



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

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

Dydd Mercher, 5 Chwefror 2014
Wednesday, 5 February 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

Rebecca Evans	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Gwyn R. Price	Llafur Labour
Jenny Rathbone	Llafur (yn dirprwyo ar ran Lynne Neagle) Labour (substitute for Lynne Neagle)
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Grace Carolan-Rees	Cedar
Sally Chisholm	Y Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol National Institute for Health and Care Excellence
Yr Athro/Professor David Cohen	Athro Economeg Iechyd Prifysgol De Cymru sydd wedi ymddeol Retired Professor of Health Economics at the University of South Wales
Yr Athro/Professor Colin Gibson	Peiriannydd Clinigol Ymgynghorol, y Sefydliad Ffiseg a Pheirianneg ym maes Meddygaeth Consultant Clinical Engineer, Institute of Physics and Engineering in Medicine
Dr Peter Groves	Clinigydd ac Is-gadeirydd Pwyllgor Cynghori ar Dechnoleg Feddygol y Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol Clinician and Vice-chair of NICE's Medical Technology Advisory Committee
Yr Athro/Professor Stephen Keevil	Llywydd, y Sefydliad Ffiseg a Pheirianneg ym maes Meddygaeth President, Institute of Physics and Engineering in Medicine
Dr Susan Peirce	Gwyddonydd Clinigol Clinical Scientist
Yr Athro/Professor Ceri Phillips	Athro Economeg Iechyd, Prifysgol Abertawe Professor of Health Economics, Swansea University

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

Chloe Davies	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk

Philippa Watkins

Y Gwasanaeth Ymchwil
Research Service

*Dechreuodd y cyfarfod am 09:19.
The meeting began at 09:19.*

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions

[1] **David Rees:** Good morning. I would like to welcome Members to this morning's session of the Health and Social Care Committee. We will continue our inquiry into access to medical technologies. The Assembly is bilingual, and therefore there is simultaneous translation from Welsh to English available on channel 1 of the headsets and amplification on channel 0. May I remind people to turn off their mobile phones—that includes me—and other equipment that may interfere with the broadcasting equipment? In the event of a fire alarm, as there is no scheduled alarm this morning, please follow directions from the ushers. We have received apologies from Lynne Neagle and Leighton Andrews. I welcome Jenny, who is substituting for Lynne this morning. Welcome to the committee.

Ymchwiliad i'r Mynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn Dystiolaeth 3 Inquiry into Access to Medical Technologies in Wales: Evidence Session 3

[2] **David Rees:** I welcome Dr Peter Groves, consultant cardiologist at Cardiff and Vale University Local Health Board and vice-chair of NICE's medical technologies advisory committee; Sally Chisholm, programme director for NICE's health technologies adoption programme; and Dr Grace Carolan-Rees, director of Cedar, which undertakes work on behalf of NICE. Good morning and welcome. Thank you for your written evidence. This provides us with opportunities to come forward with some questions for you to expand further on some of the issues. We will now remind ourselves of how medical technologies are currently evaluated for use within the NHS in Wales—clearly, there may also be experiences in England that will benefit us; where good practice exists; and, what further developments are needed to ensure a more robust system of appraisal across Wales. In line with that, I will ask Jenny to start with questions relating to the appraisals that NICE uses in its programme now.

[3] **Jenny Rathbone:** Could you summarise for us how you decide to look at particular medical technologies? How do you avoid what Dr Carolan-Rees refers to in her paper regarding the more vocal clinicians getting to the top of the pile, rather than those that are perhaps more cost-effective?

[4] **Dr Groves:** I will give some comments in my capacity as vice-chair of the medical technologies advisory committee, which is part of the medical technologies evaluation programme at NICE. That is a programme that was set up to promote new and innovative technologies and their implementation in a timely fashion within the NHS, looking specifically at opportunities to promote collaborative research with industry, looking at utility to patients and also benefits to the system. With that intention in mind at the outset, the objective for our programme was to provide an accessible route for timely technology evaluation. Therefore, the process involves notification of technologies by manufacturers directly to NICE, following which there is the creation of a submission that is then evaluated by the committee in terms of its relative merits of potentially offering clinical utility to patients and benefits to the system on the basis of the evidence available. Therefore, for our programme, the access point is a direct communication from manufacturers, the sponsors of a technology—and we would be looking at a single technology, specifically—into the medical technologies evaluation programme. Thereafter, the processes follow various layers of

decision making, which are interrogated by a committee that will either select or not select the technology. If it selects a technology, its role then is to route it to different elements of the NICE organisation to ensure that the evaluation is appropriate for that particular technology, including routing it to itself.

[5] **Jenny Rathbone:** It is a world-wide industry; there are always going to be many more innovations being offered than the NHS has funding for. How do you select the ones that you are going to take forward?

[6] **Dr Groves:** I have talked specifically about the committee that I am involved with and the MTEP process. That is just one element of the way in which technologies are evaluated by NICE. For example, the interventional procedures advisory committee is a different committee, which potentially receives notifications from us as the filtering committee, but it also has technologies that are notified to it independently of our process. They can come from anybody within the NHS: they can come from individual clinicians and people who, for example, are using a technology for the first time or in a *de nouveau* capacity. That programme is then fundamentally concerned with identifying whether there is good evidence that the technology works: is there evidence of efficacy and, if it works, is there evidence that it does so in a safe manner? Therefore, evidence is sought on safety as well. That particular programme, to which submissions can come from anybody, is fundamentally interested in establishing the safety and efficacy of newly performed procedures; it is less concerned at that particular point about the cost implications. There is also the technology appraisal programme, which Sally could talk a little bit more about, which sees technologies from a different angle.

[7] **Ms Chisholm:** In terms of how the technology appraisals come into NICE and how the decision is made about looking at them, that is where there is the main difference in as much as it is a combination of the Department of Health and NHS England that refers specific technologies to NICE to go through its technology appraisal programme. Then the evaluation process looks at that in terms of the evidence base and the potential for cost-effectiveness.

[8] The important aspect to consider about that is that the programme looks primarily at pharmaceuticals, but there are elements of medical technologies and diagnostics that, on occasion, come down that route—particularly those that are more specialist. That is critical because there is a requirement that if NICE publishes positive guidance for pharmaceuticals or medical technologies, the NHS in England must provide funding so that they are available for use, usually within 90 days. However, with the medical technologies and diagnostics guidance, although NICE might recommend something because of the positive outcomes, there is no requirement for the NHS to compulsorily comply with that guidance. This is of fundamental importance: it is critical for everybody to grasp that. Not many people grasp that in England, unfortunately.

[9] **Jenny Rathbone:** From where does the decision come to focus, or not, on those that are either cost-neutral or are going to save the NHS money? Does that come from a political level or do you make recommendations?

[10] **Ms Chisholm:** No, that comes through NICE's processes of evaluating the evidence: undertaking a robust and rigorous cost-effectiveness appraisal, looking at the circumstances of that particular technology. Another thing that is critical and which is related to that is the focus that NICE takes in making a decision to evaluate a particular technology. Therefore, within the medical technologies advisory committee, of which Peter is the vice-chair, once a decision is taken to select a technology to evaluate, a very detailed piece of work goes on, which we call the scope. That makes a decision about the circumstances in which that particular technology will be evaluated. That is really important, particularly when you are making decisions about cost-effectiveness. The recommendations that then flow through

guidance will be linked very much to the circumstances in which that technology might be used and linked to the scope. That sets the guidance for organisations like Cedar as to where they are going to evaluate the evidence of the efficacy and the cost-effectiveness of that product.

[11] **David Rees:** There will now be questions from various Members. I ask Kirsty, Rebecca and Lindsay to follow on from this.

[12] **Kirsty Williams:** The NICE process is one that is well understood, but I am interested in the relationship that Wales has with NICE. We are very fortunate that Dr Groves happens to be a clinician who practices medicine in Wales and has had a long-standing involvement in NICE processes, but it is a happy coincidence that that is the case. Dr Groves, in your evidence you said that we should not reinvest the NICE wheel in Wales, because the decisions that it makes are equally applicable to Wales, but you do talk about proposing the strengthening of formal interaction between NHS Wales and NICE. Could you give further details of what that relationship would look like?

[13] **Dr Groves:** I am happy to contribute to that discussion, but I think that Sally could perhaps comment first about the current arrangement that exists at a formal level, in her role as a formal NICE representative. Is that possible, Sally?

[14] **David Rees:** He passed the ball there. *[Laughter.]*

09:30

[15] **Ms Chisholm:** Yes, he did, very nicely. We now have a formal agreement between NICE and Wales in terms of partnership. My understanding of that is that all of our guidance et cetera is there—certainly from the health perspective, not the social care—for Wales to then decide whether or not it actually wants to look at the guidance and utilise it. That is my understanding of the formal agreement that has been put in place within the last 12 months. We have that agreement now in place with all of the devolved administrations et cetera. So, that is already there. With regard to the types of work that we undertake already in terms of our engagement with, certainly from my own programme's perspective, NHS organisations that help to inform the development of NICE guidance, I presume that there is no barrier there to prevent us from working with Welsh organisations. We would certainly welcome that because, of course, you are using those products potentially with your patients and with your population for their benefit. I do not know from your perspective, Peter, if you want to pick up on that in terms of being, as you say, a clinician in Wales who has a contribution to make.

[16] **Dr Groves:** Thank you, Sally; that is a really helpful background to my comments. What I am alluding to is that the implementation of medical technologies within the NHS, and setting guidance and processes, is a lot about identifying an agenda, things that are important and priorities. The guidance may well be applicable throughout different components of the NHS within Wales and England, but the priorities may be somewhat different at a local level. So, setting the agenda is critically important, ensuring therefore that what comes out at the other end, when it is produced, is particularly relevant to local practice. So, what I had in mind in that comment really was that, bearing in mind the current structures that exist, there is the opportunity for us in NHS Wales to potentially be more proactive in setting the agenda for some of the technologies and interventions that could, or should be, on the NICE programme or agenda. There may well be, for example, the opportunity to establish within Wales a committee or a multidisciplinary approach to setting what we see as our own priorities that could then directly link in with NICE and perhaps influence the way in which technologies are looked at and reported at a NICE level. So, that is the kind of thinking that I had in mind with that particular comment.

[17] **Kirsty Williams:** Would that be similar to the process of the All Wales Medicines Strategy Group? It takes guidance from NICE if NICE has looked at a particular pharmaceutical, but it also has the capacity, if a drug is further down the NICE list, to evaluate that on a Wales basis if the two do not match up. Are you thinking of a similar type of process?

[18] **Dr Groves:** Something similar to that, indeed, and even functioning at an earlier level. We have talked about the ways in which technologies are reported to NICE or notifications made. There may be an opportunity for such an organisation or committee to actually be proactive and say, 'Well, this hasn't been; why don't we suggest that for Wales? This is particularly important and why don't we serve as a trigger to setting some of the NICE agenda as well?'

[19] **Rebecca Evans:** I want to take you back to the points that you made on cost-effectiveness. You say in your paper, Dr Groves, that MTAC at NICE will only promote the implementation of new technologies in NHS England that are beneficial to patients and, overall, are either cost-neutral or cost-saving to the NHS. Is any consideration given to the impact on the wider public purse when looking at medical technologies? I am thinking that a technology that might present a cost to the NHS could actually provide a wider saving in terms of allowing the person to go back to work earlier or the provision of less intensive social care and so on.

[20] **Dr Groves:** Sally and I will answer that in a moment, but perhaps I can just make one or two comments first. There is an important differentiation to be made between cost-consequence and cost-effectiveness. The medical technology advisory committee does not look at cost-effectiveness; we look at cost-consequence, particularly. So, in our assessments and the way in which we scrutinise submissions, we look at the impact of the technology in terms of its cost and the cost of implementation within the system, but balance that against the potential cost savings that may accrue from lots of different potential angles—this is pertinent to the answer that I will give to your question in a moment—but looked at from an NHS perspective and over a time frame that is appropriate for that particular technology. So, that may take into account short, medium and long-term potential cost savings within the NHS from wherever they come. That is the way in which we look at technologies as a cost-consequence model, which is different from the cost-effectiveness model that is used by the technology appraisal process within NICE. An important point to make and establish at this stage is that the evidence base for medical technologies is often rather less developed than it is for pharmaceuticals and other parts of the treatment programme for patients. That is due to a large number of reasons, but a fact that we have to work with within our programme is that we often really do not have the level of research—either in quantity or in quality—that will necessarily allow us to look at refined assessments of quality of life and quantity of life that will allow cost-effectiveness data to be derived. Therefore, our function is cost-consequence analysis looked at from an NHS perspective.

[21] **Ms Chisholm:** However, in relation to the technology appraisals, NICE has now been formally asked by NHS England to start to take into account those wider determinants in terms of making those decisions about cost-effectiveness and benefits. 'Wide societal benefits' is the phrase that is being used and that work is now very actively happening in terms of the planning within NICE about how that will happen in the future.

[22] **Rebecca Evans:** So, are you in the stage at the moment of developing some kind of framework to put against your assessment?

[23] **Ms Chisholm:** Yes, as an organisation. That work is happening.

[24] **Lindsay Whittle:** You have spoken about some of your work with NICE and how it

benefits Wales. Are there any disadvantages for Wales? That is my first question. My second is: how do you identify potentially effective new technologies, and how do you ensure that they reach all parts of Wales? I appreciate that the larger, more expensive items will be concentrated in areas of greater population, but there must be other items that could reach all parts of Wales.

[25] **Ms Chisholm:** What we are perhaps starting to move into is the issue of implementation, uptake or adoption of technologies. Many of us recognise that, even though there may be positive guidance—not technology appraisals, but for medical devices and diagnostics guidance—one of the issues that is being faced not only in England but across the world is that, unfortunately, many organisations are not very sophisticated and will not necessarily have the skills to be able to take those and put them in place. We also often come on to issues related to understanding the issues around investment. With regard to cost-effectiveness, for example, or cost-benefit, as has been described, it can often take a long time for those benefits to be realised. In many places, unfortunately, the constraints of finances mean that decisions are made not to adopt technologies that might offer benefits because of the requirement to balance budgets in the short term, et cetera. So, the answer, in relation to your question, is to make sure, I would suggest, when people are recommending that technologies should be taken into account, that it is made clear what population is going to benefit and the circumstances in which it should be used, while, at the same time, encouraging people to take that long-term view of the benefits that might be delivered and not just to look at the short term.

[26] There is also some interesting evidence that is starting to appear about what the factors are that influence whether or not people actually want to use individual technologies. I do not want to go into the details of that, but it is really important in so much as the phrase that is being used is about technologies assuming what is called an ‘identity’, these are the factors that influence people to decide whether or not this is something that they want to integrate into their clinical practice. I mean that from a multidisciplinary perspective, not just from a medical clinician’s perspective.

[27] That is quite important, because those are the factors that can become the reasons why, unfortunately, sometimes good evidence-based products are not actually brought into clinical use. I am quite happy to share some of the references, so the committee can look at that in detail. However, it is very interesting. I think, Peter, you would recognise that as a practising clinician.

[28] **David Rees:** Gwyn wants to come in with an add-on to this. I will then come back to Lindsay.

[29] **Gwyn R. Price:** This is to Sally. Good morning. In May 2013, the health technology adoption programme was set up. Have you taken any evidence that you could share with us since then?

[30] **Ms Chisholm:** Yes. Very briefly, the way that the health technology adoption programme works within NICE is primarily alongside the medical technologies advisory committee process—the diagnostics and the medical devices. As that part of NICE looks at all of the evidence and consideration in terms of production of guidance, we then talk to front-line NHS people who use those technologies and try to understand from them what were the factors that encouraged them to use them and what were the difficulties that they faced in terms of getting them into practice. That might be, for example, that it means a redesign of the service to be able to use the technology most effectively. It might mean that there is specific training that needs to be undertaken, but it is also about understanding, from their view, what the benefits have been and whether, for example, they have undertaken any evaluation. What we then do is pull all of that together, particularly for the diagnostics, because those are the

two main areas that we have focused on so far. At the point when NICE then publishes positive guidance, we produce two different products, but primarily packs, that provide potential end-users and organisations that might want to use that product with some key examples from people who have already had that experience. That picks up on the influence that peer-to-peer sharing can have in terms of helping to formulate those positive identities about the benefits of technology in terms of people who want to see better outcomes for their patients.

[31] **So, so far, we have published one of those since we arrived at NICE. It is available on the NICE website—it was a product called Ambu aScope2—so, if anybody wants to look at the NICE website, you will see what we call a site demonstrator pack there, but we will also be publishing another one, I hope, in about six weeks' time. So, that is a note. That is the purpose: to support the uptake of NICE guidance.**

[32] **David Rees:** Lindsay, do you want to ask a further question?

[33] **Lindsay Whittle:** I did not hear any disadvantages of working alongside NICE, which is really positive. The only reason that I asked the question was not to catch anybody out, obviously, because I do not think that I could ever catch out three expert witnesses, but because, if there are disadvantages or even barriers, then we need to know about them so that we can help you. However, everything has been positive so far.

[34] **Ms Chisholm:** Well—.

[35] **David Rees:** You do not have to answer that; just accept the praise. [*Laughter.*]

[36] **Ms Chisholm:** No, but who am I to come here and say that there would not be any disadvantages of working with NICE? There may well be, because NICE cannot be guaranteed to always get absolutely everything right. I talked about scoping before, did I not? Sometimes, perhaps, when NICE decides to evaluate a particular technology and it sets a scope, it might not always necessarily be the right scope and it would be wrong of NICE to try to claim that. That said, people try very hard, of course, to make that right. I do not know whether or not you might want to comment on that, Grace.

[37] **Dr Carolan-Rees:** Yes. We were discussing earlier the difficulties, sometimes, where there is perhaps variation in practice and you have a limited number of clinical advisors available to guide the scope. It might miss a critical element where perhaps something that is happening in Wales is not happening elsewhere. That is all that I can add to that.

09:45

[38] **David Rees:** You did say at the start that you were looking at the link with Wales. Do you have any health bodies at the moment in Wales that actually do feed into NICE?

[39] **Ms Chisholm:** I do not actually know that, in so much as the work that would have taken place previously would have been in terms of the development of guidance, in which I am not routinely involved. However, I can go back and ask the question.

[40] **Jenny Rathbone:** One of the priorities of NHS Wales is to try to keep people in primary care more, rather than them ending up in hospital when they do not need to be there. I was interested in the point that was made in Dr Carolan-Rees's paper about the need to evaluate how they disrupt the relationship between primary and secondary care, particularly as primary care is always the poor relation; secondary care is where the power lies on the whole. Could you say how NHS Wales—now that we have this partnership arrangement with NICE—might be able to prioritise technologies that would improve the numbers of people

who could remain safely in primary care rather than ending up in hospital?

[41] **Dr Carolan-Rees:** Something that, in our experience of evaluating technologies in the programme at NICE, we have noted is that, very often, what determines that something becomes cost-saving is that very change from treatment that happens in secondary care to something that happens in primary care. So, it goes hand in hand that actually being able to move things from secondary to primary care is very often cost-saving, which is a positive benefit.

[42] **Jenny Rathbone:** How do you enable primary care to get at least as fair a shout as the secondary and tertiary sector?

[43] **Ms Chisholm:** In terms of the opportunities to use the—?

[44] **Jenny Rathbone:** Yes. It could be things that would be very useful in primary care, which might not be getting as much attention as the people with very sharp elbows in secondary care.

[45] **Ms Chisholm:** Yes, absolutely. [*Laughter.*] I think that the challenge here goes back to creating that desire within the people who are operating in primary care that this is something that they want to do. In doing that, it is very important to be able to help support them to have a system in place that will make the deployment of that technology as easy as possible. Sometimes there are infrastructure issues that need to be dealt with. They have thought about things like diagnostics. So, for example, there may be diagnostics that can be undertaken in primary care that historically may have been undertaken in secondary care, although there may still be a requirement for them to be sent to a pathology laboratory. However, there now needs to be a mechanism for that to happen in a primary care setting. Then you need to think about whether that is something that you would then encourage people to do in every single primary care centre, or would you actually say that that should be happening in a place where perhaps there are more community services. So, it is about being able not only to recommend that you might use a diagnostic, but to support the development of the infrastructure so that it is made as easy as possible. What primary care does not have the capacity for is to sort out what, in effect, becomes a potentially more complicated care pathway. It might be better for the patient, in that it is closer to their home and it might be able to happen more quickly, but, if it is more complicated, and suddenly there are lots of extra steps that get put in the way, they will become barriers to prevent that from being used, even though it might be better for patients and it might be more cost-effective. So, it is that development—not only of an understanding of the evidence of the benefit but of how it can happen in the smoothest and most effective way—that is absolutely critical in terms of whether primary care might be able to take that opportunity, if that makes sense.

[46] **Darren Millar:** Just building on this issue of evidence, Chair, I think that you, Dr Carolan-Rees, refer in your evidence paper to the very often limited evidence that is available, because of the small nature of some of these businesses that are bringing new products to market. They may not necessarily be research-based organisations. I think that you touched on it earlier as well, Peter, in that the information that comes to NICE is very often sketchy. How do you overcome that? You do not commission research as NICE, for example—

[47] **Dr Carolan-Rees:** They do. They do, yes—

[48] **Darren Millar:** Oh they do. Okay. So, to what extent does the industry itself need to invest more in research, perhaps on a collaborative basis, or to engage more with organisations such as Cedar and NICE to make it work?

[49] **Dr Carolan-Rees:** Yes, that is exactly what happens. If there is an evidence gap and

NICE makes a research recommendation, it may also commission that research, and we have facilitated a clinical trial that was funded by the manufacturer of the product. It was commissioned originally by NICE and we facilitated the trial. So, that is a model for filling the gap. I think that that is one of the real strengths of the MTEP programme that where there is a lack of evidence, there is a mechanism to fill that. There are other means of doing that than randomised controlled trials, which is the gold standard. NICE has also commissioned patient registries, which are post-market surveillance observational studies, which allow you to gather evidence that may be at a slightly lower level, but which is sufficient to fill that gap.

[50] **Darren Millar:** So, what happens if the evidence base is insufficient, or it comes back a bit wobbly even after commissioning a bit of research by the manufacturers but, at a later date, the evidence becomes clearer, shall we say, and it is clear that there may be a therapeutic benefit from one of these technologies? Does NICE revisit decisions? How regularly can it revisit a decision? Is that after a certain period of time or—

[51] **Dr Carolan-Rees:** There is a review process. It is in its early stages.

[52] **Dr Groves:** The time frame is not necessarily systematic and is dependent, sometimes, as you rightly alluded to, on the availability of new evidence, which is unpredictable. However, part of our programme gives the opportunity to manufacturers to resubmit if new evidence becomes available. Our particular programme at MTEP does not necessarily institute a systematic approach to a time frame for that.

[53] **Darren Millar:** So, it just depends on the manufacturer perhaps bringing forward the evidence to you to review. Does it always rely on the manufacturer to trigger a review or are other individuals or organisations able to bring forward suggestions for when a review might be appropriate?

[54] **Dr Groves:** In the context of the MTAC programme, it would have to come from the manufacturer, so—

[55] **Darren Millar:** Is that not a weakness in the process?

[56] **Dr Groves:** Potentially, but that really is the fundamental behind the rapidity, if you like, of the responsiveness of our particular programme to new developments. In other words, if very important evidence becomes available for a technology, the manufacturer will be minded and motivated to let us know about that as quickly as possible. Therefore, one would expect a sort of rapidity of response from our programme, because it is designed in order to be flexible in that manner. I should say that that differs from other parts of the NICE programme. The interventional procedures advisory committee functions in a different way. It would have a more formal process of the review of guidance, which is built into its process. It is not a one-size-fits-all approach for all aspects of NICE, it is just specifically that element of our programme that is less systematic, but it is systematic in the interventional procedures advisory approach.

[57] **Ms Chisholm:** The clinical guidelines and the technology appraisals do get revisited.

[58] **Darren Millar:** And just—

[59] **David Rees:** William, did you want to come in? Darren, you jumped in on William's questions there—

[60] **Darren Millar:** Oh, I am sorry.

[61] **William Graham:** You go on, and I will come in afterwards.

[62] **Darren Millar:** I just also wanted to ask about the Welsh Health Specialised Services Committee processes, of which you will be aware, that seem almost to duplicate, to some extent, some of your work. So, even if NICE interventional procedures guidance had been issued, there has to be a separate health technology assessment in Wales. Do you think that that is a sensible thing to do, or not?

[63] **Dr Groves:** I hesitate to give expert evidence on WHSSC processes.

[64] **Darren Millar:** Please do. [*Laughter.*]

[65] **Dr Groves:** I hesitate to do that, because I hope that you have someone from WHSCC coming to give evidence formally to the committee. I would not want to speak with a NICE hat on, but as a clinician—I make that very clear—working in Wales, I would concur with the sentiment of the question. In other words, my feeling is that we should avoid duplication wherever we can. As NHS Wales, we should use the information that is coming from NICE, which is a large organisation with considerable expertise over many years on how to develop guidance and how to look at evidence. My feeling, as a clinician, and as someone working within the NICE framework, is that we should use that expertise wherever we can in Wales rather than duplicate it. Local implementation is a different matter, and how we use it within NHS Wales may differ quite significantly from how it is used elsewhere in the UK. The implementation is something that needs to be considered separately. However, in terms of the point that you are making, I would entirely agree: we should avoid duplication wherever possible, speaking as a clinician.

[66] **David Rees:** Just to inform you, we do have somebody from WHSSC coming in to a future meeting.

[67] **Darren Millar:** So, to move on to implementation, which you just mentioned, in your paper you make it quite clear that there is inconsistency sometimes, because of the number of different commissioners in Wales, when new technologies are being appraised and recommended for use by NICE. To what extent would a national commissioning arrangement improve the situation? We are a country of 3 million people with a small number of health boards, are we not? Is that something that you think might improve the opportunities for patients to benefit?

[68] **Dr Groves:** It links in with the answer that I gave earlier about a structure that has a multidisciplinary approach and a strategic approach. With regard to implementation, there are different levels that we need to consider. There is definitely a role for local implementation within organisations—health boards—but I think that there is, indeed, a place for strategic national commissioning, which should be multidisciplinary and, in my opinion, take advice from clinicians, commissioners, patients and people receiving the services. One could define a structure that allows for a multidisciplinary approach that provides a national strategic framework for this kind of exercise to work in parallel with the local implementation that is, inevitably, very important within our organisations.

[69] **David Rees:** I have several people to come in on this specific point. Kirsty is next, and then back to William.

[70] **Kirsty Williams:** Thank you for that, but we know from experience that, even when guidance is published and there is a national impetus to see it taken up—. I have seen clinicians come and sit at this table and say to us, ‘I do not care what NICE tells me to do. That is not what I do in my clinic, and I am not about to start doing that in my clinic’. How do we overcome some of the barriers of individual practitioners? What can we do to persuade them to take things up, even when all of the evidence is in their favour? We have had

discussions recently about anti-coagulants, and the frustration of why certain GPs will not prescribe certain stuff. The evidence is there, but if an individual practitioner does not want to practice his or her medicine in that way, what are the sanctions that the state or the Government can impose?

[71] **Dr Groves:** It is a complex question with, I am sure, a very complex answer, but this is where it comes down to local implementation as well as strategic national implementation. Those kinds of issues would need to be addressed within the context of a local organisation and a local body, in my opinion. You are absolutely right: priorities need to be set and I think that, also, the implementation process at a national and local level needs to be aligned to a concept of prioritisation and a process of prioritisation within the constraints of budgetary limitations within NHS Wales. So, that is another facet to it. However, in terms of the regulation of practice, an organisation has responsibility for the people practising within it, so, ultimately, the answer has to be addressed at a local level.

10:00

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

[73] **William Graham:** Yes, thank you, Chair. I will quote from Cedar's written submission. It states that,

[74] 'More vocal clinicians who are persistent in their demands are more likely to get the technologies they want. Unless the decision makers are fully informed and skilled to make judgements between different demands on limited resources, the decision will not always be the best for the organisation overall.'

[75] Is this the old story that, in the greengrocer's, the awkward customer gets the best fruit? [*Laughter.*]

[76] **Kirsty Williams:** What story is that?

[77] **William Graham:** It is an old one, Kirsty. [*Laughter.*]

[78] **Dr Carolan-Rees:** It is a human factor that, if somebody is persistent—and you do have to be persistent, sometimes, to make a change to a service or acquire a technology—they are more likely to get there. It is very easy to be put off if you are not very keen or very persistent.

[79] **Ms Chisholm:** May I join the last three questions together? Incentivisation is something that is being looked at in England. A document was published by the Department of Health at the end of 2011 called 'Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS', which was a big push that was also linked on the business side with the Department for Business, Innovation and Skills to try to increase the uptake of innovation. Within that, there was recognition that, even though there is evidence-based practice regarding many things, this was not happening. A decision was made regarding, I think, six different things called 'high-impact innovations', where it was suggested that, if they were applied throughout England, there would be significant benefits for patients and there would usually be cost-effective savings. These were then written into the incentivisation system that is used in England, called commissioning for quality and innovation payments, and NHS trusts could not qualify for their CQUIN payments unless they could demonstrate that those technologies that were relevant to their organisations were being used at a set level. So, it is very complicated, and I am happy to provide some more information about that.

[80] There was another initiative underneath that, which I would like to talk about, as it

may well be relevant in thinking about prioritisation and support. This was called the NICE implementation collaborative. It has the word ‘NICE’ on the front, but it is not the National Institute for Health and Clinical Excellence’s body; it was set up by NHS England. That is a coming together of NHS organisations and it is chaired by an NHS chief executive, but it also involves many of the big industry providers, from both medical technology and diagnostics. It also involves the industry associations like the Association of the British Pharmaceutical Industry, the Association of British Healthcare Industries and the British In Vitro Diagnostics Association, the Academy of Medical Royal Colleges, and organisations like the NHS Confederation and the foundation trusts. The notion is that they explore how they can collaborate to support the uptake of innovative technologies. It is relatively early days, as it has been going for only a year. It is all linked to technologies and pharmaceuticals that have been recommended by NICE, by guidance.

[81] In the first year, it took four pieces of historic guidance and tried to understand the issues in relation to why they were not being taken up, either nationally or at a local level. There was lots of learning. Without getting in to the details, one thing that was discussed at the most recent meeting was insulin pumps, which have been around for a very long time. The conclusion of the group that had tried to look at that was that it was no good putting in a national incentive to support the uptake of that, but that that was something that had to happen locally, because the ways in which those services are delivered are so different that trying to say that it had to happen in a particular way was never going to work. So, that might be something that you want to think about. That is, for which technologies you would want to take a strategic approach, as suggested by Peter, and for which you might understand the need to have that local engagement to put them in place. It is really interesting.

[82] **William Graham:** What is the value of local pilot programmes and how are their experience and outcomes shared? I read a suggestion somewhere in here that the NHS had more pilots than British Airways. [*Laughter.*]

[83] **Ms Chisholm:** In my experience, the problem with pilot programmes is that they are small-scale and that people are not overly keen with the change that they might cause to the service that they work in. They see the change as being short-term, and if they can just work through it, it will disappear. In my experience, if people want to see a change that will become sustainable, particularly if it has a clear and established evidence base, it is much better to start out with an intention of saying, ‘This is what we want to achieve; we are not trialling this—we are going to do it and we are also going to measure the impact of what we are choosing’. That is how to convince the most reluctant people that the benefit is there.

[84] **Dr Groves:** I would just like to add that I endorse those comments. The commissioning through the evaluation initiative in England deserves some scrutiny. You may be aware of the principles behind the initiative, which is that when there may be uncertainties about the evidence of the benefit of a new technology, rather than discard the potential promise, as it were, an approach adopted in England is to have a collaboration between commissioners and providers to deliver the service, but at the same time generate the evidence. It is a very worthy initiative, and it is something that we might consider becoming involved with in NHS Wales. The first of those initiatives is about to kick off, and they are looking for providers in England to collaborate with commissioners to provide services and generate evidence. Within my speciality of cardiology, four of the subsequent technologies that will be included in that programme are cardiac ones, which are very worthy, in my opinion, of scrutiny and evidence generation.

[85] It would be a shame if NHS Wales was not allowed an opportunity to become involved in that process, and if patients in Wales were not allowed the opportunity to receive treatment through these technologies and be part of the evaluation process as well. So, speaking as a clinician in Wales, I would strongly endorse exploring the possibility of

collaborating in terms of this initiative. These types of processes need to be national because of the need to generate evidence from a relatively small number of patients. It is not something that one would want to initiate *de novo*, but there is no good reason why we could not in Wales be involved in a national process that started in England.

[86] **William Graham:** Finally, where did that initiative come from and how was it commissioned?

[87] **Dr Groves:** It has come through NHS England. My understanding of its history is that it came from within my speciality. There were a number of cardiac procedures that clinicians were very eager to institute and implement, but there was reluctance and nervousness on the part of commissioners to commit funding to them. My understanding of its history is that it came about as a result of discussions between representatives of NHS England and clinical cardiologists about those specific technologies. However, it may be worth checking the details of those facts. However, that is my understanding of its history, and that that, in a sense, triggered the thinking process that led to the suggestion and the initiative coming through NHS England.

[88] **David Rees:** Rebecca is next, then Jenny.

[89] **Rebecca Evans:** I want you to describe to us the work of the NICE implementation consultants, and whether their work extends to Wales at all.

[90] **Ms Chisholm:** Regarding the NICE implementation consultants, we call them the 'field team', which helps to describe their role. There are seven at the moment, who cover the whole of England and Northern Ireland. They are all linked to a particular geographical area and their prime role is to take the time to visit all NHS and now social care organisations within their area. They will talk primarily with senior managers within those organisations, but on occasion also with clinicians to tell them about the most recent NICE guidance, to get feedback in relation to whether people are finding it difficult, whether there are any problems with the implementation, and also to test the temperature in terms of the pressures that people are under and the impact that that is having in terms of their capacity to look at all of the guidance that is being published by NICE—we do publish a lot of guidance, which, thinking about your earlier comment, could be seen as a negative. So, that is their prime role, but they are also a bit of a conduit for those people who are involved in the production of guidance within NICE, who perhaps do not have the opportunity to spend time out in NHS and social care organisations. So, they help with that communication. At the moment there is no remit for them to be working with organisations in Wales.

[91] **Rebecca Evans:** There is nothing comparable that is happening here that you are aware of.

[92] **Ms Chisholm:** No, not that I am aware of.

[93] **David Rees:** Jenny is next.

[94] **Jenny Rathbone:** I would like to go back to the multidisciplinary teams that you think would be a good idea for evaluating new technologies. Could you tell us whether the consultation panel that used to exist—or that no longer meets in Cardiff and Vale, because it does not have a budget to implement anything—met that multidisciplinary test? If not, is it in any way a useful model that we might come back to if Wales wants to introduce the multidisciplinary model?

[95] **Dr Groves:** I am going to ask Grace to comment on that because she was more involved with what I think was a prioritisation panel. I know that she was involved in that, so

perhaps she might comment on that.

[96] **Dr Carolan-Rees:** I had a little involvement at the beginning, and I understand that it is now meeting again, so those funding issues must have been sorted out, which I am very pleased about. I am, sorry, I have forgotten your question.

[97] **Jenny Rathbone:** Did the panel meet that multidisciplinary test? My anxiety is particularly about primary care not having as big a voice as secondary care.

[98] **Dr Carolan-Rees:** I could not tell you whether—

[99] **Jenny Rathbone:** Okay; we have someone coming in who may be able to.

[100] **Dr Carolan-Rees:** I could not tell you what the involvement was of primary care, but, from my recollection, it was multidisciplinary.

[101] **Jenny Rathbone:** As far as you are aware, it did take evidence from patients as well, did it?

[102] **Dr Carolan-Rees:** Did it? I cannot remember.

[103] **David Rees:** We have—[*Inaudible.*] Kirsty, do you want to ask your final question?

[104] **Kirsty Williams:** So far, we have spent a lot of time thinking about how a good system of technology appraisal and uptake would lead to better care, better outcomes for patients and potentially cost savings, or—in the new prudent Welsh NHS that we are going to have—better use of the money. I wonder, Dr Groves, if we could develop a really good system in Wales, do you think that it would have an effect on the recruitment and retention of medical staff, given that this, again, is something that we hear a lot about in Wales as a particular problem?

[105] **Dr Groves:** I think that the short answer to that would be ‘yes’. Clinicians would be reassured in their working environment if they knew that processes were in place that would provide them with the opportunity of implementing new technologies within their speciality, within their working environment. That is something that would be an incentive and would absolutely help with the recruitment of specialists to come to work or at least to stay in Wales. It is as much about the retention of our trainees as it is about attracting people from other parts of the UK and the world.

[106] **David Rees:** I have two questions for you before we finish, and then I would like to put another point to you after that. First of all, there has been a lot of reference to poor quality in your submissions and you mentioned it this morning. The definition of quality varies, and, in a sense, I assume that you are comparing with pharmaceutical evidence. What do you understand by poor quality, because, for example, the term ‘poor quality’ is clearly mentioned in Cedar’s evidence to us? How do you define poor quality?

10:15

[107] **Dr Carolan-Rees:** There is a hierarchy of evidence, which is well accepted in health technology assessment, starting at the top with systematic reviews and randomised controlled trials, which are blinded, then moving down to observational studies and case reports and then just expert or individuals’ opinions. Very often, with medical technologies devices, the evidence is at a lower level in that hierarchy.

[108] **David Rees:** That is clear and helps us to understand. I am going to put you on the

spot a little bit, but if there was one recommendation that you would want to give to the committee as to how we could ensure better assessment of medical technologies, what would it be? I do not want to put you on the spot; if you would rather give us the answer in writing, we would be more than happy to receive it in writing. However, basically, what we are trying to find out is what recommendation you would give to us to improve access to medical technologies here in Wales.

[109] **Dr Groves:** I think that it is about having open access to all levels of people involved in delivering and receiving the service, so that there is the opportunity for the important technologies, which are going to make a difference in the right places and at the right time, to be scrutinised. So, in my opinion, it is important to set the agenda at the right level, and with the right input of opinions, so that the processes are driven by things that are really going to produce the benefits in the right places, by the right people, at the right cost. In my opinion, if one does not set the agenda correctly, you will not get the outputs and the consequences that the patients and the system need.

[110] **Ms Chisholm:** Obviously, the evidence is really important because these are devices that are going to be used with and on patients. However, having those things available does not mean that the people who may use them necessarily know how to actually put them into practice—and I do not mean from a clinical perspective. I come back to that point about these being used in complex care pathways where technologies may provide an opportunity for patients to receive their care in a different setting, or in a different way, at a different time. That needs service redesign and it is really important that the people who are going to be using and receiving that technology are involved and are given the skills and advice to allow them to make that change so that the technology can be most successfully deployed.

[111] **Dr Carolan-Rees:** I would say that completing the circle by auditing what happens at the end should not be forgotten. So, when you have made a decision and implemented it, go back to see whether it is delivering the outcomes that you were expecting. Is it making a cost saving where it was intended? Lessons should then be learnt from that audit, which should then be fed back into the next process. So, it is a full circle. Do not forget usability factors either.

[112] **David Rees:** Thank you very much for coming this morning and for your evidence today. You will get a copy of the transcript to make any factual corrections. Please keep an interest in what goes on; it is very important in terms of what goes on here in Wales and in terms of where we are going to go with this. We appreciate your input very much, both here and on a national level; it is very helpful.

10:20

Ymchwiliad i'r Mynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn Dystiolaeth 4 Inquiry into Access to Medical Technologies in Wales: Evidence Session 4

[113] **David Rees:** Good morning, and thank you very much for coming this morning. We now go into the second session this morning, and I welcome Dr Susan Peirce, a clinical scientist based in Cardiff University.

[114] **Dr Peirce:** Good morning.

[115] **David Rees:** I welcome Professor Stephen Keevil, president of the Institute of Physics and Engineering in Medicine.

[116] **Professor Keevil:** Good morning.

[117] **David Rees:** I also welcome Professor Colin Gibson, who is vice-president of the institute.

[118] **Professor Gibson:** Good morning.

[119] **David Rees:** Thank you very much for your written evidence. Clearly, the intention is to focus on the questions arising from that. I would like to start off with Gwyn Price.

[120] **Gwyn R. Price:** Good morning, everybody. I wonder whether you could tell me about the involvement of stakeholders, for example, industry, patients, clinicians, in the—. How effective do you think their involvement is, relative to the cause?

[121] **Professor Keevil:** Involvement in what sort of process or in what task?

[122] **David Rees:** The process that we are looking at is the access to medical technologies in Wales and the process to achieve that. What Gwyn is highlighting is the involvement of stakeholders during that process of accessing medical technologies and how we can approve medical technologies.

[123] **Professor Keevil:** Certainly, during the processes of assessing technologies, which I know you have heard about in a previous session, there is involvement from lots of different professions. However, when it comes to the actual implementation and adoption of technologies in individual hospitals or health boards, I am not sure that there is a great deal of involvement, certainly, of patient groups, for example.

[124] There is certainly multidisciplinary involvement, and I think that that is an important aspect of our submission—wishing to develop the role of people in our professions in medical physics and clinical engineering in uptake. They certainly have a role at the moment, and it is an important role. We feel that there is scope for that to be developed further. In the paper, we talk about the higher specialist scientific training programme that is being developed at the moment, with a view to training up a senior group of consultant clinical scientists in physics and engineering who would have a combination of skills to contribute to that local uptake and adoption of technologies. I think that that is, probably, at least part of the answer; I do not know whether Colin wants to add anything.

[125] **Professor Gibson:** Maybe just to add to that, part of the role of the consultant clinical scientist will be to engage with stakeholders as part of this process; in particular, the end user, whether you might consider that end user to be a clinician of some sort or, of course, the patient. That is critical to acceptance and rapid adoption, because, often, the devil is in the detail. Local implementation of new technologies, such as the ones that you have been talking about today, can be hampered, if you like, not because there is not good evidence or there is not an awful lot of will to make these things work, but because the devil is in the detail. Particularly when you have to consider the impact on patients and on patient pathways, it is not just right, but actually much more effective to engage with all stakeholders, particularly the users of the technology and patients in particular.

[126] **Gwyn R. Price:** That is what I was trying to get at.

[127] **David Rees:** Dr Peirce, you have, obviously, mentioned this as well, about the panels that are set up for evaluation including stakeholders. Do you have a view on that?

[128] **Dr Peirce:** I think that most stakeholders are represented at some point in the process. I suspect that patients are, probably, under-represented in that process, although we

understand that patients are more healthcare savvy and come to doctors with information from the internet, but that is, obviously, not necessarily the most robust or well-balanced information. However, we are talking about very complex processes here—about complex technologies, complex healthcare and organisational needs. That is difficult for professionals to understand, let alone patients, so, although I recognise that they should have a voice, I am not sure that in all cases it should be an even balance of stakeholder input.

[129] **Gwyn R. Price:** Do you have, as you said, Colin, the ability to go from top to bottom, taking into account the users, who are the stakeholders, to develop projects and technologies in the future? It is important to go from top to bottom.

[130] **Professor Gibson:** What we are trying to put across in our submission is that there needs to be a link between top and bottom. What we are suggesting is that the role, as described, of the consultant clinical scientist would be to form that link, to certainly understand what is needed in terms of healthcare delivery, to understand the wider health economy, to understand the individual case and to understand the people who are here to deliver these services to and for the patients, in particular. Part of my role, very specifically in my day job, is to deliver clinical services to patients in terms of rehabilitation. It is critical that acceptance of these technologies is part of what we must consider when we are assessing, prescribing and providing solutions to meet the needs of individuals. That is exactly it. It is about individuals and they vary. Their circumstances vary, their needs can be very complex and, even if there is great will on all sides to accept and make use of the newest and the best, there may be difficulties that have to be overcome, but can only be overcome according to local circumstances once they are dealt with. It is essential to cover both top and bottom and to find a way of bringing them together. That is what I am trying to say.

[131] **Gwyn R. Price:** That is what I wanted to hear. Thank you.

[132] **William Graham:** My question first is to the Institute of Physics and Engineering in Medicine. In your submission you say, and perhaps, I could ask you to enlarge upon it,

[133] ‘the financial barriers that may prevent the timely adoption of effective new medical technologies, and innovative mechanisms by which these might be overcome.’

[134] **Professor Gibson:** It goes back to what I suggested earlier: the devil is in the detail. I am sure that you will have heard already from a number of people who have given evidence that, for example, there is a tendency in healthcare to think in terms of silo budgets. So, I may invest in this area, but the financial benefits are seen in another. That in itself is an impediment to that investment because we are all very conscious of the lack of resources available. It is very difficult to make decisions today that will reap benefits tomorrow and, in particular, if those benefits are going to be reaped elsewhere and do not impact on my budget, for example. That in itself is a sort of impediment. If we can take an overview of the health economy as a whole, but also within a health organisation, so that investment in department A reaps benefits in department B and the benefits outweigh the initial investment, it makes common sense to push that forward. However, unfortunately, that, quite often, gets lost in day-to-day service delivery. So, what we are suggesting is that part of this role would be for somebody to take that into account and put forward a sound case on behalf of those willing to introduce the new technology to demonstrate that this is a net benefit for everybody. Of course, it improves outcomes for patients, which is what it is all about, fundamentally.

[135] **Professor Keevil:** I will add slightly to that. What Colin said is absolutely right: the benefit may arise in a different budget area from where the cost falls for the new technology. However, it may go even beyond that. It may be that there is an increased cost to the hospital as a whole for adopting a particular technology, but the benefits come in terms of increased quality or length of life for the patient. That does not get reflected in anybody's budget

directly. So, it is trying to have a holistic view. I think that the roles that we have talked about here that we are endeavouring to create are people, as Colin says, who would have an understanding of the technology, because they are coming from physics and engineering backgrounds, but also would have a broader understanding of how patient pathways work and health economics in the broadest sense, in addition to their technical knowledge.

[136] **David Rees:** Is that as a consequence, perhaps, of organisational structures, the budgetary pressures on the different elements of those structures and, perhaps, the silo mentality that exists maybe in some areas?

[137] **Professor Gibson:** I am sorry; I just realised that there is a button to press.

[138] **David Rees:** No, it is okay; the microphones will come on automatically.

[139] **Professor Gibson:** I think that the answer to that is 'to a certain extent'. I think that it would be unfair to say that organisations want to be in this position, but they find themselves in this position because of complexity, change and service pressures, more than anything.

10:30

[140] There are great demands on the people at the sharp end. They have some good ideas and they really want to implement them, but they do not really know how and they do not necessarily even know who to speak to in order to put them into practice. Once those ideas are scrutinised, there may well be investment or additional resources required that just do not exist currently. So, it is not that there is not the will to do this, but, perhaps, we have ended up where we are for all sorts of reasons. Perhaps, the best way that we might suggest of helping to move from that point to get to where we all would need to go is to introduce people into the front line of service delivery who have the knowledge, skills, understanding, proficiency, experience or whatever it takes in order to make this happen. We are talking about people who will be leaders, not just clinically, but in the introduction of transformational change. That is our objective.

[141] **William Graham:** You mention in your evidence that:

[142] 'In practice the lack of immediately identifiable capital finance is rarely the absolute barrier to adoption it is assumed to be.'

[143] Would you like to enlarge on that? Also, I notice a telling phrase at the end of that. You say:

[144] 'Medical equipment management departments still provide examples of expensive medical devices bought in haste and rarely (if ever) used.'

[145] I will not ask you to name and shame, but you are aware of that. Could you tell the committee how widespread that might be?

[146] **Dr Peirce:** I suspect that any clinical engineering department in any hospital around the UK will have at least one example of that. It will not necessarily be that recent as there is a greater culture of gatekeeping, scrutiny and justification in terms of acquiring technology, these days. It used to be the case that technology could find its way into hospitals by all sorts of backdoor routes. It would just appear somewhere and nobody would know how it got there or why it was there.

[147] In terms of finance, you mentioned silos; there are multiple types of silos. There are silos between organisations and healthcare sectors—possibly less so in Wales because of the

way healthcare is centrally organised here—and between departments inside a single organisation. There is a separation between capital and revenue, and there is the annualised accounting that the NHS has to cope with, which is a barrier to large-scale purchases—not necessarily the purchase of a big device; it could be lots of small devices. If you cannot plan for that to happen over several years, that can pose a barrier. However, because devices are quite complex, they can be bought in multiple ways. You can buy them as capital, and then you have to think about the revenue and the maintenance. You can lease them; there are options that are called ‘managed services’ where you, basically, pay for someone else to run your equipment. You can get the capital equipment for free by paying slightly more for the consumables. Also, there are charitable funds. People are very innovative about finding ways to fund something that they really want. However, as I said in my submission, that is not necessarily what clinicians should be doing. We are in straitened financial circumstances at the moment, but throwing money at the problem will not, necessarily, get you where you want to be.

[148] **William Graham:** This very expensive equipment that is purchased and that does wonderful things is used for only limited hours. Do you think that there is a case for after 5 p.m.?

[149] **Dr Peirce:** Yes. I understand that there are massive organisational problems with that, but in relation to things such as radiotherapy, for example, which is a little outside my area, I am sure that there are cancer patients who would be quite happy to be treated at night, if it meant that they could get it a lot quicker. Quite often, the problem, though, with radiotherapy may be access because there is not enough availability, but in other cases, you might have the opposite problem, where you have a highly specialised piece of equipment that is only suitable for a small number of cases. Then, you have the problem of not enough patients to make it financially viable or to keep the clinicians skilled enough to be able to make that a clinically effective option.

[150] **David Rees:** In relation to radiotherapy, I have met staff at Singleton, and there are occasions when the system is down on purpose because it is a way to balance the workload, and it is down for maintenance times as well. So, it is not necessarily a 24-hour piece of machinery, because there are times when it has to be down for work to be done. We just need to be aware of those issues.

[151] **Kirsty Williams:** Professor Gibson, in your paper, you ask the committee to examine how the NHS assesses the potential benefits of new and alternative medical technology. The inference is that the current system is inadequate in some way. Could you expand on what you feel the committee should look at or what the current inadequacies are within the system?

[152] **Professor Gibson:** That is not to say that there is not a lot of good work providing a lot of very good evidence: there is. However, as I mentioned earlier, the devil is in the detail when it comes to implementation and making sure that stakeholders at the sharp end are able to take that evidence and make the best use of it, according to local circumstances, which vary hugely, and according to individual case circumstances, which vary even more. If what is missing is that link between the top and the bottom of what already exists so that decisions can be made at the sharp end to improve the delivery of services, to accelerate people along pathways, to make sure that we get the best possible outcomes in the most cost-effective and clinically effective way, then it needs to be joined up. That is the suggestion. What we are suggesting is that this provides that the role of the consultant clinical scientist would be not just to facilitate that, but to lead it.

[153] **Kirsty Williams:** Dr Peirce, in your paper you are very critical of the health technologies fund, and the statement that was talked about, about lack of capital rarely being the reason. If lack of capital is rarely the reason, how do you think we end up in a situation

whereby access to the latest radiotherapy techniques is commonplace in places like the Royal Marsden and other cancer centres in England, yet in Wales we are unable to have those technologies, which are well proven, well understood and known to be better? If it is not lack of capital that created that situation, what are the factors that can lead to a situation whereby a technology that everybody agrees is a better technology is available in England but is not available here?

[154] **Dr Peirce:** Finance is a factor—if the money is not there, you are not going to have it. I am just trying to say that it is not the biggest barrier, as people think it is. There are all sorts of reasons why things do not get taken up. I cannot really comment on that case, because I do not know anything about it. My comments on the health technology fund, having been at a meeting before it was launched, were that people were very concerned that it was just about finding money to buy kit and not really considering the bigger picture around that technology. I am not saying that money is not an issue, but when it comes to the adoption and use of technology, you go from the realm of science, evidence and technology, and become involved in sociological and psychological factors about why people do or do not want things. There is obviously going to be politics in there as well. The reasons why we do not necessarily have something that lots of people might think we should have are multifactorial, and you could not pin them down to one or two things.

[155] **Kirsty Williams:** Having identified a sum of money that could be used to aid adoption and acquisition of good technology in Wales, what would your advice be to Welsh Government on how that fund can be used to best effect? If you were in charge of spending it, on what would you spend it?

[156] **Dr Peirce:** I would want to make sure that there was a good process of evaluation and prioritisation of technologies. Sometimes, the problem is that money becomes available but the time between it being advertised and it being closed is quite short, so people are scrambling around trying to work out what they can get and how they can shoehorn it into the application process. So, I think that we just need a better process of working out what it is that we need. We need to start from the idea of clinical need—what clinicians need to solve the problems that they have—rather than what technology is available or knocking on our door. It is usually about technology being pushed at the NHS and trying to find somewhere where it will fit, rather than asking what the problem is, what the available solutions are, and what best fits our local needs. You need a more holistic process for looking at a variety of technologies and solutions for the problems that we have.

[157] **David Rees:** This is the lack of systematic horizon scanning that you mentioned in your paper.

[158] **Dr Peirce:** It is not necessarily about horizon scanning. You do not necessarily need to know about upcoming technologies. There are a vast number of solutions out there, already. We have talked about people with the loudest voice—companies with the biggest promotional budget or the most aggressive salespeople will be the ones that will be heard more. Clinicians look at evidence and appraise themselves and keep themselves up to date in their own specialities, but technology might not necessarily be a part of that. Technology is sometimes evaluated in non-specialised journals, and so on. So, it is about using the skills that we have outside of the clinical area, but connected to the clinical area, to work out what the priorities should be.

[159] **Jenny Rathbone:** I want to explore this further. Certainly, the Royal Marsden hospital has a very loud voice and Velindre is performing better in terms of outcomes. You talked about your anxiety that clinical engineers who stand outside particular interest groups are not really replaced—you mentioned Cardiff and Vale. Many health boards—not just Cardiff and Vale—are linked to universities, which is why they are university health boards,

so I can see why there might be pressure within front-line services to provide more nurses, say. However, surely, it is the job of universities to ensure that we have the researchers and the clinical engineers who are going to be able to advise us on new technologies that are beneficial. So, why are universities not maintaining those sorts of key people to be able to advise the NHS on new technologies?

[160] **Dr Peirce:** There are. I am employed by Cardiff University. There are several centres of excellence around the UK in terms of clinical engineering and medical physics. They are relatively specialised areas of expertise, but in a university context, they are essentially researchers, probably. What you really need is people who are embedded in the health system and people in actual hospital clinical engineering. As a researcher, doing the evaluations that we do for the National Institute for Health and Care Excellence and with Cedar, for which I work, one of our key difficulties is trying to work out what really happens on the ground and what the clinicians do, what happens to the patients and what will happen to the patients if we introduce this technology. We are not embedded in the healthcare system; we are at a slight distance from it. I think that it is key that we need to have strong links with what goes on in day-to-day practice. The clinical engineers in hospital services are the ones who are on the ground and they talk to the clinicians and see the equipment. They know what the problems are in that locality.

[161] **Jenny Rathbone:** That is why we have joint appointments from universities and NHS clinicians. That has always been the case and, sometimes, those salaries are paid for out of university funds and sometimes they are paid for out of NHS funds, but there is that marrying up of the academic with the practical. So, why is that not happening here in Wales?

[162] **Dr Peirce:** I suspect that it is probably not a Welsh thing. People talk about having closer links between things like the NHS, academia and industry and creating smooth ecosystems and seamless working to break down these barriers that exist between the organisations. However, I think, having done collaborative research, as well, there is nothing like being in the room, on the ground with the people whose problems you are trying to solve.

10:45

[163] **Jenny Rathbone:** There is certainly that aspect. My concern—and perhaps this is something that we need to explore further outside this meeting—is why those joint appointments are not happening, if you are saying that it is not happening.

[164] **David Rees:** I am sure that it is something that we will look at, as you say, outside this meeting.

[165] **Lindsay Whittle:** Good morning. I just wanted to ask about the commissioning of new technologies. Dr Peirce, your evidence suggests that you propose a regional approach, with which I have a lot of sympathy. However, to obtain best value for money, I suppose that we should look at an all-Wales approach, which many of our witnesses seem to favour. I wonder whether there is a happy medium between both. I am afraid that, if it is an all-Wales approach, much of the new technology will be centred in areas of greater population. If you listen to other people, Wales is not just about the south-east and the M4 corridor; it is also about our rural communities, which also deserve access to new technologies. Do any of the witnesses have any ideas on how we could get a better approach to this, please? I am a little concerned about hospitals purchasing equipment that then stays in storerooms, unused. That is not the best approach, is it?

[166] **Dr Peirce:** No. In Wales it is possible that the size of the population and so on means that an all-Wales approach might work. It is something that happens in NHS England organisations, like NICE, HTA and NIHR. They can be very rigorous and produce good

evidence and recommendations and so on, but that might not be locally applicable.

[167] What I was talking about with regard to closer working with local NHS organisations is that each organisation is relatively autonomous, and they do the same things but differently—they treat the same patients slightly differently; they have different pathways and different levels of staffing and so on. Given that device technologies are so complex in terms of how they are used, it needs to be about how that fits into the local organisational structure and local ways of working. So, if you have too large a scale of an organisation, it will not seem that relevant and it will not address what those local issues are. If you have a diverse population and a geographical and organisational structure like the one that we have in Wales, I think that you need something that is a little bit more responsive to those local variations, so that we get something that is locally appropriate. It might not be appropriate for those big technologies to be everywhere—that is something that needs to be addressed. Some technologies should, perhaps, be looked at on an all-Wales basis—the bigger and more expensive things should probably be looked at on an all-Wales or possibly UK-wide basis; we do not want too much concentration in one area. As you said, that might work in the sorts of scales that we have in Wales; I am not sure. However, I am really concerned that it should have strong links with local organisations, addressing the problems that they have, rather than some sort of global idea of what is important everywhere. I might be slightly contradicting what I said earlier, but what I mean by that is that nationally set priorities are not necessarily that important in your local area. You need to get that balance right.

[168] **Lindsay Whittle:** You mentioned shared budgets. Do you have any thoughts on cross-border shared budgets? Often, we in Wales have to go to England for specialist treatments, but what is the level of travel into Wales for specialist treatments? I have to confess that I do not know.

[169] **David Rees:** It may be a question outside of your—

[170] **Lindsay Whittle:** It is about commissioning services and new technologies, however, is it not?

[171] **David Rees:** Do you have any experience or knowledge of the number of patients who may be coming into Wales for specialist treatments?

[172] **Dr Peirce:** I am pretty sure that Morriston is the adult burns centre for the south-west region. So, we have that going for us. However, in terms of the finances of patients going across the border, I am really not very versed in that. I am sorry.

[173] **Darren Millar:** I have just a brief follow-up question. In your written and oral evidence, you seem to focus on the large, expensive capital projects in terms of technology. Of course, the technologies that we are talking about can also be smaller technologies that are therapeutic, which patients might take home and administer themselves, but which are non-pharmaceutical. In terms of the availability of those technologies, is that not a completely separate mechanism? Patients would expect to be able to access certain therapies, if they have been approved by NICE and have demonstrated their clinical effectiveness. It is that sort of commissioning side of things as well that needs to be considered, is it not?

[174] **Dr Peirce:** Yes—I do not really know what else to add to that.

[175] **Darren Millar:** Do you have a view on those? What are the barriers to people being able to access those other smaller, not capital but revenue expenditure sort of technologies?

[176] **Dr Peirce:** I think that they are very similar. I tend to talk about big-ticket items, because that is what gets the attention. However, the smaller the technology, the more likely

you are to want lots of it. So, in a way, it becomes a big-ticket item. In terms of patient-use technologies, when you are transferring care between a hospital or community setting and the patient's home, the issues are very complex, and the patient environment will be very influential on whether that technology works for the patient. We have talked about the success of a device being very dependent upon how it is used, and now you are asking about taking that outside a professional area and giving it to patients. The effectiveness of the technology will be dependent on training, on its use, and on attitude and compliance. However, in terms of access—and you would like to talk about barriers and facilitators—the issues are similar; they are just on a different scale.

[177] **David Rees:** Professor Keevil, do you have a view on that? A lot of your members will be involved in those sorts of projects as well.

[178] **Professor Keevil:** Yes. There are several questions that, really, are of a piece. This is about having somebody there, embedded in the service, who has a broad understanding of the technology, the clinical application and the interface with the patient, which are all things that, in the training programme that we advocate in our paper, are being picked up. One of the very beneficial ways in which medical physics and engineering training has evolved over the past few years is that there is greater recognition that there is a patient at the end of the process and that the interface with the patient is important. That certainly plays out if we are talking about technologies that are being used in a patient's home. So, it is about having engineers who understand that.

[179] If I may say so, the discussion about the interface between the clinical setting and the university is, for me, not the critical one. There will be engineers who are based in healthcare who have academic appointments as well—shared appointments. Although I am a physicist and not an engineer, I am sort of in that position myself, so I do understand that. However, the critical thing really, for me, is having the engineer or physicist embedded in the healthcare system, so that they are able to understand all of those different aspects. The academic link may be important but, for me, it is of secondary importance.

[180] **David Rees:** You identify in your paper that the training package you have talked about is about developing the skills within the workforce. Do you think, therefore, that the voice of the clinician is far louder than the voice of the engineer and the physicist when looking at technologies and what they can bring to the table and to the patient?

[181] **Professor Keevil:** Yes—

[182] **David Rees:** And should it be?

[183] **Professor Keevil:** Well, almost to answer those questions in reverse, on whether it should be, I think that it is a multidisciplinary issue. There has to be shared understanding of that. Certainly, it is the case that the clinician, the medic, is very often driving the process and is the person who is saying, 'Well, I really need this piece of technology'. You find situations, as we have heard around the table this morning, where technologies end up being purchased and then, perhaps, it was not the ideal option and it is not perhaps used to the extent that had been envisaged. A better decision could have been made. One would hope that the people who are making these decisions are, in their minds, doing so in the best interests of their patients. They are not people going out to buy inappropriate bits of technology for the sake of it. People are making well-motivated decisions that, as far as they are concerned, are in the best interests of their patients. You would think that they would welcome input from professionals who have expertise in the technology, but they have to move from where they are as well, and have more of an understanding of the clinical interface. That is one of the things that we are trying to achieve with this programme.

[184] **David Rees:** I want to move on to post-adoption evaluation, in one sense. How do you see that? Is it effective at this point in time? Clearly, it is a major element. We heard evidence before about one of the key features being an audit of the adoption of technologies. What is the status in your mind of the post-adoption evaluation of technologies?

[185] **Professor Keevil:** I can have a go at a partial answer to that with a slightly different hat on, in that I also, like one of the witnesses that you had earlier, run an external assessment centre for NICE. What happens in that context is that, very often—as you heard earlier this morning—the decision that is made by NICE on a particular technology is based, obviously, on the evidence that exists at a particular point in time. That is a tricky balancing act, because you want to get new technologies adopted and recommended and into the clinical setting quickly, if they are to be beneficial, but of course, evidence from clinical trials and so on does not necessarily accumulate all that quickly. You are making a decision on limited and partial evidence, quite often. So, the decision on the adoption of technology cannot be the final word on the matter. There has to be an ongoing evaluation to see if that decision was right.

[186] Another thing is that technology, particularly in my area, which is medical imaging, evolves very quickly. So, a technology may be evaluated and recommended for use in a particular setting or patient group, and by the time the recommendation is made, the technology will have changed. There will be a new software release, or a new piece of hardware to go with the basic imaging equipment. So, what do you do then? How do you update the guidance that is there to reflect that change? NICE operates a process of reviewing its guidance periodically and looking at new evidence that has emerged. Therefore, it is important that evaluation continues, whether it is in the form of an audit in a specific clinical setting, or of more formal research trials that look at the benefits of a particular technology once it has become more widely used. Often, assumptions have been made in the process of making that recommendation that can be tested once it is out there in the clinic. NICE will sometimes make recommendations that say that there is some evidence regarding a particular device, but it needs to be used in a research setting in a more formal way before it can recommend its use. Then, people will often use that recommendation from NICE that research should be carried out as part of their grant application to get the funding to do that research. They will say, ‘NICE has recommended that this piece of research needs to be done on this technology’, and that is then looked at by the funding committee, which will say, ‘Clearly, if NICE has made that recommendation, that is a—’. It does not make the decision for you, but it is an indication that this research is needed.

[187] **David Rees:** Do any other Members have questions?

[188] **Dr Peirce:** May I add something? There is something new. I agree that there is an issue with post-adoption monitoring. As part of the changes in NHS England, they have started doing something that they call ‘commissioning through evaluation’. I am not sure if anyone else has brought that up. I have only recently become aware of it myself, but it is a way of trialling a new technology in standard healthcare, not as part of research, but with the proviso that it is done as part of a structured evaluation. There are a lot of unstructured pilots of technology in the NHS, and they are not evaluated, not well-structured, and they are not published. However, there is also a difficulty between crossing that line from trying something out in your clinical practice and then entering the realms of research, which is quite a difficult ask, because there are all sorts of extra regulations and financial barriers when it comes to moving into researching a piece of technology.

11:00

[189] **Professor Gibson:** May I add another perspective to this? From what I have heard, there has been what has been described as a top-down approach to evaluation. There is a different model here that is worth considering—and I am not saying that both are not

valuable. In my own field of rehabilitation engineering, the service model that we deliver is to assess clinical need, prescribe engineering solutions to meet that need, provide those solutions and then review their effectiveness on an ongoing basis. Many people with long-term conditions will change over time and we need to make sure that what we provide meets their needs on an ongoing basis. That is a service model that is common within rehabilitation engineering. Clinical engineers, as clinicians, will assess need, prescribe solutions and provide those solutions, and carry out that ongoing review of the effectiveness of those solutions. What we are suggesting in our training package is that we expand that, not just within rehabilitation engineering, but across all medical technologies, across clinical and biomedical engineering as a whole. That will be a way of making sure that, in individual cases within specific pathways, needs are met on an ongoing, continuing basis through the assessment of need and the prescription of technologies, especially new and more effective technologies to meet those needs. That complements the approach that has been described by Stephen and by Sue.

[190] **David Rees:** Thank you for that extra piece of information.

[191] To close, I would like to ask whether you would be prepared to give a single recommendation that you would like to give the committee if we were looking at improving access to medical technologies. Dr Peirce, we have not discussed it, but you have also talked about the possible regional service aspect in your paper and the way in which such a service could be constituted in one sense. So, you may want to reflect upon that as well. If you would prefer to give us a written answer, I would be happy with that. I do not want to put you on the spot, but if you have a strong view and there is a single recommendation that you want to give to us, we are happy to listen to it.

[192] **Professor Keevil:** This will not be a surprise, looking at what is in our paper, but my recommendation would be to invest in the training of this highly specialist group of consultant clinical scientists in engineering and physics who can bridge all of the different areas that we have talked about—the understanding of the technology, its clinical application and the patient interface—and bring an academic background, but also clinical skills to the problem, and have an understanding of the local environment in which they are working. So, a lot of what we have heard about around the table has been about the tension between decisions and recommendations that are made at a high level, whether UK wide or Wales wide, and how that plays out on the ground in individual clinical settings. It is really there that the person has to sit. You will not have loads of these; they are highly specialist and would be small in number. The question about how they are distributed around Wales would need to be looked at. You will clearly not have a consultant clinical engineer at this level in every small district hospital, but they would have to be close enough to have an understanding of the local clinical landscape. So, it needs some investment in that training, I would say.

[193] **Dr Peirce:** I am not really sure how it would work in practice. I suspect that we could look at what has happened with the academic health science networks in England, which were set up in 2012 and the changes that they had there. Their primary aim was to link industry, academia and the NHS organisations in their regions, and they had a remit to promote innovation and the wide-scale adoption of innovation on both a service and technology basis. It was part of its remit to try to combine the service and technology aspects. I have not really had the chance, since they were set up, to see how they have gone about that and how effective they have been, but I suspect that that might be a model to look at to start with.

[194] **David Rees:** Thank you very much; we have some of them coming in in another session, so we will have an opportunity to raise questions with them then. Thank you very much for your attendance this morning and for your written evidence. You will receive a copy of the transcript in case there are any factual inaccuracies that you wish to correct. Thank you, once again.

[195] I now call for a short recess of 10 minutes.

*Gohiriwyd y cyfarfod rhwng 11:05 ac 11:17.
The meeting adjourned between 11:05 and 11:17.*

**Ymchwiliad i'r Mynediad at Dechnolegau Meddygol yng Nghymru: Sesiwn
Dystiolaeth 5
Inquiry into Access to Medical Technologies in Wales: Evidence Session 5**

[196] **David Rees:** Welcome back to this morning's session on access to medical technologies. I welcome Professor David Cohen, formerly of the University of South Wales, and Professor Ceri Phillips, of Swansea University, both health economists. A very good morning to you. Thank you for your written papers. I remind Members that this session is focusing on the health economics in the evaluation of technologies and, perhaps, effective models that are already in use in that process and whether further work is needed in that area. May I start questioning from Members with Gwyn Price?

[197] **Gwyn R. Price:** Good morning, gentlemen. Professor Cohen, what factors should be taken into account when assessing the cost-effectiveness of new technologies? Are there weaknesses in the current process, and, if so, how would you suggest that we address those?

[198] **Professor Cohen:** I am not 100% sure what you mean by 'the current process', because, at the moment, in Wales, we do not have a process, as such. What we do have is a process for pharmaceuticals with the All Wales Medicines Strategy Group that I currently sit on, representing the discipline of health economics, and I took that over a few years ago from Professor Phillips, who was also the health economist on the All Wales Medicines Strategy Group, so we are very familiar with the processes that pharmaceuticals go through to get approval. The issue now is what else would be required for equivalent economic evaluations of technologies. I started my written submission by suggesting—maybe this is just because I am an academic who needs to define things—that I was not entirely sure that we had a definition of 'medical technologies', because the expression 'health technologies' is certainly much wider than many people think. I actually gave a definition that is used by one of the health technology international associations. It even includes pharmaceuticals. I was invited fairly late to—*[Interruption.]*

[199] **David Rees:** Let us hold on one second. There seems to be some confusion of the systems; we are getting sound from somewhere else. We will adjourn for a few minutes, as it appears that the sound from another committee room is coming through.

*Gohiriwyd y cyfarfod rhwng 11:19 a 11:25.
The meeting adjourned between 11:19 and 11:25.*

[200] **David Rees:** Welcome back and I apologise for the technology that gave us a problem. We hope that we have resolved that. You were talking about the definition of health technologies.

[201] **Professor Cohen:** I was suggesting the need for a definition, because I had seen quite a few submissions before I made my own, and some of them seemed to be equating medical technology with devices. I see absolutely no problem with that, if that is what this committee is considering. However, the definition is often used much more broadly than that. The reason that I raised that in response to your question was that, if we are talking about a simple piece of kit, for example, we are evaluating a machine that can sit in primary care, that, when a woman comes in with a urinary tract infection, on the basis of a urine sample, it immediately

identifies if it is bacterial, and which bacteria, so as to specify which antibiotic to use. At that level, you can randomise patients or do what is called a cluster trial and randomise practices, and, essentially, get the identical standard of evidence of cost-effectiveness that you would get from a drug trial.

[202] **However**, if we were thinking about technologies in a much broader sense, the standard of evidence is inevitably going to be lower, because you cannot do those sorts of studies. It is very difficult to do a randomised control trial on some of the technologies that I am thinking of. The principle should still be the same: it should be an assessment of the relationship between costs and benefits.

[203] **Gwyn R. Price:** That is, the balance between the two, really.

[204] **Professor Cohen:** The first point that I want to make is that I do not think that it is necessary anymore to argue the case, but, when I became a health economist around 1979 or so, we had to argue very strongly that evidence of cost-effectiveness was as important as evidence of clinical effectiveness. Even at the time that NICE was set up in 1999, there were still people arguing that NICE should only be looking at clinical effectiveness and had no business looking at cost-effectiveness. I think today it is implicit in this inquiry that you will be considering cost-effectiveness as well as clinical effectiveness. I am sure that all of the evidence that you have received is to that effect.

[205] So, my main point is that we now have very well-established methods for pharmaceuticals that we could apply to most technologies. NICE has its medical devices programme with some very well set-out methodological ways of assessing cost-effectiveness.

[206] **Gwyn R. Price:** You do go on to say that the wider assessments of social benefits and costs can be looked at.

[207] **Professor Cohen:** That is because I want to use the All Wales Medicines Strategy Group model, which I think is working very well for Wales at the moment. It does not exclusively look at health benefits to patients who receive them, but the economic evaluation does. We follow the NICE recommendation that says that cost-effectiveness has to be from the perspective of the NHS and personal social services. In other words, any benefits of getting people back to work cannot be taken into consideration in the cost-effectiveness equation. That is actually prescribed. Now, that is changing. We are bringing in this new beast called 'value-based pricing', and that will look at benefits more broadly than just that. So, I was just trying to make the point that, particularly with the sorts of technologies that have major organisational impacts, to simply focus on health benefits to patients could be a bit narrow, and that is what we do in the cost-effectiveness evidence in the AWMSG at the moment.

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

[209] **Darren Millar:** I am very interested in your support for the Public Health Wales proposal to establish a new board to assess health technologies in the future along similar lines to the All Wales Medicines Strategy Group. Is there a need for a completely stand-alone, separate board? How will you ensure that it avoids duplication, perhaps, with something that is already on the radar at NICE? Could we not achieve what you want in a slightly different way by extending the remit of the AWMSG so that it could comprise two slightly differently functioning parts, as it were, to deliver the outcome that you are seeking?

11:30

[210] **Professor Cohen:** I am smiling at your question, because I actually know Professor

Phillips very well, and we have discussed this very issue. He has convinced me totally—. The structure that we have now is, essentially, that AWMSG has a sub-group called the new medicines group. That group examines evidence of clinical and cost-effectiveness and makes what is called a preliminary recommendation, which AWMSG then approves or otherwise, and it then goes to the Minister for ratification. Professor Phillips has convinced me that the better way, rather than a new board, would be another equivalent of the new medicines group, which would do the nitty-gritty, intensive work in really scrutinising the submissions and then make recommendations. AWMSG is heavy on pharmacists and the like, because that is the nature of what it does, but, by broadening its membership, there is no reason why the existing AWMSG could not take recommendations from a new equivalent of the new medicines group, without a whole new structure in place.

[211] **Professor Phillips:** We conducted a review on orphan and ultra-orphan medicines for the Minister. Part of the terms of reference was to assess the extent to which AWMSG was seen to be an appropriate vehicle. We talked to many stakeholders, including clinicians, who were surprisingly positive about the role of AWMSG in regard to this and were keen that we did not put in recommendations to change things, because they felt that that was a vehicle with something that should be highly regarded in a Welsh context. We also talked to NICE, because it was also looking at orphan and ultra-orphan medicines, and it was impressed by the transparency of the Welsh processes and was keen to look at what we were suggesting. What we recommended was that, by keeping appraisal of technologies in the broader sense within the AWMSG umbrella, it can do lots of things. It already has an infrastructure and processes that are seen to be working, so fitting devices and non-medicines technologies under that umbrella does not require that much investment. I also think that they can benefit from each other, so that there can be learning across the piece. The clinicians who use technologies extensively and who would engage with that process earlier than perhaps they do at the moment would benefit. There is then the whole issue of commissioning these technologies. What we recommended was that WHSSC also come under the umbrella of AWMSG, so that it becomes integrated and so that we do not have delays. At the moment, recommendations are going out from AWMSG to the service, but then there are infrastructure requirements and there may be capital requirements that WHSSC will then make a judgment on. That can lead to delays and patients not getting what people have recommended that they receive in good time.

[212] **Darren Millar:** I am very interested in your ideas here, because there has been criticism that WHSSC, effectively, reappraises technologies even after they have been approved by NICE, and that perhaps there is a bit of duplication before commissioners can make things available more locally for clinical use.

[213] **Professor Phillips:** Indeed.

[214] **Darren Millar:** So, do you see this as an opportunity to have more consistency in terms of potential access to these sorts of technologies in Wales, and to have one methodology for pharmaceuticals and health technologies that can be beneficial and streamlined?

[215] **Professor Phillips:** That is a good way of putting it, I think—streamlining it. I think that AWMSG has always been seen as the front door in terms of getting medicines appraised. The problem in Wales is that there have been many backdoors as well. What happens is that those backdoors can lead to inconsistency and postcode issues, whereas if it was streamlined and if everything came in through the front door, then, obviously, medicines would go in one direction and other technologies would go in another, and it would all then go back to the AWMSG committee to make the final recommendation and then to the Minister. However, it would be about ensuring that, during that process, the Welsh Health Specialised Services Committee was involved, so that it was not something that WHSSC was picking up post

recommendation, but that it was actually engaged. WHSCC does have a seat at the AWMSG table and it is probably surprising, sometimes, that these things get delayed because WHSCC does its own appraisal on a broader perspective, because it is not just looking at the impact on patients; it is looking at the overall budgetary impact and what these things would actually cost to commission.

[216] **Darren Millar:** Some pharmaceutical interventions will require the use of some technologies, will they not? They will go hand in hand very often. To what extent does AWMSG have experience of appraising technologies that go hand in hand with pharmaceutical interventions? Do we have the base of expertise to be able to extend that remit? For example, we have heard evidence that suggested that the vaccination stuff is so specialised that it is probably best left to the UK-wide processes, rather than for us to develop our separate processes here in Wales. Does the same principle necessarily apply to health technologies?

[217] **Professor Phillips:** An interesting example to use to answer that question is Herceptin, which obviously caused a lot of consternation and debate when it was being appraised. Speaking to oncologists about that, they said that Herceptin worked very well in women for whom it would work well, but did not work well in women for whom it did not work well; the difficulty was actually in determining which women they were. There was an infrastructure and a whole testing regimen that needed to be in place, and hospitals that had that regimen, and could therefore identify the women in whom it would work, would obviously be the place to where patients should be recommended. However, there were so many places that did not have that particular testing regime that meant there were additional costs. When AWMSG does the appraisals, it looks at cost-effectiveness and at the costs to the service, and those infrastructure costs should be factored in. You develop different scenarios so that, for a hospital that already has that infrastructure and does not need to invest in it, there will obviously be a different type of analysis that would be undertaken. However, you have to identify all the relevant costs associated with that technology and its implementation; otherwise, it is not a true representation of reality.

[218] **Darren Millar:** In terms of Wales having the capacity and the expertise to do its own thing on this rather than leave it to the UK-wide process, do you think we have sufficient expertise and capacity to be able to deliver, under the umbrella of AWMSG, technology appraisals?

[219] **Professor Phillips:** I think that there is considerable expertise and experience at AWMSG level and, again, in speaking to clinicians, they want to be involved more and engaged more in that process, so much so that they contribute to the appraisal process. Then, when the recommendation comes, there is a sense of ownership. Going back to the early days of AWMSG, every appraisal had a specialist clinician presenting the evidence for that particular therapy. That was taken away when the new medicines group was established, but the new medicines group can now actually call on specialist advice as and when required. Sometimes, that advice is brought in from England if necessary. The process is rigorous and robust, and if there are gaps in the Welsh expertise, then we can call on experts from England.

[220] **David Rees:** Kirsty has a quick supplementary question on this.

[221] **Kirsty Williams:** Yes, on the role-play, but you can come back to me if you want.

[222] **Darren Millar:** I have a final question on the commissioning arrangements. You mentioned that, sometimes, it can feel as though there is a postcode lottery within Wales. Obviously, it is a small country and there are relatively few health boards, but that certainly ought not to be the case. Are you a supporter of an all-Wales commissioning model for these newer technologies?

[223] **Professor Phillips:** I am a supporter, because we need to ensure that there is consistency. Inequities exist because of the backdoors. Last week, I had a meeting about individual patient funding requests, which are now being reviewed as well. I would not say that I was banging the table, but I was making the point that we have a number of IPFR panels in Wales, and the composition of which is different, the extent to which they factor in cost-effectiveness is variable and we are getting different decisions. We are a small country. To achieve consistency and equity across the board, we need to try to have just one front door for as many of these difficult decisions that we have. If you include all stakeholders as part of that process, you will see that it avoids some of the issues that we have seen in recent months and years, where people feel that decisions have been made behind closed doors. AWMSG meetings are public meetings, so anyone can attend. It is transparent and the documents are on its website. It is a vehicle that we should be proud of in Wales.

[224] **Darren Millar:** I have one final question—

[225] **David Rees:** Kirsty wants to come in now, then William.

[226] **Darren Millar:** But my point is on this—

[227] **David Rees:** I will come back to you, Darren.

[228] **Kirsty Williams:** The AWMSG process has an awful lot to recommend it, but despite the high regard in which it is held, it seems to us in the evidence that we have had that there is still a problem, though, in getting the implementation and uptake of pharmaceutical drugs that have gone through that system. So, it is not a question of individual patient funding requests—a drug is available, and yet we still have a problem with universal and equitable take-up. In your evidence, Professor Cohen, you said that

[229] ‘The organisational effects of introducing new technologies, however, will often be significantly greater than when introducing new medicines’.

[230] So, if we cannot get it right for medicines, if we have not been able to crack it for pharmaceuticals, and if the challenges for technology are greater, how will we avoid issues around the postcode lottery and universal availability? Actually, Professor Cohen, you disagree with Professor Phillips, because you say that there should not necessarily be the same all-Wales status that medicines have.

[231] **David Rees:** Let Professor Phillips answer that one first, and then Professor Cohen can come back on it.

[232] **Professor Phillips:** If you get two health economists in a room, you will get at least three answers. So, I am not surprised about the differences.

[233] What I would recommend—. This is, perhaps, not having looked at technologies in as much depth and detail as we did for the orphan and ultra-orphan therapies, which were very challenging and difficult areas—. We talked to people around Wales, and the reason they felt that the implementation uptake was different was because of the fact that there were so many hurdles that still had to be jumped through and over when the Minister announced to the service that this had been recommended. When AWMSG was established, there was an expectation that the recommendations would become real, in terms of becoming available within three to six months. That has followed the NICE pattern. That has fallen by the wayside, in a sense, probably because of financial issues, given that health boards are seeking to manage budgets and are therefore careful in getting these new therapies in, but also because of the other hurdles that we have already alluded to in terms of WHSSC. If you bring

all of that under one umbrella, and the process is streamlined and integrated, then, hopefully, we will at least minimise the extent of those differences within areas. Different health boards have different agendas, and we spoke quite extensively to people in Aneurin Bevan Local Health Board about this. They felt that the health boards should be part of the appraisal process as a major stakeholder—which they are, to some extent—and should be given greater involvement earlier than they have at the moment, where they only appear at the AWMSG committee, so that they can inform the executives within the health boards that technologies are being appraised and may well come on stream within three to six months. It gives them a heads-up as to what might be happening.

11:45

[234] **Professor Cohen:** I do not disagree that much with Professor Phillips in principle. I certainly would not disagree if we were talking about the sort of device that I have mentioned before, which just sits in a general practitioner's surgery. We would want to see equity and see it applied across the board. We are doing a study now, which is not through the AWMSG—Cardiff University has funding from the European Commission to do this evaluation—and I would hope that if the evidence of cost-effectiveness was strong, it would be employed everywhere, because every GP surgery is much the same.

[235] I was thinking back to my definition of what we mean by 'technologies', and we could be talking about some massively costly things that we simply could not expect. I always think of Hywel Dda LHB—it cannot put magnetic resonance imaging machines and the like in place; you might only find those in Cardiff, Swansea and so on. If a technology is a hugely expensive piece of equipment and has big organisational implications in terms of identifying a lot more people, let us say, who require treatment, then we cannot expect the smaller-populated health boards to behave in exactly same way as, say Cardiff and Vale University Local Health Board—and this is very different from just talking about a particular drug and considering whether we should give it to certain patients. We find it incredibly disappointing that the AWMSG comes up with very firm recommendations, ratified by the Minister, that something is or is not approved, and then you look at behaviour and see that—. One would naively assume that if it was not approved, it would not be given, and if it were approved, it would be given, but life is not always like that.

[236] **David Rees:** We return to Darren to finish off.

[237] **Darren Millar:** I want to ask one final question about the arrangements within the AWMSG and whether there might be a view from the witnesses on this. The AWMSG makes recommendations, as opposed to decisions, about access; NICE makes decisions and your recommendations have to be endorsed by a Minister, which can further delay their implementation across Wales because there is often a delay of weeks, months or whatever that might be. Do you feel that there needs to be a change in approach if these other changes are being made so that the AWMSG or its successor—whatever its successor's title will be, if these new arrangements are adopted—has a decision-making power rather than simply a power to make recommendations to Welsh Ministers?

[238] **Professor Cohen:** It is an intriguing question. There is an argument that these should not be political decisions. It is mainly academics, lay representatives and other experts who make the recommendations. We had a situation very recently where the AWMSG did not recommend a drug, which was considered to be an ultra-orphan drug, for children with cystic fibrosis—not only because cystic fibrosis is relatively rare, but because it is only suitable to treat children who have a particular genetic marker. The Minister overturned that decision but immediately set up the inquiry that Professor Phillips mentioned into the whole process of how we look at orphan and ultra-orphan drugs. Quite honestly, I am often very frustrated with the AWMSG because we have no rules to work to. We have a basic decision rule on how

much we would be willing to spend for an extra unit of health for normal drugs, and we accept that we will be prepared to pay more for drugs that have orphan or ultra-orphan status, but nobody tells us how much, and yet we have to come up with the recommendation.

[239] To answer the question, I think that it was very fortunate that it was, ultimately, a politician's decision to overturn the recommendation and set up this inquiry at the same time. If our decisions were binding, it would have simply been, 'No, end of story' and it would not have been approved. So, part of me wants to say that I do not like political decisions being made by overriding the rigorous processes to come up with the initial recommendation. However, on the other hand, I can see advantages to it. I think that this was an example where it was good that the Minister had the ultimate say. So, I am sitting on the fence on this one, which is not terribly helpful.

[240] **David Rees:** I think that you have given us quite clear pros and cons to that argument, so we will take that matter further.

[241] **Professor Phillips:** It is interesting that the committee in Scotland also made the same decision as AWMSG, and it was a Scottish Minister who overturned the decision, or the recommendation, there. I probably subscribe to the view that it is worth having a back stop, who probably should be the Minister for health, yes.

[242] **Darren Millar:** Even if that means delays for patients.

[243] **Professor Phillips:** In principle, the recommendation goes to the Minister and he should then respond within 28 days, which seems a reasonable timescale.

[244] **William Graham:** In this committee, we have heard quite a bit about horizon scanning. How does that fit in, if at all, into these various committees that you have described today?

[245] **Professor Phillips:** There are new technologies being developed all of the time. In a sense, clinicians like to get their hands on new toys and new equipment and they want to utilise them. I think that it is the same process, in the sense that manufacturers will liaise with clinician groups, networks and relevant commissioners to ensure that they are aware of what is likely to be coming on stream. It is, perhaps, not as well regulated as medicines. The difficulty is that the equipment does not necessarily need to be licensed in the same way as pharmaceutical products would be. NICE and AWMSG would only appraise therapies and medicines that have actually been given a licence. That is not necessarily the case in terms of some of the devices and technology. So, there has to be a certain amount of care and that probably gives even greater rationale for ensuring that they are appraised in terms of effectiveness, safety and cost-effectiveness.

[246] **William Graham:** Who would really have the responsibility of spotting something that would be of great benefit, other than in the way that you describe, so that it could then be implemented for the benefit of all? Cost obviously comes into it, but I am thinking, there are some good examples, are there not, of pharmaceuticals suddenly obviating the need for invasive surgery? The duodenal ulcer was one of the most commonly known. So, what I am getting at is that it is easy to have a health authority spend large sums of money on a particular piece of equipment, whereas, on the horizon, there is perhaps a drug, or a better piece of equipment that does the job at half of the cost or less. How can it be brought together, so that you are aware of what we are likely to see in the future?

[247] **Professor Phillips:** In terms of medicines, there are ongoing discussions with the pharmaceutical industry, and it engages and the Association of the British Pharmaceutical Industry plays an important role in that. There are different societies for manufacturers of

equipment and they obviously engage with clinicians and commissioners. The Welsh Health Specialised Services Committee, for example, is aware of what is likely to be coming forward. I remember WHSSC asking my advice on some cardiac equipment that was being made available. It was terrified about the cost that this might entail and there was no evidence of benefit, so it set up an expert panel to see what exactly this would mean in terms of patient care and costs.

[248] The evidence base underpinning that meeting was quite light, really. However, the clinicians were quite vociferous in saying that this, potentially, could save a number of lives and also speed up the processes. David has mentioned that the evidence is not necessarily as fulsome in the technologies as in medicines, because of the ability to conduct randomised controlled trials and so on. Nevertheless, I think that if one can engage with clinicians earlier and with the manufacturers, which is currently the norm in medicines, we should be able to fit it within the current systems that we have in Wales.

[249] **David Rees:** May I just build upon that one little bit? One of the bits of evidence that we have received highlights that many small and medium-sized enterprises are involved in the development of some of these technologies. Is there a difficulty for small businesses in getting access?

[250] **Professor Phillips:** We have been involved recently in evaluating what they call single-use instruments for surgical procedures. It has been an interesting study because we have been doing it with our college of engineering. An SME has asked us to provide advice on cost-effectiveness of single-use instruments, and it has been asking the college of engineering to actually design these instruments. The area that we looked at was tonsillectomy. We have spoken to consultants who do the ear, nose and throat surgery. They say that the difficulty with single-use instruments is that the feel of them—the actual design in terms of the angles of the instruments—is such that they are not quite the same. They cannot be fully replicated, so there is a tendency to always revert to the standard instruments. With the risks now of contamination being virtually eradicated through some of the cleaning processes that are around, the potential benefits for single-use instruments in terms of avoiding the risk of getting BSE, CJD and so on, has more or less been eliminated. So, the costs involved in having a set of single-use instruments are probably not sustainable. The SME is grateful for that sort of advice early in the process rather than making these things and then finding that there is no market for them, because the clinicians are not going to be using them.

[251] **David Rees:** So, the SMEs are able to have that access. That is the crucial thing.

[252] **Professor Phillips:** Yes.

[253] **Jenny Rathbone:** That is an excellent example of where the technology moves on, making the technology that you are trying to test redundant. I just wanted to pick up on Professor Cohen's remarks that the case for clinical effectiveness, safety and cost-effectiveness will have to be lower than that applied for medicines. How then do we build in the evaluations of whatever it is, to ensure that, once we start using these instruments on tonsils, we expand all knowledge of whether they are the best available technologies?

[254] **Professor Cohen:** My first comment will be: not in all cases. There clearly are cases where there is no reason that the standard of evidence need be any lower if the technology is such that you can reasonably be expected to conduct a randomised trial. We cannot hold the gold standard of AWMSG at the moment and say that any evidence of both clinical and cost-effectiveness—and even safety—that does not meet the gold standard means that the case has not been made and, therefore, we do not recommend it. If we did that, virtually nothing would be recommended, because it is very rare. In particular, the problem that we have is that we

always want to assess some new drug against the most commonly used alternative at the moment, whereas many of the drug trials are assessing their drug against a placebo. So, they will look at their drug versus placebo, and the evidence will be there, and they will look at the alternative drug versus placebo, and then pull the evidence together as if it were what we call a head-to-head trial. There are terrible problems with that. The studies often have different entry and exclusion criteria, and inclusion and exclusion criteria. They have different populations, they use different measures of effects, and there are different lengths of follow-up periods. So, we have to compromise and say, 'There is a lot of uncertainty. The evidence was not quite right, but on the whole—'. We do this particularly with the economics—much more so than the evidence of safety and efficacy, which come much more from rigorous trials.

[255] Perhaps I could also mention another thing, which follows on from Ceri's point about whether this will be used in practice. Economists always prefer evidence from what is called pragmatic trials, which simply means, in English, trying to replicate what would happen in the real world. Many of the studies that produce the evidence that comes to AWMSG are from very highly, tightly controlled trials. In other words, if you are in the trial and it says, 'Take this medicine three times a day with water', they ensure that it is taken three times a day with water. In a pragmatic study, you are told, as a patient, to take three times a day with water, but if you choose not to or to flush it down the toilet or whatever, that is the reality, and we like these trials. We very rarely see pragmatic trials, which provide the real evidence of what is going to happen in the real world.

12:00

[256] In the case of medical technologies, I imagine that that may be an even bigger problem, because, with the evidence, you may get some highly enthusiastic clinicians who are really keen to do it and they will provide the evidence, but you will then put the thing into practice and find that, in fact, the clinicians just do not like it or will not use it. We want evidence of acceptability as well as just what the thing looks like in an ideal world, in a research environment.

[257] **Jenny Rathbone:** We accept the argument, so how are we going to ensure that we get an evaluation of the pragmatic application?

[258] **Professor Cohen:** I do not think that we are ever going to get that, and it is going to be even more difficult in the case of medical technologies to have pragmatic trials. I am simply saying that, at the moment, we compromise the quality of evidence in terms of making the decision. We often say, 'Well, it's the best that they could do and, no, it's not gold standard but that's okay'. We are just going to have to set a lower bar for that. That is just something that the committee would have to come to some sort of an agreement on with regard to what the acceptable level of evidence would be. It would definitely be lower than it is at the moment for drugs.

[259] **David Rees:** I have two more people who want to ask questions—Rebecca and then Kirsty—and then I think that that will be it.

[260] **Rebecca Evans:** I am wondering how strong the pull is of technologies for clinicians and whether there is a role for investment in technologies in perhaps solving some of the quite serious recruitment challenges that we have, particularly in the more sparsely populated health board areas. You mentioned Hywel Dda earlier, which is what made me think of this. Or is it the case, from a health economics perspective, that investment in the big-ticket items that we have been talking about for part of this morning should always be in the areas of the highest density population? Is there an argument for investing in more rural areas?

[261] **Professor Cohen:** There are several issues there and there are trade-offs. The big

trade-off that we accept in health economics is between efficiency and equity. From an efficiency point of view, basically, forget about Hywel Dda and tell them all to go elsewhere to receive their care. If you want to have access that is reasonably equitable, you have to compromise your efficiency, because it is often far more costly to provide services in less well populated areas. In answer to what you were suggesting at the start of your question, I would just want to repeat a statement that economists make all the time, which is that evidence of cost-effectiveness is not a replacement for decision making. It is only an aid to decision making and the decision makers have to take on board many other perspectives other than the economic. I think that there is a perception out there across the UK that NICE is obsessed with cost-effectiveness and that, if it is cost-effective, it is approved and that if it is not, it is not. That is simply not true, and I know that it is certainly not true in the case of AWMSG. We listen to the special interest groups and we get the consultants' opinions and so on, so there can be very many good reasons apart from economics for making a decision.

[262] **Rebecca Evans:** How about the pull of technologies for clinicians? Will clinicians go to the technology or do they expect it to come to them?

[263] **Professor Phillips:** I think that it is probably an education process for clinicians and, indeed, patients. Years ago, we looked at diabetic retinopathy and what we called 'a man in a van'. The man in the van would go to GP practices and photograph the eyes of diabetics, and those photographs would be digitally sent to a reading centre, which could more or less immediately say whether that person had sight-threatening retinopathy. The GPs still wanted confirmation, so patients were often still referred to the hospital to have a specialist assess them. The technology had been designed to remove that particular interaction between the patient and the specialist in order that the patient would not go there for a test, but for a procedure. Clinicians perhaps need to be confident in the technology and patients need to be educated that they do not always need to see a specialist; it can be done remotely. On telemedicine, tele-healthcare, the jury is still out on whether it works in terms of its effectiveness and cost-effectiveness, but a lot of the studies seem to suggest that, if there was an appreciation of what it was doing from a clinician perspective and a patient perspective, there would be greater uptake and, perhaps, a release of resources, in that patients would not need to go to hospitals to have those out-patient appointments. That said, I think that the whole issue of rurality is a difficult one and for people who have to travel perhaps to Morriston or to Cardiff from mid Wales to utilise some of the big kit that is being put in there, rather than at Bronglais, it is problematic, but in order for those kits to be cost-effective, you need to have a critical mass of patients to utilise them. So, it is a trade-off, and a difficult one.

[264] **David Rees:** Kirsty, your last question.

[265] **Kirsty Williams:** Do you think that the committee is barking up the wrong tree by concentrating on this particular issue? Is there value to be gained for the Welsh NHS as a whole if we create a system that tries to do medical technologies better, or are we just barking up the wrong tree, having seen a problem that actually does not exist?

[266] **Professor Phillips:** Personally, I do not think that you are barking up the wrong tree. The policy direction in Wales is to have an integrated health and social care system, and as part of that system, we need an integrated approach to the appraisal of medicines, therapies, devices and technologies. I think that we need to streamline the way that we do things. It will enhance patient benefit and it will probably release resources. Some work has shown that probably over 10% of patients who enter hospitals will have something going wrong to them, and that would include devices not working when they should have worked. There could, obviously, be medicines issues as well, but the costs associated with those adverse events mean that people are staying in hospital unnecessarily and also, in some cases, dying unnecessarily. So, I think that it is essential that we have a robust and rigorous appraisal mechanism for all technologies and therapies, and that needs to be an integrated, whole-

system approach.

[267] **Professor Cohen:** I very broadly agree with that. I was not sure if your question was, ‘Do we need the separate evaluation process for technologies?’ or ‘Do we need a separate one in Wales, and not just rely on what NICE is doing in England?’ I think that there is a strong case for Wales using the AWMSG example. You could use the same argument: if we have NICE, what do we need AWMSG for? We do look very carefully at what NICE will be appraising in the near future and stay away from those. The Welsh population is also quite different, not just in terms of size. We also consider the budget impact when AWMSG makes a recommendation, which is something that the new medicines group does not look at at all: it is just looking at the clinical evidence. The budget impact has a lot of weight as to whether things are recommended or not. That is purely on the basis of estimates of how many people in Wales will be eligible, what the uptake will be and how many are currently being treated with whatever the alternative is and so on. These are very local-to-Wales issues, and they would not be addressed by simply leaving everything to NICE. I imagine that the situation would be even more so in the case of medical technologies.

[268] **David Rees:** Thank you very much. Now, I have asked the same question to all witnesses today, so I will give you the same opportunity, although I think that I know which answer might be coming. If you had one recommendation that you would like to give to the committee in relation to its consideration of improving access to medical technologies, do you have an ability to give us that one recommendation now? If you would rather have time to think about it, please feel free to take that time and come back to us in writing.

[269] **Professor Phillips:** My recommendation would be to move ahead with getting an appraisal mechanism in Wales for medical technologies and to bring it under the umbrella of the AWMSG framework, because that has been shown to work. Obviously, it is not perfect, but no system is perfect. I think that the expertise and experience gained over many years can be brought to bear on medical technologies, and it would demonstrate to the service that we are serious in Wales about ensuring that everything that patients receive, all services and all interventions, have been thoroughly assessed to demonstrate that they work, that they are safe, and that they represent good value for money.

[270] **Professor Cohen:** At the risk of having two economists agree with each other—we did actually collude before, when we were sitting in the waiting room. The television screen was on with your earlier sessions, and we heard the question that you asked. We were cheating a little bit, but I agree entirely with what Ceri has said. In terms of structure, all we really need is the equivalent of a new medicines group; call it a new medical technologies group, and they could both feed into AWMSG. There is no reason why the current AWMSG could not consider preliminary recommendations in the same way that it does for medicines.

[271] **David Rees:** Thank you very much, and thank you for your evidence this morning, and for your written evidence. You will receive a copy of the transcript for the identification of any factual inaccuracies. Once again, thank you very much for coming along.

12:10

Papurau i’w Nodi Papers to Note

[272] **David Rees:** We have one paper to note and that is the letter from the Chair of the Communities, Equality and Local Government Committee relating to the Welsh language. We have prepared a note at this point in time. I would also like to inform you that we are seeking to invite the Welsh Language Commissioner to a future session of the committee,

particularly as she has already taken part in the inquiry into primary care in Wales on the use of the Welsh language in primary care. So, I will put that as an indication that we will be looking for.

[273] **William Graham:** We do not seem to have a copy of the letter.

[274] **David Rees:** I did have it. We will get copies to you.

[275] Before we close, I remind you that the next session of the committee will be next Thursday, 13 February, when we will be in Swansea University in the morning to take evidence in a public session into bariatric services. Then we have a lunch session with academics and, in the afternoon, we go to Morriston to meet with clinicians. If you have not yet made arrangements with the clerking team, please do so. Some of you have already done so. We will do that in private in a second. Please make arrangements with the clerking team for travel if you need to. I close the meeting.

*Daeth y cyfarfod i ben am 12:12.
The meeting ended at 12:12.*