National Assembly for Wales

Health and Social Care Committee

Access to medical technologies in Wales

Evidence from Royal College of Anaesthetists Advisory Board in Wales / NSAG Anaesthesia – MT 3

Royal College of Anaesthetists Advisory Board in Wales

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Inquiry into Access to Medical Technologies in Wales

1.0 The Royal College of Anaesthetists Board in Wales / NSAG Anaesthesia welcomes the opportunity to comment on the consultation into medical technologies in Wales. Our Board represents anaesthetists, critical care medicine and pain medicine specialists from across Wales and views from our members have been sought in preparing this response. Our lay member also contributed to our response.

When the term “anaesthetists” is used in this response it refers to the different members of our board and is equally applicable to critical care and pain medicine.

2.0 Anaesthetists report that they often feel that as a service speciality interest in supporting or developing equipment in our fields is often lower than for some other fields that have more obvious “public perception” e.g. cancer, heart disease. However, before this stance is taken a better and fuller assessment of the actual benefits to patients should be undertaken. Improvements in anaesthesia, critical care and pain medicine can make significant improvements to patient outcomes. In particular pain medicine deals with complex patients for whom there is often many years of on-going treatment and cost to the NHS and other services. Greater developments in this area could result in large savings in the longer term if patients can be returned to employment or less dependence on social and health services.

3.0 With regard to commissioning the recent attempt to introduce non-leuer lock connectors has shown just how poorly coordinated developments of (simple) technology are undertaken in Wales and the rest of the UK. As this involves some of the simplest equipment in hospitals (needles and syringes) it would have been thought that a robust process could have been devised to come to a workable solution. However, after several years of uncertainty and arguably too many companies involved, the situation is not resolved and there has been no widespread change in UK practice. To compound issues a number of adverse events have been reported where clinicians have been unable to connect different pieces of equipment together due to mix of different connectors being used.

4.0 Capital programmes at a hospital level are often flawed in that there is often a battle between competing departments for the limited monies available. The process to assess and allocate is often little more than a lottery and often results in each department being allocated

”their slice of the cake”. This does not take into account the differing capital requirements of different departments and nor does it properly evaluate the benefits of all the bids. All too often any scoring system is very easy to manipulate and is weak in differentiating between different equipment. The result of this may be purchase of inappropriate equipment and / or the delay in purchase of vital or important equipment.

5.0 In the process of commissioning it is important to link the clinical knowledge of the front line staff or end users with the commissioning / procurement staff as while each group has the necessary skills in their own are the lack of understanding between the two can result in poor value and the wrong equipment being purchased. Anaesthetic equipment ids highly specialised and anaesthetists via their training have a better understanding of both the equipment and the principles on which they operate than many staff groups do. They are this ideally placed to contribute to the commissioning and procurement process and yet often their involvement is relatively small or delayed.

6.0 Given the current financial situation of healthcare in Wales as well as other parts of the UK it is almost inevitable that when costs are to be reduced it often appears “easier” to look to capital costs to be reduced as reducing revenue costs especially staff salaries is a much more complex and difficult process. Due to the high proportion of healthcare costs that relate to salaries the size of the capital aspect is therefore disproportionally hit if a fixed % budget reduction is all applied to capital schemes. When this happens the result is often that old or outdated equipment is not replaced until it fails or an adverse incident occurs. At this time there is often little time to carefully consider options and employ a robust procurement process. Poor value or purchase of the wrong equipment may be the result.

7.0 Spend-to save schemes have been used in Wales and this may allow capital outlay for equipment that will ultimately result in longer term savings. However, these schemes are limited and we would encourage a greater use of such schemes. However, we would also wish to see other “benefits” other than just financial “savings” considered as part of the process. Quality of care or safety also need to be considered in the process, although we accept this can be harder to measure than financial savings.

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