Health and Social care Committee

Access to medical technologies in Wales

MT ToR 6 - Welsh Association for Gastroenterology and Endoscopy (WAGE)

ACCCESS TO MEDICAL TECHNOLOGIES IN NHS WALES: Terms of Reference and scope of inquiry

Response from Welsh Association for Gastroenterology and Endoscopy (WAGE)

1. Existing well-established technologies

Access and availability should be measured in relation to external benchmarks (e.g. compare activity by population in England, Scotland and Northern Ireland).

Factors to consider include:

a) Impact of waiting times (e.g. underprovision of colonoscopy in Wales is demonstrated by BSG UK national audit), conflicting clinical commitments (gastroenterologists often have competing demands for acute general medical intake and the care of large numbers of medical inpatients, which restricts time available for delivery of endoscopy duties).

b) Impact of geography and regional availability (some more specialized procedures are only available in larger centres, and access is much more difficult for patients referred from smaller centres, informal clinical pathways exist but are often met with reluctance from individual LHBs to refer externally to other health boards). Examples include endoscopic submucosal dissection for complex polyps, (ESD); other examples include provision of specialized surgery and medical management of intestinal failure.

c) Impact of lack of equipment, theatre space or trained teams to deliver certain technologies

2. Newer but already NICE-approved technologies

a) Impact of conflicting funding priorities that prevent evidence-based but expensive or specialized technologies from being implemented in hospitals, because of costs, or the impact on waiting lists for more routine procedures (examples of new technologies include treatment of complex polyps and radiofrequency ablation for dysplastic Barrett's oesophagus). Health Boards don't tend to prioritise these developments

against competing and more traditional priorities despite clinical and cost effectiveness

b) Impact of funding mechanism in Wales. Because there is no direct funding for Trusts providing certain procedures, and because money doesn’t follow patients in Wales, there is often minimal incentive to provide new, approved technologies. There is a shortage (or unacceptable delays) in national strategic planning in service developments.

c) Impact of inability to fund new equipment. Annual bidding rounds within Health Boards should be used for upgrading old equipment with newer devices, with more advanced technology (eg acquiring endoscopes that are capable of magnification and electronic chromo endoscopy; surgical video-choledochoscopies that allow dissemination of Lap CBD clearance; laparoscopic ultrasounds that allow interrogation of the biliary ductal system without the need for radiation). Because of increased costs, and competition within a very limited budget, these bids often fail..

d) Impact of differing criteria for procedures compared to other regions of UK. (e.g. bariatric surgery is underprovided in Wales, and the criteria for acceptance of patients are much more stringent than elsewhere in the UK. If NICE guidance was adhered to we'd need a much larger capacity for provision of this service).

3. Approval and adoption of new technologies

a) Decision-making process is often slow and patchy because it is devolved to the Health Boards. (e.g. there should be central strategic planning and a network for the provision of Endoscopic Ultrasound services).

b) Not all technologies are reviewed in the Welsh Health Specialised Services Committee, and selection criteria, definitions and decisions on which technologies to adopt are often slow. When included in the WHSSC portfolio, decisions on funding can be slow at times, and approval of funding for procedures in England can be very delayed.