welcome the extra investment for the ambulance service and recognise how difficult it is in the current climate to find extra money. I have a question about the use of private ambulances, which there has been some focus on in Gwent. Clearly, the priority has to be patient safety, but what steps have you taken to ensure that, where private ambulances are used, every attempt has been made to ensure that the NHS provides that service first?

[239] **Mark Drakeford:** I thank Lynne for that question, because it is a chance to set the record straight on this point. In south-east Wales in particular, WAST has faced, over certain points in the year, difficulty in filling all of the shifts that it needs to fill in order to provide the service that is required. It faced that difficulty during August, because you have issues of leave and other things, and it is facing it over weekends in the month of September as well. I have made it clear to WAST that I expect it to work its way through a hierarchy of decision making. The first thing I need to know is that it has offered all of those shifts to the people who work for the Welsh ambulance service. If it cannot fill all of those shifts with people who work for it directly in the emergency medical service, then it needs to see whether there are people who work in patient transport services or the St John Ambulance brigade or some of the other services it uses who, provided that they have the proper clinical training to do so, would take any of those shifts. If it still has shifts to fill, then it can look to see whether there are people employed in ambulance services along our border—in public service ambulances—who would be willing to take shifts. It is only when it has exhausted those three courses of action can it then go and secure services from private ambulances. As a result, two private ambulances have been used, and they are confined to use at weekends. In the end, patient safety is the priority, and if we have to fill shifts in that way, then that is how we will fill them. However, it is a last resort and not a first resort.

[240] **David Rees:** Several Members have indicated that they have questions. Does anyone have questions on the ambulance service? I call on Alun and then Kirsty.

[241] **Alun Davies:** I understand from your earlier reply to Elin Jones that you are moving quite quickly to implement the findings of the McClelland review. I just wanted to clarify that. What you are doing is finding the resources in order to provide the resources that the ambulance service needs. Perhaps I read too much into these things, but I tended to read from your reply that you had taken some difficult decisions in very difficult circumstances to ensure that the ambulance service has the resources that we believe it requires in order to deliver on these performance ambitions. Does that mean that the blockage to achieving that level of performance and delivery lies within the service rather than the structures around the service? Are you content with the management within the service and that it can deliver on the McClelland demands?

[242] **Mark Drakeford:** I might ask Andrew to add a bit to my response. It is important that we point to those legitimate contextual things that make the job of the ambulance service itself more difficult. I will give you just two of them. These days, if you are a fully trained and competent paramedic, you are a very saleable person indeed. There are many other opportunities for you outside the ambulance service, where you will find employers that are very keen to make use of your services. So, while WAST has a plan to recruit, it faces a position where, having trained and invested in people, those people are very mobile and it can lose people as well as recruit them. Not all of the problems that WAST faces are of its own making. We have succeeded in Wales in reducing handover times across almost all our LHBs. We have some outstandingly good performance—handover times in Cwm Taf are under 10 minutes on average and that puts it at the top end of the UK scale—but we still have some spots of difficulty. Cardiff has been one over this summer, while it has remodelled its A&E department, where ambulances arriving at an A&E department were unable to transfer their patients into that A&E department. That meant that it could not get the ambulance back on the road and its performance figures suffered, and that is not because of something that was in its hands to influence.

[243] So, I do not want to talk ourselves into a position where we just think that WAST itself is responsible for all of the problems that it faces. It is not; there are constraints on it. However, there are responsibilities that lie with WAST and it is for it to discharge. Maybe Andrew will say a bit more.

[244] **Dr Goodall:** Just to build on the Minister's comments, we do need to make sure that we target the system. One of the changes with the joint ambulance committee that has been put in place is to make sure that the local health boards are very clear on their local needs in respect of what the ambulance service needs to be providing. It can have the opportunity to develop its own specification and WAST has actually aligned itself to make sure that its structures do fit with those health board templates, so it becomes a local system discussion, but with everybody needing to make their own contribution. Relationships have been in place over the years, but the McClelland review brought in a different governance approach to make sure that that could be driven. That also included some responsibilities for recognising that there was a need to push on some of the staffing issues and to work forward.

[245] However, the additional comment that I would make is that we are not just in a static position; we are seeing the level of ambulance demand that is coming through the system. If I just take July, where we have seen some early signs of some improvement: in July 2010, four years ago, 7,000 patients were responded to within eight minutes; in July 2014, 8,500 patients were responded to within eight minutes. It is about making sure that everybody is aware, and from a community perspective, that it is not just a static issue around demand. That has continued to grow for all of the reasons that have been highlighted around demographic changes, but none of that removes the responsibility from the service to still make sure that it can keep pace with that and continue the improvement.

[246] **Kirsty Williams:** Minister, over the summer, there has been discussion and some indication of industrial action that, potentially, could exacerbate the problems that we have experienced in the Welsh ambulance service and make it even more difficult for the Welsh ambulance service to meet your targets. At the time, I believe that the statement from your department was that issues around industrial relations were not a matter for you; it was a matter for the Welsh ambulance trust. Is that credible, given that you fund the Welsh ambulance trust and have overall responsibility for ensuring a timely emergency service for Welsh patients? At what stage of failure to meet targets, despite the considerable investment that you have made financially, and despite the new governance arrangements, will you feel that you have to intervene and do something even more radical if we are to create the emergency service that I know you and your colleagues want to provide?

[247] **Mark Drakeford:** There are probably two questions there. On the first, it is very important for me to be completely clear that the relationship between employers and employees has to be discharged between those people who are the employers and those people who are their employees. I do not myself employ the ambulance drivers or other people who work for WAST; the Welsh Ambulance Services NHS Trust is the employer. I am not prepared for the idea to go around to trade unions or employers that every time they fail to resolve issues between them, the answer is to think that I will be the backstop and the judge of last resort; I am not. It is for them to get around the table and it is for them to resolve these things. The changes that WAST wishes to introduce in terms and conditions in Wales are already the terms and conditions that exist in Scotland and in England. All parties to those discussions have a responsibility to get around the table to find a way through the difficulties that they have identified and then to come to a conclusion. The answer is not to think that, every time you hit a difficulty, you can pass the ball to the Welsh Government and it will do it for you. That is absolutely impossible.

[248] The second question that Kirsty raised is: do we reach a point where we think that the ambulance trust simply cannot deliver on the responsibilities that have been given to it? I do not think that we are anywhere near that point as yet. We have to be prepared to give the new people who are there and the new arrangements that we put in place a chance to deliver on them. They are confident that they can. We monitor it very carefully. I said in the Chamber before the recess that what I expect to see is a pattern of improvement. I expect to see the ambulance service not creating miracles, but on a sustained path to reaching a point where the service it provides is one that those who work in it and use it can be confident in and proud of the work that is done. That is a question that is alive and that we keep under review all the time.

[249] **David Rees:** We will go back to Elin because I know that she has a couple of questions. Minister, you did mention that the transfer times at A&E were coming down, but clearly we have all seen times when there have been multiple numbers of ambulances outside A&E, particularly at major trauma hospitals in south Wales, as well as a few times when there have been no ambulances outside—I will say that. What is your view of the surge capacity within those hospitals to deal with the large numbers that come in at certain times, so that we do not have a situation where we have multiple ambulances outside A&E units, wasting time effectively, but also not being able to transfer patients into the units themselves?

[250] **Mark Drakeford:** As I say, I think that the figures here demonstrate that the NHS, over the last 12 months and slightly longer, has been able to bear down on those figures. Ambulances go to hospitals—that is an inescapable fact—and there will be times when, in a completely unpredictable way, you get a spike in demand. We have analysed spikes in demand across the Welsh NHS and they do not conform to any predictable pattern. They can happen at any time on any day. Things will happen and ambulances will end up at the hospital door. What we then have to be sure of is that the hospital is able to turn those ambulances around as quickly as possible. We have had examples in Wales where, sometimes, well over 10 ambulances are at a hospital, whereas an hour before there were none and an hour later there was one. As long as hospitals are able to do that, there will be points inevitably when ambulances will be conveying people to hospitals in large numbers. Andrew may say a bit about how hospitals have achieved the improvements.

[251] **Dr Goodall:** Members will know of particular attention paid to this over the last winter period, where we just changed the way that we planned for that. Part of that was fundamentally looking at the surge capacity, not just over periods of months and through the winter months, but actually at different times of the day and week as well. I think that we learnt a lot through that process and we were actually able to show greater resilience within the unscheduled care system from that. We have been able, as the Minister has outlined, to

show an improvement in the figures around handover, for example, moving into the summer months. So I think that, from a hospital perspective and the way that that system works, we have got a lot more information that we can actually use. I think that the important thing as well is that, although we go into another winter period and we all plan, we learnt from that process in March and it is being fed back into our system. So, as we receive the three-year plans and the annual expectations for different organisations, balancing the demand with the capacity is one of the critical moments of focus within the reports. That may be about bed capacity, but it is particularly about alternatives. So, again, in terms of things that we have learnt from last winter, we know that the ambulance service did put in an alternative around falls and patients who could be deployed to community services and that we were able to target 3,000 patients, for example, in a very specific period to go into alternative services. So, I would not want to just focus on the hospital capacity. I think that a lot of this remains about making sure that the signposting to the community services is in place.

[252] **David Rees:** We will go back to Elin.

14:00

[253] **Elin Jones:** I have two quick questions. One is on the GP workforce and we are hearing alarm bells from different parts of Wales around the retirement of elderly GPs and that there will be a shortage of GPs filling those roles. A GP surgery in my constituency unexpectedly announced that it was going to close permanently over the summer. Can you give us any indication of what additional measures you are undertaking as a Government to ensure that, over the next 10 years, you are putting in place now the right training opportunities to start training up additional GPs who will, hopefully, stay to practice in Wales?

[254] Secondly, on cardiac surgery in south Wales and the contracting of such surgery outside of Wales, in the report that you have given us I read something that I had not previously understood, which is that the priority had been to ensure that surgery was given to patients in south-east Wales first and south-west Wales to follow—if I have understood paragraph 62 clearly enough. I had not been aware that there was that kind of priority in the system. That does explain why nobody with whom I have spoken in my area who is on a cardiac list has been offered a place in Bristol. What I want to know is what real progress is being made. How many operations have been contracted out of Wales for this? What impact are you having on the waiting list for cardiac surgery in south Wales? How can you provide me with some assurance that those people waiting in west Wales also have access to this opportunity?

[255] **Mark Drakeford:** On GPs first, just to give a small amount of context, Chair, the number of GPs working in Wales went above the 2,000 mark for the first time last year. Numbers have grown steadily—they are not falling, but growing. The proportion of GPs who are aged 55 and over in Wales is practically identical to England and other places; I think that we are 1% below England and 1% above Scotland. Northern Ireland has a more difficult problem than we do.

[256] Where Elin is absolutely right is that there are parts of Wales where there are GP recruitment issues emerging. We are tackling them in a variety of ways. I might ask Ruth to give you some specifics on the 10-point action plan that we have to try to make sure that we make it easier for people who are on the performers list in England to practice in Wales, to make it easier for people who want to retire from full-time employment to stay in part-time employment in the workforce and to find different ways that GP practices can organise themselves, because the old general-medical-services form of organisation is increasingly not attractive to people coming into the profession.

[257] On the final point that Elin asked about, on how to sustain that into the future and how to create the workforce that we will need in 10 years' time, you will know that I have asked Mel Evans, with three others, to look at the investment that we make in medical education and the education of the professions allied to medicine. We spend £350 million every year on that agenda, and we do it because people in Wales believe that, by helping people through their training and education, we are creating people willing to work in the Welsh NHS in future.

[258] I have become less confident that we get an adequate return on that investment. Do we get enough people who go through our education systems then being willing to work in the Welsh NHS? I have asked them to give me an early report on incentives in the system. Is it possible to use the considerable sums of money that we use now in incentives to put more in the hands of those people who commit to working in Wales post their education, while leaving those people who, absolutely fairly, and with no sense of criticism of them, want to leave their options open and who may decide to pursue a career elsewhere? If we are able to do that, I hope that that will be one of the things that we can do to persuade more of those people, in whom we invest heavily through their education, to give us a return on that and to come to work in primary care and other parts of our system.

[259] Ruth might be able to give you more information, because she has been leading the specifics on GP recruitment and retention.

[260] **Dr Hussey:** Briefly, there are some very practical, short-term issues that GPs are raising with us. The challenge is different in different parts of Wales, as I think you have described. Over the summer, I have been to Powys. I met a number of practice GPs there to talk about their particular circumstances, which are very different to what was discussed when I met GPs in the Llŷn peninsula; there is a different mix of issues. The challenge for us is to work out how we can best help different areas in different ways.

[261] We need to look at practical short-term things, as the Minister said. Can we do something about the performers list, to enable it to be easier to get some locums in the short-term, when gaps suddenly appear? We are working on that. It is a legal process, so we are taking advice on how to do that. Hopefully, we will come forward with ideas on improvements. You mentioned also the 10-year outlook, and I think that that is where we need to be focusing. Again, with the Wales Deanery, we are looking at practical models of more junior doctors training in community settings and GP settings. It is encouraging to see the medical school students out on placements in disadvantaged communities, learning more about working with the community.

[262] The really long-term change coming towards us—I think that we have mentioned it in committee before—is the Greenaway report, which is about changing the nature of medical training, so that it is more generalist training. There have been some workshops planned across the UK to look at different aspects of the Greenaway report and the practical issues. We were very keen to be a part of the primary care discussion, because we believe that primary care is the foundation of a really strong health service in Wales. So, we are really trying to contribute to that, and that is a way of trying to build for the long term. Ministers also asked our workforce colleagues to pull together a workforce plan—a multidisciplinary one.

[263] I think that the other challenge for us is the types of illnesses that are coming to primary care now; they are really changing in the mix and the type of support that people need. We have talked about chronic illnesses before. So, we need to make sure that we are also developing practice nurses. There are some practices—we heard about them at a big event that we had with the NHS over the summer, to look at primary care—where pharmacists are based in practices, doing repeat prescriptions and checking medicines. We

heard about practice nurses who are undertaking clinical consultations.

[264] We have a number of different aspects that we are trying to pull together, both for the immediate practical challenges for GPs, who are a critical part of our primary care system, and in making sure that, over the 10-year period, we are looking at all of the other staff that we need as well. That work is very much in play at the moment.

[265] On a final note, I was very pleased that, over the summer, the Minister was able to announce some money to help health boards think about developing staff and offering some workforce opportunities. Those bids and proposals are coming forward now, so we will be looking at those. So, it is practical short-term things, but also an eye on the longer term, as you say.

[266] **David Rees:** Before you answer the question about cardiac services, Alun has a supplementary question about GPs.

[267] **Alun Davies:** We have been through similar experiences in Blaenau Gwent as well. My question is about the plans that you have for strengthening primary care. I think that we rush towards the acute sector without perhaps spending enough time considering some of the improvements that are required, and that are being made, in terms of primary care. I suspect that, in the last five minutes, you may well have answered most of those sorts of concerns and questions, but are there any particular issues or programmes that you have in place that will strengthen the primary care sector?

[268] **Mark Drakeford:** Strategically, the key thing, I believe, is that the primary care workforce of the future will not look like the primary care workforce of the past. Where GPs may be more difficult to recruit, what we have to do is strengthen the wider primary care team to make sure that GPs are able to use their time looking after those people that only GPs are able to look after. In order to do that, you have to displace some of the work that they currently undertake to other members of the team who are equally clinically competent. On the role of the clinical pharmacist, I described earlier the scheme that we have in which we try to persuade patients not to go to the GP, but to go to the pharmacist instead; what if that pharmacist was in the GP surgery? When you rang to make an appointment for any of the 17 things that are on the list in the minor ailments scheme, instead of being asked to go somewhere else, you would simply be given an appointment in the GP surgery itself. Studies by the University of Warwick suggest that anything up to 40% of the consultations that GPs carry out today could just as clinically competently be carried out by other members of the primary care team. Some of those people are easier to recruit, because they have already been through the education system. We have a real opportunity in Wales to think about primary care in a different way and not simply think that the answer to today's problems is to try to recreate for the future a system exactly as we had it in the past.

[269] **John Griffiths:** On GPs and access to GP services, Mark—which I take in the round, as you describe; not necessarily GPs themselves, but all services and staff based at GP practices—I still get a steady stream of constituency complaints about what is perceived as inadequate access to GP surgeries, particularly from people who work office hours and commute lengthy distances to work. They feel that they simply do not have the ability to access those GP services as they would wish and as they believe they should be able to. We heard some evidence earlier that there is some element of patients voting with their feet in terms of access in urban areas, particularly, where it is easier to do so. So, it really does matter to patients. My local paper today carries an article that talks about something like 80% of local GP practices meeting requirements set by the health board in terms of access, so I think that it is improving. Presumably, when patients see that 80% of practices are meeting requirements, but 20% are not, if they are in that 20%, they may think long and hard about the quality of service they are receiving. It is a very important area and we have made some

progress, but I wonder what you will now do to drive that forward and make sure that, hopefully, everyone in Wales enjoys the sort of access that should be available.

[270] **Mark Drakeford:** The first thing—this is the point that John makes—is that we have to do more to make sure that all practices in Wales are open throughout their contractual hours. Considerably more of them are doing so than was the case three years ago, but we are not there with everybody yet. We have eliminated half-day closing in a good part of Wales, but not absolutely everywhere. We have an ongoing debate with the profession about the issue of people who live in one place and work in another and how they can get access to GP services. What GPs say to us is that, where they have extended opening hours after 6.30 p.m., either the demand does not exist for it, so they sit there with very few people coming in, or the people who come in are people who could just as easily have come in during more narrow opening hours. So, we have negotiated with GPC Wales an experiment that will start before the end of next month. It will be happening in Newport as well as in Swansea and Cardiff. Somebody who is registered with a GP where they live will be able to attend a GP surgery where they work for routine appointments. The sort of complaint that I hear of is somebody who needs a routine blood test—I am making this up now—they live in Pontypridd, they work in Cardiff, and they would have to take half a day off in order to go to their surgery in Pontypridd to have something that is predictable, planned and routine. The idea is to see whether that person would be able to make an appointment with a GP close to where they work in Cardiff to get over the problem of not being able to be seen at home during normal hours. We are going to do that on an experimental basis, on an agreed basis with the GP community in Swansea, Cardiff and Newport. We have identified the practices that are willing to participate. There has been quite a good take up of it, particularly in Newport, as it happens. Then, we will review that to see whether this is a more effective and efficient way of providing a service to the people you identified, rather than expecting services in the round to stay open for what may not be, in aggregate form, a very large demand.

14:15

[271] **David Rees:** Paul now has a question on GP services. I am conscious of the time, and I have a long list of people who want to contribute, and Paul wants to ask some other questions as well. I have a long list of questions, so, if we could be succinct in our questions, I would be grateful.

[272] **Paul Davies:** On access to GP services, you have made it absolutely clear in your paper that access to GP services after 6.30 p.m. has remained stable at 11%. I want to clarify what your ambition is as a Government. Will you be setting a target, because, clearly, you want to see an improvement as far as that figure is concerned?

[273] **Mark Drakeford:** My ambition as Minister is to improve access after 6.30 p.m. for those people who may need it. So, it is important to know who those people are and why they need access at the moment after 6.30 p.m. By and large, they are the people who John identified; they are people who are travelling back to where they live from where they work and cannot get back in time in order to get an appointment during normal hours. One solution is to keep the surgery open for longer, so, when they get home, they can get an appointment, but, an alternative solution, and potentially a better solution, is to allow them to have an appointment during the normal surgery hours where they work, rather than where they live. It is an important question that Paul is exploring here; all I am trying to say is that I am less attached to a particular mechanism than I am to solving the problem. If there is a better way of solving the problem that gets the people who need access after 6.30 p.m. at the moment access in a different way that suits them better and which GPs believe to be a better use of their time and resources, I would be just as happy to go with that. We are experimenting with it and we will assess the two side by side.

[274] **Paul Davies:** So, this is all about patient choice.

[275] **Mark Drakeford:** It is all about trying to provide services in a way that matches individual patient circumstances.

[276] **David Rees:** Can you go back to the cardiac services question?

[277] **Mark Drakeford:** Yes. Very briefly, in relation to time, 126 patients in Wales either have been treated in one of the four centres outside Wales already. A small number of those are planned and are in the diary and are about to happen. Cardiff came first not because it was prioritised over west Wales, but because the issues in Cardiff were identified first. They were identified about six months earlier than the problems at Morriston were identified. So, they just had an earlier start down the track. We are no longer sending patients from south-east Wales to one of those four centres because nobody at Cardiff is waiting for more than 36 weeks, and Cardiff, in its negotiations with the Welsh Health Specialised Services Committee, is now able to provide a service that means that nobody will be waiting for more than that. Nineteen patients from west Wales have already gone to centres elsewhere. I expect that number to grow; I want it to grow more quickly than it has over the last couple of months as we work with clinicians in Hywel Dda and in Abertawe Bro Morgannwg to make sure that they take advantage of the facility that we are now putting on offer to get their waiting times into balance, and I expect that to happen for patients in the south-west, as we have now already achieved by using that mechanism in the south-east.

[278] **Paul Davies:** Minister, in the past, you have made it clear, when I have criticised and challenged your decisions, for example to close the special care baby unit and to downgrade paediatric services at Withybush hospital, that these decisions have been based on clinical advice and advice that you have received from the medical profession. Given that the BMA, which, let us not forget, represents 7,000 members in Wales, is advising you that in order to rescue health services from imminent meltdown, an independent inquiry of the health service should now take place right across Wales, surely you should be consistent and follow this advice as well, by allowing that inquiry to go ahead.

[279] **Mark Drakeford:** I have not seen this report from the BMA, I am afraid. I know that it is there and I will be reading it over this weekend. There is a debate scheduled for the Assembly on Wednesday of next week, and I look forward to debating it fully then.

[280] **Paul Davies:** Clearly, I will not get anywhere with that particular question, so let me try another one. In your paper, you have made it absolutely clear that you have been working with the Minister for Finance and Government Business over the summer to establish,

[281] 'what we can do to support new models of service delivery'.

[282] Can you tell us a little bit more about that and expand on it?

[283] **Mark Drakeford:** Yes, by all means. Thank you for that question. The work that I have been carrying out with the Minister for finance over the summer is as a result of the Nuffield report that we referred to earlier. Nuffield looks at whether or not the health service in Wales is affordable into the future. It comes to the conclusion that it is, provided that the health service goes on changing services in a way that will make it sustainable. Nuffield says that if change had not happened in the Welsh NHS, the gap between the money that we have and the money that we need today would be £1.3 billion.

[284] It proceeds to look at a series of actions that the health service has taken and puts a cash value against each one and says that, because the health service has been able to negotiate, for example pharmaceutical prices at a lower level than was anticipated three years

ago, it has saved the equivalent of, I think, about £300 million or so; because it is treating chronic conditions in the community rather than in hospital, it has saved about £400 million; and because length of stay in Welsh hospitals has reduced over that period, it has saved around £200 million. As a result, the £1.3 billion gap has reduced to £200 million, according to Nuffield, in this year and £250 million next year.

[285] However, it is absolutely clear in the report that if we do not go on with the journey of remodelling services, then our capacity to go on funding the service in the way that we need to will be compromised. So, I have been talking with the Minister for finance over the summer on the basis of the Nuffield report about what we need to do as a Government to support the NHS in that ongoing journey of moving services, where we can, from hospital to the community, remodelling the workforce in primary and in secondary care, and creating a set of services that we can be confident will be there not just today, but into the future.

[286] **Paul Davies:** So, I take it from that that you will be making further announcements in due course on some of these new models.

[287] **Mark Drakeford:** Yes, this is certainly not a concluded conversation, absolutely. It is a conversation that we will go on having over the months and probably years ahead, as, right across Wales, we face the need for change in order to create sustainability.

[288] **Paul Davies:** I note from your paper—and, of course, you have already made announcements that you are ensuring that spot checks actually take place now in all district general hospitals—that regular reports on progress are being provided. May I ask you what they are telling you?

[289] **Mark Drakeford:** Yes. Thank you. Spot checks have now been completed. They were carried out on 70 wards in 20 hospitals across Wales. The spot checks, you will remember, were specifically designed to look at the four immediate issues that the Andrews report into circumstances in the Princess of Wales and Neath Port Talbot hospitals identified. Professor Andrews raised four concerns in the care of elderly patients in some parts of those hospitals—nutrition, hydration, continence care and medicines management. The spot checks teams have been going in unannounced right across Wales to look at those four things. The good news is—and I am sure that we will all be glad to know—that the spot checks teams say that they find far more examples of good practice than they do of anything that is going wrong. In three of the four things, they come across isolated and individual incidents of things that need to be done better and they resolve those by involving senior staff on the spot.

[290] Therefore, there is no systemic evidence of substandard care in Welsh hospitals in relation to nutrition, hydration and sedation. In sedation in particular, they say that the real evidence is of people coming into hospital with sedation regimes that were not satisfactory and those things being put right and made better by people on the wards. However, in medicines management, there is a more general pattern of things that need to be put right, particularly around storage of medicines and safe storage of them. We will publish the Wales-wide report of all the spot checks so that people can see what went on right across Wales. Through a steering group, which is jointly chaired by the chief medical officer and the chief nursing officer, we will pick up the learning that needs to be done on medicines management in particular and then make sure that we take those messages across the whole of the system.

[291] **David Rees:** Thank you. Several people want to come in but, because of the timescale, I will go through the list that I have now. First, I call Lynne.

[292] **Lynne Neagle:** I just wanted to ask about reconfiguration. Your paper reports on the progress that has been made in implementation in some areas. Are you able to provide any further information on how the changes are bedding in?

[293] **Mark Drakeford:** Thank you, Lynne. In north Wales, the major round of reconfiguration came to an end finally with an agreement between the CHC and the local health board. They are now implementing those changes. Implementation is not absolutely easy everywhere. I say to the health board and to the local population—and I have met protest groups and others—that, in the capital programme of the Welsh Government, we have set money aside to help those changes to happen at Blaenau Ffestiniog, Llangollen and Flint, for example, and that I want to see that money spent. It is really important that those local groups and the health board reach agreements together so that they can take advantage of the capital money that is now on offer. I say to them that there are schemes all around Wales ready to go—no doubt in constituencies of Members around the table—that I am not able to fund because I am holding money to honour the commitments that were made in the north Wales reconfiguration programme. I will not be able to do that indefinitely. They need to come forward with those schemes so that we can fund them.

[294] The south Wales programme, as you know, again, came to an end without any reference to me as Minister, and the plans are now being moved forward to implement those things. As far as Hywel Dda is concerned, I am very pleased to be able to report this afternoon that the legal challenge to changes at Prince Philip Hospital and Worthybush hospital have now come, as far as I can tell, to the final conclusion, where the latest appeal court judge has confirmed every other judgment that has been made in this long process about what the health board did, met all of the standards that were required, and there is no legal recourse for protesters against those things. It has taken thousands and thousands of pounds out of budgets that could have been used for the care of patients in those areas. I think that it is very good news for patients that we have reached the end of that road.

[295] **Lynne Neagle:** I have some questions on social services, but I will do that in the financial bit.

[296] **David Rees:** I therefore turn to Kirsty.

[297] **Kirsty Williams:** On reconfiguration could you outline for me what an acute healthcare alliance is and what that means for services at Bridgend and Merthyr, and could you confirm that the long-term intention to move to such a healthcare alliance system was consulted on during the south Wales plans? As someone who attended all of the south Wales plans' consultation meetings in my constituency, I do not recall that term being used once, nor do I recall any reference in that consultation to moving to a three-hospital model. Could you tell me when the long term actually is?

[298] **Mark Drakeford:** I am going to defer on the detail of this to Dr Goodall who was in the room at the time and will provide a better answer, I am sure.

[299] **Dr Goodall:** As we went through consultation at the time—and, of course, I have changed my role now to an oversight role, but I think that it is helpful to just reflect back on it—we needed a mechanism going forward. The agreement was made about reducing the number of some of the specialist hospitals. We just needed an ongoing mechanism to make sure that the governance was going to work across organisations. Organisations sat around the table on the south Wales programme in a very broad sense. Powys sat around that table very fundamentally because of some of the flow of patients that had actually occurred at that time. As an outcome of the consultation process, the organisations felt that they wanted to ensure that there was a way of the clinicians linking with each other, initially on these more fragile services that started the discussion and to allow some further ongoing discussions about other areas to network. There were clearly going to be some relationships between different areas and organisations. As an example, it was quite clear that Aneurin Bevan Local Health Board, as an area, would need to link to Powys, for example, and clearly it will need to link to Cwm

Taf in terms of Prince Charles Hospital. There would be flows from Cardiff, in particular, right through to the Royal Glamorgan Hospital, but at the same time we would need to make sure that there could be some liaison between the Princess of Wales Hospital and the Royal Glamorgan.

14:30

[300] So, the intention is to put in a governance mechanism, which does need to be overseen by the health boards but which will actually allow people to get on with more of the day-to-day relationships, what it would look like in practice, to sign off the protocols and make sure that they would actually happen. So, I think that it was an output of the consultation to make sure that the organisations would actually carry on working through all of those at this stage. The pressures still exist in the system. I think that there still remains a challenge to make sure that hospitals can work together for the future. The outcome, of course, was to end up with both Prince Charles Hospital and the Princess of Wales Hospital retaining the level of services on the specialist side, with some changes around the Royal Glamorgan Hospital model. Those are all being worked through at this stage in terms of an implementation plan—

[301] **Kirsty Williams:** I know that, but I am still not clear what an acute healthcare alliance is, what the consequences are of moving to that three-hospital model for services at Bridgend and Merthyr, and what the timescale for that is.

[302] **Dr Goodall:** In respect of the acute care alliances, as I said, it is in the governance framework to allow the organisations to continue the relationship. It is overseen by the south Wales programme board. I think it just allows things to be on a more local level. That is the intention. The outcome of the consultation was support from communities, with 70% of people agreeing with the option that was presented, which was for a five-hospital model, actually, for south Wales and to work that through.

[303] **David Rees:** *[Inaudible.]*

[304] **Dr Goodall:** There is clearly a need to just make sure that the governance works between organisations, as much as we have to have an overarching mechanism, whether it is for south Wales or, as is often the case, on an all-Wales basis as well.

[305] **David Rees:** Is that okay, Kirsty?

[306] **Kirsty Williams:** Well, that is not what it says here, but I will write to the Minister.

[307] **David Rees:** I now have Alun, Oscar and John. Alun is first.

[308] **Alun Davies:** I want to take us onto a different subject.

[309] **David Rees:** Yes, fine.

[310] **Alun Davies:** I was reading through some of your papers, Minister. You refer to a number of different legislative items that you have been managing and implementing. I was wondering whether you could give us an update on the situation with the implementation of legislation.

[311] **Mark Drakeford:** Thanks. The department has a very busy legislative contribution. We will be involved in four main things over the coming months—no, five things, I am sorry. We will continue to bring through the Assembly the legislation that flows from the Human Transplantation (Wales) Act 2013, the Food Hygiene Rating (Wales) Act 2013 and the Social

Services and Well-being (Wales) Act 2014. All of those are now on the statute book and all of them have very significant pieces of subsidiary legislation that flow from them, a number of which are subject to the superaffirmative procedure, so they will be fully debated through committee and on the floor of the Assembly. We are working hard to make sure that all of that is in good order and that it will come before Assembly Members as promised. On the social services side, the regulation and inspection Bill is due for publication in—

[312] **Mr Heaney:** February.

[313] **Mark Drakeford:** February. I was going to say January, as I knew that it was just after Christmas. Over the early summer and through the recess period, we have been working very hard on the responses that have come in to the public health White Paper. So, there were over 700 replies to the White Paper. It will culminate in a Bill that we will bring forward to the Assembly about this time next year. I remain committed to advancing the public health agenda in Wales, making maximum use of the powers that we have, and deriving the greatest possible benefit we can for our population in Wales, so that avoidable harm and illnesses that need never have happened are borne down upon to the greatest possible extent.

[314] **David Rees:** Okay. I am conscious of the time, Minister, and I have committed to individuals asking questions. If we go on to general scrutiny at this point in time, are you okay to continue without a break?

[315] **Mark Drakeford:** Yes.

[316] **David Rees:** Okay, Oscar is next.

[317] **Mohammad Asghar:** Thank you very much indeed and thank you very much, Minister. On 23 July, my father-in-law went to hospital, and on 24 August, a couple of weeks ago, he died in the Royal Gwent Hospital. So, I was going there virtually twice a day. My hat is off to the staff and the doctors for the care that they gave to my father-in-law. I must admit that it was a world-class service that he received, although he died his natural death. I have a long list of questions but will ask one or two. The ambulance service is doing a wonderful job, but I think that you could consider the staff having their lunch boxes in the ambulance rather than going to the canteen. I know that it is a natural call, to go for food, but they could cut down on the 45 minute to an hour in the canteen having lunch. You know, you can imagine the ambulances standing there while they are having their lunch and then they go to their call after 45 minutes. That is not acceptable. So, if you consider giving them lunch within the ambulance, that may help to reduce the ambulance times. That is my first point.

[318] My second point is on work-related stress with the nurses and the doctors. I have been through this and I am very well aware of the time here, but the fact is that doctors and nurses are in a hell of a constraint. I can assure you, Minister, that they are virtually—. When the time comes to 6 o'clock or 7 o'clock, when the nurses are finishing their shift, their performance is not as good as when they started earlier on in the morning. That is one area that you have to consider seriously in every hospital. That is my personal experience. They are wonderful, so I am not complaining here, the service and everything, but we must care for those who deliver the health service. So, that is not there. I do not know what the NHS is doing to care for our health service providers. Have you got any idea how to do that?

[319] Finally, we do not have the time, but there is also the issue of death certificates. There was a weekend and then a bank holiday and everything, and, in our culture, we do not have our dead bodies for more than 24 hours. However, in this case, it stayed there for more than a week, which is really not acceptable, especially in our culture. So, would you consider letting somebody go, especially on a Sunday, if it has to be, to give a death certificate? It has to be the right person to do the job, and to do the religious ritual according to our belief. Thank you.

[320] **Mark Drakeford:** First of all, may I thank Oscar for what he said about the care that was received at the Royal Gwent? I am sure that it was a very difficult month that you had. So, obviously, we think of you in that, too, but I was very grateful for what you said there.

[321] On the three specific points that you raised, the issue of meal breaks and the ambulance service is a really hot topic. It is one of the things that Kirsty referred to earlier, and that she would like me to sort out with the ambulance service. I cannot resolve it, but the service must. The idea of people being able to take their meal breaks in the ambulance itself I do not think is one of the options currently being explored, but it is a very live issue and I am sure that we can relay that possibility to those who are involved in this.

[322] Twelve-hour shifts are what I think you were referring to in terms of work-related stress. They are an issue of concern and we talk to the Royal College of Nursing about them. For some people, they are a very attractive part of the way that they manage to organise their working lives. For people who have childcare and other considerations, working three long days in a week rather than five shorter days is something that they do because it is the right thing for them. There are concerns about how you keep going in the last part of a 12-hour shift, and we continue to talk to the college about that.

[323] I am very aware of the death certification issue. It is a very live issue in the Cardiff West constituency among the Riverside community. It is a coroner's issue, however, not a health service issue. It is the coroner who has to provide that certification. We know that, in other parts of the United Kingdom, coroners have special arrangements where someone of the Muslim heritage can be sure that the certification will be carried out in a timely fashion in order to allow religious observation to be maintained. We would like coroners in Wales to draw on that experience and we are and have been in discussions with them. We will continue to do that.

[324] **John Griffiths:** You were talking earlier, Mark, about the Nuffield report and the need to make substantial progress in terms of being more efficient and effective in delivering health services and the way that we use funding. In your evidence paper, you talked about prudent healthcare and the need for people to take more responsibility for their own health. I think that that is a big part of the agenda of producing a fitter and healthier Wales and making good use of resource if we can drive forward. One aspect of that, I think, is people exercising more. I know that you work with organisations such as Sport Wales and that some good progress has been made, but I wonder whether you could just set out some of your thinking, because it is so fundamental and far-reaching in terms of our getting to the good health that we want to have in Wales. How can we drive forward that crucial agenda that really will move us on? I think that it is about the short term as well as the medium and long term.

[325] **Mark Drakeford:** So much of what the health service has to deal with every day is stuff that need never have happened. So much of heart disease, diabetes and other chronic conditions we know are avoidable by choices that people make earlier in their lives. The Government has a responsibility, I believe, to create the conditions in which people are able to make the right decisions, but once Government has created those conditions, we have to have a conversation with the public about their willingness to play their part and then take advantage of those circumstances. We do not do enough as Governments collectively yet to provide those conditions.

[326] There has been a lot of debate recently about sugar, for example, which is related to your question about obesity, exercise and so on. I believe that there is more that Government should do in its negotiations with the food industry to try to reduce the level of sugar in processed and pre-prepared foods. Whether we want to or not, we are all eating sugar all the time, because it comes in things that we are bound to eat, and we do not know that it is in

there. To be fair to the UK Government, in its responsibility to deal with the food industry, which is a voluntary deal, it can point to some real reductions in salt in processed food, and it can tell you that substantial numbers of people who would have had a stroke three years ago, have not had a stroke now because salt levels have reduced, with everything that that does to blood pressure levels.

[327] I think that we need to be a bit more mandatory with the food industry: not just asking, but insisting. However, in order to progress the public health of the nation, there is more that Governments can do. There are many other examples that I could give, but once Government has done that—and this is the point, and this is where it is tricky and so on, but unavoidable, I believe—we have to have conversations with people. If you deliberately put yourself in harm's way, and if you know that harm will happen if you act in that way, when the harm happens, can the first question be, 'So, what's the health service now going to do about it all?' Does responsibility transfer at that point from that individual and become a problem for the health service to take responsibility for? The health service is, thank goodness, free of charge at the point of use, but I do not believe that it is free of obligation. Part of prudent healthcare is about a different sort of conversation between the service and the user. Very often, it is the service's problem. We invite people to hand their problem over to us and rob them of responsibility, but we need a conversation with users that puts the responsibility for making things better not on one side of the table, but in the middle. Then, to use the jargon, in a co-production way, you combine the contributions that you make, and that way we get better results for everybody.

[328] **David Rees:** Kirsty, do you have a last question on general hospitals? I see that you do not. Minister, are you okay to continue straight on? We will go into the financial scrutiny session, in that case, and Lynne had a question on social services.

[329] **Lynne Neagle:** I have two questions, and the first is on social services. Your report, Mark, draws attention to the fact that spending on social services has decreased slightly at local government level, obviously because of the very difficult times that we face. I am very conscious that we are now in a period where there is no protection given specifically to social services. I just wondered whether you could update the committee as to what monitoring is being undertaken at Welsh Government level, not just of the actual spending, but of where those cuts are falling at a local level.

[330] **Mark Drakeford:** Thank you, Lynne. I will probably ask Albert to give you some of the specifics. I talked about these concerns with Gwenda Thomas when she was responsible for social services, and did so very recently.

14:45

[331] One of the things that she felt was helping the situation was the intermediate care fund, which was £50 million. Unfortunately, it was a one-year scheme. However, £35 million of that was revenue and £15 million was capital funding. That has helped and is helping in this year to bridge the difficulties that social services departments have faced, and there are other specific grants in the system too—grants to do with the Act, and so on, that are helping in this year. However, Albert will be able to give you more specifics than I can.

[332] **Mr Heaney:** Thank you very much, Minister. In terms of the question, local government budgets are set through the revenue support grant, as you will know. Therefore, local government determines the priorities across the departments. The health and social care agenda has been about producing efficiencies to improve the life opportunities for citizens, and we have seen across Wales a response by directors of social services working together with health to try to generate new models of care. That is about thinking about things differently.

[333] In terms of the cost base and budgets, there are discussions that take place between my directorate for social services and integration and local government colleagues to monitor spend and work together with the Association of Directors of Social Services Cymru. However, that determination is done at a local level.

[334] Significantly, the intermediate care fund—and I will talk about this first, if I may—has been a one-year funding opportunity that was created to generate the levers for change to assist health and social care in coming together. Although it is at an early stage in the year of the implementation for intermediate care, we have seen a significant number of health and social care initiatives, led by local government, health and the third sector working together. During the ministerial visit to the regional local health board and local authority footprints, we heard feedback from colleagues, professionals, local politicians and health boards indicating that this was making a substantial cultural change and already leading to different practices. This all fits together, because, in terms of unscheduled care, if we get this right and we get the social care, community care and health interface, we should be assisting those citizens who can be supported in the community without ever having to go into a hospital setting.

[335] With regard to the approach that has been taken in relation to the legislation change, we were very pleased that the Social Services and Well-being (Wales) Act 2014 came into being in terms of its establishment on 1 May. Its implementation will begin in April 2016, but significantly, to assist that, the Minister has been using the transformation grant, which is a grant of £1.5 million. That is being delivered this year across the regional footprints. So, once again, it is supporting the direction of travel regarding public service reform and the indications that came out of some of the work that Sir Paul Williams did, et cetera. So, that footprint and development is in hand.

[336] The transformation grant and transformational approach are already beginning to look at developing the capacity, so that directors of social services and health colleagues have the capacity to deliver the changes required. However, we are already seeing significant progress. I will cite one example that the previous Deputy Minister for Social Services was very proud of, namely the national adoption service. This service, in terms of cost but also generating the number of children coming through the looked-after system who then go into adoptive placements—both for the carers and their own duty and their needs—is coming on-stream. We know that that will go live in November. So, while there is a great deal of worry about the overall picture for finances, we are trying to develop a much more efficient service and develop efficiencies in the way that we work, both together across organisations, but also to serve citizens in our community.

[337] **Lynne Neagle:** I would also like to ask the Minister about resource allocation. You have indicated that that is an area that you are reviewing. Is an update available on that, please?

[338] **Mark Drakeford:** Yes. I have had some very detailed discussions with senior officials about our approach to resource allocation. What we are going to do is try to divide the work into things that we feel that we can do immediately and some things that need a longer term consideration. In the immediate sense, here are two examples of what we are doing: we have brought forward a review of the use of ring-fence mechanisms in health budgets. The mental health ring-fence is by far the biggest. We have moved the review of that forward a year and we have just let the contract for an independent review of the way that the mental health ring-fence operates in Wales.

[339] We are going to update the Townsend population-based formula that we use, so that the way that money is put through the formula for next year will have a refreshed set of data

at the base of it. It will, in particular, have the latest population estimates from the 2011 census, so that we are making sure that we are putting money where the population is, but mindful of some of the things that the Nuffield report said about age profiles and the way that that affects spend in some health boards in Wales. We are also going to update that part of the formula. That will mean that money will move around the system, and in a way that we have all signed up to, which is that we want money and need to be better matched.

[340] So, there is a lot of practical work going on in the short run on those things and then there are some longer term things that we need to look at to see whether the formula needs to be further updated so that, hopefully, when investment in public services picks up again, we will be better placed to go on making sure that we match spend with need.

[341] **David Rees:** Okay. There are questions from Elin and then Kirsty.

[342] **Elin Jones:** Various other Ministers have been cutting budgets in-year over the past few months—I can think of the Minister for education, where Welsh for adults and apprenticeships funding have been cut in-year, and the word on the street is that that is all going to be channelled towards the NHS in-year. I wondered, therefore, if you are in a position to tell us what additional funding you are expecting from the Minister for finance within this financial year to fund the NHS.

[343] **David Rees:** We are aware that the Minister for finance will be making a statement on the budget.

[344] **Mark Drakeford:** Obviously, Chair, I am not in a position to provide that update. Discussions continue with the Minister for finance and she will be making her determinations on budget matters and will lay those before the Assembly according to the timetable that she has already announced.

[345] **Elin Jones:** I am not talking about next year's budget; I am talking about the in-year budget.

[346] **Mark Drakeford:** Any budgetary changes will be negotiated with the Minister for finance, and she will intend to make a global announcement of changes in-year and next year, if there are any.

[347] **Elin Jones:** Fine; point made.

[348] **Kirsty Williams:** May I ask about the health boards that you were not able to sign off on their three-year plans? There is a significant number of organisations where that was not the case and they have been asked to submit one-year plans. I have no argument with that at all. While you have been very specific that you have signed off on three-year plans, could you confirm that all the one-year plans have also now been agreed with those health boards?

[349] **Mark Drakeford:** They have; yes.

[350] **Kirsty Williams:** Going back to the issue of resource allocation, I welcome what you say about looking at the age of the population because we know that that is one of the greatest indicators of usage of health services, as well as poverty and deprivation, and I also note, in paragraph 26 of your report, a bullet point that states that you are addressing problems in funding flows between NHS organisations and communities. I have always had a particular interest in how money flows around the Welsh NHS and whether that is fair to all constituent parts. Could you give us an update on what that work has looked like, and your conclusions?

[351] **Mark Drakeford:** Certainly. I might ask Martin to describe where the work has got

to. You are absolutely right to point to it and it links to your earlier question about alliances. If the future is one in which there will be greater flow across health board borders for the purposes that the south Wales programmes identifies, then the issue of how money flows with patients becomes more of an issue than in the past. Up until now, the NHS in Wales has tended to regard this as a practical problem to be solved between boards.

[352] **Kirsty Williams:** To the advantage of some and the disadvantage of others perhaps.

[353] **Mark Drakeford:** Yes, I think that that is probably fair to say. I think that we have got to the point where we feel that if cross-border flows are going to be a larger part of the landscape of health services in the future, then we will need a more overt, agreed mechanism for passing money with that activity and Martin has been helping to try to codify that.

[354] **Mr Sollis:** We have had groups looking at the principles involved in how we do that. I know that we are specifically looking at this as part of the south Wales plan alliance forum as part of the patient flows work, because part of those information flows is about making sure that the money flows when that need is there and that there is agreement of the principles on that basis. So, in terms of the reconfiguration work that is going on, that patient flow issue is a very live one; it is currently being discussed in the fora that were described earlier on and they are looking to address the short-term issues. I think that there is a bigger issue around how we do that in the longer term across the whole of the Welsh system. We have looked at it in the director of finance group and we are currently looking at it with chief executives in terms of agreeing principles on how that is done.

[355] **Mark Drakeford:** Nothing on that has come to me yet, as Minister, in terms of the conclusions that they are drawing. When it does, while I am very keen that we have a system that makes sure that those organisations that carry out the work get the money to support them, and that we have mechanisms that promote cross-border working rather than getting in the way of it, I am also anxious, depending on the advice that I get, not to invent a huge bureaucratic industry in which we spend an awful lot of money ourselves on people chasing invoices from one part of what is one system, in the end, to another. So, it is about trying to get the balance between those things right.

[356] **David Rees:** Paul, you are next.

[357] **Paul Davies:** My question follows on from Kirsty Williams's question. You have made clear in your paper that you want to deliver health services closer to people's homes and obviously, as a Member who represents a rural area, delivering services in a rural area can be very challenging and delivering services will inevitably cost more. I appreciate that you are carrying out a review now of resource allocation, but will you, as a Government, confirm that you will attach a rural premium to delivering health services across Wales, especially in geographically challenging areas? You mentioned earlier that you want to put the money where the population is, so I would be interested in your comments.

[358] **Mark Drakeford:** What I can say in answer to Paul's question is this: the Townsend formula itself has a rurality component in it. It was extensively debated and there were a lot of lively views on it when Peter Townsend was carrying out his work. In any review that we do of the formula, I will make sure that that rurality dimension is given proper attention in the way that we work through whether the formula needs to be updated or improved. So, we are not going to forget it; it is not going to be treated as though it is not a matter for proper concern. It is a legitimate thing for us to think about in Wales given the nature of our populations, but I am not committing to any particular result from that, other than to say that we will pick up the debate, which was very real, and make sure that we bring it up to date to today's circumstances.

[359] **David Rees:** Are Members happy with that? Gwyn, you have a question.

[360] **Gwyn R. Price:** I have a small one. How was the decision on utilising the £25 million contingency fund to support more flexible planning regimes made? Have you any comments on whether anything has been taken out of that fund for 2014-15 at the moment?

[361] **Mark Drakeford:** The way that we are deploying that is to try to support those four organisations where we have been able to agree three-year plans. There was a lot of very proper attention given as the financial flexibilities Bill went through the Assembly to make sure that we had robust mechanisms in place to test three-year plans as they came forward. I am not disappointed that only four of them have been approved in the first run around this track, because I think that it shows that we have done our best to set the bar high and to approve only those plans where we are genuinely convinced that financial service and workforce planning have come together in a credible way to provide for a three-year horizon.

15:00

[362] As anticipated, those plans often require some extra investment at the beginning of the plan in order to drive out savings in years 2 and 3 and to balance over the cycle. The contingency fund is being used to provide that support to those organisations that have credible plans to do so. I do not think that we have actually parted with any of the money to health boards yet, but those health boards that have had approval know that it is on the basis that we will give them the assistance that they need in the early part of the planning cycle so that they can deliver on the service change and the savings that they drive out as a result.

[363] **Gwyn R. Price:** Thank you.

[364] **David Rees:** Thank you, Minister. I have a couple of questions. I know that we have time. I am just going to ask very short-answer questions. When you present figures to me I like to understand them, and, when I see negative figures in your table, where it states 'allocations of additional funding provided' and it talks about technical accounting processes and perhaps reconciliation, are those negative figures actually just an accounting process of recalculation of depreciation and reconciliation or are they actually money taken out from the health board?

[365] **Mr Sollis:** Gosh, I would have to explain the world of an accountant.

[366] **David Rees:** Perhaps you could just do so, very simply, for me, just so that I can confirm.

[367] **Mr Sollis:** They will really vary. In terms of depreciation, these are 'non-cash issues' that are ring fenced—

[368] **Elin Jones:** We are back to non-cash.

[369] **Mr Sollis:** Yes, sorry—and some real cash, and some of the other technical issues are based on annual management expenditure, which is done annually. So, they are a world of their own. However, the real cash issues are in the departmental expenditure limit and the other items that are there.

[370] **David Rees:** It is just that when I see figures and I see negatives I want to make sure that I understand why they are negatives. On the innovative financing, what progress has been made by the Welsh Government on the innovative financing?

[371] **Mark Drakeford:** We know that the demand for capital expenditure in the Welsh

NHS over the years ahead is likely to be beyond the capital budgets that we now have via the Westminster Government. So, we are having to think differently about how we will meet some of those capital demands. We have two particular strands that we are pursuing actively, and the one that is the most advanced is the Velindre hospital scheme—the replacement for the Velindre Cancer Centre in Cardiff, where the Minister for finance has agreed that we can work up plans to see whether that could be financed through a non-dividend distribution model. In the end, there is no disguising it: if you are borrowing money you have to be able to pay it back. Public capital does not require you to borrow. Alternative financing methods require you to borrow money and then you have to find a way of paying it back in the future. So, you want to borrow money in the cheapest way that you possibly can. You do not want to be inventing systems in which money is sucked off to private profit. We are in substantial discussions with the European Investment Bank and others around the Velindre model, and that is making good progress. We have had a more preliminary discussion about the primary care estate and whether, if we were to take a new approach to that, and to bundle up—which, I think, is the technical term—schemes from across Wales into a single national primary care investment, we would be able to attract investment into that from outside the normal public capital regime as well. None of these things are without down sides as well as up sides, but, given the circumstances that we are in, we cannot afford not to be willing to look at innovative ways of doing business.

[372] **David Rees:** Thank you, Minister. Before we finish, we have a matter for clarification perhaps. Do you want to ask the question, Elin, or do you want me to do so?

[373] **Elin Jones:** I just wanted some clarification on ministerial responsibilities and the change. It seems almost that, from what I have read, the Deputy Minister is responsible for the running and performance of the NHS and you are responsible for everything else. Perhaps you could just explain the exact responsibilities that the Deputy Minister now holds.

[374] **Mark Drakeford:** Chair, I do not think that that is a question for me. It is the First Minister who disposes ministerial responsibilities. He will have published the list, as he has derived them so far. There may be some further clarification that his office will provide to the Table Office to assist Members when they come to tabling questions and so on. However, the division of responsibilities between Ministers is a matter for the First Minister and not for Ministers themselves.

[375] **Elin Jones:** I just do not understand it, that is all. I thought I was asking a question that was easily answered, but obviously not. [*Laughter.*]

[376] **Mark Drakeford:** Well, as I said—

[377] **David Rees:** I think that the Minister has given his answer and we will respect the answer that he has given.

[378] **Elin Jones:** Okay.

[379] **David Rees:** Thank you, Minister, and your officials, for your attendance this afternoon. Thank you very much. You will get a copy of the transcript to check for any factual inaccuracies that may appear and please let us know if there are any. Thank you very much. We look forward to seeing you next week.

[380] **Mark Drakeford:** Thank you very much.

[381] **David Rees:** May I remind Members that, this morning, we agreed to take the next two items on the agenda in private? Therefore, we will now move into private session.

Daeth y cyfarfod cyhoeddus i ben am 15:06.
The public meeting ended at 15:06.