NHS England

Consultation Guide

Stereotactic Radiosurgery and Radiotherapy Services

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Stereotactic Radiosurgery and Radiotherapy Services

Consultation Guide

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Contents

Introduction

1. NHS England became responsible for the commissioning of Stereotactic Radiosurgery and Stereotactic Radiotherapy (SRS/SRT) services in April 2013. As the direct commissioner of these services, NHS England commissions care pathways for patients who require SRS and SRT for intracranial conditions, such as benign and malignant brain tumours.

2. In 2013/14, NHS England carried out a needs assessment and service review of SRS/SRT in order to quantify the level of SRS/SRT treatment needed by the residents of England and determine the number of SRS/SRT providers required to meet that need.

3. A report detailing the findings of that needs assessment and service review, and the conclusions and recommendations arising from it. This consultation guide should be read in conjunction with that document.

4. As a national commissioner , NHS England is in the position, for the first time, to examine the national need for, and establish the capacity requirements of, SRS/SRT in a coordinated way, so that we can secure equitable geographical access for patients requiring these services.

5. This Consultation Guide aims to explain the thinking behind the changes proposed to the way SRS/SRT services are delivered and commissioned; why we are consulting on those proposals, as well as setting out the detail of the various options for change, their relative merits and the preferred option of NHS England.

6. The Guide subsequently outlines several consultation questions that NHS England is seeking responses to. It also describes how NHS England will collate feedback from stakeholders and use this information to inform a decision concerning the level of activity and service provision for SRS/SRT. View details about how to respond to the consultation.

Why We Are Consulting

7. NHS England is committed to ensuring patients have access to consistent high quality, effective, efficient services that represent value for money and are sustainable in the longer term.

8. The current arrangements for the provision of SRS/SRT, as set out in the Needs Assessment and Service Review document, have led to duplicated and excess capacity in certain areas, leaving much of the country with poor levels of access. The review concludes that NHS England has an opportunity to

address the current legacy issues, for the first time taking a strategic approach to the level and location of SRS/SRT capacity in order to achieve better outcomes for patients. Any changes in levels of service provision, through either commissioning increased or decreased capacity, would be undertaken in a coordinated way.

9. NHS England wants to ensure that, in the approach taken, any financial risks for providers and commissioners are minimised, by ensuring that any recommendations for the future configuration and commissioning of SRS/SRT are in line with the strategic intentions for these services, and with those outlined in the publication 'Everyone Counts: Planning for Patients 2014-15 – 2018-19'.

10. The Needs Assessment and Service Review outlined two scenarios, both of which indicated that a significant increase in the demand for SRS/SRT could be predicted, over a relatively short period of time. Although the demand scenarios were different, they both represent a significant change to the level of SRS/SRT capacity which is currently available.

11. The Review also argues that the services should be operating at 85% capacity, , which would mean that despite a large increase in SRS/SRT treatment, the number of providers required may be less than the combined number of current providers, plus aspiring market entrants. This is reflected in the options for change.

12. NHS England is publicly consulting on these proposed changes, and wants to hear from interested stakeholders, in particular from those who require, or have used SRS/SRT services, and their families, as well as from clinicians and other staff working in this service area, and from those with a wider interest.

The Options for Change

13. The Project Team, consisting of a small number of NHS England staff and clinicians from the Stereotactic Radiosurgery Clinical Reference Group, identified two key variables to address:

- the level of treatment needed for the residents of England, as predicted in Scenarios A and B; and
- whether the service should operate for five or seven days a week.

14. Scenario A was based on the level of need identified in the suite of NHS England Clinical Commissioning Policies, using this information to identify where SRS/SRT might be required. The predicted growth in this scenario represented a doubling of treatment compared to the current level.

15. Scenario B was based on an expected growth demand based on the treatment rates of some other European countries. The predicted growth

demand in this scenario equated to more than trebling the current level of treatment.

16. A review of the elements of growth anticipated under Scenarios A and B, and exploring the variables of five and seven-day working weeks, produced four options for change

17. The following options 1 and 3 are based on a five-day working week. The "part-time" machines are assumed to be operating two days a week for SRS/T and the remaining time for radiotherapy. In options 2 and 4, for the seven-day working week, the "part-time" machines are assumed to be operating four days a week for SRS/T.

Option 1: Under this option NHS England would plan to commission activity at the levels suggested in **Scenario A** as this is the most likely current scenario for the need requirements for SRS/T across a **five-day service**.

Option 1 has a planning assumption of between 8 and 25 machines, depending on the mix of dedicated and part time machines.

Option 2: Under this option NHS England would plan to commission activity at the levels suggested in **Scenario A** as this is the most likely current scenario for the need requirements for SRS/T across a **seven-day service**.

Option 2 has a planning assumption of between six and 12 machines, depending on the mix of dedicated and part time machines.

Option 3: Under this option NHS England would plan to commission activity at the levels suggested in **Scenario B** which would align capacity to levels that increase access rates **five-day service**.

Option 3 has a planning assumption of between 14 and 45 machines, depending on the mix of dedicated and part time machines.

Option 4: Under this option NHS England would plan to commission activity at the levels suggested in **Scenario B** which would align capacity to levels that increase access rates to those seen internationally and implement an active plan to achieve this across a **seven-day service**.

Option 4 has a planning assumption of between 10 and 22 machines, depending on the mix of dedicated and part time machines

Option Appraisal and Preferred Option

18. For all of the options considered, the Project Team recommended that centres be sited around the country more equitably than is the case in current commissioning arrangements. The relative merits of each option were outlined by the Project Team and are as follows:

Option 1 (Scenario A, five-day working)

(i) The projected activity is in line with the volumes specified in existing NHS England clinical commissioning policies. There is less risk of overcapacity given uncertainty of growth rates to international levels.

(ii) A five-day service may be easier for centres to staff than a seven-day service.

(iii) This is in line with the current culture of many trusts of providing most elective treatment on week days.

(iv) There may be a wider range of interested providers as some providers might withdraw from the procurement process under other options because of an inability to support seven-day working

(v) The machine delivering SRS/T will be idle 2/7ths of the week (29%), leading to a higher cost per case than is possible within seven-day working. A higher cost per case means less funding is available for other NHS services, and less likelihood of extending the range of conditions the treatment can be used for in future, due to reduced cost-effectiveness.

(vi) In five-day working, more centres are needed to meet the capacity requirements in comparison to the number of centres needed for seven-day working. This leads to greater geographical accessibility, but at higher cost.

(vii) Five-day working is not in line with the national strategic direction of moving towards seven- day provision of services.

(viii) This option is able to achieve activity levels that are higher than Scenario A.

Option 2 (Scenario A, seven-day working)

(i) The activity is in line with the volumes specified in existing NHS England clinical commissioning policies. This option has the lowest risk of overcapacity given the uncertainty of growth rates to match international levels, or if the uptake is closer to the base case incremental growth levels.

(ii) A seven-day service may be harder for centres to staff than a five-day service. However, once established it will more able to be a sustainable centre of excellence.

(iii) Some providers might withdraw from the procurement process because of an inability to support seven-day working.

(iv) There is no idle capacity at weekends leading to a lower cost per case than five-day working.

(v) This option is aligned to the national strategic direction of moving towards seven-day service provision.

(vi) This option requires fewer centres to meet patient need, and would therefore lead to less geographical accessibility than options which require more centres, although inequity in geographical accessibility is addressed under all options.

(vii) This option is less able to respond to activity levels that are higher than Scenario A

Option 3 (Scenario B, five-day working)

(i) This option can deliver activity which exceeds the volumes specified in existing NHS England clinical commissioning policies, so the costs and benefits of any changes in indications would be subject to future prioritisation against other health needs. Providers would bear the risk that future decisions did not find further extensions to access cost-effective, compared to other healthcare priorities or affordable, under future funding constraints.

(ii) This option is based on activity which matches levels achieved in equivalent countries. However, many of these countries spend a higher percentage of GDP on healthcare than the UK, and have different thresholds for determining whether care is cost-effective, so it is not certain that the NHS in England would adopt similar policies.

(iii) There is a risk of unused capacity if the substantial increase in commissioned activity is not realised.

(iv) This option has the highest risk of overcapacity, which would adversely affect value for money and provider sustainability.

(v) Establishing a large number of centres to deliver this option may dissipate too thinly the specialised skills and experience required to deliver SRS/SRT.

(vi) Having a larger number of centres means that geographical accessibility is maximised.

(vii) Five-day working suits the current culture of many trusts of providing most elective treatment on week days

(viii) There may be a wider range of interested providers as some providers might withdraw from the procurement process under other options because of an inability to support seven-day working arrangements.

(ix) The machine delivering SRS/T will be idle 2/7ths of the week (29%), leading to a higher cost per case than is possible within seven-day working

(x) Five-day working is not in line with the national strategic direction of moving towards seven-day service provision.

Option 4 (Scenario B, seven-day working)

(i) This option can deliver activity which exceeds the volumes specified in existing NHS England clinical commissioning policies, so the costs and benefits of any changes in indications would be subject to future prioritisation against other health needs. Providers would bear the risk that future decisions did not find further extensions to access cost-effective, compared to other healthcare priorities or affordable, under future funding constraints.

(ii) This option is based on activity which matches levels achieved in equivalent countries. However, many of these countries spend a higher percentage of GDP on healthcare than the UK, and have different thresholds for determining whether care is cost-effective, so it is not certain that the NHS in England would adopt similar policies.

(iii) There is a risk of unused capacity if the substantial increase in commissioned activity is not realised.

(iv) A seven-day service may be harder for centres to staff than a five- day service. However, once established it will more able to be a sustainable centre of excellence.

(v) Some providers might withdraw from the procurement process because of an inability to support seven-day working.

(vi) This option means that there will be no idle capacity at weekends leading to a lower cost per case than five-day working.

(vii) This option is aligned to the national strategic direction of moving towards seven-day services provision.

(viii) This option would deliver less geographical accessibility than five-day working, although the additional activity predicted as part of the growth modelling for Scenario B means that there would be more machines than Option 2 and roughly the same as Option 1.

19. The Needs Assessment and Service Review, and the four options for change, were presented to the Specialised Commissioning Oversight Group (SCOG) in July 2014.

20. The project team recommended Option 2 as a preferred option. SCOG endorsed that recommendation, and agreed that the options for change should be the subject of public consultation.

21. SCOG decided on Option 2 as the preferred option as it is based on seven-day working, which aligns to the national strategic direction of moving towards seven-day service provision. Additionally, the risk of overcapacity is minimised if clinical trends change more slowly than expected because the centres providing the service could revert to fewer days per week. The avoidance of machines lying idle 2/7^{ths} of the week will ensure best price for the NHS. Option 2 could be superseded by further expansion of national capacity should the activity levels increase beyond those described in Scenario A.

22. It was recognised that in planning for Option 2, future increases in capacity would still be possible should activity levels rise beyond those described in Scenario A, in order to mitigate any risk of future under-capacity.

Consultation Questions

23. NHS England would like to hear your views on the following questions, which can be answered via the online survey:

(i) NHS England's preferred approach is to commission SRS/SRT services that are available for patients seven days a week, in line with plans for other NHS services, rather than just Monday to Friday. Do you agree with this approach?

(ii) There is some uncertainty about how quickly the use of SRS/SRT treatments will become more common. If clinical practice changes gradually, a growth rate of 12.5% per year has been forecast. NHS England's clinical policies are based on widening access to treatment, so, if clinical practice moves more rapidly, to match these policies, a growth rate of 27% per year has been forecast. If, however, in the future, NHS England were to changes its policies, a growth rate of 35% per year for seven years has been forecast.

NHS England's preferred approach is to base plans for the level of use on the 27% per year growth rate, which is based on the treatments that will be required under NHS England's existing clinical commissioning policies. Do you agree with planning for this level of demand?

(iii) If you do not agree with Option 2, the preferred option, do you agree with any of the remaining options for change?

(iv) The use of machines that are dedicated to delivering SRS/SRT (such as Gamma Knife® and CyberKnife®) does mean ensuring that a large enough

population catchment to ensure it is economic to provide the machines. On the other hand, use of a LINAC means that SRS/SRT can be combined with other radiotherapy treatments and offered on a part-time basis. The review did not find evidence to suggest that one type of machine achieves better outcomes than another.

Do you agree that a mixture of Gamma Knife®, linear accelerators and CyberKnife® machines should be used to provide SRS/SRT services commissioned by NHS England?

(v) Are there any other considerations which need to be taken into account, which have not been covered in the options for change? If so, please tell us what those considerations are, and explain the reasons for your answer.

(vi) Are there any inequality/health equalities issues which you think should be considered in making a decision about the future commissioning of SRS/SRT services in England? If so, please tell us what these issues are and explain the reasons for your answer.

24. You can respond to this consultation on line.

Collating Feedback and Next Steps

25. The consultation is open to everyone and will run from Monday 3 November to midnight on Monday 26 January 2015.

26. All feedback received via the online consultation will be collated and summarised and a report of the consultation findings will be considered by the Specialised Commissioning Oversight Group (SCOG).

27. NHS England will publish a report outlining the key themes of the consultation findings on its website.

28. Details relating to the procurement phase of the project will be published in the New Year.