	National Assembly for Wales Health and Social Care Committee.
Purpose:	The Welsh NHS Confederation's response to the inquiry into access to medical technologies within primary care.
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Introduction

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

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

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

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

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

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

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

The terms of reference

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

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

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

Examples of how new technologies have benefited primary care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other barriers

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

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

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

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

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

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

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

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

Recommendations

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

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

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

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

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

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

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

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

Conclusion

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

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

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