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Health and Social care Committee

Access to medical technologies in Wales

MT ToR 24 BMA Cymru

National Assembly for Wales
Health and Social Care Committee

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Inquiry into access to medical technologies in Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Health and Social Care Committees inquiry into access to medical technologies in Wales.

The British Medical Association represents doctors from all branches of medicine all over the UK. It has a total membership of just 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, it 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 has consulted our members across Wales on access to medical technologies and we do wish to bring a number of their comments to your attention which we hope may be useful in drafting the terms of reference for this piece of work.

We look forward to contributing to any future work undertaken in this area. Please do not hesitate to contact BMA Cymru Wales should you require any further information.

Comment 1- from a Medical Academic

I have spent most of my career researching into 2 types of medical technology a) devices for cardiovascular intervention and invasive imaging and b) devices for non invasive imaging. The introduction of new technology is regulated by the MHRA on a strict basis with companies having to submit extensive portfolios of research, safety and efficacy, manufacturing processes before any clinical trials. Relatively few centres are used by international companies for these trials most are in England or Scotland and Wales tends to miss out. There is a current initiative to encourage companies to bring work into Wales and I hope we can do this to encourage research in this area and to bring in investment.

As for intravascular devices most of them are now manufactured in Eire and sold here. It would be helpful to encourage inward investment to have Wales take advantage of the Health Board system which would avoid too much duplication of permissions for trials between health boards.

In terms of the uptake of more expensive technologies we need a 'plan' for Wales as we again tend to miss out in comparison to England only recently having PET and slowly introducing high quality CT. In the past we have tried central purchasing equipment which failed and was not used and because a lack of training lots of mammography and cardiac ultrasound machines were gathering dust. We need to match technology with expertise and address lack of proper planning.

So I think the enquiry should cover:
a) Planning for introduction of high end technology at present we have a plan for cardiac imaging being produced by a committee with limited experience in that subject - we must involve the professionals early and often and make this transparent.

b) Planning for research should include technology and a method of organising this research to attract companies and inward investment. Linking technology to research in Universities may be helpful in providing further investment and attracting in companies i.e. why now Wales rather than Eire?

c) Access to technology must be accompanied by overall plans for patient access and plans for training and recruiting the staff to run the technology. We need to move away from providing everything in Cardiff and then expecting patients in N Wales to go to England.

I'm not an expert on disposable testing and 'low tech' equipment but I do know this is another area where we can advance the use of this low tech equipment in Wales. Again there are a number of UK companies which would like to get 'real world' feedback and involvement. My point about Eire is that a large number of the companies that settle there would also do so in Wales if we could create an environment which is sensitive to manufacture and testing and joint research. We often in the profession have suspicion about company involvement in research and the NHS however in the area of this type of work there is much to gain from local employment, better value for money in encouraging local joint working. By doing so we can ensure high quality and good feedback.

Most of our really good inventions go abroad then get sold back to us at enormously inflated prices.

Comment 2 – From a Hospital Consultant

I'm unclear if the Committee is looking at specific technologies - existing and on the horizon - or in general terms?

For gynae, for example, are they going to look at the contradiction between NICE that says IVF etc are highly effective technologies, but Wales rations patients to only 2 cycles, against NICE guidance?

This then gets into robotic surgery and the political decision becomes whether we invest huge sums of money to benefit a few patients when so many patients lack the basics, basics that may be stopping them from getting back to work because of cash shortages.

Cardiac technologies must be on the remit - along with access times and trained practitioner availability. I leave IVF to people's discretion. Access to ultrasound scanning in obstetrics may be too specific - there is no fetal medicine budget in the South and lots of women end up in Bristol in the South and Liverpool in the North who don't really need to leave Wales.

I like the idea of how to get expensive kit here at discounted cost and encouraging the development of technologies here - which Cardiff University certainly does. I am sure there are many other examples than the particular one I am thinking of.

Comment 3 – from a GP

We immediately think of high end complex technologies, PET scans and the like. However any review must include "low grade technology" as this tends to be applied to vast numbers of patients.

When I first started in practice, I had an otoscope, an ophthalmoscope, a patellar hammer, a sphyg and stethoscope. In truth, these are still the items that I use most!

However, since those days, we have added an enormous amount of technology to our day to day provision of primary care.

ECG, Spirometry, pulse oximetry, audiometry, doppler testing of circulation and foetuses and 24 hour BP monitoring. Not forgetting, of course, that UK primary care has probably the most sophisticated data base in the world.

However, the biggest change is in near patient testing. For some time, blood sugars are measured using glucometers. In the past 5 years, warfarin has been managed in house using strip reagent technology and INR meters. This has revolutionised the management of anticoagulation outside hospitals.

This is where the field will really take off.

Intricate technology gets cheaper and I can envisage all routine blood tests being done in house, with the only outside influence being a routine external calibration visit.

From a primary care perspective, I think this is where cutting edge technology will apply. It gives us the ability for one step diagnosis with quicker referral. We won't have to wait for the phone call from the lab later that day.

There is the possibility of immense savings when this technology is rolled out, reduced transportation of specimens, one GP visit instead of two, and more rapid diagnosis.

In thinking about the very newest, most sophisticated, and very expensive technologies that apply to a few, remember those more mundane technologies that can improve the situation for a much larger cohort of patients.

Comment 4 – from a Medical Academic

High end technologies like PET will remain a scarce resource, but what we often think of as 'high tech' is actually or should be more readily available. Many hospitals have MRI scanners now. These tend to be used for 'bog standard' static imaging. There is a lot more that can be done with the available technology - e.g., looking at blood flow, functional MRI - of function not just structure. Wales has expertise in these areas, but mostly in the academic world. Persuading the NHS to move beyond the status quo can be a challenge.

Microchip and gene chip technologies are moving apace allowing near to pt testing and monitoring at affordable costs.

Comment 5 – From a Public Health Doctor

To add a slightly different perspective on this topic:

When a new therapeutic agent is introduced we have an elaborate pre launch testing and not very effective post marketing surveillance system, (the yellow card). With medical devices we have nothing and often no proper prelaunch testing either.

New surgical methods or equipment are tried on tens of patients and then promoted around the world as better than the established way of doing things without any realistic comparison and certainly limited evaluation. Different canullae are purchased on cost grounds alone, new catheters introduced... the list is endless.

It is often the basic stuff that makes the most difference. I'm not aware that an evaluation of the change to synthetic materials for gloves has been evaluated. (I suspect it would show benefits but we simply don't know.) I am aware of

at least one surgical technology introduced to speed up the procedure and reduce risks that we have shown in Wales has increased risks for a minimal saving in time, as the operation was not the rate limiting step.

What I would like to see is a properly resourced and developed monitoring system established in Wales. We are leading the world in that ENT has the single use instrument surveillance, currently undergoing its economic assessment; it has already highlighted risks that were unknown before. We are leading the world in the approach to the new neuraxial connector.

We have the expertise in SMTL in Bridgend, CEDAR in Cardiff, and PHW on surveillance, plus the integrated service model which allows proper complete review of patients care via SAIL in Swansea and NWIS.

So it is important to consider not just the introduction of new technologies, but their evaluation in the real world as part of the equation.

I would suggest that the committee consider how we get

1. Widespread clinical engagement;
2. A non-patient evaluation as part of the evaluation (for example mannequin work, simulators, human factors);
3. Surveillance to provide a monitoring system which can ensure the safe introduction of new technologies;
4. Health economics to ensure we are spending money wisely.

And get this delivered to ministers and clinicians.