

Integrated Impact Assessment Report for Clinical Commissioning Policies

Policy Reference Number	B01X09		
Policy Title	Proton Beam Therapy for Cancer of the Prostate		
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Section A - Activity Impact			
Theme	Questions	Comments (Include source of information and details of assumptions made and any issues with the data)	
A1 Current Patient Population & Demography / Growth	A1.1 What is the prevalence of the disease/condition?	A1.1 106.7 per 100,000	
	A1.2 What is the number of patients currently eligible for the treatment under the proposed policy?	A1.2 0 (Not routinely commissioned policy)	
	A1.3 What age group is the treatment indicated for?	A1.3 Not applicable (Not routinely commissioned policy)	
	A1.4 Describe the age distribution of the patient population taking up treatment?	A1.4 Not applicable (Not routinely commissioned policy)	
	A1.5 What is the current activity associated with	A1.5 In 2014/15 15,710 treatment episodes were delivered in England.	

	<p>currently routinely commissioned care for this group?</p> <p>A1.6 What is the projected growth of the disease/condition prevalence (prior to applying the new policy) in 2, 5, and 10 years?</p> <p>A1.7 What is the associated projected growth in activity (prior to applying the new policy) in 2,5 and 10 years?</p> <p>A1.8 How is the population currently distributed geographically?</p>	<p>0 patients have been sent for Proton Beam Therapy for Prostate Cancer</p> <p>A1.6 There has been an increase in incidence through to 2012 due to earlier testing and an aging population. More recent figures suggest that this has levelled off.</p> <p>A1.7 At 2 and 5 years 0 (Not routinely commissioned policy). Unable to say at 10 years as potential research activity worldwide may change evidence base and commissioning policy</p> <p>A1.8 Evenly</p>
<p>A2 Future Patient Population & Demography</p>	<p>A2.1 Does the new policy: move to a non-routine commissioning position / substitute a currently routinely commissioned treatment / expand or restrict an existing treatment threshold / add an additional line / stage of treatment / other?</p> <p>A2.2 Please describe any factors likely to affect growth in the patient population for this intervention (e.g. increased disease prevalence, increased survival).</p> <p>A 2.3 Are there likely to be changes in geography/demography of the patient population and would this impact on</p>	<p>A2.1 Confirms not routinely commissioned position</p> <p>A2.2 Research activity worldwide may change evidence base and commissioning policy. Increased prevalence.</p> <p>A2.3 Yes, this is a predominantly a disease of older men (65-79) and therefore an ageing population would suggest an increase in prevalence.</p>

	<p>activity/outcomes? If yes, provide details.</p> <p>A2.4 What is the resulting expected net increase or decrease in the number of patients who will access the treatment per year in year 2, 5 and 10?</p>	<p>Age standardised mortality has however fallen. New prognostic factors to identify aggressive disease requiring intervention in the elderly may allow a surveillance policy in a significant number of patients. As fractionation reduces and the quality of radiotherapy improves there is likely to be increasing demand for treatment.</p> <p>A2.4 Years 2 & 5 – 0 Unable to say at 10 years as potential research activity worldwide and cost of capital equipment may change evidence base and commissioning policy</p>
A3 Activity	<p>A3.1 What is the current annual activity for the target population covered under the new policy? Please provide details in accompanying excel sheet.</p> <p>A3.2 What will be the new activity should the new / revised policy be implemented in the target population? Please provide details in accompanying excel sheet.</p> <p>A3.3 What will be the comparative activity for the 'Next Best Alternative' or 'Do Nothing' comparator if policy is not adopted? Please details in accompanying excel sheet.</p>	<p>A3.1 0 –Prostate Cancer is not included on the indications lists within the current NHS England Clinical Policies</p> <p>A3.2 0 – Not routinely commissioned policy.</p> <p>A3.3 Current conventional radiotherapy treatment. 15,710 treatment episodes in 2014/15</p>
A4 Existing Patient Pathway	<p>A4.1 If there is a relevant currently routinely commissioned treatment, what is the current patient pathway? Describe or include a figure to outline associated activity.</p>	<p>A4.1 Yes. 15,710 treatment episodes conventional IMRT/IGRT radiotherapy in 2014/15.</p>

	<p>A4.2. What are the current treatment access criteria?</p> <p>A4.3 What are the current treatment stopping points?</p>	<p>A4.2 Prostate Cancer requiring treatment with radiotherapy.</p> <p>A4.3 Single treatment course of IMRT/IGRT radiotherapy.</p>
<p>A5 Comparator (next best alternative treatment) Patient Pathway</p>	<p>A5.1 If there is a 'next best' alternative routinely commissioned treatment what is the current patient pathway? Describe or include a figure to outline associated activity.</p> <p>A5.2 Where there are different stopping points on the pathway please indicate how many patients out of the number starting the pathway would be expected to finish at each point (e.g. expected number dropping out due to side effects of drug, or number who don't continue to treatment after having test to determine likely success). If possible please indicate likely outcome for patient at each stopping point.</p>	<p>A5.1 Following diagnosis and staging confirming localised disease, treatment options assessed in MDT and recommendations plus options then discussed with patient. 15,710 treatment episodes of IMRT/IGRT radiotherapy were delivered in 2014/15</p> <p>A5.2 Not applicable</p>
<p>A6 New Patient Pathway</p>	<p>A6.1 Describe or include a figure to outline associated activity with the patient pathway for the proposed new policy.</p> <p>A6.2 Where there are different stopping points on the pathway please indicate how many patients out of the number starting the pathway would be expected to finish at each point (e.g. expected</p>	<p>A6.1 0 (Not routinely commissioned policy)</p> <p>A6.2 Not applicable (Not routinely commissioned policy)</p>

	<p>number dropping out due to side effects of drug, or number who don't continue to treatment after having test to determine likely success). If possible please indicate likely outcome for patient at each stopping point.</p>	
A7 Treatment Setting	<p>A7.1 How is this treatment delivered to the patient?</p> <ul style="list-style-type: none"> ○ Acute Trust: Inpatient/Daycase/ Outpatient ○ Mental Health Provider: Inpatient/Outpatient ○ Community setting ○ Homecare delivery <p>A7.2 Is there likely to be a change in delivery setting or capacity requirements, if so what? <i>e.g. service capacity</i></p>	<p>A7.1 Not applicable (Not routinely commissioned policy)</p> <p>A7.2 Not applicable (Not routinely commissioned policy)</p>
A8 Coding	<p>A8.1 In which datasets (e.g. SUS/central data collections etc.) will activity related to the new patient pathway be recorded?</p> <p>A8.2 How will this activity related to the new patient pathway be identified?(e.g. ICD10 codes/procedure codes)</p>	<p>A8.1 Not applicable (Not routinely commissioned policy)</p> <p>A8.2 Not applicable (Not routinely commissioned policy)</p>
A9 Monitoring	<p>A9.1 Do any new or revised requirements need to be included in the NHS Standard Contract Information Schedule?</p>	<p>A9.1 Not applicable (Not routinely commissioned policy)</p>

	<p>A9.2 If this treatment is a drug, what pharmacy monitoring is required?</p> <p>A9.3 What analytical information /monitoring/ reporting is required?</p> <p>A9.4 What contract monitoring is required by supplier managers? What changes need to be in place?</p> <p>A9.5 Is there inked information required to complete quality dashboards and if so is it being incorporated into routine performance monitoring?</p> <p>A9.6 Are there any directly applicable NICE quality standards that need to be monitored in association with the new policy?</p> <p>A9.7 Do you anticipate using Blueteq or other equivalent system to guide access to treatment? If so, please outline. <i>See also linked question in M1 below</i></p>	<p>A9.2 Not applicable (Not routinely commissioned policy)</p> <p>A9.3 Not applicable (Not routinely commissioned policy)</p> <p>A9.4 Not applicable (Not routinely commissioned policy)</p> <p>A9.5 Not applicable (Not routinely commissioned policy)</p> <p>A9.6 Not applicable (Not routinely commissioned policy)</p> <p>A9.7 Not applicable (Not routinely commissioned policy)</p>
Section B - Service Impact		
Theme	Questions	Comments (Include source of information and details of assumptions made and any issues with the data)
B1 Service Organisation	B1.1 How is this service currently organised? (i.e. tertiary centres, networked provision)	B1.1 Local diagnosis linked to specialised urology MDTs. IMRT/IGRT delivered in commissioned radiotherapy treatment centres.

	B1.2 How will the proposed policy change the way the commissioned service is organised?	B1.2 Not applicable (Not routinely commissioned policy)
B2 Geography & Access	<p>B2.1 Where do current referrals come from?</p> <p>B2.2 Will the new policy change / restrict / expand the sources of referral?</p> <p>B2.3 Is the new policy likely to improve equity of access?</p> <p>B2.4 Is the new policy likely to improve equality of access / outcomes?</p>	<p>B2.1 Geographically even spread</p> <p>B2.2 Not applicable (Not routinely commissioned policy)</p> <p>B2.3 Not applicable (Not routinely commissioned policy)</p> <p>B2.4 Not applicable (Not routinely commissioned policy)</p>
B3 Implementation	<p>B3.1 Is there a lead in time required prior to implementation and if so when could implementation be achieved if the policy is agreed?</p> <p>B3.2 Is there a change in provider physical infrastructure required?</p> <p>B3.3 Is there a change in provider staffing required?</p> <p>B3.4 Are there new clinical dependency / adjacency requirements that would need to be in place?</p>	<p>B3.1 Not applicable (Not routinely commissioned policy)</p> <p>B3.2 Not applicable (Not routinely commissioned policy)</p> <p>B3.3 Not applicable (Not routinely commissioned policy)</p> <p>B3.4 Not applicable (Not routinely commissioned policy)</p>

	<p>B3.5 Are there changes in the support services that need to be in place?</p> <p>B3.6 Is there a change in provider / inter-provider governance required? (e.g. ODN arrangements / prime contractor)</p> <p>B3.7 Is there likely to be either an increase or decrease in the number of commissioned providers?</p> <p>B3.8 How will the revised provision be secured by NHS England as the responsible commissioner? (e.g. publication and notification of new policy, competitive selection process to secure revised provider configuration)</p>	<p>B3.5 Not applicable (Not routinely commissioned policy)</p> <p>B3.6 Not applicable (Not routinely commissioned policy)</p> <p>B3.7 Not applicable (Not routinely commissioned policy)</p> <p>B3.8 Not applicable (Not routinely commissioned policy)</p>
B4 Collaborative Commissioning	B4.1 Is this service currently subject to or planned for collaborative commissioning arrangements? (e.g. future CCG lead, devolved commissioning arrangements)	B4.1 Not applicable (Not routinely commissioned policy)
Section C - Finance Impact		
Theme	Questions	Comments (Include source of information and details of assumptions made and any issues with the data)
C1 Tariff	<p>C1.1 Is this treatment paid under a national prices*, and if so which?</p> <p>C1.2 Is this treatment excluded from national prices?</p>	<p>C1.1 Not applicable (Not routinely commissioned policy)</p> <p>C1.2 Not applicable (Not routinely commissioned policy)</p>

	<p>C1.3 Is this covered under a local price arrangements (if so state range), and if so are you confident that the costs are not also attributable to other clinical services?</p> <p>C1.4 If a new price has been proposed how has this been derived / tested? How will we ensure that associated activity is not additionally / double charged through existing routes?</p> <p>C1.5 is VAT payable (Y/N) and if so has it been included in the costings?</p> <p>C1.6 Do you envisage a prior approval / funding authorisation being required to support implementation of the new policy?</p>	<p>C1.3 Not applicable (Not routinely commissioned policy)</p> <p>C1.4 Not applicable (Not routinely commissioned policy)</p> <p>C1.5 Not applicable (Not routinely commissioned policy)</p> <p>C1.6 Not applicable (Not routinely commissioned policy)</p>
C2 Average Cost per Patient	<p>C2.1 What is the revenue cost per patient in year 1?</p> <p>C2.2 What is the revenue cost per patient in future years (including follow up)?</p>	<p>C2.1 Not applicable (Not routinely commissioned policy)</p> <p>C2.2 Not applicable (Not routinely commissioned policy)</p>
C3 Overall Cost Impact of this Policy to NHS England	<p>C3.1 Indicate whether this is cost saving, neutral, or cost pressure to NHS England.</p> <p>C3.2 Where this has not been identified, set out</p>	<p>C3.1 Cost Neutral. However policy is designed to clarify evidence base and commissioning position due to some unjustified commercial and media pressures from commercial PBT centres in the EU and proposed within the UK that would be hugely inflationary.</p> <p>C3.2</p>

	the reasons why this cannot be measured.	
C4 Overall cost impact of this policy to the NHS as a whole	<p>C4.1 Indicate whether this is cost saving, neutral, or cost pressure for other parts of the NHS (e.g. providers, CCGs).</p> <p>C4.2 Indicate whether this is cost saving, neutral, or cost pressure to the NHS as a whole.</p> <p>C4.3 Where this has not been identified, set out the reasons why this cannot be measured.</p> <p>C4.4 Are there likely to be any costs or savings for non NHS commissioners / public sector funders?</p>	<p>C4.1 Cost Neutral</p> <p>C4.2 Cost Neutral</p> <p>C4.3</p> <p>C4.4 No</p>
C5 Funding	C5.1 Where a cost pressure is indicated, state known source of funds for investment, where identified. <i>e.g. decommissioning less clinically or cost-effective services</i>	C5.1 Not applicable (Not routinely commissioned policy)
C6 Financial Risks Associated with Implementing this Policy	<p>C6.1 What are the material financial risks to implementing this policy?</p> <p>C6.2 Can these be mitigated, if so how?</p> <p>C6.3 What scenarios (differential assumptions) have been explicitly tested to generate best case, worst case and</p>	<p>C6.1 None (Not routinely commissioned policy)</p> <p>C6.2 Not applicable</p> <p>C6.3 Not applicable (Not routinely commissioned policy)</p>

	most likely total cost scenarios?	
C7 Value for Money	<p>C7.1 What evidence is available that the treatment is cost effective? <i>e.g. NICE appraisal, clinical trials or peer reviewed literature</i></p> <p>C7.2 What issues or risks are associated with this assessment? <i>e.g. quality or availability of evidence</i></p>	<p>C7.1 Not routinely commissioned policy partly because no evidence available on cost effectiveness of PBT over conventional treatment</p> <p>C7.2 None – no evidence available (see evidence review)</p>
C8 Cost Profile	<p>C8.1 Are there non-recurrent capital or revenue costs associated with this policy? <i>e.g. Transitional costs, periodical costs</i></p> <p>C8.2 If so, confirm the source of funds to meet these costs.</p>	<p>C8.1 Not applicable (Not routinely commissioned policy)</p> <p>C8.2 Not applicable (Not routinely commissioned policy)</p>

For public consultation