

Integrated Impact Assessment Report for Clinical Commissioning Policies

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| Policy Reference Number | B01X14 | | |
| Policy Title | The use of Stereotactic Ablative Radiotherapy (SABR) in the treatment of Prostate Cancer | | |
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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) |
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| A1 Current Patient Population & Demography / Growth | <p>A1.1 What is the prevalence of the disease/condition?</p> <p>A1.2 What is the number of patients currently eligible for the treatment under the proposed policy?</p> <p>A1.3 What age group is the treatment indicated for?</p> | <p>A1.1 This policy proposes not to routinely commission SABR as a treatment option for patents with prostate cancer.</p> <p>A1.2 Prostate cancer is the commonest cancer among British males. It affects about one in twelve men over a lifetime, giving rise each year to about 30,000 new cases and 10,000 deaths.</p> <p>A1.3 The treatment is indicated for adults (over 18 years), in accordance with the NHS Prescribed Services Manual.</p> |

A1.4 Describe the age distribution of the patient population taking up treatment?

A1.4 The disease varies widely in its clinical course, tending to be more aggressive in younger men. Sometimes prostate cancers grow so slowly that they pose no threat to health or longevity – autopsies in men over eighty years of age show that most have malignant tissue in their prostate glands, but they died with prostate cancer, not of it. Survival rates are better than for many other cancers.

Prostate cancer is particularly common among older men; two-thirds of those who die from prostate cancer are over the age of 75 years.

A1.5 What is the current activity associated with currently routinely commissioned care for this group?

A1.5 It is estimated that this treatment pertains over 7,700 patients per year that are currently treated with external beam conventional radiotherapy. (NATCANSAT data)

A1.6 What is the projected growth of the disease/condition prevalence (prior to applying the new policy) in 2, 5, and 10 years?

The incidence is rising in line with cancer incidence rates this is estimated at 2% per year.

2017/18 8,011 spells
2020/21 8,501 spells
2025/26 9,385 Spells

A1.7 What is the associated projected growth in activity (prior to applying the new

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| | <p>policy) in 2,5 and 10 years?</p> <p>A1.8 How is the population currently distributed geographically?</p> | <p>A1.8 The distribution of these cancers is difficult to assess with certainty given the known issues in disease classification and recording.</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 activity/outcomes? If yes, provide details.</p> | <p>A2.1 The policy moves to a non-routinely commissioning position. It should be noted that the policy does not in itself alter the number of patients requiring treatment using existing treatment options.</p> <p>A2.2 Not applicable – this is a non-routine commissioning position that doesn't alter the number of alternative treatments being delivered.</p> <p>A2.3 Overall this is a common cancer but annual increases in the detection of prostate cancers of about two percent are estimated.</p> |

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| | <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>A2.4 A 2% increase in the number of interventions associated with this policy has been included.</p> <p><i>Total Number of Prostate cancer spells</i></p> <p>2016/17 7,854 2017/18 8,011 2018/19 8,171</p> <p><i>Total Number of conventional RT Episodes</i></p> <p>2016/17 7,854 2017/18 8,011 2018/19 8,171</p> <p>It should be noted that recording of radiotherapy activity on SUS is very limited</p> |
| <p>A3 Activity</p> | <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</p> | <p>A3.1 Current year activity relates to 7,700 episodes.</p> <p>See A2.4</p> <p>A3.3 The comparative activity is conventional radiotherapy See A2.4</p> |

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| | Nothing' comparator if policy is not adopted? Please details in accompanying excel sheet. | |
| 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>A4.2. What are the current treatment access criteria?</p> <p>A4.3 What are the current treatment stopping points?</p> | <p>A4.1 – A6</p> <p>External beam radiotherapy is widely used to treat prostate cancer. Compared with external beam radiotherapy</p> |
| A5 Comparator (next best alternative treatment) Patient Pathway | <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</p> | <p>A5.1 The 'next best' alternative routinely commissioned treatment is conventional radiotherapy.</p> <p>A5.2 Not applicable</p> |

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| | <p>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> | |
| A6 New Patient Pathway | <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 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>A6.1 The pathway would not change from that set out within K4.1.</p> <p>A6.2 Not applicable.</p> |
| A7 Treatment | A7.1 How is this | A7.1 The treatment is carried out in |

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| Setting | <p>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>the inpatient setting.</p> <p>A7.2 Not applicable.</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 The underlying procedure would be recorded in SUS</p> <p>A8.2 Not applicable</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</p> |

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| | <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</p> <p>A9.3 Not applicable</p> <p>A9.4 Not applicable</p> <p>A9.5 Not applicable</p> <p>A9.6 Not applicable</p> <p>A9.7 Not applicable</p> |
| Section B - Service Impact | | |

| Theme | Questions | Comments (Include source of information and details of assumptions made and any issues with the data) |
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| B1 Service Organisation | <p>B1.1 How is this service currently organised? (i.e. tertiary centres, networked provision)</p> <p>B1.2 How will the proposed policy change the way the commissioned service is organised?</p> | <p>B1.1 SABR is delivered for non-small cell lung cancer and clinical trials by 17 centres in England, or CtE in 17 centres (slightly different set) in England</p> <p>B1.2 No change</p> |
| 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 Tertiary centres by existing pathways and MDT arrangements</p> <p>B2.2 No. The policy will not alter the referral process for liver cancer.</p> <p>B2.3 Moving to a consistent commissioning position across England will improve equity of access.</p> <p>B2.4 The policy will have no impact on equality of access or outcomes.</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>B3.1 Some centres are already delivering this form of treatment as part of the SABR CtE programme for some indications and this will continue</p> |

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| | <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>B3.5 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.</p> | <p>B3.2 Not applicable</p> <p>B3.3 Not applicable</p> <p>B3.4 No. There are no new dependencies associated with this policy.</p> <p>B3.5 No. There are no changes to the support services that need to be put into place.</p> <p>B3.6 No. There are no changes to provider/inter-provider governance arrangements.</p> <p>B3.7 No change is expected.</p> <p>B3.8 The policy will be secured through the usual commissioning/decommissioning</p> |
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| | publication and notification of new policy, competitive selection process to secure revised provider configuration) | |
| 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 These services are not part of national collaborative commissioning or devolution arrangements. |
| 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>C1.3 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>C1.1 SABR is not covered by a national tariff</p> <p>C1.2 N/A</p> <p>C1.3 Yes – the local price is based on the national radiotherapy tariffs.</p> |

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| | <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>C1.4 The local price for 15-16 is £4,856 based on 5 SABR fractions. The price has been tested as part of the SABR CtE. For modelling, the price has been uplifted by 1.1% to 16-17 rates and by 10% to reflect average MFF.</p> <p>C1.5 N/A</p> <p>C1.6 No – policy is for Not Routine Commissioning</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 £3,479</p> <p>C2.2 £2,354 (Reduction reflects moving from an average of 31 fractions in Yr 1 to 20 fractions from Year 2.</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 the reasons why this cannot be</p> | <p>C3.1 Cost Saving of £16.3k per year from reducing IFRs.</p> <p>C3.2</p> |

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| | 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 – alternative treatment commissioned by NHS England.</p> <p>C4.2 Cost Saving –see M3</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> | |
| C6 Financial Risks Associated with Implementing this Policy | C6.1 What are the material financial risks to implementing this policy? | C6.1 There are not expected to be any material financial risks associated with this policy |

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| | <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 most likely total cost scenarios?</p> | <p>C6.2 Not applicable</p> <p>C6.3 Not applicable</p> |
| 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 This question was asked as part of the evidence review which found that there is extremely limited evidence in relation to cost effectiveness of the procedure.</p> <p>C7.2 No risks have been identified as evidence of cost effectiveness was not identified.</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.</p> <p>C8.2 Not applicable.</p> |