Consultation Report

Topic details

Title of policy or policy statement:	Stereotactic radiosurgery (SRS) and stereotactic radiotherapy (SRT) to the surgical cavity following resection of cerebral metastases (all ages).
Programme of Care:	Cancer
Clinical Reference Group:	Radiotherapy
URN:	1857

1. Summary

This report summarises the outcome of a public consultation that was undertaken to test the policy proposition.

2. Background

Cerebral metastasis is the formation of a secondary tumour in the brain. SRS or SRT, a form of radiotherapy, is often the primary treatment for cerebral metastases. However, sometimes the cerebral metastasis is too large for SRS/SRT and surgery is the alternative treatment option. In most cases, the metastasis will be completely removed.

The standard practice after complete surgical removal of a metastasis at most centres is observation however, some centres have started to use SRS/SRT to the surgical cavity after complete resection. This policy proposition considered whether this practice should continue and be routinely commissioned.

It is important to note that NHS England does commission the use of SRS/SRT in people with partially resected cerebral metastases and where the disease returns post-surgery (NHS England Reference: NHSCB/ D05/P/d). This commissioning position is unaffected by the new policy proposition.

The proposition has been subject to stakeholder testing and public consultation in line with the standard Methods.

3. Publication of consultation

The policy proposition was published and sign-posted on NHS England's website and was open to consultation feedback for a period of 30 days from 23rd January 2020 till 22nd February 2020. Consultation comments have then been shared with the Policy Working Group (PWG) to enable full consideration of feedback and to support a decision on whether any changes to the policy might be recommended.

Respondents were asked the following consultation questions:

- Has all the relevant evidence been taken into account?
- Does the impact assessment fairly reflect the likely activity, budget and service impact? If not, what is inaccurate?

- Does the policy proposition accurately describe the current patient pathway that patients experience? If not, what is different?
- 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 have been described?
- Are there any changes or additions you think need to be made to this document, and why?

4. Results of consultation

There were 11 responses to public consultation of which:

- 3 were from clinicians, one of whom was reporting on behalf of a trust;
- 3 were on behalf of service providers;
- 1 was an individual patient response;
- 1 response was submitted on behalf of the NICE Guideline Committee for Brain tumours (primary) and brain metastases in adults; and
- There were 3 'other' responses – this consisted of one non profit professional, one patient research ambassador and one radiotherapy network.

Of the 11 responses, 3 actively supported the policy proposition. The remaining 6 respondents raised the following;

- Four respondents noted the divergence of this policy from NICE guidance NG99 which states *"Consider adjuvant stereotactic radiosurgery/radiotherapy to the surgical cavities for people with 1 to 3 brain metastases that have been resected*". These respondents queried why the policy was different to these guidelines.
- One respondent noted that although the same evidence had been considered as part of the policy development, as was considered by NICE in the development of Guideline 99 (NG99), one paper (Mahajan et al, 2017), in particular, suggested that there was a benefit in local control rates for patients with the use of SRS/SRT in this indication, particularly for those with tumours >2.5cm. This respondent felt this evidence had not been appropriately interpreted in the development of the policy.
- One respondent cited additional evidence (six papers) that supported the use of SRS/SRT in this indication and felt that this had not been considered as part of the policy development process.
- One respondent suggested that for some people living further away from a MRI or SRS/SRT services, they would prefer to have SRS/SRT straight after treatment as opposed to active surveillance as recommended by the policy proposition.

5. How have consultation responses been considered?

Responses have been carefully considered and noted in line with the following categories:

- Level 1: Incorporated into draft document immediately to improve accuracy or clarity

- Level 2: Issue has already been considered by the CRG in its development and therefore draft document requires no further change
- Level 3: Could result in a more substantial change, requiring further consideration by the CRG in its work programme and as part of the next iteration of the document
- Level 4: Falls outside of the scope of the specification and NHS England's direct commissioning responsibility

All feedback from public consultation has been graded as Level 2 (see Section 6 below).

6. Has anything been changed in the policy as a result of the consultation?

Comments have been reviewed by the Policy Working Group and the National Programme of Care (NPoC), and feedback is as follows:

- The PWG and NPoC note the reference to NG99 (NICE,2018) and the NICE guideline subcommittee response suggesting that there is a difference in local control rates, particularly for those with metastases >2.5cm. However:
    - NICE Guidelines are a type of NICE product that do not carry funding directions. As such, it is appropriate for NHS England, as a direct commissioner of prescribed specialised services, to consider the evidence and reach a different conclusion.
    - All of the evidence used to develop NG99 was considered as part of the Evidence Review. On review of the available clinical evidence, the Specialised Services Clinical Panel concluded that introduction of this treatment in this indication did not demonstrate that there were any significant benefits or any differences in overall survival or quality of life (see Clinical Panel Report). Neither did the Clinical Panel consider that the evidence review (including a review of the Mahajan et al (2017) paper) identified a sub-group of patients who would benefit from the treatment, as suggested by the NICE Guideline Subcommittee.
    - Post consultation, NICE has confirmed that the sub-group data, referred to within their consultation response, is not available for review. NICE has also confirmed that, while this is a promising intervention, the strength of the available evidence is not sufficient to justify a departure from NHS England's commissioning position. For this reason, the NICE Centre for Guideline Development will be revising the relevant guideline in due course.

- The additional evidence submitted as part of consultation has been reviewed by the PWG Public Health Lead. Three of the papers referenced had already been reviewed as part of the consultation and the remaining three papers did not meet the search criteria (the PICO) for policy proposition. For this reason, it has been concluded that this additional evidence does not materially affect the conclusions of the existing evidence review and as such, no changes to the policy are required. An Evidence Report was completed as part of this review.

As a result, no changes have been made to the policy proposition.

7. Are there any remaining concerns outstanding following the consultation that have not been resolved in the final policy proposition?

None.