Integrated Impact Assessment Report for Clinical Commissioning Policies

Policy Reference Number			
Policy Title	Commissioning Medicines In Children		
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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?	This will be dependent on the particular intervention and indication. There were 198 IFR requests for children during the 15/16 financial year of which 30 would have been considered under this policy.
	A1.2 What is the number of patients currently eligible for the treatment under the proposed policy?	30 requests under the IFR process have been received in a 12 month period that would have been considered under the proposed policy
	A1.3 What age group is the treatment indicated for?	Any patient under the age of 18
	A1.4 Describe the age distribution of the patient population taking up treatment?	As per A1.3

	A1.5 What is the current activity associated with currently routinely commissioned care for this group?	Most of the treatments are oral so activity will largely be OP based but there may be some day case activity where treatment is delivered by IV infusion
	A1.6 What is the projected growth of the disease/condition prevalence (prior to applying the new policy) in 2, 5, and 10 years?	This is impossible to predict given the policy will cover any indication for adults
	A1.7 What is the associated projected growth in activity (prior to applying the new policy) in 2,5 and 10 years?	As per A1.6
	A1.8 How is the population currently distributed geographically?	The population will be distributed evenly across England although more activity may take place within specialised children's centres
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?	The policy will expand access to patients under the age of 18 where there is an existing NICE TA or NHS England policy within the adult population
	A2.2 Please describe any factors likely to affect growth in the patient population for this intervention (e.g. increased disease prevalence, increased survival).	The only factor would be a growth in approved NICE TA's and/or NHS England policies which would apply to the paediatric population
	A 2.3 Are there likely to be changes in geography/demography	Not anticipated

	of the patient population and would this impact on activity/outcomes? If yes, provide details.	
	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?	As per A1.6. There were 30 IFR cases in 15/16 where this policy would have applied
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.	This figure is unknown as these patients are likely to be accessing some services currently due to their specific disease but the population is diverse.
	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.	For the 30 requests received there would be an additional 31 day cases for IV infusions; 2 sessions for intravitreal implants and circa 50 additional OP visits.
	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 sheet.	As per A3.2 given there could be many different interventions. It is quite possible that the 'do nothing' scenario would lead to higher activity costs eg acute admissions
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.	There will be numerous patient pathways. However the treatment provided under the proposed policy will be a recognised part of that pathway in the adult setting.
	A4.2. What are the current treatment access	Numerous

	criteria? A4.3 What are the current treatment stopping points?	 As per A4.2
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 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.	There is unlikely to be a routinely commissioned option when a clinician is accessing treatment under the proposed policy Impossible to provide an answer to this question given the diversity of possible treatment options
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	As per A3.2 As per A5.2

	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.	
A7 Treatment Setting	A7.1 How is this treatment delivered to the patient? ○ Acute Trust: Inpatient/Daycase/ Outpatient ○ Mental Health Provider: Inpatient/Outpatient ○ Community setting ○ Homecare delivery	IV infusions will be delivered as day cases attendance in the acute sector. All other treatments are either oral or sub cut and can therefore be delivered in the home setting.
	A7.2 Is there likely to be a change in delivery setting or capacity requirements, if so what? *e.g. service capacity*	No
A8 Coding	A8.1 In which datasets (e.g. SUS/central data collections etc.) will activity related to the new patient pathway be recorded?	Some data collection would be anticipated in biologic registries. Otherwise data through the minimum data set and SUS would be expected.
	A8.2 How will this activity related to the new patient pathway be identified?(e.g. ICD10 codes/procedure codes)	As per A8.1
A9 Monitoring	A9.1 Do any new or revised requirements need to be included in the NHS Standard Contract Information Schedule?	None

	A9.2 If this treatment is a drug, what pharmacy monitoring is required?	Nothing above the usual monitoring required in the adult population
	A9.3 What analytical information /monitoring/ reporting is required?	None
	A9.4 What contract monitoring is required by supplier managers? What changes need to be in place?	None
	A9.5 Is there inked information required to complete quality dashboards and if so is it being incorporated into routine performance monitoring?	No
	A9.6 Are there any directly applicable NICE quality standards that need to be monitored in association with the new policy?	No
	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*	Blueteq may be used for some indications but that will be based on whether it is being used in the adult setting
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)	Through Children's services some of who will be tertiary

	B1.2 How will the proposed policy change the way the commissioned service is organised?	It won't – it will reduce the need for IFR requests
B2 Geography & Access	B2.1 Where do current referrals come from?	From across the country
	B2.2 Will the new policy change / restrict / expand the sources of referral?	No
	B2.3 Is the new policy likely to improve equity of access?	Yes as it will reduce the need for IFR requests and standardise the way such requests are handled
	B2.4 Is the new policy likely to improve equality of access / outcomes?	As per B2.3
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?	No – these treatments are already provided but in the adult setting and to some extent in the paediatric setting. The policy will standardise access.
	B3.2 Is there a change in provider physical infrastructure required?	As per B3.1
	B3.3 Is there a change in provider staffing required?	As per B3.1
	B3.4 Are there new clinical dependency / adjacency requirements that would need to be in place?	As per B3.1

	B3.5 Are there changes in the support services that need to be in place?	As per B3.1
	B3.6 Is there a change in provider / inter-provider governance required? (e.g. ODN arrangements / prime contractor)	No
	B3.7 Is there likely to be either an increase or decrease in the number of commissioned providers?	Not anticipated
	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)	n/a
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)	No although CCG's may be interested in adopting the policy for their commissioned services
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?	No these treatments are excluded to tariff. Some activity costs will be covered within tariff but these are bundled in as part of the overall cost

	C1.2 Is this treatment excluded from national prices?	Yes
	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?	No costs will be paid as pass through
	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?	n/a
	C1.5 is VAT payable (Y/N) and if so has it been included in the costings?	VAT will be payable for use within Trusts and has not been included
	C1.6 Do you envisage a prior approval / funding authorisation being required to support implementation of the new policy?	In some cases where a Blueteq form is required in the adult setting
C2 Average Cost per Patient	C2.1 What is the revenue cost per patient in year 1?	£408k based on IFR requests received during 15/16 where this policy would apply
	C2.2 What is the revenue cost per patient in future years (including follow up)?	Difficult to estimate as other drugs will come on line that this policy will apply to
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.	Likely to be cost pressure although this will be offset by avoidance of other costs eg in patient admission, other therapies

	C3.2 Where this has not been identified, set out the reasons why this cannot be measured.	As per C3.1
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).	As per C3.1
	C4.2 Indicate whether this is cost saving, neutral, or cost pressure to the NHS as a whole.	As per C3.1
	C4.3 Where this has not been identified, set out the reasons why this cannot be measured.	As per C3.1
	C4.4 Are there likely to be any costs or savings for non NHS commissioners / public sector funders?	As per C3.1
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*	None have been identified – it should be noted that a number of children are currently funded through this system. The policy standardises access across the country. Access to drugs via this policy could be cost saving as per C3.1
C6 Financial Risks Associated with Implementing this Policy	C6.1 What are the material financial risks to implementing this policy?	Higher uptake of drugs than anticipated from IFR requests received during 15/16
	C6.2 Can these be mitigated, if so how?	Uptake of drugs through this policy could be monitored and if uptake is higher a view could be taken as to whether an individual policy is required t for that drug/indication
	C6.3 What scenarios	None

	(differential assumptions) have been explicitly tested to generate best case, worst case and most likely total cost scenarios?	
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*	Medicines accessed under this policy will either have been approved via a NICE TA or NHS England policy for adults
	C7.2 What issues or risks are associated with this assessment? *e.g. quality or availability of evidence*	Not all evidence is translatable to the paediatric population but the stated criteria for access through the policy should mitigate this
C8 Cost Profile	C8.1 Are there non-recurrent capital or revenue costs associated with this policy? *e.g. Transitional costs, periodical costs*	No
	C8.2 If so, confirm the source of funds to meet these costs.	n/a