The Royal College of Ophthalmologists (RCOphth) response to NHS England's consultation on specialised commissioning for in-year service developments, individual funding requests, funding experimental and unproven treatments, and continuing funding after clinical trials

1. Introduction

1.1 The Royal College of Ophthalmologists welcomes the opportunity to respond to this consultation.

1.2 The RCOphth is the professional body for ophthalmologists and we champion excellence in the practice of ophthalmology on behalf of our members to optimise care for patients. We work with leaders across the eye health sector to help shape eye services for the benefit of patients, and provide guidance on commissioning ophthalmology services.

1.3 We have set out our responses to the consultation questions below.

2. Overview

Q: On a scale of 1 (not clear) to 5 (very clear) how clear are the revised set of policies overall in setting out how NHS England makes funding decisions?

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Q: What are the potential gaps in the set of generic policies? Are there any foreseeable cases that would not be addressed by this suite of policies?

2.1 There is a worrying provision gap for individual patients who are not classed as 'exceptional' or 'rare' under IFR policy criteria, but are clinically deemed to be in urgent need of a treatment that they are not covered to receive.

2.2 Service development is not designed to address this situation, since the evidence threshold is aimed at new treatments with "a strong impact supported the highest quality clinical research".

2.3 Assessing individual requests using this process is therefore inappropriate since there is unlikely to be sufficient time or resource to produce the evidence required, leaving patients without the treatment they need. An alternative mechanism to deal with these cases is needed.

Q: Do the changes being proposed create any risks, issues or potential adverse impacts for patients/stakeholders generally or for any particular groups?

2.4 As above, patients who need urgent treatment that is not routinely funded as individuals or as a cohort can be at risk. This will include persons with learning or physical disability who may not be able to communicate their situation or exceptionality.

3. In-year Service Developments Policy

Q: On a scale of 1 (not clear) to 5 (very clear) how clear is the in-year service development policy on circumstances in which it should apply?

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Q: On a scale of 1 (not clear) to 5 (very clear) how clear is the policy on the process to be followed, including the role of the Clinical Priorities Advisory Group and the required information?

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Q: How could the in-year service development policy be improved, in terms of the clarity and the process to be followed?

3.1 The requirement for in-year service developments to be cost neutral or cost saving does not take into consideration wider cost-effectiveness and value, which would be a fairer way to assess applications.

3.2 Removing the limitation of in-year service development to just specialised services should also be considered.

Q: How could the in-year service development policy be improved to provide greater certainty in dealing with clinically critically urgent cases in a fair and open way?

3.3 In the recent deliberations on use of adalimumab for uveitis in children, there was a delay in agreeing to commission this treatment despite the data supporting its use for sight threatening uveitis. Likewise, the lack of data for adults meant there was limited access unless exceptionality could be proven. Therefore, there should be flexibility in level of evidence required to support a change or new policy.

3.4 Improving the speed of implementation is also important for ensuring receive the treatment they need in clinically safe timeframes.

4. Individual Funding Requests Policy

Q: On a scale of 1 (not clear) to 5 (very clear) how clear is the IFR policy on the circumstances in which it should be applied and the basis for taking decisions?

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4.1 Clear guidance on whether to send IFRs to specialised and non-specialised commissioning structures would be welcome. IFRs are sometimes passed between sides (CCGs and specialised commissioning) which delays processing and can lead to patient harm.

Q: On a scale of 1 (not clear) to 5 (very clear) how clear is the IFR policy on the process to be followed in determining whether NHS England will support an IFR?

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Q: What are your concerns, if any, with the revised policy for including on determining exceptionality and rarity?

4.2 The expertise of the panel and how the panel members are chosen can be important. Panel members should have the knowledge and experience in the area to make clear and informed decisions, and have no conflicts of interest.

Q. What are your concerns with the process to be followed for IFRs including in urgent circumstances?

4.3 The frequency of meetings (fortnightly) can be too long in some cases.

5. Funding for Experimental and Unproven Treatments Policy

Q: On a scale of 1 (not clear) to 5 (very clear) how far does the policy on experimental and unproven treatments provide clarity on the circumstances in which funding can be sought?

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Q: How could the policy on experimental and unproven treatments be improved? And how could we provide greater clarity and certainty?

5.1 There must be proper safeguards for experimental and unproven treatments. Further information on this within the policy would be welcome.

5.2 Closer collaboration with the MHRA and also with companies/pharma may allow better access.

6. Continuing Funding after Clinical Trials Policy

Q: On a scale of 1 (not clear) to 5 (very clear) how far does the policy on continuing funding after clinical trial provide clarity on the circumstances in which funding can be sought?

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Q: Do you think there are any areas of the continuing funding after clinical trial policy that require further clarity?

6.1 The proposals for NHSE and NICE to work more closely and for fast track (by NICE) technology appraisals and highly specialised technologies are useful in this area. However, closer collaboration with companies may allow quicker and greater access where cost is an issue.