Integrated Impact Assessment Report for Clinical Commissioning Policies

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)
A1 Current Patient Population & Demography / Growth	A1.1 What is the prevalence of the disease/condition?	A1.1 This policy proposes not to routinely commission SABR as a treatment option for patents with prostate cancer.
	A1.2 What is the number of patients currently eligible for the treatment under the proposed policy?	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.
	A1.3 What age group is the treatment indicated for?	A1.3 The treatment is indicated for adults (over 18 years), in accordance with the NHS Prescribed Services Manual.

		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	

	policy) in 2,5 and 10 years? A1.8 How is the population currently distributed geographically?	A1.8 The distribution of these cancers is difficult to assess with certainty given the known issues in disease classification and recording.
A2 Future Patient Population & Demography	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? A2.2 Please describe any factors likely to affect growth in the patient population for this intervention (e.g. increased disease prevalence, increased survival). 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.	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. A2.2 Not applicable – this is a non-routine commissioning position that doesn't alter the number of alternative treatments being delivered. A2.3 Overall this is a common cancer but annual increases in the detection of prostate cancers of about two percent are estimated.

	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?	A2.4 A 2% increase in the number of interventions associated with this policy has been included. *Total Number of Prostate cancer spells* *2016/17 7,854* *2017/18 8,011* *2018/19 8,171* *Total Number of conventional RT Episodes* *2016/17 7,854* *2017/18 8,011* *2018/19 8,171* It should be noted that recording of radiotherapy activity on SUS is very limited
A3 Activity	A3.1 What is the current annual activity for the target population covered under the new policy? Please provide details in accompanying excel sheet.	A3.1 Current year activity relates to 7,700 episodes.
	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.	See A2.4
	A3.3 What will be the comparative activity for the 'Next Best Alternative' or 'Do	A3.3 The comparative activity is conventional radiotherapy See A2.4

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

	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.	
A6 New Patient Pathway	A6.1 Describe or include a figure to outline associated activity with the patient pathway for the proposed new policy. 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.	A6.1 The pathway would not change from that set out within K4.1. A6.2 Not applicable.
A7 Treatment	A7.1 How is this	A7.1 The treatment is carried out in

Setting	treatment delivered to the patient? ○ Acute Trust: Inpatient/Daycase/ Outpatient ○ Mental Health Provider: Inpatient/Outpatient ○ Community setting ○ Homecare delivery A7.2 Is there likely to be a change in delivery setting or capacity requirements, if so what? *e.g. service capacity*	the inpatient setting. A7.2 Not applicable.
A8 Coding	A8.1 In which datasets (e.g. SUS/central data collections etc.) will activity related to the new patient pathway be recorded? A8.2 How will this activity related to the new patient pathway be identified?(e.g. ICD10 codes/procedure codes)	A8.1 The underlying procedure would be recorded in SUS A8.2 Not applicable
A9 Monitoring	A9.1 Do any new or revised requirements need to be included in the NHS Standard Contract Information Schedule?	A9.1 Not applicable

	A9.2 If this treatment is a drug, what pharmacy monitoring is required?	A9.2 Not applicable
	A9.3 What analytical information /monitoring/ reporting is required?	A9.3 Not applicable
	A9.4 What contract monitoring is required by supplier managers? What changes need to be in place?	A9.4 Not applicable
	A9.5 Is there inked information required to complete quality dashboards and if so is it being incorporated into routine performance monitoring?	A9.5 Not applicable
	A9.6 Are there any directly applicable NICE quality standards that need to be monitored in association with the new policy?	A9.6 Not applicable
	A9.7 Do you anticipate using Blueteq or other equivalent system to guide access to treatment? If so, please outline. *See also linked question in M1 below*	A9.7 Not applicable
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 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
	B1.2 How will the proposed policy change the way the commissioned service is organised?	B1.2 No change
B2 Geography & Access	B2.1 Where do current referrals come from?	B2.1 Tertiary centres by existing pathways and MDT arrangements
	B2.2 Will the new policy change / restrict / expand the sources of referral?	B2.2 No. The policy will not alter the referral process for liver cancer.
	B2.3 Is the new policy likely to improve equity of access?	B2.3 Moving to a consistent commissioning position across England will improve equity of access.
	B2.4 Is the new policy likely to improve equality of access / outcomes?	B2.4 The policy will have no impact on equality of access or outcomes.
B3 Implementation	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?	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

	B3.2 Is there a change in provider physical infrastructure required?	B3.2 Not applicable
	B3.3 Is there a change in provider staffing required?	B3.3 Not applicable
	B3.4 Are there new clinical dependency / adjacency requirements that would need to be in place?	B3.4 No. There are no new dependencies associated with this policy.
	B3.5 Are there changes in the support services that need to be in place?	B3.5No. There are no changes to the support services that need to put into place.
	B3.6 Is there a change in provider / inter-provider governance required? (e.g. ODN arrangements / prime contractor)	B3.6 No. There are no changes to provider/inter-provider governance arrangements.
	B3.7 Is there likely to be either an increase or decrease in the number of commissioned providers?	B3.7 No change is expected.
	B3.8 How will the revised provision be secured by NHS England as the responsible commissioner? (e.g.	B3.8 The policy will be secured through the usual commissioning/decommissioning

	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	C1.1 Is this treatment paid under a national prices*, and if so which?	C1.1 SABR is not covered by a national tariff
	C1.2 Is this treatment excluded from national prices?	C1.2 N/A
	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?	C1.3 Yes – the local price is based on the national radiotherapy tariffs.

	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?	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.
	C1.5 is VAT payable (Y/N) and if so has it been included in the costings?	C1.5 N/A
	C1.6 Do you envisage a prior approval / funding authorisation being required to support implementation of the new policy?	C1.6 No – policy is for Not Routine Commissioning
C2 Average Cost per Patient	C2.1 What is the revenue cost per patient in year 1?	C2.1 £3,479
	C2.2 What is the revenue cost per patient in future years (including follow up)?	C2.2 £2,354 (Reduction reflects moving from an average of 31 fractions in Yr 1 to 20 fractions from Year 2.
C3 Overall Cost Impact of this Policy to NHS England	C3.1 Indicate whether this is cost saving, neutral, or cost pressure to NHS England.	C3.1 Cost Saving of £16.3k per year from reducing IFRs.
	C3.2 Where this has not been identified, set out the reasons why this cannot be	C3.2

	measured.	
C4 Overall cost impact of this policy to the NHS as a whole	C4.1 Indicate whether this is cost saving, neutral, or cost pressure for other parts of the NHS (e.g. providers, CCGs). C4.2 Indicate whether this is cost saving, neutral, or cost pressure to the NHS as a whole. C4.3 Where this has not been identified, set out the reasons why this cannot be measured. C4.4 Are there likely to be any costs or savings for non NHS commissioners / public sector funders?	C4.1 Cost Neutral – alternative treatment commissioned by NHS England. C4.2 Cost Saving –see M3 C4.4 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*	
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

	C6.2 Can these be mitigated, if so how?	C6.2 Not applicable
	C6.3 What scenarios (differential assumptions) have been explicitly tested to generate best case, worst case and most likely total cost scenarios?	C6.3 Not applicable
C7 Value for Money	C7.1 What evidence is available that the treatment is cost effective? *e.g. NICE appraisal, clinical trials or peer reviewed literature*	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.
	C7.2 What issues or risks are associated with this assessment? *e.g. quality or availability of evidence*	C7.2 No risks have been identified as evidence of cost effectiveness was not identified.
C8 Cost Profile	C8.1 Are there non-recurrent capital or revenue costs associated with this policy? *e.g. Transitional costs, periodical costs*	C8.1 Not applicable.
	C8.2 If so, confirm the source of funds to meet these costs.	C8.2 Not applicable.