



Welsh Association for Gastroenterology and Endoscopy  
Cymdeithas Gastroenteroleg ac Endosgopi Cymru

[National Assembly for Wales](#)

[Health and Social Care Committee](#)

[Access to medical technologies in Wales](#)

Evidence from Welsh Association for Gastroenterology and Endoscopy – MT 15

October 2013

**CONSULTATION ON ACCESS TO MEDICAL TECHNOLOGIES IN NHS WALES**  
**Response from Welsh Association for Gastroenterology and Endoscopy**  
**(WAGE)**

**1. Introduction:**

1.1 WAGE represents healthcare professionals who contribute to the management of gastrointestinal and hepatobiliary disease in Wales. The Association is recognised by Welsh Government as the National Specialty Advisory group representing physicians, surgeons, paediatricians, radiologists and pathologists as well as clinical nurse specialists, many of whom are involved in the delivery of endoscopy. WAGE would welcome the opportunity to give oral evidence if invited.

1.2 Gastrointestinal and hepatobiliary endoscopy play a crucial role in the diagnosis, staging and treatment of a wide range of disorders including many pre-cancerous and cancerous conditions. The full potential of endoscopic therapy as an alternative to surgery is increasingly evident in managing early cancer of the gastrointestinal tract. Advances in endoscopic technology and technique can sometimes deliver minimally invasive as well as cost effective therapy for the patient.

1.3 Lower gastrointestinal endoscopy has achieved the most attention during the last 7 years due to the introduction of a national bowel screening programme aimed at early detection of polyps and cancers. The reduction in bowel cancer mortality arises not only from earlier detection of cancer, but also from its prevention through removal of adenomatous polyps during

screening colonoscopy. The introduction of bowel screening poses its own challenges in the field of new technologies, because more complex and time-consuming therapeutic techniques such as endoscopic submucosal dissection, trans-anal endoscopic microsurgery and laparoscopic approaches are increasingly needed for management of screening-detected pathology as minimally invasive alternatives to traditional open surgery.

1.4 WAGE welcomes the Welsh Government's consultation in the field of access to new (non-drug) technologies. Herein we set out some specific examples of NICE-approved and other new technologies relevant to the diagnosis and treatment of gastrointestinal and hepatobiliary diseases. We then describe examples of barriers that members have encountered in trying to introduce new technologies.

## 2. NICE-approved technologies

Some specific examples of those relevant to gastrointestinal endoscopy and their mapping to the issues requested by the Committee include:

2.1 Endoscopic submucosal dissection (ESD) of oesophageal (IPG355), gastric, duodenal and ampullary lesions (IPG 359 and 360) and lower gastrointestinal lesions (IPG 335). There is a substantial evidence base favouring ESD in removal of pre-malignant lesions and early cancer of the GI tract.

2.2 Radiofrequency ablation (RFA) of pre-malignant change occurring within Barrett's oesophagus (IPG 344). It is approved for treatment of pre-cancer and early oesophageal cancer in Barrett's oesophagus. There are over 30 centres offering this treatment in England, Scotland and Northern Ireland. Wales is the only area with no access to RFA. Currently patients have to be referred to England by individual clinicians and Health Boards on the basis of Individual patient funding requests (IPFR). The capital cost of RFA is around £50k, and the cost per patient treated is around £1,500. Individual Health Boards do not see it as a priority despite this treatment being much less costly and much safer than open surgical treatment. It is for these reasons that RFA is often recommended as the preferred treatment modality by regional upper GI cancer multidisciplinary team meetings.

2.3 Double Balloon Enteroscopy - or deep endoscopic examination for diseases of the small bowel. This form of endoscopy is included within the investigation pathway for iron deficiency anaemia in guidelines from the British Society of Gastroenterology (BSG), and can sometimes be used in therapy such as cauterizing bleeding points or dilating strictures. Patients in Wales are currently being sent to Bristol for this form of endoscopy.

2.4 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.) It is accepted that WHSSC is in the process of seeking agreement to increase the number of such procedures from 80 to 300 per year. Nonetheless if NICE guidance were to be followed we'd need a much larger capacity for provision of this service).

2.5 Miscellaneous: oesophageal function tests (manometry and 24 hour pH testing) where the underlying technology is rapidly advancing. A forward investment plan, therefore, needs to be identified; ano-rectal physiology, for which the same constraints apply; and capsule endoscopy, which incurs significant capital and revenue costs but is an important diagnostic test for a relatively small number of patients.

**2.6 Common theme** - Health Boards (LHBs) may flag up NICE-approved new technologies to Clinical Directors, asking them to appoint a Lead Clinician to develop business cases. Within a context of capacity constraints and shortage of funds, LHBs don't tend to prioritise these developments against the delivery of existing treatment priorities despite evidence of clinical and cost effectiveness. It is not surprising that clinicians find it frustrating writing business cases to support bids for such interventions when so few are approved.

2.7 For each of the above examples, Welsh consultants have the expertise and training to deliver the technology within Wales but lack support from their individual Health Boards. WAGE perceives that such interventions are best delivered on a supra-regional (tertiary) basis, given the lower volumes and specialist nature of these interventions in comparison with standard endoscopic procedures, and that a national joined-up approach is required.

### **3. Approval and adoption of other newer technologies (Early Adoption) - Illustrated example**

Wales lags behind the rest of the UK in the provision of many relatively new endoscopic technologies. One example is "Spyglass" - a type of miniature endoscope that can be guided up the bile duct at ERCP to enhance diagnosis and delivery of therapy in some forms of biliary disease. Spyglass has not been the subject of a NICE technology approval but is available in many centres in England. It is a good example of a technology that should be available in just one centre in Wales.

#### **4. Financial Barriers & Barriers to Timely Adoption**

4.1 Financial Constraints & Commissioning- because money doesn't follow patients in Wales, there is often minimal incentive for LHBs to invest in the provision of new, approved technologies. There is a lack of national strategic planning in the development and delivery of tertiary services for new technologies.

4.2 Decision-making is often slow and patchy, and in most cases it is devolved to LHBs. One example in recent years was the consensus among experts in the delivery of endoscopic ultrasound (EUS) that there would be many advantages to centralizing the South Wales service as opposed to the current 3-4 smaller centres using expensive equipment just once per week. The proposal was discussed at one of the monthly meetings of the Health Board Chief Executives, and the conclusion was that it was up to each individual LHB to prioritise investment in this service as they saw fit. This was an unfortunate outcome, which has impeded development of a modern, cost effective EUS service in Wales, and an important opportunity for setting up a viable service with adequate volumes for training (meeting national standards) was missed.

4.3 Not all technologies are reviewed in the Welsh Health Specialised Services Committee. Decisions on selection criteria, definitions which technologies to adopt are often slow. Even when the intervention is included within the WHSSC portfolio decisions on funding can take months. Delays in the approval of funding for procedures delivered in England are also common.

#### **5. Suggested Innovative solutions -**

5.1 Annual bidding rounds within LHBs should be used for upgrading old equipment with newer devices, with more advanced technology (e.g. acquiring endoscopes that are capable of magnification and electronic chromo endoscopy; surgical video-choledochoscopies that allow dissemination of laparoscopic bile duct clearance; laparoscopic ultrasound probes 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 usually fail.

5.2 A strategic, all-Wales approach is needed to the commissioning of such technologies so that all-Wales access is ensured, and services are refreshed as technology advances. Coordinated strategic planning and commissioning incorporating a list of technologies, available local expertise, options for coordinated service delivery (along with identified financial streams from each Health Board to contribute to these) should

be within the remit of an All Wales Strategic Gastroenterology and GI Surgical Group. Some gastroenterological investigations are only cost-effective when provided on a regional or sub-regional basis but the lack of strategic coordination means that commissioning of such services is ad hoc and unsatisfactory.

5.3 Partnership with Industry and Higher Education Institutions (HEI) - There is potential for collaboration with Industry in areas of Research & Development. In addition to the evaluation of new technologies, this approach lends itself to trials of comparative efficacy and cost effectiveness assessments in some of the areas where new technology is seen to be naturally aligned with areas of interest within University research departments. Collaboration between universities (e.g. the recent Health Technology ideas pilot by SARTRE (Sevenside Alliance for Research - collaboration between Cardiff & Bristol) and similar themes for technology collaboration between Cardiff, Swansea & Bangor with Industry participation hold great potential for innovative solutions if supported conceptually as well as financially by the Welsh Government.