# Integrated Impact Assessment Report for Service Specifications

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| **Service Specification Reference** | B10/S/a | | |
| **Service Specification** | Thoracic Surgery | | |
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| **Section K - Activity Impact** | | | |
| **Theme** | **Questions** | | **Comments** (Include source of information and details of assumptions made and any issues with the data) |
| K1 Current Patient Population & Demography / Growth | K 1.1 What is the prevalence of the disease/condition? | | K1.1 The service specification is brand new and relates to Section 18 of the NHS Prescribed Services Manual, which states that 'Adult thoracic surgery services include all services provided by Adult Thoracic Surgery Centres including outreach when delivered as part of a provider network' is the |

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| | | commissioning responsibility of NHS England. The scope of this service is both malignant and non-malignant disease, with roughly a 50:50 split between the two. The service specification clarifies a number of important aspects:<br><br>• That services must specialise in thoracic surgery, in-line with current training arrangement for junior doctors; and<br>• That centres should be carrying out a minimum of 70 resections for primary lung cancer – because of the very clear link to outcomes.<br><br>The ten year prevalence of lung cancer is 36,653 (2013), with fairly stable incidence rates (falling in men, rising in women). Therefore the application of 1% growth to activity, related to demographic changes, is reasonable. |
| | K1.2 What is the number of patients eligible for this service under currently routinely commissioned care arrangements? | K1.2 Information from the 2010-2011 Society for Cardiothoracic Surgery (SCTS) Thoracic Surgical Register shows that only 29 hospitals throughout England provided thoracic surgery. |

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| | | 22,548 operations were carried out in total, of which 15,302 were classified as major procedures. The number of total/major operations performed within each of the 29 units ranged from 237/183 to 1,974/1,197 procedures per year. |
| | K1.3 What age group is the service indicated for? | K1.3 The service is for adults (aged 18 years and over), in accordance with the national prescribed services manual. |
| | K1.4 Describe the age distribution of the patient population taking up treatment? | K1.4 Lung cancer incidence is strongly related to age, with the highest incidence rates being in older males and females. In the UK in 2011-2013, on average each year around 6 in 10 (61%) cases were diagnosed in people aged 70 and over (Cancer Research UK).<br><br>Age-specific incidence rates rise steeply from around age 45-49 and peak in the 85-89 age group for males and in the 80-84 age group for females. Incidence rates are higher for males than females in those aged 40-44 and from age 55-59, with no significant sex differences in younger age groups. This gap is widest at age 90+, when the male:female ratio of age-specific incidence rates (to |

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| | | account for the different proportions of males to females in each age group) is around 22:10 (Cancer Research UK). |
| | K1.5 What is the current activity associated with currently routinely commissioned care for this group? | K1.5 See K1.2. |
| | K1.6 What is the projected growth of the disease/condition prevalence (prior to applying the new policy) in 2, 5, and 10 years | K1.6 Incidence is a more relevant indicator of likely activity growth. For malignant disease, incidence rates are stable (falling in men, rising in women). Therefore the application of 1% growth to activity, related to demographic changes, is reasonable |
| | K1.7 What is the associated projected growth in activity (prior to applying the new policy) in 2,5 and 10 years | K1.7 Please see K1.6, the growth figures are the same, i.e., based on incidence. |
| | K1.8 How is the population currently distributed geographically? | K1.8 Incidence and mortality for lung cancer is strongly related to smoking and alcohol. Generally both have below average rates in the south and midlands of England and higher in a band across the formerly highly |

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| | | industrialised north of England (ONS, 2010). The geographical pattern of non-malignant disease is not known. |
| K2 Future Patient Population & Demography | K2.1 Does the new specification: 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? | K2.1 Not applicable. The service specification is brand new, having not been put in place during the first wave of NHS England specialised commissioning service specification development. |
| | K2.2 Please describe any factors likely to affect growth in the patient population for this service (e.g. increased disease prevalence, increased survival) | K2.2 No additional factors, not previously listed within K1.6 and K1.7, have been identified. |
| | K 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 | K2.3 No changes have been identified. |
| | K2.4 What is the resulting expected net increase or decrease in the number of patients who will access the service per year in year 2, 5 and 10? | K2.4 Please see K1.6 and K1.7. |
| K3 Activity | K3.1 What is the current annual activity for the target population covered under the new specification? Please provide details in | K3.1 No change is expected to the annual activity rates for the service, as a result of the revised service |

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| | accompanying excel sheet | specification. However, activity will change over time as a result of demographic changes and changes to incidence rates. Please see K1.5, K1.6 and K1.7. |
| | K3.2 What will be the new activity should the new / revised specification be implemented in the target population? Please provide details in accompanying excel sheet | K3.2 Not applicable. The new service specification is not expected to alter the numbers of people diagnosed with lung cancer. However, the specification does outline minimum volumes for thoracic surgery centres to undertake. This is based upon evidence relating to lung cancer outcomes and centre volume. It is expected that these changes will drive a switch to lung surgery for primary lung cancer from chemotherapy or radiotherapy treatments. |
| | K3.3 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 | K3.3 Not applicable. |
| K4 Existing Patient Pathway | K4.1 If there is a relevant currently routinely commissioned service, what is the current patient pathway? Describe or include a figure to outline associated activity. | K4.1 See K 1.1 and K1.2. |

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| | K4.2 What are the current treatment access criteria? | K4.2 For malignant disease, access to the specialist MDT will predominantly be via referral following a confirmed or suspected diagnosis of lung cancer. However, some patients will be referred directly to a tertiary centre, where this is the local hospital. For non-malignant disease, access is by referral to the specialist centre, usually acting as a tertiary receiver of the referral. |
| | K4.3 What are the current treatment stopping points? | K4.3 Not applicable. |
| K5 Comparator (next best alternative treatment) Patient Pathway | K5.1 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. | K5.1 Not applicable. |
| | K5.2 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. | K5.2 Not applicable. |

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| K6 New Patient Pathway | K6.1 Describe or include a figure to outline associated activity with the patient pathway for the proposed new service specification<br><br>K6.2 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. | K6.1 Not applicable, the service specification will not alter the number of thoracic surgery diagnoses or treatments. However the proportion of surgical to non-surgical intervention is expected to change.<br><br>K6.2 Not applicable. |
| K7 Treatment Setting | K7.1How is this treatment delivered to the patient?<br><br>K7.2 Is there likely to be a change in delivery setting or capacity requirements, if so what?<br>*e.g. service capacity* | K7 The bulk of services, i.e., surgical interventions, are performed on an in-patient basis. However, some assessment and follow-up care is commissioned by NHS England where this activity is performed in the Specialist Centre.<br><br>K7.2 No change in the delivery setting is expected as a result of the implementation of the service specification. |
| K8 Coding | K8.1 In which datasets (e.g. SUS/central data collections etc.) will activity related to the new | K8.1 Not applicable, however all relevant activity (i.e., associated with the |

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| | patient pathway be recorded? | service specification) is recorded on SUS. |
| | K8.2 How will this activity related to the new patient pathway be identified?(e.g. ICD10 codes/procedure codes) | K8.2 Not applicable. |
| K9 Monitoring | K9.1 Do any new or revised requirements need to be included in the NHS Standard Contract Information Schedule? If so, these must be communicated to CTownley@nhs.net, ideally by end of October to inform following year's contract | K9.1 No changes are required. |
| | K9.2 If this treatment is a drug, what pharmacy monitoring is required? | K9.2 Not applicable. |
| | K9.3 What analytical information /monitoring/ reporting is required? | K9.3 Not applicable. |
| | K9.4 What contract monitoring is required by supplier managers? What changes need to be in place? | K9.4 Not applicable. |
| | K9.5 Is there inked information required to complete quality dashboards and if so is it being incorporated into routine performance monitoring? | K9.5 Not applicable. |

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| | K9.6 Are there any directly applicable NICE quality standards that need to be monitored in association with the new policy?<br><br>K9.7 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* | K9.6 These have been built into the service specification.<br><br>K9.7 Not applicable. |
| **Section L - Service Impact** | | |
| **Theme** | **Questions** | **Comments** (Include source of information and details of assumptions made and any issues with the data) |
| L1 Service Organisation | L1.1 How is this service currently organised (i.e. tertiary centres, networked provision)<br><br>L1.2 How will the proposed specification change the way the commissioned service is organised? | L1.1 The services are tertiary centres as part of larger clinical networks for cancer.<br><br>L1.2 The revised service specification represents the current care pathways more accurately and reflects the appropriate quality metrics for the service. Therefore, no change in how the service is commissioned is expected as a result of the implementation of the service specification. |

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| L2 Geography & Access | L2.1 Where do current referrals come from?<br><br>L2.2 Will the new specification change / restrict / expand the sources of referral?<br><br>L2.3 Is the new policy likely to improve equity of access?<br><br>L2.4 Is the new policy likely to improve equality of access / outcomes? | L2.1 Please see K4.1 and K4.2<br><br>L2.2 No change.<br><br>L2.3 No change.<br><br>L2.4 No change. |
| L3 Implementation | L3.1 Is there a lead in time required prior to implementation and if so when could implementation be achieved if the policy is agreed?<br><br>L3.2 Is there a change in provider physical infrastructure required?<br><br>L3.3 Is there a change in provider staffing required?<br><br>L3.4 Are there new clinical dependency / adjacency requirements that would need to be in place?<br><br>L3.5 Are there changes in the support services that | L3.1 The revised service specification should be introduced no later than from April 2017. However, in some areas it may be possible to implement this during 2016/17, by negotiation and agreement with the 28-30 current thoracic surgery providers.<br><br>L3.2 Not applicable.<br><br>L3.3 Not applicable.<br><br>L3.4 Not applicable.<br><br>L3.5 Not applicable. |

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| | need to be in place?<br><br>L3.6 Is there a change in provider / inter-provider governance required? (e.g. ODN arrangements / prime contractor)<br><br>L3.7 Is there likely to be either an increase or decrease in the number of commissioned providers?<br><br>L3.8 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) | <br><br>L3.6 Not applicable.<br><br>L3.7 It is likely that there will be a small decrease in the number of providers, which are mostly considered to be already in the pipeline of changes.<br><br>L3.8 Through local commissioning teams working collaboratively with providers. In some areas it may be necessary to run a selection process. |
| L4 Collaborative Commissioning | L4.1 Is this service currently subject to or planned for collaborative commissioning arrangements? (e.g. future CCG lead, devolved commissioning arrangements)? | L4.1 There are no known collaborative commissioning or devolution plans associated with these services on a national basis. |
| **Section M - Finance Impact** | | |
| **Theme** | **Questions** | **Comments** (Include source of information and details of assumptions made and any issues with the data) |
| M1 Tariff | M1.1 Is this service paid under a national prices*, and if so which? | M1.1 to M1.3 The service is predominantly funded through national |

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| | M1.2 Is this service excluded from national prices? | prices, however there are some arrangements in place for pass-through and some local price arrangements. |
| | M1.3 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? | |
| | M1.4 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 | M1.4 Not applicable. |
| | M1.5 is VAT payable (Y/N) and if so has it been included in the costings? | M1.5 Not applicable. |
| | M1.6 Do you envisage a prior approval / funding authorisation being required to support implementation of the new specification? | M1.6 Not applicable. |
| M2 Average Cost per Patient | M2.1 What is the revenue cost per patient in year 1?<br><br>M2.2 What is the revenue cost per patient in future years (including follow up)? | M2.1 and M2.2 Not applicable, there is no single price for a patient accessing services covered by the Thoracic Surgery service specification. |
| M3 Overall Cost Impact of this Policy to NHS England | M3.1 Indicate whether this is cost saving, neutral, or cost pressure to NHS England? | M3.1 The revised service specification is expected to be cost neutral to NHS |

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| | M3.2 Where this has not been identified, set out the reasons why this cannot be measured? | England.<br><br>M3.2 Not applicable. |
| M4 Overall cost impact of this policy to the NHS as a whole | M4.1 Indicate whether this is cost saving, neutral, or cost saving for other parts of the NHS (e.g. providers, CCGs)<br><br>M4.2 Indicate whether this is cost saving, neutral, or cost pressure to the NHS as a whole?<br><br>M4.3 Where this has not been identified, set out the reasons why this cannot be measured?<br><br>M4.4 Are there likely to be any costs or savings for non NHS commissioners / public sector funders? | M4.1 The revised service specification is cost neutral to other parts of the NHS.<br><br>M4.2 Cost neutral.<br><br>M4.3 Not applicable.<br><br>M4.4 No costs or savings have been identified for non NHS commissioners / public sector funders. |
| M5 Funding | M5.1 Where a cost pressure is indicated, state known source of funds for investment, where identified | M5.1 Not applicable. |
| M6 Financial Risks Associated with Implementing this Policy | M6.1 What are the material financial risks to implementing this service specification?<br><br>M6.2 Can these be mitigated, if so how?<br><br>M6.3 What scenarios (differential assumptions) | M6.1 There are no known financial risks associated with the implementation of the revised service specification.<br><br>M6.2 Not applicable.<br><br>M6.3 Not applicable. |

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| | have been explicitly tested to generate best case, worst case and most likely total cost scenarios | |
| M7 Value for Money | M7.1 What evidence is available that the treatment is cost effective?<br><br>M7.2 What issues or risks are associated with this assessment? | M7.1Not applicable.<br><br>M7.2 Not applicable. |
| M8 Cost Profile | M8.1 Are there non-recurrent capital or revenue costs associated with this specification?<br><br>M8.2 If so, confirm the source of funds to meet these costs. | M8.1 There are no non-recurrent capital or revenue costs associated with the service specification.<br><br>M8.2 Not applicable. |