NHS England

Stereotactic Radiotherapy and Radiosurgery service specification:

Consultation outcome report

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Cross Reference	Stereotactic Radiosurgery/Stereotactic Radiotherapy Needs Assessment and service review - 02469; Stereotactic Radiosurgery/Stereotactic Radiotherapy Consultation Guide - 02468, Stereotactic Radiosurgery/Stereotactic Radiotherapy Needs Assesment and Service Review Consultation report - 03468, Stereotactic Radiosurgery/Stereotactic Radiotherapy service specification consultation guide - 03809
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Document Status

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Stereotactic Radiotherapy and Radiosurgery service specification: Consultation outcome report

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1 Acknowledgments

NHS England would like to thank all of the individuals, patient groups and organisations that supported the consultation in some way.

2 Introduction

1. Stereotactic Radiosurgery and Radiotherapy Services (SRS/SRT) are forms of hypo-fractionated radiotherapy used in the treatment of patients with intracranial conditions, such as benign and malignant brain tumours. The technology used delivers precisely directed beams of radiation to the target site, meaning that there is less of risk of damage to healthy tissue surrounding the target area.

2. These are specialised services, delivered by a highly skilled team of people, and provided in a limited number of hospitals across the country. Services are delivered using a number of different technologies/platforms.

3. This report summarises the findings from the responses received to the consultation on the proposed changes to the service specification for SRS/SRT services. This follows and builds on an earlier consultation on the needs assessment and service review of SRS/SRT services in the treatment of intracranial conditions which was undertaken by NHS England during 2013-14.

4. A report of the findings of this earlier review was published, and options for change were consulted on for a period of 12 weeks between 3 November 2014 and 26 January 2015. This report can be found at: https://www.engage.england.nhs.uk/survey/options-for-change

3 Background to the Consultation

5. NHS England took responsibility for commissioning SRS/SRT in April 2013 and inherited a number of different commissioning arrangements which meant that patients were experiencing variable access to services depending where in England they lived. To tackle this NHS England undertook a review of these services in the treatment of intracranial conditions during 2013-14.

6. Among the options for change consulted on was a preferred option - ‘Scenario A’ and ‘Option 2’, essentially meaning that:

   a) capacity should be procured to deliver 5,239 cases per year;
   b) seven-day working should be adopted within SRS/SRT services, in line with NHS England’s strategic ambitions; and that
   c) NHS England would need to procure between six and 12 machines to deliver this activity.

7. NHS England received more than 200 responses to its consultation and published a report, setting out the key themes collated (Appendix 1), in June 2015. This report included details of the steps taken by NHS England as a result of the feedback received. The consultation report can be found at: http://www.england.nhs.uk/commissioning/spec-services/latest-news/

8. The responses received reflected a broad range of opinion, however many questions were raised about the clinical and operational assumptions underpinning the preferred option put forward by NHS England. The outcome of the consultation was published in a report on 10 June 2015 and outlined the responses received to the consultation. The feedback was used to revise the preferred option proposed by NHS England and inform the procurement process.

9. Following the closure of the Stereotactic Radiosurgery Clinical Reference Group (CRG) in January 2015, work to conclude the findings of the SRS/SRT service review has been led by the Cancer Programme of Care (PoC) and the Central Nervous System (CNS) Tumours CRG. Further information about the CRG can be found at: http://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-b/

10. During February 2015, an Expert Reference Group (ERG) for SRS/SRT was formed as a time-limited sub-group of the CNS CRG. The role of the ERG is to support the service review through the provision of clinical advice, and support, to develop required commissioning products, such as the service specification.

11. ERG members were selected through an 'expressions of interest' process open to the existing membership of the SRS, Radiotherapy and CNS Tumours CRGs. The membership is multi-disciplinary and includes: (i) Clinical Oncologists; (ii) Neurosurgeons; (iii) Patient and Public Voice (PPV) representatives; (iv) Medical Physicists; and (v) SRS/SRT Radiographers

12. The consultation report also described a revised clinical model (Table 1). The model was developed by the ERG in response to comments received during consultation which highlighted the need for SRS/SRT services to reflect the diversity of patient need and service requirements associated with the different clinical indications for which SRS/SRT treatment can be used.

Table 1: The clinical model

Tier 1 activity (neuro-oncology)	Deemed to be of lower complexity and able to be carried out in most, larger co-located (same city or as part of a broader strategic alliance) neurosurgery & (neuro) clinical oncology units. This includes cerebral metastases and non-skull base meningiomas and follows the patient pathway for patients via a regional neuroscience (neuro-oncology) MDT and in conjunction with TYA MDTs and pathways
Tier 2 activity (skull-base & pituitary)	Includes tumours such as Vestibular Schwannoma, meningioma, etc requiring co-

	location with a full skull-base team and following the patient pathway via a regional skull-base MDT in a neurosurgical centre. Pituitary indications require full pituitary MDT. Together with tier one this should allow >100 procedures per year, per unit.
Tier 3 activity (Vascular)	Includes cases such as Cerebral Arteriovenous Malformations and cavernomas. Requiring co-location with a full vascular MDT and full imaging support services, such as Digital Subtraction Angiography
Tier 4 activity (other non-tumour indications)	Includes trigeminal neuralgia. Lower volume; best carried out in fewer centres, enabling appropriate staffing skill-mix, MDT support, co-located services and appropriate equipment. Requires co-location of relevant MDTs – functional, epilepsy, pain services

13. Any patients approved for treatments though the Individual Funding Request (IFR) process for any indication not listed within the four tier model which would include “lesioning” for movement disorders, epilepsy, and pain will be managed as part of Tier 4.

14. A number of other changes to the service specification are now proposed; the most significant of these are the introduction of:
    a. A minimum population planning requirement of 2 million;
    b. A minimum activity requirement of 100 cases per annum for Tier 1 and Tier 2 services;
    c. The use of existing neurosciences networks as a structure for the SRS/SRT service model; and
    d. An explicit requirement for SRS/SRT services to be supported by ‘integrated neurosurgery and radiotherapy’ teams located in the same geographical area or city.

15. It was felt that due to the revisions to clinical model and service specification, that these proposed changes should be tested with all interested parties via a formal consultation process.

4 Summary of Stakeholder Engagement Activity

4.1 Approach to consultation

16. Due to the fact that the consultation took place over the summer period an additional 22 days was added to the length of consultation.

17. The consultation started on **24 July 2015** and concluded at 12pm on **13 October 2015**. https://www.engage.england.nhs.uk/survey/srs-srt_service_revision/supporting_documents/Consultation%20guide.docx

18. A Consultation Guide was published explaining the proposed changes and outlined a series of questions for stakeholders to consider. Alongside this a revised service specification document was published which highlighted the proposed changes.

19. In order to capture stakeholder views on the proposed changes to the service specification, a survey was developed. The survey was hosted alongside the proposed service specification and a consultation guide online with links to consultation available via the latest news section of the specialised commissioning web pages http://www.england.nhs.uk/commissioning/spec-services/latest-news/

20. Responses to the consultation could be submitted via an online portal. The consultation was publicised via the NHS England website and through internal and external communication briefs. A direct mail to NHS England stakeholders (including NHS organisations, charities, patient organisations, industry, partner organisations and professional bodies) was also undertaken.

21. In addition, to help clarify any points or questions arising from the proposed changes to the service specification, five webinars, (two of which were dedicated to patient organisations, charities and professional bodies and three for clinicians and provider organisations) and a stakeholder workshop were arranged enabling them to respond formally to the consultation.

22. As part of the consultation process, Clinical Reference Groups were also invited to respond to the proposed changes.

4.2 Response to the consultation

23. The total responses to the consultation is itemised below:

Responses via the on line Portal	Participants in the Webinars	Attendees at the Provider Event
128	**62**	**58**

24. Respondents to the online portal included 65 responding as clinicians, 48 responding as individuals, 2 on behalf of clinical societies, 2 from voluntary / charitable organisations, 2 from manufacturing companies, 2 professional bodies and 2 CRG chairs.

25. All of the detailed responses captured during the webinars and stakeholder workshop have been considered in the production of the consultation report. However, these responses were not necessarily in the same format as the online survey responses, therefore the detailed responses have been summarised separately (see section 6) to the response by question section (section 5).

5 Key findings and themes from the online survey

5.1 Summary of the responses received through the online survey

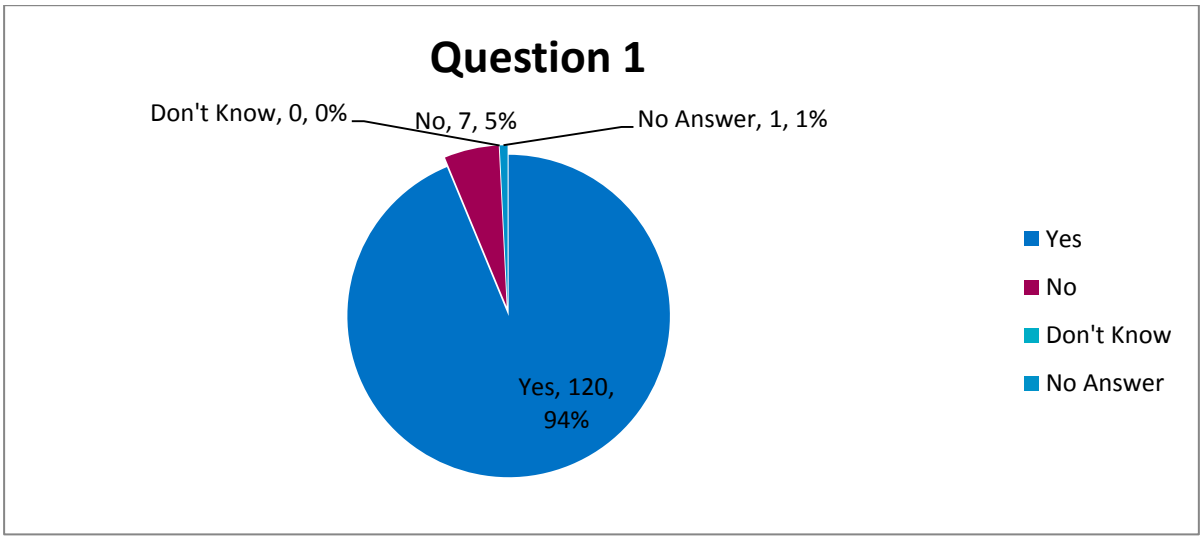
26. 128 responses were received via the online survey from clinicians, provider organisations, patient organisations, individuals and as others, including the President of the Society of Neurological Surgeons, and the Society and College of Radiographers.

27. As well as providing responses to the survey questions, most respondents qualified their view with free-text comments. Both the qualitative and quantitative data has been discussed by the Expert Reference Group on fortnightly calls and in the feedback review meeting.

28. A summary of themed comments have been included alongside the quantitative response to each question. In addition to responses through the portal, two organisations submitted written responses. These submissions have been considered alongside the quantitative data represented below.

5.2 Survey responses by question

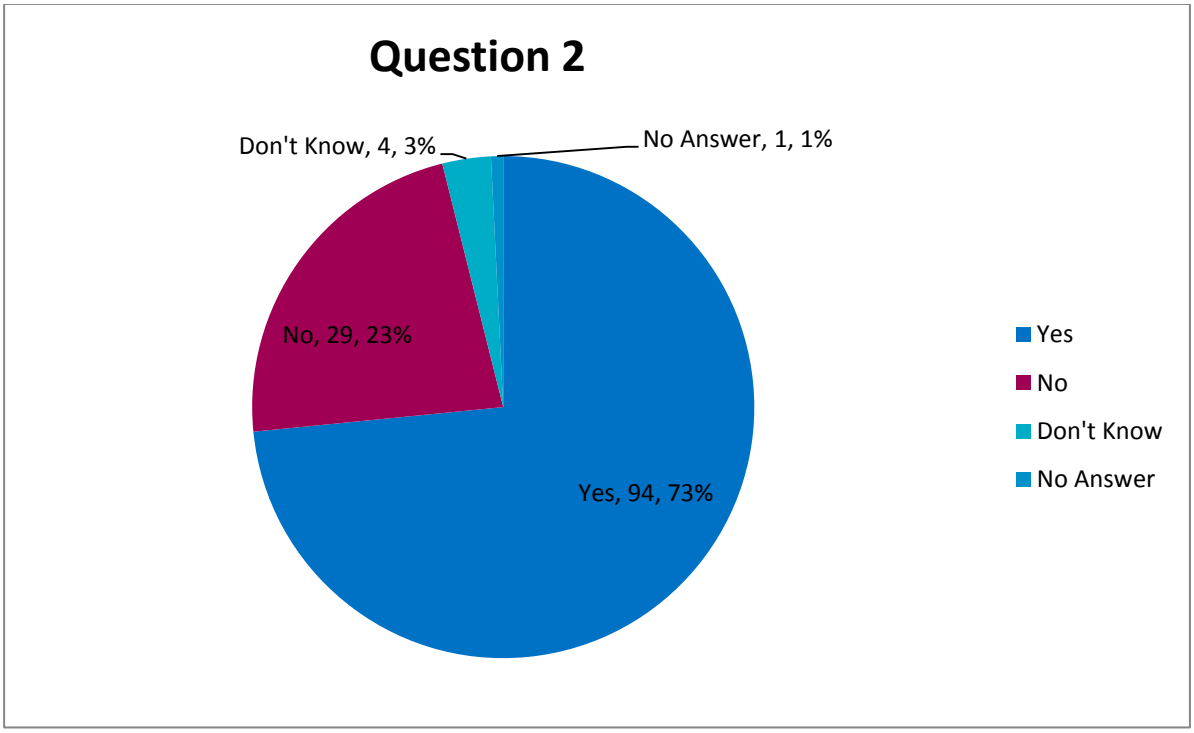
29. **Question 1** - *Do you agree that there should be equitable geographical access across England to Tier 1 and Tier 2 SRS/SRT services, so that clinical indications, such as cancer, can be treated close to home?*



30. The vast majority of respondents (94%) agreed that there should be equitable geographical access to SRS/SRT.

31. While many comments recognised the proposed equity of access across England as a major improvement to the current arrangements, some commentators suggested that more consideration should be given to the impact of travel times and access to SRS/SRT.

32. **Question 2** - *Do you agree that the treatment of rare benign indications (Tier 3 and Tier 4) should be concentrated into larger 'supra-network' centres to ensure availability and maintenance of clinical expertise?*

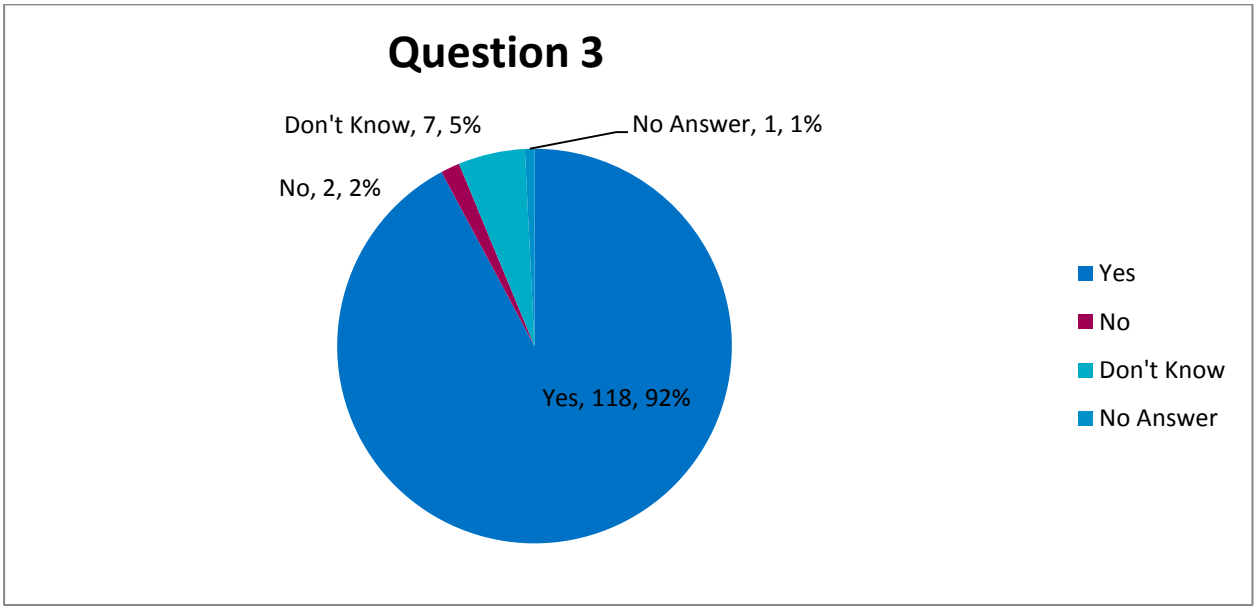


33. A large majority (73%) of respondents supported the principle that rarer, more complex indications should be concentrated into larger supra-regional centres. However, there was discussion about the type of indications within each of the tiers.

34. Many comments made via the online survey and during the webinars questioned whether pituitary adenomas should be included in tier 3 / 4 as it was felt that these could be safely and effectively treated in the tier 1 / 2 centres.

35. A notable minority (23%) did not support the proposal for two tier 3 and tier 4 centres. Commentators questioned whether two supra-regional centres would allow sufficient capacity for future growth in SRS/SRT treatment while others raised concerns about whether patients would be prepared, or able, to travel significant distances for treatment.

36. **Question 3** - *Do you agree that paediatric patients requiring complex cancer SRS/SRT treatment should be concentrated into a small number of dedicated centres for this treatment?*



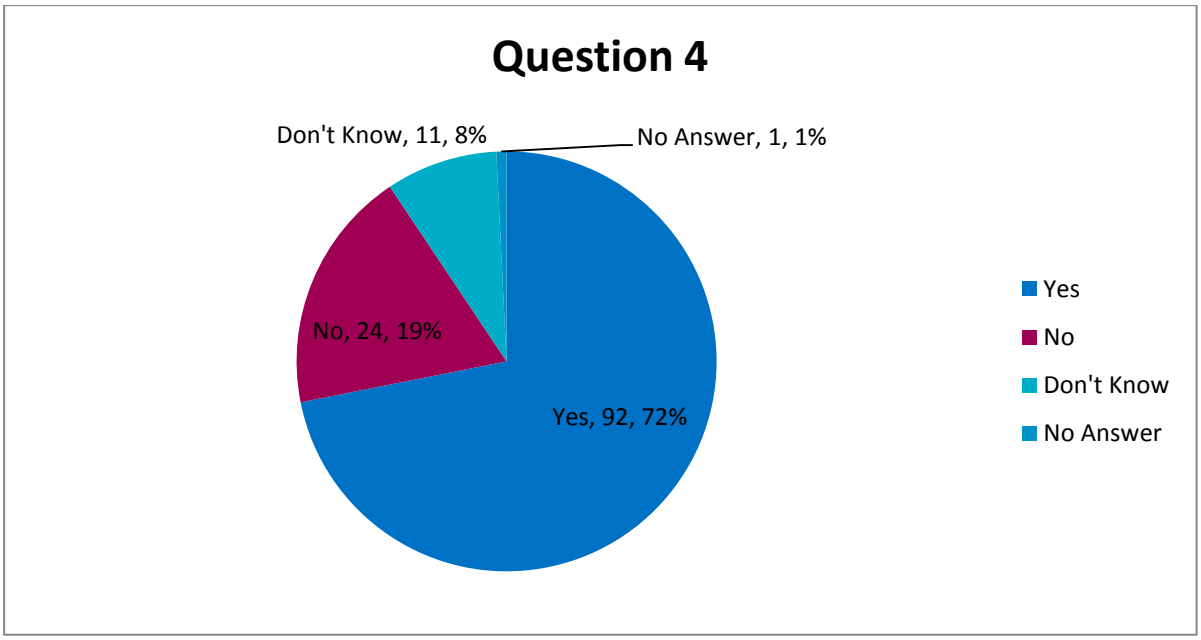
37. A clear majority of respondents (92%) supported the proposal that there should be a small number of dedicated centres for paediatric patients requiring complex cancer SRS/SRT treatment. Comments indicated that these dedicated centres would build expertise and ensure quality.

38. Of those disagreeing with the proposal, there tended to be support children with very complex cancers being treated in dedicated centres but some questioned whether all paediatric care should be managed by two centres or whether older children and those not requiring general anaesthetic could be treated in centres closer to their home.

39. Other comments relating to this question tended to focus on consideration of the range of services co-located with the specialised centres.

40. Additional comments caution against restricting the treatment platform that could be used for paediatric patients.

41. **Question 4 -** *Do you agree that neurosciences networks should form the basis of the proposed 'SRS/SRT Tier 1 and Tier 2' geographies?*

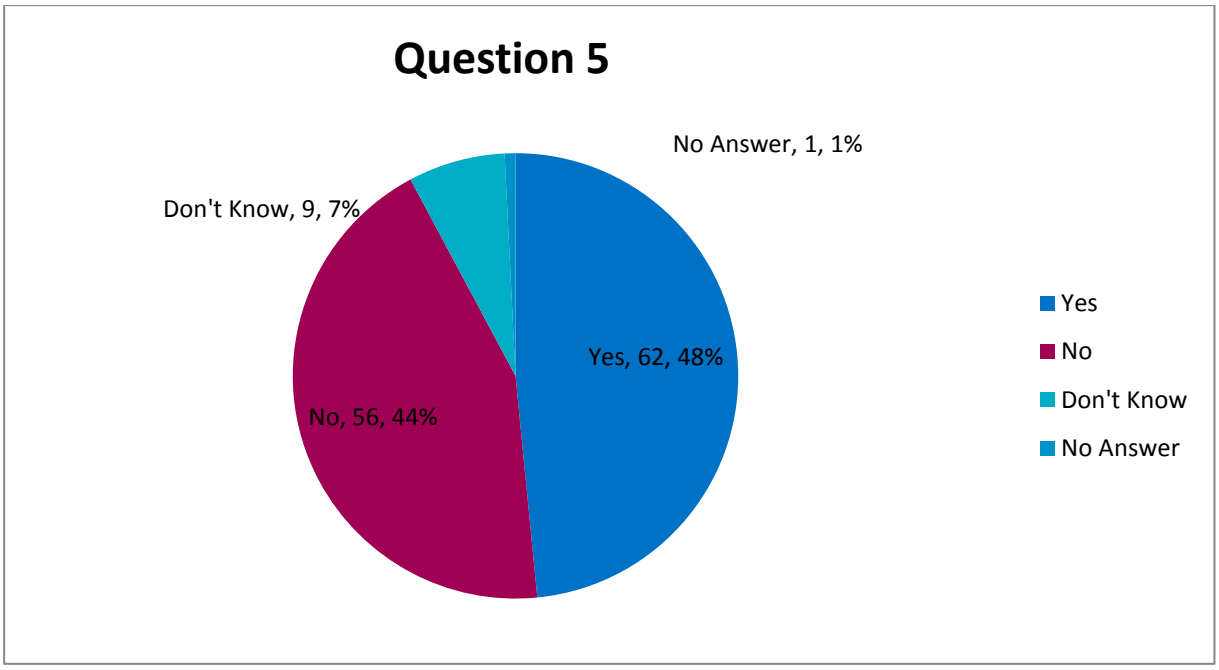


42. The majority of respondents (72%) supported the principle that neuroscience networks should form the basis of tier 1 and tier 2 geographies. Although several commented that there needs to be consideration of existing cancer networks to ensure there isn't disruption to care pathways.

43. A notable minority (19%) did not agree, with some respondents commenting that the network groupings will lead to wide variations in population numbers and does not take into account the general spread of the population, local geography or patient access.

44. Other commentators stated that the restriction of one provider per network is unnecessary suggesting that commissioners should be open to the possibility of more than one SRS/T provider per neuroscience network which they feel would improve equitable geographic access and patient choice.

45. **Question 5** - *Do you agree with the requirement for Tier 1 and Tier 2 services to be based on a population footprint of two million and delivering 100 cases per year in order to develop high-quality, efficient and safe services?*



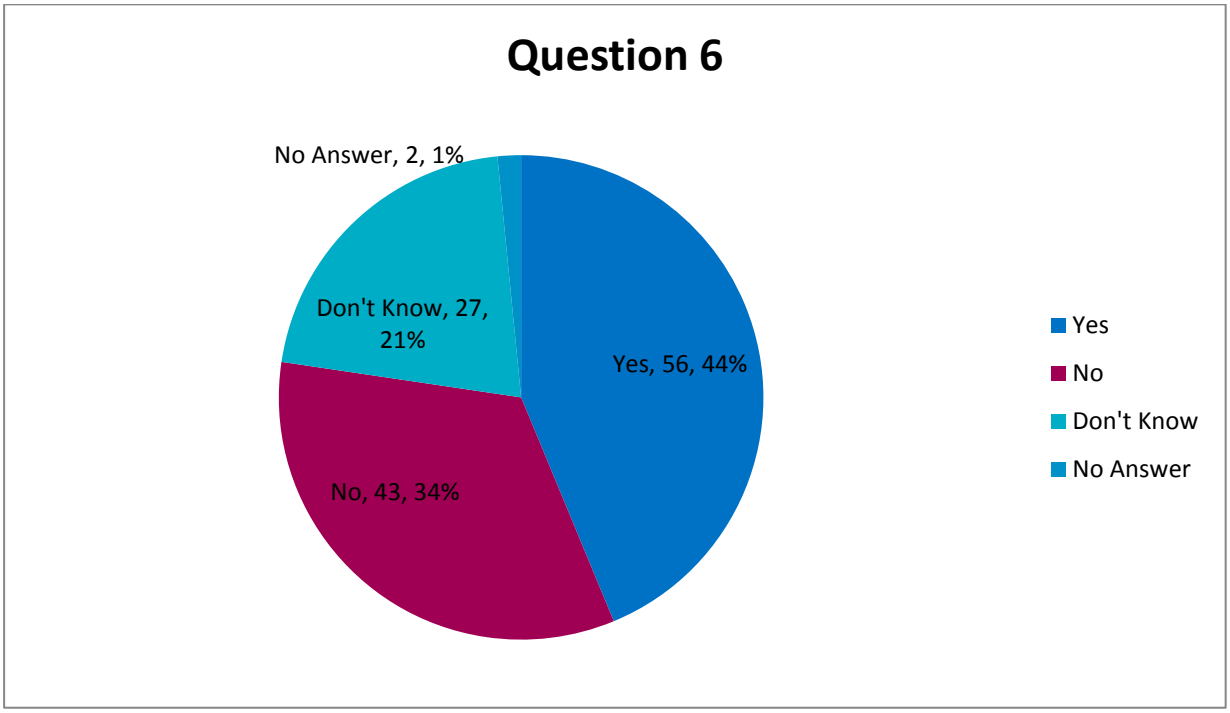
46. Feedback on caseload requirements for tier 1 and tier 2 services was more finely balanced with more respondents (48%) supporting the proposal compared to those who did not agree (44%).

47. A review of the free text comments reveals that there is no consensus of opinion among those that do not agree with the minimum 100 caseload with some respondents suggesting that it should be set lower in line with Radiotherapy peer review measures, and others that it should be higher in order to maintain competency and quality.

48. Some commentators expressed concern that setting a minimum caseload will encourage over treatment.

49. Many of the comments expressing concern at the two million population footprint cite issues of rurality and more dispersed populations suggesting that this will mean patients having to travel further.

50. **Question 6:** *Where neurosciences networks have been amalgamated to create a population footprint of over two million (section 3.2.2 of the service specification), do you agree with the proposed 'grouping'?*



51. Perspectives on amalgamation of neuroscience networks were mixed with a slightly higher number of respondents supporting the proposed groupings. Few comments were made in relation to this question.

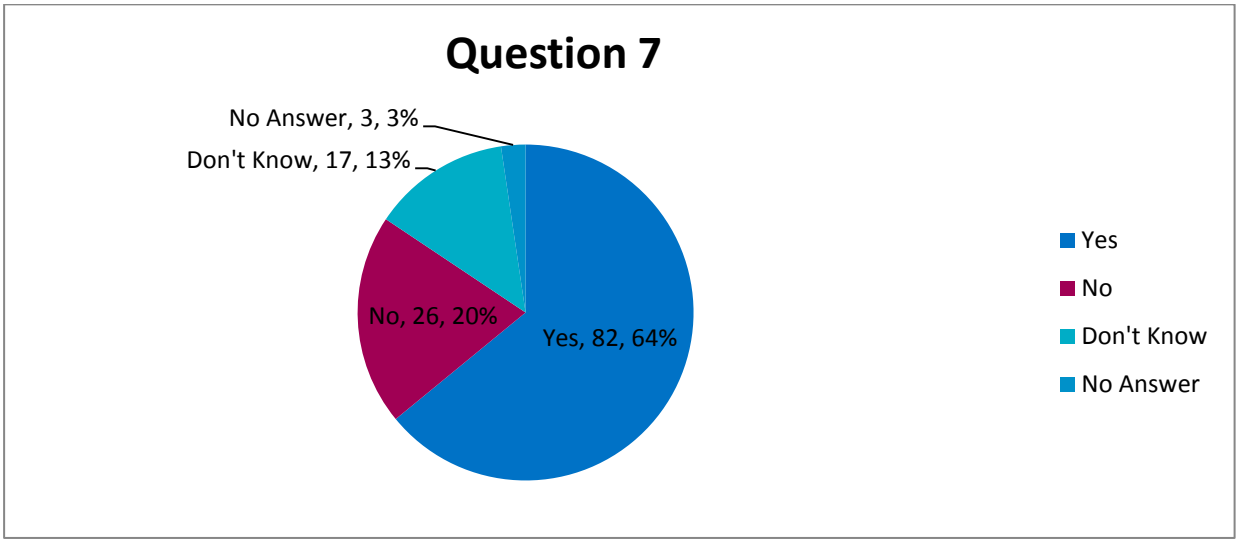
52. Those expressing support considered the amalgamation of networks the only practicable way of defining the two million population footprint which would be required to provide adequate caseloads to provide expert delivery.

53. Those that did not support the amalgamations of networks tended to raise concerns about the impact of the groupings on individual providers or specific populations.

54. Commentators particularly noted the impact of network amalgamations on areas of low population density, pointing out the significant travel distances patients would face if there is only one provider in these networks.

55. A small number of responses suggested that SRS /SRT is similar to other stereotactic treatment delivered to tumours in the body (SABR) whilst others supported the development of an integrated MDT, specialist team and treatment approach to the service as defined within the specification.

56. **Question 7**: *Do you think that the revised standards, as set out in Section 4 'Key Service Outcomes', are appropriate for this service?*



57. The majority of respondents (64%) felt the key service outcomes were appropriate. However there are several suggestions about how these could be strengthened, particularly setting expected parameters and ensuring the outcomes are clearly measurable. Particular clarity is needed around definitions of staff training.

58. It was suggested that the proposed service outcomes should act as a minimum dataset but could be more ambitious in order to drive service improvement.

59. Several commentators suggested that patient experience outcomes need to be included including measures of quality of life post-treatment.

60. **Question 8:** *Please provide any comments that you may have about the potential impact on equality and health inequalities which might arise as a result of the proposed changes that we have described, particularly in relation to the geographies that currently have more than one SRS/SRT service*

61. Within the responses, there is recognition that the proposed geographies go some way to address inequalities of access. However commentators suggest that rural populations may be more greatly affected by proposals to concentrate SRS / SRT services into limited number of specialised centres based generally in large urban areas.

62. There are concerns that older people, those with co-morbidities and those in lower socio-economic groups would particularly struggle with significant travel for treatment.

63. Other comments suggest that inequality of outcome will be improved through clear referral pathways, standards and regular monitoring.

6 Key messages and themes from engagement events

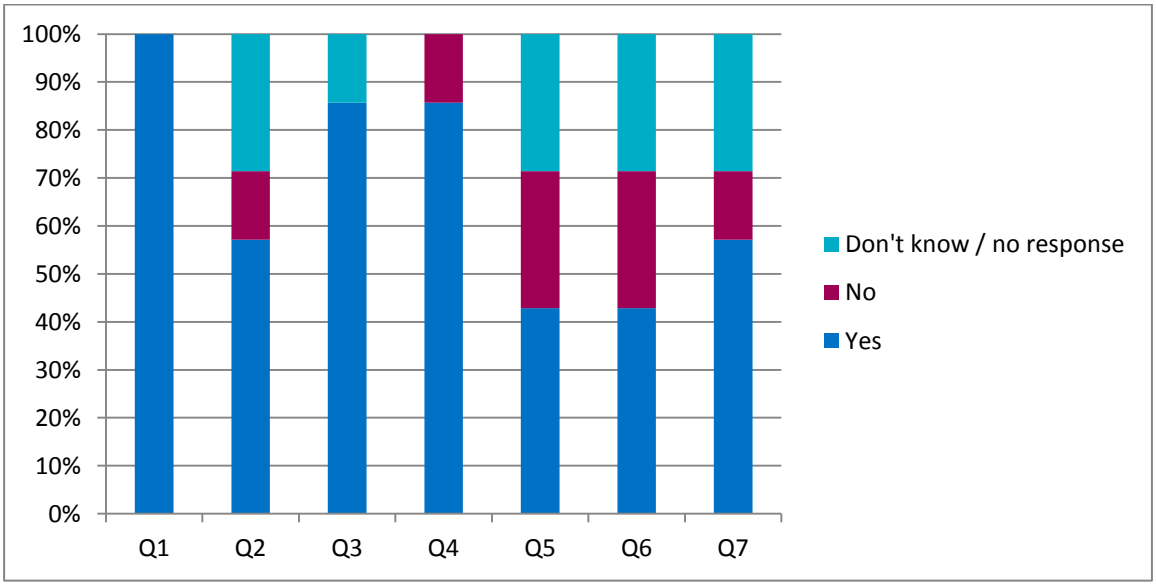
6.1 Summary of themes from the stakeholder workshop

64. There were 58 attendees at the event of which 45 were clinicians or representatives from NHS trusts and 13 were patients/representing patients groups or other.

65. Participants were divided into smaller mixed stakeholder groups for a discussion session. They were asked to sit apart from those from the same organisation as themselves.

66. The table discussions were focused around the same questions asked via the online portal. The feedback below represents general perspectives from each table but may not be reflective of all views present.

67. The feedback from the workshop largely reflected the online survey feedback in terms of support expressed for the proposals



68. The main themes arising from the table discussions were:

a) Querying the definition of ‘equitable’?
b) Financial implications of increased travel and the issue for NHS of reimbursement.
c) Movement of expertise and risk of loss of expertise.
d) Varying views on geographical groupings including the view that there should be three or four “supra networks” covering North, South, East and West
e) Referral pathway issues.
f) Questions around whether 100 patient caseload was appropriate
g) The Implications for patients especially in relation to patient experience and outcomes.
h) Requirement for robust audit mechanisms to ensure that commissioners are not commissioning for numbers but for quality.

6.2 Summary of themes from the webinars.

69. The webinars generated a great deal of discussion and interest in the proposals. Generally a high degree of support for the proposals was expressed by participants. This included comment that participants felt reassured by the information as described and how the modelling had been undertaken.

70. The webinars provided the opportunity for participants to better understand the principles and drivers for the consultation and to seek clarification or raise challenges to the proposals.

71. The webinar discussions largely reflected feedback received through the other consultation mechanisms and can be generally categorised as:

a) Support for aspects of the proposals
- There was generally strong support voiced for the model from professional organisations and cancer charities on the call.
- There was recognition that linking tier 3 and 4 indications together would avoid low volume activity
- There was recognition of the need for strong connections to specialist MDTs and teams in order to consider the broad range of treatments.
- There was recognition that patients required the full infrastructure of care was balanced with the view that this was just another form of radiotherapy treatment.

b) Questions on the content of the proposed service specification
- Possibility for centres to be able to provide tier 3 services without tier 4.
- Whether more than two centres delivering Tier 3 and 4 services could be sustained particularly to balance the access for paediatric patients.
- Discussion as to whether pituitary treatments should be included in Tier 4
- Clarity and evidence of requirement for centres to treat 100 cases per year
- Questions relating to cases per year for Tier 1 / 2 services but recognising a balance between volume, competency and access was appreciated.
- Trigeminal neuralgia was considered easy to treat by some and very complex by others

c) Suggestions about how the service specification or future contract could be strengthened
- Real clarity is needed to ensure that robust referral pathways both to and from the SRS/SRT centre are in place.
- Consideration of travel times for treatment and equitable access
- Inclusion of robust monitoring and key service outcomes for patients

d) Questions about the future procurement process
- Clarity that procurement would be an open competitive process
- Question around how a joint service could be delivered

7 NHS England response to the feedback

7.1 How the feedback has been considered

72. Throughout the consultation, the Expert Reference Group has considered the feedback (quantitative and qualitative) during fortnightly phone calls.

73. The SRS/SRT project group has received monthly updates on themes and perspectives captured through the consultation.

74. On 15 October, the Expert Reference Group met to consider all of the feedback received and to recommend whether the service specification would require amendment as a result of the comments submitted.

75. The table below summarises the feedback received by question and the action that has been recommended.

We asked	You said	We did
Do you agree that there should be equitable geographical access across England to Tier 1 and Tier 2 SRS/SRT services so that clinical indications, such as cancer, can be treated close to home?	Yes – 94% No – 5% Don't know – 1%	Strong support - No action required.
Do you agree that the treatment of rare benign indications (Tier 3 and Tier 4) should be concentrated into larger 'supra-network' centres to ensure availability and maintenance of clinical expertise?	Yes – 73% No – 23% Don't know – 4% No answer – 1% Some responders, received via the portal and the webinars/event, indicated good clinical grounds for moving pituitary adenomas to T2 from T4. Some responders raised the issue of the proposed number of T3/4 units in the revised service model. The feedback generally indicated that (NHS Trusts especially) more units would be preferable.	Pituitary adenomas are now included within Tier 2. No action required in relation to the issue of the number of T3/4 units. This is because this issue was the subject of careful consideration ahead of public consultation and no 'fresh' or compelling evidence or information was put forward by responders. Furthermore, it is noted that the vast majority of this type of activity is currently delivered in only one unit and that other providers are not currently delivering the full range of T3/4 treatments. Finally, it is noted that during the SRS consultation event

We asked	You said	We did
		patient groups had strongly articulated the preference to travel to centres of excellence for treatment of complex and rare conditions.
Do you agree that paediatric patients requiring complex cancer SRS/SRT treatment should be concentrated into a small number of dedicated centres for this treatment?	Yes – 92% No – 2% Don't know – 5% No answer – 1%	Strong support - No action required; however the wording in relation to paediatric general anaesthetic has been clarified following discussion at October Clinical Priorities Advisory Group (CPAG).
Do you agree that neurosciences networks should form the basis of the proposed 'SRS/SRT Tier 1 and Tier 2' geographies?	Yes – 72% No – 19% Don't know – 8% No answer – 1%	Strong Support - No action required.
Do you agree with the requirement for Tier 1 and Tier 2 services to be based on a population footprint of two million, and delivering 100 cases per year, in order to develop high quality, efficient and safe services?	Yes – 48% No – 44% Don't know – 7% No answer – 1% Generally concerns related to the issue of rural areas and centres with small volumes. Responders often indicated support for the need to concentrate activity into higher-volume units; however there were differing views about what the activity volume or population level should be.	No action required – the issues raised during consultation were considered by NHS England carefully ahead of the consultation. No compelling 'fresh' evidence was put forward that articulated another approach.
Where neurosciences networks have been amalgamated to create a population footprint of over two million (section 3.2.2 of the service specification), do you agree with the proposed 'grouping'?	Yes – 44% No – 34% Don't know – 21% No answer – 1% Opposition to this proposal was mostly related to the impact of	The issues raised in consultation were very carefully considered by NHS England ahead of public consultation. This consideration led to the proposed service

We asked	You said	We did
	this proposal on a number of current providers and concern that these would be closed as a result of the service specification.	specification allowing for units in rural areas (and these are generally where there is lower population density and lower overall population, i.e., those where network populations have been amalgamated) to enter into partnership arrangements with shared protocol and MDT. However, the specification has been amended in light of the responses in the following way: • Replace MDT requirement with a requirement to hold a quarterly audit meeting, as opposed to a weekly MDT. • The audit and service review meeting could cover a range of items, but must as a minimum include discussion of: (i) performance and quality outcomes; (ii) casemix; (iii) audit of treatments; (iv) Protocols and policies; and (v) critical incidents and near misses. These changes have been balanced by clarifying that such units must submit single data returns.
Do you think that the revised standards, as set out in Section 4 'Key Service Outcomes', are appropriate for this service?	Yes – 64% No – 20% Don't know – 13% No answer – 3%	No action required – however, following discussion at October CPAG and on review of the consultation responses it is agreed to develop the outcome metric definition ahead of contract award.

We asked	You said	We did
		Linked to this the ERG will ensure that all clinically appropriate assessments metrics highlighted in clinical commissioning policies are included within the specification. Such as the Karnofsky Performance Status – which is a recognised measure of functional status and quality of life for patients treated with SRS/SRT for cerebral metastases The service specification has been amended in a minor way to clarify this intention.

Other changes made since consultation which are not related to specific consultation questions but have been considered by NHS England working through the ERG, Project Group and the Clinical Priorities Advisory Group are:

- The wording of the service specification with regard to the definition of SRS/SRT was strengthened with the addition of the term 'hypo-fractionation'. This is to provide a clearer distinction between SRS/SRT and other techniques using a lower number of fractions.

- A clarification sentence has been added to the 'Treatment Planning' section of the specification to make clear that it is expected that treatment will be delivered by specialist radiographers rather than Consultants.

- The frequency of specialist MDTs referring into the SRS service has been clarified within the specification, which now indicates that such MDTs meet weekly.

- Wording in the specification relating to whole body dose was clarified to ensure that consistency. This issue has been addressed because the specification states that any of the three treatment platforms can be used, which is an aspect of the specification was unchanged from the original specification. The wording now reads: '*Providers should ensure that Children, Teenage and Young Adults requiring SRS/SRT for the treatment of benign disease should ensure that the treatment is planned to deliver the very lowest possible whole body radiation dose'*. This has changed from: '*Children, Teenage and Young adults with benign disease should be considered for treated using a platform that delivers the very lowest possible whole body radiation dose'.*

75.1. Keep in touch

For updates on the SRS/SRT procurement exercise and any latest developments please visit the CNS CRG page, sign up to be a registered stakeholder of the group or subscribe to the specialised commissioning stakeholder newsletter