Professional organisation statement template

Thank you for agreeing to give us a statement on your organisation's view of the technology and the way it should be used in the NHS.

Healthcare professionals can provide a unique perspective on the technology within the context of current clinical practice which is not typically available from the published literature.

To help you in making your statement, we have provided a template. The questions are there as prompts to guide you. It is not essential that you answer all of them.

Please do not exceed the 8-page limit.

Your name:

[redacted] **and** [redacted]

Name of your organisation: Royal College of Nursing

Are you (tick all that apply):

- Specialists in the treatment of people with the condition for which NICE is considering this technology
- Members of the RCN Ophthalmic forum

What is the expected place of the technology in current practice?

How is the condition currently treated in the NHS?
For patients that have been symptomatic for greater than three months and have not responded adequately to laser:

'Off label' Triamcinolone may be used. Also there is some emerging anecdotal evidence that photodynamic therapy with reduced laser fluence may also be of benefit to reducing the macular oedema.

I*n what setting should/could the technology be used* –

It is our belief that this should be carried out in secondary care as it is a specialised treatment. It is required to be implanted in the vitreous cavity (IVT) thus it needs to be delivered under aseptic technique to reduce the risk of endophthalmitis. This is performed by an appropriately trained healthcare professional. The patient also requires monitoring to check for other side effects such as raised intraocular pressure.

Additional professional input (for example, community care, specialist nursing, other healthcare professionals)?

As the incidence is increased in people with diabetes and hypertension, it is important that their healthcare professional in primary care takes an active role in their treatment plan to ensure the best possible diabetic and hypertensive control.

If the technology is already available, is there variation in how it is being used in the NHS? Is it always used within its licensed indications? If not, under what circumstances does this occur?

To our knowledge the use of slow release implant of IVT dexamethosone 0.7mg has only been used in clinical trials in the UK.

*Please tell us about any relevant **clinical guidelines** and comment on the appropriateness of the methodology used in developing the guideline and the specific evidence that underpinned the various recommendations.*

There are currently guidelines written by the RCO for intraviteal drug administration re- sterility, antibiotic prescribing, training and technique for administration. As these have been written by a body of UK specialists they are widely accepted by clinicians practising in the UK.

The advantages and disadvantages of the technology/ Implementation issues

Funding applications prior to treatment inevitably delay patient outcomes and if delay occurs once treatment needs are identified, this could result in unnecessary loss of sight.

Clinically it is important that once the patient is identified with significant macular oedema then treatment should commence at that point in time.

Intravitreal administration of drugs in ophthalmology is a well established practice, more so in the last few years, following the introduction of Anti-Vegf treatments for ARMD.

The proposed technology will be clinically easy to carry out due to previously introduced technology processes following a similar clinical route. It is now common practice in ophthalmic units throughout the country for IVT drugs to be delivered in the OPD clinics, whereas previously it was always delivered in the 'ophthalmic theatres'. This move to OPD was necessary due to the increasing demand of IVT for ARMD and the need to develop 'clean rooms' that fulfilled control of infection criteria outside of theatre.

If this technology is given a positive appraisal, it will not be new to those already well established IVT systems. The biggest problem will be sustaining the workload as both staff resources and capacity in most units are already extremely stretched!

It will not be possible to introduce an additional indication for IVT clinics without careful consideration to the possibility of employing more clinical staff and expanding room capacity at eye units. Without these additional services the waiting time for the technology, both current and new indications will rise considerably and one can only

speculate that the quality of care will decline due to the increased workload and over burdened staff!

Another consideration is not just additional resource needs in IVT clinics but those of the imaging departments in eye units. Fluorescein angiography (FFA) and ocular coherence tomography (OCT) are essential tools for diagnostic and management of retinal pathologies and this new technology will need growth in both staffing and equipment in these departments.

Another consideration is the possible retreatment rates and adverse events. In reviewing the literature, it is apparent that the treatment effect is only sustained for the first couple of months so repeated injections will be required. Along with this, the possibility of raised intraocular pressure and formation of cataracts will mean that these patients will require frequent monitoring.

As previously stated, as this is a specialised area, the administration of this technology will need to be carried out by ophthalmic specialist in secondary care. This cost implication will need to be taken into account during the appraisal.

Conclusion:

The impact of visual disturbance and vision loss is known to have a profound impact on quality of life, especially if the other eye is already affected. As this technology has been shown to improve best-corrected visual acuity by 15 letters or greater in the clinical trials, we owe it to our patients suffering macular oedema to receive it on the NHS.

As IVT, as a route for drug administration, is now well established in ophthalmology and is well tolerated by those receiving it, we anticipate that with an increase in resources including staff resources, this new technology will also be well accepted by both patients and clinical staff.