Integrated Impact Assessment Report for Service Specifications

Service Specification Reference	B14/S/a		
Service Specification	Urological cancers – Specialised kidney, bladder and prostate cancer services		
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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? K1.2 What is the number of patients eligible for this service under currently routinely commissioned care arrangements?		K1.1, K1.2 **Prostate cancer** is a form of cancer that develops in the prostate and accounts for 25% of all male cancers. In 2010, there were more than 40,000 newly diagnosed cases of prostate cancer in the UK, with a crude incidence

		rate of 136 cases per 100,000 population. **Bladder cancer** is any of several types of malignant growths of the urinary bladder. The most common type of bladder cancer begins in cells lining the inside of the bladder and is called transitional cell carcinoma. In UK there were over 10,000 new cases of bladder cancer diagnosed. The Incidence of bladder cancer is higher in males than in females, The crude incidence rate per 100,000 population for bladder cancer is 25 in men and 9.0 in women. One year relative survival estimates for bladder cancer also differ between males and females at 78% and 64% respectively. **Kidney cancer** is a form of cancer that develops in the kidneys. The two most common types of kidney cancer, reflecting their location within the kidney, are renal cell carcinoma (RCC) and urothelial cell carcinoma (UCC) of the renal pelvis. In 2010, there were over 9,639 newly diagnosed cases of kidney cancer in the UK. The crude incidence rate per 100,000 population

		is 15.9 in men and 9.6 in women. Cancer of the renal pelvis is less common with around 500 cases per year. Relative survival estimates for kidney cancer (excluding renal pelvis) are similar for both sexes at 70 per cent for males and 68 per cent for females.
	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: **Kidney cancer:** There is a 1.5:1 predominance in men over women, with peak incidence occurring between 60 and 70 years of age (Public Health England, 2015). **Bladder cancer:** Is rare under the age of 50, with the peak age standardised rate (ASR) occurring in men aged 75-79 and in women over the age of 85 in the U.K. (Public Health England). **Prostate cancer:** Prostate cancer is predominantly a disease of older men

		(aged 65–79 years) but around 25% of cases occur in men below the age of 65
	K1.5What is the current activity associated with currently routinely commissioned care for this group?	K1.5 See K1.1, K1.2 and K1.6.
	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, as follows: **Kidney cancer:** The rate of new diagnoses (incidence) of kidney cancer has risen significantly in England since 2011 and in 2013 there were 8,562 new diagnoses in England (Public Health England, 2015). **Bladder cancer:** In the U.K. there has been a progressive decline in bladder cancer incidence rates since a peak in the early 1990's, with overall ASR falling from 18.4 per 100 000 in 1993 to 11.5 in 2008, although this decline is far more pronounced in men than women. This trend in the U.K. corresponds to declining incidence and mortality rates in the European Union (EU) since the

		early 1990's and in USA since the 1970's (Bosetti 2011, Ferlay 2008, Zhang 2011). **Prostate cancer:** Incidence is stable, therefore activity is likely to grow in-line with demographic changes.
	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.
	K1.8 How is the population currently distributed geographically?	K1.8 **Kidney cancer:** Cases of kidney cancer are unevenly distributed throughout England, with higher incidence and prevalence being observed in the North as compared to the South. However, kidney cancer is the eighth most common cancer in the UK, as such will impact all areas of England. It should be noted that kidney cancer is also more common in males than females. **Bladder cancer:** The distribution of bladder cancer is difficult to assess with

		certainty given the known issues in disease classification and recording. However, it does impact more males than females and older people (ONS). **Prostate cancer:** Cases of prostate cancer are unevenly spread through England, with higher age-standardised rates in the South-East as compared to the North-East (Cancer Registrations Statistics, 2015).
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 revised service specification provides: • Additional service models for health economies to use as guide where there is an appetite to go beyond Improving Outcomes Guidance requirements; • Clarification on how IOG standards can be met, i.e., the types of service configuration that are permitted; • Clarification on procedure volumes; and • Revised service outcome metrics.

	K2.2 Please describe any factors likely to affect growth in the patient population for this service (e.g. increased disease prevalence, increased survival) 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 K2.4 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?	K2.2 No additional factors, not previously listed within K1.6 and K1.7, have been identified. K2.3 No changes have been identified. 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 accompanying excel sheet 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	K3.1 No change is expected to the annual activity rates for the service, as a result of the revised service 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 Not applicable. The new service specification is not expected to alter the numbers of people diagnosed with either/and kidney, bladder and prostate

		cancer.
	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 The prescribed services manual defines that the adult specialist urology surgery services includes all services provided by Adult Urology Surgery Centres including assessment if performed and the Specialist Centre. The activity associated with this service specification is contained within section K1.5. The aim of the specialised urological cancer service is to deliver high quality holistic care so as to increase survival while maximising a patient's functional capability and quality of life and to ensure ready and timely access to appropriate supportive care for patients, their relatives and carers. The service will be delivered through a specialist urology multi-disciplinary team. The patient pathway begins with either a GP referral to secondary care or an emergency admission resulting in a diagnosis of a urological cancer. Typically, patients will present through a

		GP referral to secondary care and may access surgical interventions through a referral to the tertiary provider, i.e., to the specialist MDT within the cancer network.
	K4.2 What are the current treatment access criteria?	K4.2 Access to the specialist MDT will predominantly be via referral following a confirmed diagnosis of a urological cancer. However, some patients will be referred directly to a tertiary centre, where this is the local hospital.
	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	K5.2 Not applicable.

	indicate likely outcome for patient at each stopping point.	
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 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 urological cancers diagnosed. K6.2 Not applicable.
K7 Treatment Setting	K7.1How is this treatment delivered to the patient? K7.2 Is there likely to be a change in delivery setting	K7 The prescribed services manual defines that the adult specialist urology surgery services includes all services provided by Adult Urology Surgery Centres including assessment if performed and the Specialist Centre. 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.

	or capacity requirements, if so what? *e.g. service capacity*	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 patient pathway be recorded? K8.2 How will this activity related to the new patient pathway be identified?(e.g. ICD10 codes/procedure codes)	K8.1 Not applicable, however all relevant activity (i.e., associated with the service specification) is recorded on SUS. 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 K9.2 If this treatment is a drug, what pharmacy monitoring is required? K9.3 What analytical information /monitoring/ reporting is required? K9.4 What contract monitoring is required by supplier managers? What changes need to be in	K9.1 No changes are required. K9.2 Not applicable. K9.3 Not applicable.

	place? K9.5 Is there inked information required to complete quality dashboards and if so is it being incorporated into routine performance monitoring? K9.6 Are there any directly applicable NICE quality standards that need to be monitored in association with the new policy? 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*	K9.4 Not applicable. K9.5 Not applicable. There is a draft quality dashboard in development. K9.6 These have been built into the revised service specification. 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) 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. L1.2 The revised service specification enables some health economies to

		move beyond IOG in terms of their configuration and sub-specialisation. However, the specification does not move away from IOG requirements as a minimum compliance requirement. Therefore, the service specification enables commissioners and providers to work collaboratively to agree the best service delivery model and configuration for the geography in question.
L2 Geography & Access	L2.1 Where do current referrals come from? L2.2 Will the new specification change / restrict / expand the sources of referral? L2.3 Is the new policy likely to improve equity of access? L2.4 Is the new policy likely to improve equality of access / outcomes?	L2.1 Please see K4.1 and K4.2 L2.2 No change. L2.3 No change. 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? L3.2 Is there a change in provider physical	L3.1 The revised service specification should be introduced from April 2017, in order to allow local commissioning teams sufficient time to consider the implications and agree commissioning plans with providers. L3.2 Not applicable.

	infrastructure required?	
	L3.3 Is there a change in provider staffing required?	L3.3 Not applicable.
	L3.4 Are there new clinical dependency / adjacency requirements that would need to be in place?	L3.4 Not applicable.
	L3.5 Are there changes in the support services that need to be in place?	L3.5 Not applicable.
	L3.6 Is there a change in provider / inter-provider governance required? (e.g. ODN arrangements / prime contractor)	L3.6 Not applicable.
	L3.7 Is there likely to be either an increase or decrease in the number of commissioned providers?	L3.7 No change.
	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)	L3.8 Through local commissioning teams working collaboratively with providers.
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)?	
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? M1.2 Is this service excluded from national prices? 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 M1.5 is VAT payable (Y/N) and if so has it been included in the costings? M1.6 Do you envisage a prior approval / funding	M1.1 to M1.3 The service is predominantly funded through national process, however there are some arrangements in place for pass-through (drugs and devises) and some local price arrangements. M1.4 Not applicable. M1.5 Not applicable. M1.6 Not applicable.

	authorisation being required to support implementation of the new specification?	
M2 Average Cost per Patient	M2.1 What is the revenue cost per patient in year 1? 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 Kidney, Bladder and Prostate 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? M3.2 Where this has not been identified, set out the reasons why this cannot be measured?	M3.1 The revised service specification is cost neutral to NHS England. 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) M4.2 Indicate whether this is cost saving, neutral, or cost pressure to the NHS as a whole? M4.3 Where this has not been identified, set out the reasons why this cannot be measured? 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. M4.2 Cost neutral. M4.3 Not applicable. 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? M6.2 Can these be mitigated, if so how? M6.3 What scenarios (differential assumptions) have been explicitly tested to generate best case, worst case and most likely total cost scenarios	M6.1 There are no known financial risks associated with the implementation of the revised service specification. M6.2 Not applicable. M6.3 Not applicable.
M7 Value for Money	M7.1 What evidence is available that the treatment is cost effective? M7.2 What issues or risks are associated with this assessment?	M7.1Not applicable. M7.2 Not applicable.
M8 Cost Profile	M8.1 Are there non-recurrent capital or revenue costs associated with this specification? 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. M8.2 Not applicable.