



**ACCESS TO MEDICAL TECHNOLOGIES – CALL FOR FURTHER EVIDENCE ON  
ACCESS WITHIN PRIMARY CARE**

29 August 2014

**Inquiry by National Assembly for Wales' Health and Social Care Committee**

**Response from BMA Cymru Wales**

INTRODUCTION

BMA Cymru Wales is pleased to provide a further response to the inquiry by the National Assembly for Wales' Health and Social Care Committee into access to medical technologies, focusing on this occasion on access to such technologies within primary care.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales is aware that there are a number of positive examples across Wales of new medical technologies being used effectively in primary care settings. We are also pleased to note the leading role in the use of ICT that has been undertaken by primary care within the NHS in Wales. However, in relation to the use of new technologies, we also know that there is much variation in application, and concern amongst our members regarding barriers to accessing such technologies. We recognise that technology has enormous potential to make significant and cost-effective contributions to healthcare (both mental and physical), especially where it can assist in preventing the need for patients to access secondary care services. Such an approach is entirely in accord with the principles of prudent healthcare as recently advocated by the Bevan Commission<sup>1</sup> and also has the potential to enhance self-management by patients of certain chronic conditions.

For these reasons we welcome the Committee's inquiry in this area and are delighted to have the opportunity to contribute this further response on behalf of General Practitioners in Wales, which focuses specifically upon access to medical technologies within primary care.

In gathering evidence to inform this submission, we canvassed views from BMA members across Wales. Amongst the responses we received, the following examples of medical technologies being used effectively within a primary care setting were highlighted:

<sup>1</sup> <http://www.bevancommission.org/sitesplus/documents/1101/Bevan%20Commission%20Simply%20Prudent%20Healthcare%20v1%2004122013.pdf>

- Oxygen saturation monitoring (e.g. for patients with COPD).
- 24-hour monitoring of blood pressure.
- Heart monitoring using ECG (electrocardiogram) machines and hand held ultrasound machines.
- Hand-held dopplers for management of chronic ulcers.
- Telephone consultations (e.g. for patients living in remote areas, for patients who may have a high domiciliary care need or for giving test results).
- Some GPs find it useful for patients to text pictures to them – e.g. of skin rashes.
- Electronic transmission of video or still images for consultant opinion (e.g. dermatology).

### Areas and suggestions for progress

#### **ICT systems**

Within the NHS in Wales, we would consider that primary care has taken a leading role in driving forward ICT development. We note that a national programme is underway to centralise systems and data storage, refining the software options for practices down to two clinical packages.

BMA Cymru Wales also notes, however, that the level of development that has taken place in primary care ICT has not been matched within secondary care settings. As such, we would consider that Wales is still a long way from achieving a single health record that can, where agreed, be accessible across primary and secondary care using systems which operate effectively and robustly.

In our view, additional investment is greatly required in secondary care ICT systems to bring them up to the standard that exists within primary care so as to enable an effective electronic interface to be created between the two. We note for instance that the current systems in place do not allow electronic data sharing in ways which many people would consider basic, such as accessing images electronically (e.g. x-rays). The Welsh Clinical Communications Gateway (WCCG) for instance does not permit the sending of files greater than 8 MB in size, thereby preventing many images being sent electronically at sufficient quality. Such limitations need to be addressed. We further believe that investment also needs to be made to enable an effective ICT interface between health and social care, which we observe is almost non-existent at present.

We believe that an integrated and effective ICT system, with capability to operate across primary and secondary care, would offer the single most effective solution to improving the patient pathway in NHS Wales. Developments such as the Welsh Clinical Portal are seeking to address this. It aims, for instance, to overcome the problem of different systems not 'talking to each other' e.g. systems handling information such as test results, discharge letters, secondary care referrals or general administrative details. At present because different systems used within the NHS are not integrated, valuable time may be wasted by clinical teams, such as district nurses, having to spend time duplicating clinical entries on more than one system.

In addition to helping facilitate electronic referrals and the management of test results and requests, greater use of software systems that are accessed online also provides the advantage of centralised upgrading and maintenance. Disadvantages may result from a reliance on central servers as well as difficulties for GP practices and healthcare providers in the border areas of Wales as they aren't currently able to use these systems effectively for cross-border referrals. Indeed thought needs to be given to how cross-border communications can be improved. At present GPs on the Welsh side of the border for instance can't straightforwardly email consultants across the border for advice as they are not within the Welsh NHS systems. Nor are Welsh practices presently able to use WCCG for cross-border referrals to secondary care, and there is a lack of a connection from Wales into the *Choose and Book* system which operates within the NHS in England.

A further consideration which needs to be borne in mind, particularly in relation to more rural parts of Wales, is the variability that still exists in terms of access to sufficiently fast broadband and cellular networks which may preclude access to some ICT solutions in certain localities.

As we have already indicated, there may be benefits for patients in certain circumstances in being able to undertake telephone consultations with GPs. This might be of particular benefit to patients living in remote areas or to those patients who may, because of their medical condition, have difficulty in travelling to a GP's surgery. A further development of such an approach might be the use of video conferencing using software such as Skype which can be readily accessed using smart phones or tablet computers. One note of caution that may need to be considered, however, is the outcome of a recent study by researchers at Exeter Medical School<sup>2</sup> which concluded that consultations undertaken over the phone do not reduce workload pressure in busy GP surgeries because patients who receive such a consultation are then more likely to require a follow-up appointment. Other concerns on the use of telephone consultations include a loss of access to non-verbal cues which can otherwise aid diagnosis, potential issues around other parties being unknowingly present and how such consultations are recorded.

### Commissioning

We recognise that technological solutions need to be integrated into existing and future care models. A more joined up approach to the commissioning of new technologies would certainly be very much welcomed by GPs. A clinically-led approach to commissioning would, in our view, make a huge difference to effective service delivery.

We do not consider that the use of local commissioning expertise is currently well facilitated in Wales. We would note, for instance, that GPs are rarely involved in the local management of the NHS. At present, GP cluster networks are not supported adequately and are also vastly variable across Wales. We believe that they do, however, offer considerable potential to improve local commissioning – provided they are used for more than just administering the Quality Outcomes Framework (QOF) as is currently the case in some parts of Wales.

A major barrier that our members identify in adopting or investing in some of the more expensive medical technologies is uncertainty about the longer-term commissioning commitments and priorities of local health boards. For instance a practice may determine to invest in an effective new medical and diagnostic technology only for the local health board to then change its priorities months later, potentially rendering the technology useless in that practice and hence a waste of investment.

We would therefore recommend that key to overcoming such financial barriers would be the identification of specific dedicated funding streams that could cover the introduction of new technologies within primary care.

It has to be recognised that the funding GP practices receive is allocated to cover the existing costs of the services they provide and, like other parts of the NHS in Wales and other Welsh public services, GP practices are already under considerable financial pressure after a number of years of below inflation funding increases.

This also needs to be taken in context with the fact that the NHS in the UK as a whole already provides considerable value for money in comparison to the healthcare systems of comparable industrialised nations, as evidenced by the most recent report on this issue published by the Commonwealth Fund<sup>3</sup>. That report ranked the UK's NHS as first overall, including for the quality of the care provided and its overall level of

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<sup>2</sup> <http://www.bbc.co.uk/news/health-28602156>

<sup>3</sup> [http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755\\_davis\\_mirror\\_mirror\\_2014.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf)

efficiency, despite it costing less per head than all but one of the other ten national healthcare systems assessed.

The challenge for both Welsh Government and local health boards in this current financial climate is therefore to determine how resources might be freed up from elsewhere to cover the costs of introducing new technology solutions, particularly if the use of such technology solutions might reduce costs overall in addition to providing other potential benefits, such as improving the self-management by patients of chronic conditions and furthering the principles of prudent healthcare.

We would suggest this might be achieved by looking at creative approaches to resource allocation. For instance, if the introduction of some particular new technology usage within primary care might reduce or eliminate the need for patient referrals to secondary care (e.g. by enabling diagnostic testing or treatment monitoring to be undertaken within primary care far more cost effectively) then anticipated savings from secondary care budgets could be captured in advance. This could enable funding to be transferred to primary care budgets to cover the costs of introducing the new technology in the first place.

If it is not deemed possible to capture such savings in advance, however, then an alternative approach might be to look at an 'invest to save' fund to pump prime the use of new technologies within primary care. This may involve financial benefits being realised over subsequent years, an approach that may be able to be better facilitated by the recent decision to move to a three-year budgetary cycle for local health boards. Such an 'invest to save' approach would also be consistent with the Welsh Government's recent establishment of an intermediate care fund.

It is important that the whole costs of introducing new technologies are fully taken into account. For instance, a fund might be created to facilitate the purchase of new equipment but it may also need to cover the funding of any training needs that might be required to enable the equipment to be used, maintenance costs of the equipment, or the cost of any consumables that may be required for its use on an on-going basis.

Putting financial considerations aside, thought also needs to be given by Welsh Government and local health boards as to how decisions to commission new technological solutions might be driven forward, rather than this just being left to individual practices that are already overstretched to consider in an ad-hoc manner. Individual practices may lack the expertise to be able to identify what technologies could be worthy of investment. We would therefore suggest such commissioning decisions might be driven forward at the level of GP cluster networks. By adopting such an approach, this could enable more effective negotiation of costs with suppliers as well as assisting in the identification of manufacturers. A cluster-led approach to commissioning would also be better tailored to the needs of the particular local population served.

### **Near patient testing**

BMA Cymru Wales believes that the use of new technologies can provide opportunities within a primary care setting to expand on the existing use of near patient (or point-of-care) testing, thereby covering a greater number of conditions and illnesses than is currently the case and reducing the need for patients to be referred on to secondary care for different types of testing or treatment monitoring.

The following examples derived from articles that have been published in the British Journal of General Practice, provide illustration of the sorts of near-patient solutions that might be identified:

#### *Example 1 – May 2012<sup>4</sup>*

*'The D-Dimer test in combination with a decision rule for ruling out deep vein thrombosis in primary care: diagnostic technology update'*: This review looked at studies on the effectiveness of testing for suspected Deep Vein Thrombosis (DVT) by testing for D-dimer – a small protein fragment present in

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<sup>4</sup> <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338064/>

the blood after a clot is degraded by fibrinolysis. It concluded that this test could enable DVT to be ruled out by a point-of-care testing method in about half of patients with suspected lower leg DVT, negating the need for them to be referred to secondary care for an ultrasound scan.

*Example 2 – Nov 2012<sup>5</sup>*

*'Point-of-care INR coagulometers for self-management of oral anticoagulation: primary care diagnostic technology update'*: This review looked at studies undertaken on self-management through use of a home monitoring device for INR (international normalized ratio) as a measure of the effectiveness of oral anticoagulant therapy (e.g. use of warfarin). It concluded that the use of such point-of-care testing is as accurate as tests carried out in a laboratory setting.

*Example 3 – Nov 2013<sup>6</sup>*

*'Association between point-of-care CRP testing and antibiotic prescribing in respiratory tract infections: a systematic review and meta-analysis of primary care studies'*: About 80% of patients with respiratory tract infections (RTIs) are prescribed antibiotics despite the fact RTIs seldom require antibiotics for treatment. Increased use of antibiotics is significantly associated with the development of drug-resistant bacteria. This review demonstrated a clear correlation between the use of point-of-care testing for C-reactive protein (CRP) – an acknowledged biomarker to diagnose bacterial infection – and reduced prescription rates of antibiotics for RTIs.

In relation to *Example 2* above, we would note that this could be of particular benefit to patients who might otherwise need to travel long distances to hospital for monitoring to be carried out (e.g. following transplant surgery).

Near patient testing in GP surgeries offers the potential for delivering more convenient provision of services for patients. We are also aware of a pharmacist-led warfarin/INR service operating in the Abertawe Bro Morgannwg University Health Board area.

One consideration in the use of near patient testing, however, may be the acceptability of such diagnostic testing to patients themselves. Sometimes a patient will want to be referred to a specialist for the sake of their 'peace of mind', so consideration may also need to be given to patients' acceptance of such tests taking place within primary care settings.

### **Sharing best practice/identifying target populations**

We would consider that it is important to facilitate effective communication between GP practices and health boards in order to share best practice, including identifying and reviewing the use of new technologies and better ways of working.

We would wish to highlight two areas where we consider general practice in Wales is making good progress in this regard.

Firstly, we would point to the involvement of general practice in Wales with the SAIL Databank<sup>7</sup>. SAIL (which stands for Secure Anonymised Information Linkage) is an initiative funded by the Welsh Government's National Institute of Social Care and Health Research (NISCHR). It is a Wales-wide research resource which focuses on improving health, well-being and service delivery. It brings together a wide range of routinely collected health-related datasets from different origins in a way that enables the data to be robustly anonymised. Because it holds only anonymised data, it enables researchers using the data it collects to carry out their work without knowing the identities of the individuals represented in the datasets.

<sup>5</sup> <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3481522/>

<sup>6</sup> <http://www.ncbi.nlm.nih.gov/pubmed/24267862>

<sup>7</sup> <http://www.saildatabank.com/>

Although signing up to SAIL is voluntary, 58% of GP practices in Wales have signed up to date. By health board area, this breaks down as follows:

Aneurin Bevan – 47 %  
Betsi Cadwaladr – 50%  
Cardiff and Vale – 49%  
Cwm Taf – 38%  
Hywel Dda – 70%  
Powys – 47%  
Abertawe Bro Morgannwg – 100%

Secondly, we believe that the recent development of GP cluster networks offers a key potential for the sharing of best practice and experiences of the use of new medical technologies. Cluster networks however need to be fully operational in all parts of Wales in order for this to be effective; currently this is not the case. As we have indicated previously in this response, we believe it is important that cluster networks are properly developed.

#### Future developments

We recognise the potential offered by smart phone apps, especially in areas such as self-health monitoring and management. Tablets, smartphones and even 'non-smart' standard phones can be used to offer diagnostic, monitoring, and therapeutic functions. A recent article in *The Guardian*<sup>8</sup> outlined how mental health care in particular might benefit from the use of such technology:

*"...researchers at Oxford and elsewhere<sup>9</sup> have shown that SMS and voice-calls can be used to assess mental health status, deliver talking therapies (eg cognitive behavioural therapy) and stimulate behavioural change. Higher-spec devices such as smartphones and tablets can perform the same functions in more user-friendly ways, for instance through multimedia apps, and can also draw on a wider range of sensors and capacities – eg accelerometers, GPS and camera – to generate richer data and smarter interventions. The Mobilize! system developed in Chicago<sup>10</sup>, for example, uses 38 smartphone sensor values alongside user input to predict psychological status and deliver tailored therapeutic interventions for unipolar depression. Mobile mental health already has the capacity to revolutionise the way we evaluate, monitor and treat mental illness, especially in poorer countries where mental health workforces barely exist."*

#### Other considerations

The pressure that already exists within general practice at this time of on-going restraint in the financing of public services and increasing difficulties in GP recruitment has to be recognised. Whilst the use of new technologies may bring many benefits, including in certain circumstances avoiding the need for patients to be referred to secondary care for diagnostic testing or treatment, the potential workload implications on already overstretched GPs needs to be fully taken into account. In order for GPs to free up capacity in the working day to take on the use of new technologies, it may therefore need to be accepted that something else would have to give. Creative solutions to this might involve elements of GP's existing workloads being undertaken by others within wider primary care teams, but that in turn will have a resource implication. It is therefore important to ensure that any transfer of workload from secondary to primary care as a result of the use of new technologies is adequately resourced, and properly evaluated in order to avoid any unintended consequences.

<sup>8</sup> <http://www.theguardian.com/healthcare-network/2014/aug/12/technology-treat-mental-health-conditions>

<sup>9</sup> <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921773/>

<sup>10</sup> <http://www.jmir.org/2011/3/e55/>

Conclusions and key recommendations

BMA Cymru Wales very much recognises the potential benefits that could be derived from increasing the use of medical technologies within primary care settings, as well as the enthusiasm that exists amongst many of our GP members to drive such initiatives forward. However, in order to develop a less piecemeal approach to the use of such new technologies than exists at present, it is important to overcome the key barriers that GPs face in having sufficient time and funding to develop such approaches.

We would recommend that the Committee gives thought to calling on the Welsh Government and local health boards to look at creative solutions to overcoming these barriers, such as looking at ways in which financial resources might be transferred from secondary to primary care to match the transfer of work from secondary to primary care that the use of a new technology within primary care could facilitate. This might be undertaken through capturing anticipated savings from secondary care budgets in advance, or by looking at the creation of 'invest to save' funding that could pump prime the use of new technologies. Similarly, we believe that thought also needs to be given as to how capacity can be created that could enable GPs and wider practice teams to be able to utilise and realise the benefits of the wider use of medical technologies.

BMA Cymru Wales also believes that GP cluster networks offer significant potential to drive forward the commissioning of new technology solutions within primary care. We recognise, however, that this would require the concept of GP cluster networks to be further developed in many localities than is currently the case.

Ensuring existing ICT systems used within the NHS in Wales can be better integrated should also be regarded as a key priority in our view. We recommend that a clear investment strategy is brought forward to ensure that secondary care ICT systems can be brought up to the standard that already exists within primary care in order to assist in the development of a single health record that can be accessed across both primary and secondary care.

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