

## Integrated Impact Assessment Report for Clinical Commissioning Policies

<b>Policy Reference Number</b>	D08X07		
<b>Policy Title</b>	DBS for post stroke pain		
<b>Accountable Commissioner</b>	Jacque Kemp	<b>Clinical Lead</b>	John Hughes
<b>Finance Lead</b>	Alison Taylor, Peter Davies	<b>Analytical Lead</b>	
<b>Section A - Activity Impact</b>			
<b>Theme</b>	<b>Questions</b>	<b>Comments</b> (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?	<p>A1. 1This policy proposes a non-routine commissioning position for DBS for post stroke pain.</p> <p><b>Chronic Post Stroke (CPSP)</b> prevalence amongst stroke patients ranges between 1 and 12% according to different estimates (Hosomi et al 2015). The wide range of the estimated prevalence arises as a result of different populations of patient studied and different tools for assessing pain severity. There are approximately 142,000 strokes in the UK/year and around 50,000 stroke victims die shortly afterwards. Of the 92,000 who survive, 30% (27,600) make full recovery, 65% (60,000) are disabled, and 5% (4,600) develop CPSP</p>	
	A1.2 What is the number of patients currently eligible for the treatment under the proposed policy?	<p>A1.2 There is currently a do not routinely commission policy published on NHS England website</p>	

	<p>A1.3 What age group is the treatment indicated for?</p> <p>A1.4 Describe the age distribution of the patient population taking up treatment?</p> <p>A1.5 What is the current activity associated with 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>A1.3 The treatment is indicated for adults (aged 18 years and over)</p> <p>A1.4 As the prevalence of chronic pain increases with age the number of patients presenting is likely to increase with this demographic</p> <p>A1.5 This is currently a not routine commissioned treatment and a policy is published</p> <p>A1.6 No future changes in the prevalence of post stroke pain has been identified and therefore the rate in A1.1 is expected to grow in line with</p> <p>A1.7 The policy proposes that DBS for PSP is not routinely commissioned</p> <p>A1.8 No geographical distribution has been identified for patients with post stroke pain.</p>
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?	A2.1 The policy proposes that DBS for PSP is not routinely commissioned

	<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>A2.4 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>A2.2 Demographics as detailed in A1.6</p> <p>A2.3 None known</p> <p>A2.4 The policy proposes that DBS for PSP is not routinely commissioned therefore there are no anticipated increase or decrease in patients accessing treatment</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 Nothing' comparator if policy is not adopted? Please details in accompanying excel</p>	<p>A3.Current annual activity detailed in A1.5</p> <p>A3.2 As in A2.4 the number of patients receiving DBS for post stroke pain will be zero</p> <p>A3.3 There is no comparative treatment as these are patients who have exhausted all other treatments and no best alternative treatment as these are patients have exhausted all other treatments. They will remain on their current treatment.</p>

	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 No currently commissioned pathway</p> <p>A4.2 N/A</p> <p>A4.3 N/A</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 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 N/A The policy proposes that DBS for PSP is not routinely commissioned</p> <p>A5.2 N/A The policy proposes that DBS for PSP is not routinely commissioned</p>
A6 New Patient Pathway	A6.1 Describe or include a figure to outline associated activity with the patient pathway for	A6.1 The policy proposes that DBS for PSP is not routinely commissioned

	<p>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>A6.2 N/A- The policy proposes that DBS for PSP is not routinely commissioned</p>
A7 Treatment Setting	<p>A7.1 How is this treatment delivered to the patient?</p> <ul style="list-style-type: none"> <li>○ Acute Trust: Inpatient/Daycase/ Outpatient</li> <li>○ Mental Health Provider: Inpatient/Outpatient</li> <li>○ Community setting</li> <li>○ Homecare delivery</li> </ul> <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 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>A7.2 N/A - The policy proposes that DBS for PSP is not routinely commissioned</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>A8.1 SUS</p>

	A8.2 How will this activity related to the new patient pathway be identified?(e.g. ICD10 codes/procedure codes)	A8.2 procedure codes
A9 Monitoring	<p>A9.1 Do any new or revised requirements need to be included in the NHS Standard Contract Information Schedule?</p> <p>A9.2 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</p>	<p>A9.1 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>A9.2 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>A9.3 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>A9.4 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>A9.5 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>A9.6 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>A9.7 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p>

	treatment? If so, please outline. <i>See also linked question in M1 below</i>	
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	<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 This is currently not routinely commissioned</p> <p>B1.2 N/A - The policy proposes that DBS for PSP is not routinely commissioned</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 Referrals to the tertiary pain centre come from secondary care specialist pain centres</p> <p>B2.2 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>B2.3 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>B2.4 Equality of access will remain the same</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</p>	<p>B3.1 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>B3.2 N/A - The policy proposes that DBS for</p>

	<p>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. publication and notification of new policy, competitive selection process to secure revised provider configuration)</p>	<p>PSP is not routinely commissioned</p> <p>B3.3 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>B3.4 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>B3.5 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>B3.6 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>B3.7 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>B3.8 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p>
B4 Collaborative Commissioning	B4.1 Is this service currently subject to or planned for collaborative commissioning arrangements? (e.g. future CCG lead,	B4.1 N/A - The policy proposes that DBS for PSP is not routinely commissioned



	devolved commissioning 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 N/A not routinely commissioned
	C1.2 Is this treatment excluded from national prices?	C1.2 N/A not routinely commissioned
	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 N/A not routinely commissioned
	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 N/A not routinely commissioned
	C1.5 is VAT payable (Y/N) and if so has it been included in the costings?	C1.5 N/A not routinely commissioned
	C1.6 Do you envisage a prior approval / funding authorisation being required to support implementation of the new policy?	C1.6 N/A not routinely commissioned
C2 Average Cost per Patient	C2.1 What is the revenue cost per patient in year 1?	C2.1 £30k per annum, consisting of device cost £18k plus £12k inpatient/outpatient activity cost

	C2.2 What is the revenue cost per patient in future years (including follow up)?	C2.2 Broadly same, plus small extra cost for annual outpatient follow ups. However, device needs to be replaced every 9 years on average, so cost rises in longer term.
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 measured.</p>	<p>C3.1 The policy proposes that DBS for PSP is not routinely commissioned. Therefore it should be cost neutral</p> <p>C3.2N/A</p>
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 Likely to be cost neutral to other parts of the NHS</p> <p>C4.2 Cost neutral</p> <p>C4.3 N/A</p> <p>C4.4 None identified</p>
C5 Funding	C5.1 Where a cost pressure is indicated, state known source of funds for investment, where identified. e.g. <i>decommissioning less clinically or cost-effective services</i>	C5.1 N/A
C6 Financial Risks	C6.1 What are the	C6.1 No material financial risk identified

<p>Associated with Implementing this Policy</p>	<p>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 most likely total cost scenarios?</p>	<p>C6.2 N/A</p> <p>C6.3 N/A</p>
<p>C7 Value for Money</p>	<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 N/A</p> <p>C7.2 N/A</p>
<p>C8 Cost Profile</p>	<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 N/A - The policy proposes that DBS for PSP is not routinely commissioned</p> <p>C8.2 N/A</p>