Integrated Impact Assessment Report for Service Specifications			
Service Specification Reference Number	URN: 1746		
Service Specification Title	Children's Cancer Networks Proposal **for routine commission** (source A3.1)		
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About this Impact Assessment: instructions for completion and explanatory notes
• Each section is divided into themes. • Each theme sets out a number of questions. • All questions are answered by selecting a drop down option or including free text. • Free text boxes are provided to enable succinct relevant commentary to be added which explains the rationale for response or assumption. Please limit responses to 3 sentences of explanatory text. • Data in this document is either drawn from one of the relevant service specification documents or a source for the information is provided. • Where assumptions are included where data is not available, this is specified.

Section A - Activity Impact	
A1 Current Patient Population & Demography / Growth	
A1.1 Prevalence of the disease/condition.	Cancer in children is rare, with around 1,600 cases (under 15 years old) diagnosed per year in the UK. Childhood cancers are different to cancers affecting adults and tend to occur in different parts of the body; around 41% are leukaemias and lymphomas, 25% brain tumours, with the remaining conditions comprising a wide range of solid tumours. As the age of the patient increases, bone sarcoma and epithelial tumours, which are more commonly seen in adults, are found. *Source: Service Specification Proposition section 3.2*
A1.2 Number of patients currently eligible for the service according to the proposed service specification commissioning criteria.	1,408 (Estimated number for England only) *Source: Service Specification Proposition section 3.2*
A1.3 Age group for which the service is proposed according to the service specification commissioning criteria.	**Children** The Specification covers children and teenagers aged 0 to 15 years, up to the 16th birthday. Some children's cancer services may treat patients up to their 19th birthday, by the agreement of Teenage and Young Adult Principal Treatment Centres.
A1.4 Age distribution of the patient population eligible according to the proposed service specification commissioning criteria	The highest incidence of cancer is among children aged 0-4 years. Incidence falls among children aged 5-14 years and then begins rise again among teenagers aged over 15 years. The incidence of childhood cancer by Region is similar across the UK.

	Source: Service Specification Proposition section 3.2
A1.5 How is the population currently distributed geographically?	**Evenly** *Source: Service specification proposition section 3.2*
A2 Future Patient Population & Demography	
A2.1 Projected changes in the disease/condition epidemiology, such as incidence or prevalence (prior to applying the new service specification) in 2, 5, and 10 years?	**Increasing** The incidence of paediatric cancer is expected to continue to increase in line with current trends, i.e., approximately 10% more children diagnosed per million population with every decade. These increases are likely to be in specific tumour types, including bone tumours and germ cell tumours in line with recent trends. The factors driving this increase are currently unknown. Increased incidence coupled with improving survival rates are expected to continue to increase the absolute number of patients using adult late effects services. *Source: Service specification proposition section 3.3*
A2.2 Are there likely to be changes in demography of the patient population and would this impact on activity/outcomes?	See section A2.1

A2.3 Expected net increase or decrease in the number of patients who will be eligible for the service, according to the proposed service specification commissioning criteria, per year in years 2-5 and 10? Are these numbers in line with ONS growth assumptions for the age specific population? If not please justify the growth assumptions made.	See section A2.1
A3 Activity	

A3.1 What is the purpose of new service specification?	**<u>Revision to an existing published service specification</u>**
	
	It is important to note that the revision process has resulted in:
	• The Paediatric Oncology Service Specification being split into:
	  ○ Children's Cancer Network – Principal Treatment Centres Service Specification
	  ○ Children's Cancer Network – Paediatric Oncology Shared Care Unit Service Specification
	• The integration of the Children's and TYA Chemotherapy Service Specification into each of the new children's cancer specifications. This means that there will no longer be a standalone Children's and TYA Chemotherapy Service Specification.

A3.2 What is the annual activity associated with the existing pathway for the eligible population?	1,408
A3.3 What is the estimated annual activity associated with the proposed service specification proposition pathway for the eligible population?	1,408

A4 Patient Pathway	
A4.1 **Patient pathway** Describe the current patient pathway and service.	Children's cancer services in England are delivered through Children's Cancer Networks, each co-ordinated through a Network Co-ordinating Group and comprising a Principal Treatment Centre (PTC) and a number of Paediatric Oncology Shared Care Units (POSCUs). All children aged 0-16 must be diagnosed and treated by the PTC; supportive care and some chemotherapy treatments can be delivered by POSCUs. PTCs and some POSCUs are also co-located children's cancer surgery services which fall outside the scope of the children's cancer service specifications. The PTC hosts the decision-making MTD(s) and is responsible for: (i) diagnosis; (ii) directing and providing treatment; and (iii) directing the aftercare pathway, including long-term follow and transition service provision. POSCUs are further grouped into one of three different levels depending on the complexity of care that is provided: • **Level 1** – this represents the most basic cancer care and includes inpatient supportive care and outpatient chemotherapy; • **Level 2** – incorporating level 1 care and day case chemotherapy • **Level 3** – this is the most complex level of care, incorporating both level 1 and 2 care and also delivery of inpatient chemotherapy. The majority of POSCUs in England, and particularly supporting London PTCs which see the largest volume of overall patient activity, are currently designated as Level 1, however, over a fifth of these units do not currently deliver any chemotherapy.

	Across England there are thirteen Children's Cancer Networks, comprising of thirteen PTCs (operating on sixteen delivery sites) and eighty-one POSCUs (fifty-five Level 1; fourteen Level 2; and twelve Level 3).
A4.2. What are the current service access and stopping criteria?	Children with cancer can be referred to the PTC from a multitude of different places, including primary, secondary and tertiary care. All children with a suspected or confirmed diagnosis of cancer must be referred to the PTC for a diagnosis and treatment planning. All patients will be treated under the management of the PTC. Some patients may require supra-specialist care and may be referred to other centres to access this care. Once children with cancer have completed their active treatment, they will usually continue to receive aftercare from the PTC for several years. Some children may experience long term side effects as result of their cancer treatment and will therefore require ongoing care provided by the PTC or may require transition into either TYA or adult services for continuous care.
A4.3 What percentage of the total eligible population are: a) Referred b) Meet any existing criteria for care c) Considered to meet any existing exclusion criteria	a) 100% b) 100% c) 0%
A4.4 What percentage of the total eligible population is expected to: a) Be referred to the proposed service b) Be eligible for care according to the proposed criteria for the service c) Take up care according to the proposed criteria for the service	a) 100% b) 100% c) 100%

d) Continue care according to the proposed criteria for the service?	d) 100%
A4.5 Specify the nature and duration of the proposed new service or intervention.	**Life long** After initial treatment, children with cancer require long term care to manage the side effects of their cancer treatment. Some children with cancer will transition into either TYA cancer services and adult services for continuous care.
A5 Service Setting	
A5.1 How is this service delivered to the patient?	*Select all that apply:* Emergency/Urgent care attendance ☒ Acute Trust: inpatient ☒ Acute Trust: day patient ☒ Acute Trust: outpatient ☒ Mental Health provider: inpatient ☐ Mental Health provider: outpatient ☐ Community setting ☐ Homecare ☐ Other ☐
A5.2 What is the current number of contracted providers for the eligible population by region?	NORTH: 5 PTCs 11 Level 1 POSCUs

	<table><tr><td>MIDLANDS & EAST</td><td>3 PTCs (delivered over 4 sites) 10 Level 1 POSCUs 3 Level 2 POSCUs 4 Level 3 POSCUs</td></tr><tr><td>LONDON</td><td>2 PTCs (delivered over 4 sites) 25 Level 1 POSCUs 7 Level 2 POSCUs 1 Level 3 POSCU</td></tr><tr><td>SOUTH</td><td>3 PTCs 8 Level 1 POSCUs 4 Level 2 POSCUs 7 Level 3 POSCUs</td></tr></table>
A5.3 Does the proposition require a change of delivery setting or capacity requirements?	**Not yet known** See Section B1.2.
A6 Coding	
A6.1 Specify the datasets used to record the new patient pathway activity. *expected to be populated for all commissioned activity	*Select all that apply:* <table><tr><td>Aggregate Contract Monitoring *</td><td>☒</td></tr><tr><td>Patient level contract monitoring</td><td>☒</td></tr><tr><td>Patient level drugs dataset</td><td>☐</td></tr><tr><td>Patient level devices dataset</td><td>☐</td></tr></table>

	Devices supply chain reconciliation dataset ☐ Secondary Usage Service (SUS+) ☒ Mental Health Services DataSet (MHSDS) ☐ National Return** ☐ Clinical Database** ☒ Other** ☐ ** Systemic Anti-Cancer Treatment (SACT) Database
A6.2 Specify how the activity related to the new patient pathway will be identified.	*Select all that apply:* OPCS v4.8 ☒ ICD10 ☒ Service function code ☐ Main Speciality code ☒ HRG ☒ SNOMED ☐ Clinical coding / terming methodology used by clinical profession ☐
A6.3 **Identification Rules for Drugs:** How are any drug costs captured?	**Not applicable**
A6.4 **Identification Rules for Devices:** How are device costs captured?	**Not applicable**

A6.5 **Identification Rules for Activity:** How are activity costs captured?	**Already correctly captured by an existing specialised service line (NCBPS code within the PSS Tool)** NCBPS23A – Paediatric Cancer
A7 Monitoring	
A7.1 **Contracts** Specify any new or revised data flow or data collection requirements, needed for inclusion in the NHS Standard Contract Information Schedule.	**None**
A7.2 **Business intelligence** Is there potential for duplicate reporting?	**No**
A7.3 **Contract monitoring** Is this part of routine contract monitoring?	**Yes**
A7.4 **Dashboard reporting** Specify whether a dashboard exists for the proposed service?	**Yes** There is currently a quality dashboard for paediatric oncology services. This will be amended to reflect the quality metrics included in the revised service specifications. Compliance against the dashboard measures are regularly reviewed by the local specialised commissioning teams and National Programme of Care. It is anticipated that these dashboards will become available to the Children and Young People's Cancer Clinical Reference Group.

A7.5 **NICE reporting** Are there any directly applicable NICE or equivalent quality standards which need to be monitored in association with the new service specification?	**Yes** NICE Quality Standards for Children and Young People with Cancer (2014) These standards have been incorporated into the revised service specification where applicable.
Section B - Service Impact	
B1 Service Organisation	
B1.1 Describe how the service is currently organised? (i.e. tertiary centres, networked provision etc.)	See section A4.1
B1.2 Will the specification change the way the commissioned service is organised?	**Yes** The following changes are proposed to the revised service specifications: **1. Strengthening Network function:** The Network role has been written as an Operational Delivery Network, reflecting the responsibilities to agree and direct patient pathways. The specification now explicitly articulates the constitution of the Network and allows each Network to recommend shared care service configuration for commissioners to enact. This is to ensure that local cancer systems can start to take ownership of these pathways in a structured way. **2. Principal Treatment Centres (PTCs):** (i) The service specification acknowledges the increasing role and importance of supra-Network services and the place of national clinical advisory panels and MDT structures in the care pathway and requires PTC participation in any

	such structures; (ii) Some aspects of the MDT structures hosted by the PTC that are currently described as 'should have', i.e., the Psychological MDT, have been described as 'must haves'; (iii) Clinical co-dependencies have been clarified; (iv) Responsibilities for clinical trials have been clarified and strengthened; and (vi) Recovery Package has been included, this also outlines the expected communication with GPs. 3. **Integration of Chemotherapy Services within the PTC and POSCU service specifications:** Both service specifications now include the chemotherapy delivery function, reuniting delivery with oncology services and the MDT. This will enable Networks to more easily determine local chemotherapy delivery for children which can only take place in PTCs and specifically designated POSCUs. 4. **Shared Care:** The model of shared care has been simplified by the introduction of two levels: a. Standard supportive care with no chemotherapy provision, designed to increase access to supportive care in areas where this has been limited by the availability of a chemotherapy workforce (mostly in the North). These units are and will continue to be co-located with paediatric emergency care units to enable safe and quick access to supportive care services, including the management of bacterial sepsis. b. Enhanced, which is sub-classified into two groups, Level A Enhanced POSCUs which will provide out-patient and daycare bolus or infusional chemotherapy, and Level B Enhanced POSCUs which will also provide in-patient chemotherapy. This will enable each Network to both tailor services to the local population's needs but also ensure greater consistency of provision between providers and Networks. Critical mass is required to safely and sustainably deliver chemotherapy and this is now clearly stated in the revised service

	specification. This is to ensure that there is sufficient activity to enable providers to invest in service provision and meet the standards in the specification, such as workforce, facilities, and e-prescribing. It is recommended that: a. Enhanced Level A POSCUs will be expected to manage, on average over a five-year period, a caseload of at least 10 new patients each year; and b. Enhanced Level B POSCUs will be expected to manage, on average over a five-year period, a caseload of at least 20 new patients each year. The impact of the proposals is anticipated to be as follows: • There will be no change to the number of Children's Cancer Networks or the number of Children's PTCs across England. • Children's PTCs may want, over time, to change POSCU provision in order to improve the care and experience of care offered to patients. This will be driven by a local needs assessment which should take into account and balance: rising incidence, changing clinical practice, co-location of related services, access and travel times.
B1.3 Will the specification require a new approach to the organisation of care?	**Other** See Section B1.2.
B2 Geography & Access	
B2.1 Where do current referrals come from?	*Select all that apply:*

	<table><tr><td>GP</td><td>☒</td></tr><tr><td>Secondary care</td><td>☒</td></tr><tr><td>Tertiary care</td><td>☒</td></tr><tr><td>Other</td><td>☐</td></tr></table>
B2.2 What impact will the new service specification have on the sources of referral?	**No impact**
B2.3 Is the new service specification likely to improve equity of access?	**Increase** The changes should mean that emergency and supportive care arrangements are put in place in geographies which are currently less well served, such as the North of England. *Source: Consultation Guide and Impact Assessment, Section B1.2*
B2.4 Is the new service specification likely to improve equality of access and/or outcomes?	**Increase** See Section B2.3. *Source: Consultation Guide and Impact Assessment, Section B1.2*
B3 Implementation	
B3.1 Will commissioning or provider action be required before implementation of the proposition can occur?	**Contract action and Service organisation action**

	It is anticipated that in Year 1 of implementation (April 2019 – March 2020) each Network, with the support of the relevant PTC and local commissioning teams, will agree its Network configuration including the number and designation of POSCUs required. Provider contracts will be amended to reflect the designation of shared care service providers from April 2020 onwards. It is important to note that any changes to local configuration of services would be subject to NHS England's standard operating processes and procedures. It is anticipated that each provider organisation within the Network will complete a Memorandum of Understanding (MoU), or other written agreement, setting out the role of the Network and the role of each provider organisation within the Network.
B3.2 **Time to implementation:** Is a lead-in time required prior to implementation?	**<u>Yes - go to B3.3</u>** It is anticipated that full implementation of the revised service specifications will be achieved by April 2020. See Section B3.1 above. All current providers of children's cancer services will be maintained until the revised Network configuration is agreed.
B3.3 **Time to implementation:** If lead-in time is required prior to implementation, will an interim plan for implementation be required?	**<u>Yes</u>** See Section B3.1 and B3.2 above.
B3.4 Is a change in provider physical infrastructure required?	**<u>No</u>** Currently no changes in provider physical infrastructure are anticipated, however, this may change over time and in line with agreed Network configuration. See Section B1.2.

<table>
<tr><td>B3.5 Is a change in provider staffing required?</td><td><u>No</u>

Currently no change to provider staffing levels are anticipated.</td></tr>
<tr><td>B3.6 Are there new clinical dependency and/or adjacency requirements that would need to be in place?</td><td><u>No</u>

It should be noted that the revised service specifications clearly set out the clinical co-dependency requirements for both PTCs and POSCUs. Networks will be expected to work with local commissioning teams to assess compliance against these standards during implementation.</td></tr>
<tr><td>B3.7 Are there changes in the support services that need to be in place?</td><td><u>No</u></td></tr>
<tr><td>B3.8 Is there a change in provider and/or inter-provider governance required? (e.g. ODN arrangements / prime contractor)</td><td><u>Yes</u>

See Section B3.1.</td></tr>
<tr><td>B3.9 Is there likely to be either an increase or decrease in the number of commissioned providers? If yes, specify the current and estimated number of providers required in each region</td><td><u>Not yet known</u>

See Sections B1.2 and B3.1 above.</td></tr>
<tr><td>B3.10 Specify how revised provision will be secured by NHS England as the responsible commissioner.</td><td><table>
<tr><td>Publication and notification of new service specification</td><td>☒</td></tr>
<tr><td>Market intervention required</td><td>☐</td></tr>
<tr><td>Competitive selection process to secure increase or decrease provider configuration</td><td>☐</td></tr>
</table></td></tr>
</table>

	Price-based selection process to maximise cost effectiveness ☐ Any qualified provider ☐ National Commercial Agreements e.g. drugs, devices ☐ Procurement ☐ Other* ☒ *See Section B3.1.
B4 Place-based Commissioning	
B4.1 Is this service currently subject to, or planned for, place-based commissioning arrangements? (e.g. future CCG lead, devolved commissioning arrangements, STPs)	**No**
Section C - Finance Impact	
C1 Tariff/Pricing	
C1.1 How is the service contracted and/or charged? Only specify for the relevant section of the patient pathway	*Select all that apply:* **Drugs**: Not separately charged – part of local or national tariffs ☐ **Drugs**: Excluded from tariff – pass through ☐ **Drugs**: Excluded from tariff – other ☐

	Devices	Not separately charged – part of local or national tariffs	☐
		Excluded from tariff (excluding ZCM) – pass through	☐
		Excluded from tariff (excluding ZCM) – other	☐
		Via Zero Cost Model	☐
	Activity	Paid entirely by National Tariffs	☐
		Paid entirely by Local Tariffs	☐
		Partially paid by National Tariffs	☒
		Partially paid by Local Tariffs	☒
		Part/fully paid under a Block arrangement	☐
		Part/fully paid under Pass-Through arrangements	☐
		Part/fully paid under Other arrangements	☐
C1.2 **Drug Costs** Where not included in national or local tariffs, list each drug or combination, dosage, quantity, **list** price including VAT if applicable and any other key information e.g. Chemotherapy Regime. NB discounted prices or local prices must not be included as these are subject to commercial confidentiality and must not be disclosed.	Not applicable.		
C1.3 **Device Costs** Where not included in national or local tariff, list each element of the excluded device, quantity, **list or expected** price including VAT if applicable and any other key information. NB: Discounted prices or local prices must not be included as these are subject to commercial confidentiality and must not be disclosed.	Not applicable.		

C1.4 **Activity Costs covered by National Tariff** List all the HRG codes, HRG descriptions, national tariffs (excluding MFF), volume and other key costs (e.g. specialist top up %)	Activity costs are captured under the following prescribed service line: *Children's services – Cancer*. There is a specialist top up for children's cancer services between 44% - 64%.
C1.5 **Activity Costs covered by Local Tariff** List all the HRGs (if applicable), HRG or local description, estimated average tariff, volume and any other key costs. Also indicate whether the Local Tariff(s) is/are newly proposed or established and if newly proposed how is has been derived, validated and tested.	Not applicable.
C1.6 **Other Activity Costs not covered by National or Local Tariff** Include descriptions and estimates of all key costs.	Not applicable - there are no activity costs not covered by local or national tariffs.
C1.7 Are there any prior approval mechanisms required either during implementation or permanently?	**No**
C2 Average Cost per Patient	
C2.1 What is the estimated cost per patient to NHS England, in years 1-5, including follow-up where required? Are there any changes expected in year 6-10 which would impact the model?	Not applicable - a financial model has not been drawn up. Current activity is paid at national tariff so there will be no change to the unit cost and, overall, there are no expected changes in patient numbers as a result of the service specification.

C3 Overall Cost Impact of this Service specification to NHS England	
C3.1 Specify the budget impact of the proposal on NHS England in relation to the relevant pathway.	**Cost neutral** It should be noted that each PTC, which must host the Children's Cancer ODN, will also receive additional resource from NHS England over the three-year period to support implementation of the new service specifications and strengthen the network function.
C3.2 If the budget impact on NHS England cannot be identified set out the reasons why this cannot be measured.	Not applicable
C3.3 If the activity is subject to a change of commissioning responsibility, from CCG to NHS England, has a methodology for the transfer of funds been identified, and calculated?	Not applicable
C4 Overall cost impact of this service specification to the NHS as a whole	
C4.1 Specify the budget impact of the proposal on other parts of the NHS.	Budget impact for CCGs: **No impact on CCGs** Budget impact for providers: **Unknown** Any impact on providers is expected to be minimal but has not been quantified. See section B1.2 for further detail on impact on providers.
C4.2 Taking into account responses to C3.1 and C4.1, specify the budget impact to the NHS as a whole.	**Cost neutral**

C4.3 Where the budget impact is unknown set out the reasons why this cannot be measured	Not applicable.
C4.4 Are there likely to be any costs or savings for non-NHS commissioners and/or public sector funders?	**No**
C5 Funding	
C5.1 Where a cost pressure is indicated, state known source of funds for investment, where identified, e.g. decommissioning less clinically or cost-effective services.	Not applicable.
C6 Financial Risks Associated with Implementing this Service specification	
C6.1 What are the material financial risks to implementing this service specification?	Not applicable. There is no change to the unit cost or overall patient numbers as a result of this specification.
C6.2 How can these risks be mitigated?	Not applicable
C6.3 What scenarios (differential assumptions) have been explicitly tested to generate best case, worst case and most likely total cost scenarios?	Not applicable
C6.4 What scenario has been approved and why?	Not applicable

C7 Value for Money	
C7.1 What published evidence is available that the service is cost effective as evidenced in the evidence review?	Not applicable.
C7.2 Has other data been identified through the service specification development relevant to the assessment of value for money?	*Select all that apply:* Available pricing data suggests the service specification is equivalent cost compared to current/comparator service specification ☐ Available pricing data suggests the service is lower cost compared to current/comparator treatment ☐ Available clinical practice data suggests the new service specification has the potential to improve value for money ☐ Other data has been identified ☐ No data has been identified ☒ The data supports a high level of certainty about the impact on value ☐ The data does not support a high level of certainty about the impact on value ☐
C8 Non-Recurrent Costs	
C8.1 Are there non-recurrent revenue costs associated with this service specification?	**No**

C8.2 Are there any non-recurrent provider capital costs associated with the service specification?	**No**