Public Document Pack

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MONDAY 8 APRIL 2019

Supplementary Pack

Agenda item 8 – Access to Dentistry
(Pages 1 – 2)

Agenda item 9 – West Yorkshire and Harrogate Cancer Alliance.
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LS11 5BD

Councillor Helen Hayden
Chair, Scrutiny Board
(Adults, Health and Active
Lifestyles)
3rd Floor (East)
Civic Hall
LEEDS, LS1 1UR

29 March 2019

Dear Councillor Hayden,

I write in response to your letter dated 15 March 2019, regarding urgent care dental services across West Yorkshire.

Urgent Dental Care

At its meeting in March and July 2018, and in subsequent communication, West Yorkshire Joint Health Overview and Scrutiny Committee was advised of NHS England's intention to commission an urgent dental care patient pathway.

Urgent dental care will be accessed by the patient through one of two routes: making arrangements with their own dentist; or the patient makes a call to 111, provided by Yorkshire Ambulance Service (YAS). NHS111 should be used when it's not possible to make arrangements with the patient's regular dentist or if the caller does not have access to a regular dentist.

The new pathway, commissioned from 1 April 2019, includes:

- NHS 111 – the initial call handling.
- Dental Clinical Assessment and Booking Service (referred to as 'CABS') – dental calls are transferred to this service by NHS111. This service will (clinically) assess the caller to determine if they need an urgent dental appointment, or will signpost to other health care services, or provide self-care advice;
- Urgent dental treatment (UDT), provided by Lot-based services (UDTs), as well as urgent dental care provided within existing GDP contracts at approximately 75 practices across the patch.

This service has been commissioned to offer the following:

- the CABS service, which is interoperable with NHS111, and open 24 hours a day.
- urgent dental treatment provided within each lot 365 days a year; this will be a mixture of fixed 'urgent care sites; in Wakefield, Bradford, Leeds and Huddersfield and by utilising slots within identified general dental practices.
- all callers will be assessed using the NHS dental module algorithm, with at least 50% of callers assessed by a dental professional;
- a minimum dataset has been implemented which will enable the providers to ensure they can ensure slots according to need.
- encourage all patients seen to source a regular dentist.

The model does present a risk around patient behaviour and imbedding the new pathway however, to mitigate this risk it is proposed to roll out a patient leaflet or poster, outlining how and when NHS111 should be used, how patients can access regular dentists, if they do not have one and a key deliverable of all urgent dental treatment will be for the call handlers to speak to the patients to encourage them to seek a dentist, should they not have one. Providers will be asked to establish a system which identifies 'repeat callers'.

There is no typical patient of urgent dental care, the service will be available to anyone who has a clinical need and who cannot see a dentist in a primary care setting, either as they don't have access to a regular dentist, or their dentist is closed when they have a clinical need. As a result, there is not typical patient group. However, patient engagement was undertaken via the current providers of urgent dental treatment and through Healthwatch.

A patient engagement exercise was carried out by NHS England's regional communications' team early in 2018. A questionnaire was sent to providers and they were asked to encourage patients attending for treatment to complete a questionnaire. Around 400 responses were received and the feedback was incorporated into the service specification.

Amongst the questions asked in this short questionnaire, we asked patients what they felt about clinic times, locations and travel and whether they had access to a regular dentist. With the findings of these patient questionnaires, consideration was given to these findings when drawing up the service specifications. The impact for the patient will be positive and beneficial as the previous pathway did not include dental processionals carrying out the triage and assessment. Having dental professionals forming part of the team of call handlers and advisors (at CABS) will improve the provider's ability to 'consult and complete' in the one call.

Following the recent procurement, the new providers are as follows:

Service	Provider
NHS 111	Yorkshire Ambulance Service
Clinical Assessment & Booking Service	Local Care Direct (LCD)
Urgent Dental Treatment	
• Humber Coast and Vale	Night Dental
• South Yorkshire & Bassetlaw	Taptonville House Limited / Dental Partners
• West Yorkshire and Harrogate.	Night Dental

In addition to the appointments that will be provided by the contracted urgent dental treatment providers, procured through this process, there are around 35,000 appointments each year that will continue to be provided by primary care dental providers. All appointments can only be accessed, following the patient calling NHS111 and being transferred to CABS, who will book the nearest available appointment to the patient.

Additional investment into primary

In addition to the above, it is anticipated that additional investments in primary care will reduce the requirement on the urgent care pathway as more people access urgent care from their regular dentist. Across Yorkshire and the Humber an additional £5m has been invested into 20 constituencies to ensure that more dentists can offer additional appointments to patients. Between July and December 2018 6, 255 additional patients were seen across Yorkshire and the Humber, of which 2,500 additional patients were seen in West Yorkshire. This investment will continue until 2021 with regular reviews taking place to ensure more patients can access a regular dentist.

Furthermore, work has begun to consider allocating investment in areas of high need to support the inequalities agenda. We would be pleased to share this work with JHOSC as it develops.

Yours sincerely

Emma Wilson
Head of Co-Commissioning (Yorkshire & Humber)

Title of meeting:	**West Yorkshire and Harrogate Cancer Alliance Board**	**Agenda Item:**	**9**
Date of Meeting:	**30.10.18**	**Public/Private Section:**	
Paper Title:	**West Yorkshire and Harrogate Cancer Waiting Times update**	Public	
		Private	
		N/A	✓

Purpose (this paper is for):	Decision	✓	Discussion	✓	Assurance		Information	

Report Author and Job Title:	**Fiona Stephenson, Head of Quality and Optimal Pathways, WY&H Cancer Alliance**

Recommendation (s):

It is recommended that the West Yorkshire and Harrogate Alliance Board:

1. Note the progress updates contained in the following paper and acknowledge the significant efforts of Trust managers, teams and clinical staff for their ongoing work on this topic
2. Note the current Cancer Waiting Times position, recent trends and current challenges
3. Note the Alliance response to recent national support for focussed additional non recurrent resource to deliver improvements in the urology pathway, specifically the prostate cancer pathway
4. Note the progress made on the West Yorkshire and Harrogate (WY&H) wide, the West Yorkshire Association of Acute Trusts (WYAAT) Strategy and Operations Group endorsed programme of activity to recover the 62 day standard through a focussed system-wide effort to undertake cancer pathway diagnostic deep dive analysis, to continue to achieve inter-provider transfer (IPT) referral by day 38 and deliver optimal pathways of care and experience for patients
5. Advise on what additional further action could be taken to assist with the recovery of the 62 day standard for patients in WY&H.
6. Consider how our Alliance should continue to provide system-wide assurance and effectively hold each other to account for the delivery of optimal pathways for patients and in particular the recovery of Cancer Waiting Times Standards.

Executive Summary:

Despite extensive system wide activity and a shared commitment to improve pathways and experience for patients, the recovery of the 62 day cancer waiting times standard continues to challenge the West Yorkshire and Harrogate health care system. Since March 2018, cancer 62 day performance has deteriorated from 84.6% to 74.9% in August 2018. One of the main factors contributing to this drop in performance has been the 27% increase in referrals for prostate cancer (which has also been seen nationally) which has resulted in additional pressures in diagnostic and cancer treatment services. The Alliance has submitted a proposal in response to the recent additional national resource made available to respond to this which is described in Section 2.1.

West Yorkshire and Harrogate continue to work together to identify the root causes of system demand and capacity challenges and seek collaborative solutions to these. Individual organisations have detailed recovery plans in place and an update on the Alliance wide recovery plan is described in the accompanying paper.

Our Alliance strategy as part of the WY&H Integrated Care System, has been to take a multi stranded approach; identifying and implementing the 'quicker wins' where possible; standardising Cancer Waiting Time (CWT) policy, taking a medium term approach to address the wider causes such as workforce and equipment shortages, connect with the Integrated Care System enabling work streams (such as workforce, digital, primary care) and to continue influence at a national level.

Through Alliance partnership working with the West Yorkshire Association of Acute Trusts (WYAAT) there has been a continued commitment to collaborate to recover the standard. Recent efforts by Trusts with support from NHS Improvement Intensive Support Team focussing on the prostate, lung and colorectal cancer pathways have identified areas for process improvements that could potentially have positive impact by the New Year.

This paper provides a detailed account of our approach and activity to date, describes our strategy for targeting resource and action at the most challenged pathways and Trusts, with all Trusts working together to improve and deliver system wide improvements for all.

We acknowledge that this is a lengthy paper and future Board updates will provide a shorter exception report on progress.

The Board is asked to endorse this approach to maintain momentum and provide future direction for areas of focus.

Outline of engagement activity – public/patient, clinical, stakeholder	Patient panel engagement in the development of optimal cancer pathways
Risk Assessment:	Risk in terms of progress against planned action is low. However, risk against standard recovery as per the national plan is high.
Finance/ resource implications:	Risk to Q3 and Q4 CTF funding have not been realised due to re adjustment of performance to take account of rise in prostate cancer referrals. It is anticipated that an Alliance plan for the use of WY&H redirected non recurrent CTF resource to support CWT recovery in 18/19 should be finalised by the end of November.
Do any decisions need further approval at CCG/Provider/Local Authority level (Please specify)	

West Yorkshire and Harrogate Cancer Waiting Times update

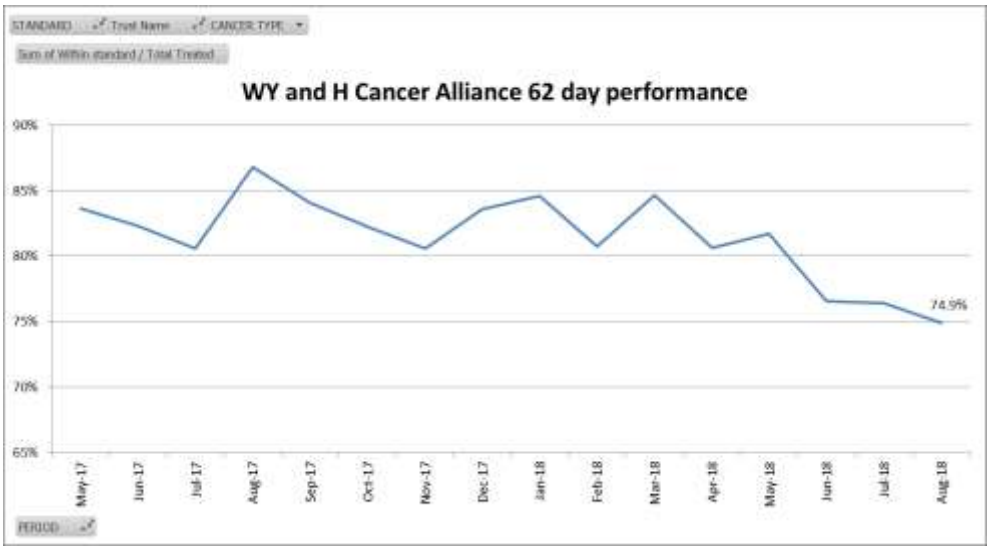
1. Introduction

The Board has received regular updates on progress and has endorsed an Alliance wide Recovery Plan for the 62 day cancer waiting times standard supported by WYAAT Chief Executives and Chief Operating Officers which included a number of pieces of Alliance wide activity. West Yorkshire and Harrogate (WY&H) Cancer Alliance are proactively supporting the recovery of the 62 day CWT standard; leading a collaborate system wide response with engagement from operational managers and clinicians, NHS England, (North Region) and Yorkshire and Humber DCO office and NHS Improvement.

The paper below provides further detail on the current Cancer Waiting Times position and actions and interventions being undertaken locally to recover the standard.

2. CWT position update summary

The West Yorkshire and Harrogate Cancer Alliance is currently performing at 74.9% against the 62 day wait target of 85%. Of the 7 cancer alliances in the North region, WY&H currently has the second lowest performance against this target, based on in month performance. The graph below shows the performance trend from May 2017 – August 2018. Over the 16 month period, performance exceeded target once in August 2017, and reached within 1% of target for 3 months.



The graphs in **Appendix 1** illustrate the performance of the six Trusts within the Alliance. All graphs use the same scale to aid comparison. Individual provider performance reflects the overall challenges and variation we see as an Alliance system.

Reports from providers on the fortnightly teleconference call the Alliance has with Trusts and CCGs, indicates there are some improvements in the 62 day performance monthly position for September. The Trusts who generally meet the standard (Airedale, Calderdale and Huddersfield and Harrogate) are reporting some recovery, but this is not consistent achievement month on month. Those Trusts who are currently not meeting the standard (Bradford, Leeds and Mid Yorkshire) report some small upward improvements but are still experiencing significant challenges to recovering their performance.

2.1 CWT performance deterioration and increase in urology referrals

Since March 2018, in WY&H, cancer 62 day performance has deteriorated from 84.6% to 74.9% in August 2018. One of the main factors contributing to this deterioration in performance has been an increase in urology referrals of 27% in Apr – July 2018 compared to the same period last year.

£10m of funding has been made available nationally to support improvements in performance on the 62 day pathway in 2018/19, particularly within the prostate pathway. This national resource, which was previously withheld from Alliances for non-delivery of the 62 day standard, was made available at very short notice and Alliances were asked to submit proposals on behalf of stakeholders. In WY&H our indicative share of this allocation is c£415,000 (non-recurrent). To note, this is a different pot of resource to that described in section 3.1 below.

In the North Region, this short term recovery plan is being co-ordinated by NHS England (North) in collaboration with NHS Improvement and Alliances. The North's plan original proposal was to target waiting list monies for cancer at increasing diagnostic capacity to reduce the backlog of patients in urology, lower and upper GI cancer pathways. From a WY&H perspective, our greatest performance delays are in our prostate cancer pathways and we agreed with Region that we should continue to focus effort on the prostate pathway - as we have been doing and already have a detailed understanding of the issues and bottlenecks. The Alliance has submitted an adapted proposal which targets the non-recurrent resource at initiatives aimed at reducing waiting times and backlogs. This includes additional outpatient appointments, some MRI and reporting capacity, additional capacity to delivery biopsy and some additional consultant surgical time to fully utilise theatre capacity. We anticipate feedback and decision by 26 October. Governance and financial transfer arrangements will also be clarified.

3. Actions & interventions being undertaken locally to recover the standard

3.1 System wide and Trust recovery plans across WY&H – priorities for improvement and use of Alliance redirected non recurrent CTF resource to support 62 day recovery

The Alliance Board, as part of the reprioritisation of our transformation plans, redirected a proportion of our non-recurrent Cancer Transformation Funds (CTF) resource (up to £400k) to support the recovery of the 62 day standard. Following this, in March 18, the WYAAT Strategy and Operations Group (SaOG) endorsed an approach to deploy this resource for system wide benefit and to target the resource in the areas, pathways and Trusts that would result in the greatest benefit for the whole system. An Alliance wide improvement programme was quickly mobilised that focussed on our most challenged pathways which are prostate, colorectal and lung.

All Trusts are now working with NHSI Intensive Support Team to undertake a deep dive whole pathway analysis of prostate, colorectal and lung cancers. Initial findings from the prostate pathway analysis point to potential areas for improvement in administrative, Multi-disciplinary Team processes, some diagnostic processes and access to non-surgical oncology Consultants.

It is anticipated that this first initial assessment of all three pathways will have been completed by mid-November. The rapid response and engagement of all Trusts with this work is testament to the priority given to this. In addition to individual Trust implementation plans, opportunities for cross Trust collaboration and sharing of capacity will also be identified. The implementation plans will identify where, if feasible, the CTF non-recurrent redirected resource can be utilised for best effect.

Following this initial pathway analysis, more detailed capacity and demand analysis will be undertaken with Trusts (using some of the redirected CTF non recurrent resource) to enable a more strategic approach to planning for a sustainable recovery which would allow the system to respond to future demands, identify capacity gaps and where there may be opportunities to collaborate.

Although there remain significant workforce challenges that are not amenable to short term funding solutions and often require a national response, we are exploring opportunities for cross Alliance work to address workforce issues including for example, the capacity and configuration of non-surgical oncology and the development of advanced practitioner's roles. These will be reviewed and considered as contribution to the improvement plans. Additional fixed term programme management and analytical support is being secured and will provide extra focus to work alongside Trust teams to progress implementation plans and actions during Q3 and Q4.

A summary update on the above will be taken to the WYAAT SaOG for agreement to proceed including an Alliance proposal for the use of the (up to) £400k redirected non recurrent CTF resource to support CWT recovery in 18/19.

3.2 Optimal pathways

Delivery of the optimal pathways is a system requirement set out in the 18/19 NHS England planning guidance. Multidisciplinary Optimal Pathway Groups for colorectal, lung, prostate and upper GI cancer have been established which take a whole pathway approach and oversee the implementation of the national optimal pathways to improve treatment and patient experience. This includes assessment of current position against national pathways, understand current and future demand and capacity and agree specific improvement plans to address any gaps, with timeframes. The groups are also leading cross Alliance and organisation work to develop networked solutions to imaging, pathology and endoscopy capacity challenges including workforce. The table below describes a high level assessment against each of the optimal pathways and there is encouraging movement towards full implementation. All Groups endorse the clinical steps outlined in the pathways – the challenge all Trusts acknowledge is achieving the timings and milestones against the standards set out in the optimal pathways.

Optimal Pathways	Airedale	Bradford	C&H	Harrogate	Leeds	Mid Yorks
Lung - Is a straight to CT pathway in place for suspicious chest x-ray	Y	Y	Y	N	Y	Y
Prostate - Is MRI available as a triage before biopsy	Y	Y	N	Y	Y	Y
Upper GI - Do people with suspicious symptoms go straight to test	Y	Y	Y	Y	Y	Y
Lower GI - Do people with suspicious symptoms go straight to test	Y	Y	N	Y	Y	N

Lung:

All Trusts have self-assessed compliance with meeting the National Optimal Lung Cancer Pathway, and are meeting the lung cancer optimal pathway clinical standards as described, although there are on-going and changing challenges in achieving the clinical standards consistently and in a sufficiently timely way. This includes diagnostic test capacity EBUS (where we have identified the Trusts with capacity issues, and are offering additional capacity support via redirected Transformation Funding to CWT recovery), and accessing PET CT within the agreed quality standards. We are providing the external provider (Alliance Medical) with specific data from Trusts where this happens, who are supporting Trusts to access additional capacity where possible.

Clear and up to date guidelines for the management of patients with Lung Cancer have been published the production of which have been supported and facilitated by WY&H CA, and production of an agreed IPT pathway for Lung patients is underway.

Colorectal:

All Trusts have self-assessed against the colorectal optimal pathway. The gap analysis was completed in September and has identified where Trusts are implementing the clinical steps and identified areas/gaps in straight to test for eligible patients. Mid Yorkshire Trust and Calderdale and Huddersfield are not currently delivering straight to test for eligible patients but are exploring options to take this forward. The colorectal pathway group will complete a further assessment against timed milestones and work with individual Trusts to agree timescales for achievement.

Clear and up to date guidelines for the management of patients with Colorectal Cancer have been published the production of which have been supported and facilitated by WY&H CA, as has production of an agreed IPT pathway for colorectal patients.

Prostate:

A gap analysis completed in June against the clinical steps identified that all Trusts are in agreement with and aiming to deliver the clinical standards in the optimal pathway. Calderdale and Huddersfield are currently not delivering mpMRI before biopsy as part of the initial diagnostic pathway but are developing plans to identify MRI capacity and reporting to enable this to be delivered. The prostate pathway group will present a position statement and overview against pathway delivery at their next meeting in November. As part of the whole pathway review, Trusts are taking forward the delivery of Risk Stratified Follow Up and patient centred self-management for prostate cancer patients, providing more appropriate tailored follow up and potentially releasing staff and outpatient capacity to redirect to newly diagnosed patients and those with more complex needs. A further assessment of achievement against timed milestones will be completed in advance of this. The prostate pathway deep dive described above will inform where improvements need to be made and/or further analysis/capacity needed.

Clear and up to date guidelines for the management of patients with Urological Cancers have been published the production of which have been supported and facilitated by WY&H CA, as has production of an agreed IPT pathway for urological cancer patients.

Networking Diagnostics

In addition to the optimal pathway work, the Cancer Alliance is collaborating with a number of initiatives as part of an enabling programme of work. This includes supporting clinical leadership as part of the Yorkshire Imaging Collaborative, establishing a foundation to enhance the roll out and digital pathology network in all hospitals and bringing endoscopy providers and commissioners into a community of practice to share best practice and explore opportunities for sharing capacity. The Alliance is also working with Health Education England to identify cancer workforce needs and current capacity gaps.

3.3 Trust recovery plan implementation

All Trusts are proactively engaged and supporting the recovery of the 62 day standard, individually and collaboratively. There is Executive and Board level support to prioritise and deliver cancer recovery in both Provider and Commissioning organisations. All Trusts hold weekly PTL meetings, escalating to daily if required. In addition, Trusts have invested in additional senior level and administrative capacity to proactively manage the patient through their diagnostic and treatment pathway. Directorate liaison roles and pathway navigators are in place within organisations. There are weekly calls between LTHT and referring hospitals to review and track cancer pathways that transfer between organisations.

3.4 Supporting 2 ww referrals for suspected cancer and good patient experience

CCGs, GP Cancer Leads and Trusts are working together to ensure that patients who are referred on a suspected cancer pathway receive information about their referral, are aware of the reason for the referral and are available to attend an appointment within 14 days.

3.5 Inter provider transfer (IPT) and day 38 data

All providers have worked collaboratively and produced an IPT framework that describes the principles, the definitions and the operational MDT requirements to support and maintain improved performance and patient experience. Eighteen cancer site pathways have been revised with timings and include clinical and administrative requirements for transfer. The lead Chief Operating Officer and the WYAAT SaOG have endorsed the WY&H Inter Provider Transfer Framework and have ensured that Trusts are ready and supporting the process for data uploads to the new CWT system from October 1. Alliance representatives are engaged and members of both national Task and Finish Groups.

As the new system and rules are implemented, the nominated Lead COO (Airedale FT) will oversee the adoption and implementation of the IPT and seek support of fellow COOs to ensure individual Trusts CE level support is maintained and that any issues requiring a system wide response or mediation are taken forward.

Ongoing work is underway to improve diagnostic referral pathways including increasing the proportion of patients who receive a decision to treat by day 38, which will improve the overall 62 day standard compliance.

The Alliance facilitated a meeting to review the pathways and timelines for those patients whose care passes through three acute organisations. This had been signalled by Alliance Board and WYAAT CEOs and is being overseen by the WYAAT Strategy and Operations Directors Group. The initial review identified that the true number of patients who are required to be transferred for care across organisations is relatively small and that the planned individual pathway improvement work will proactively seek to address the issues identified and seek alternative and more streamlined pathways for these patients.

3.6 High Impact Actions

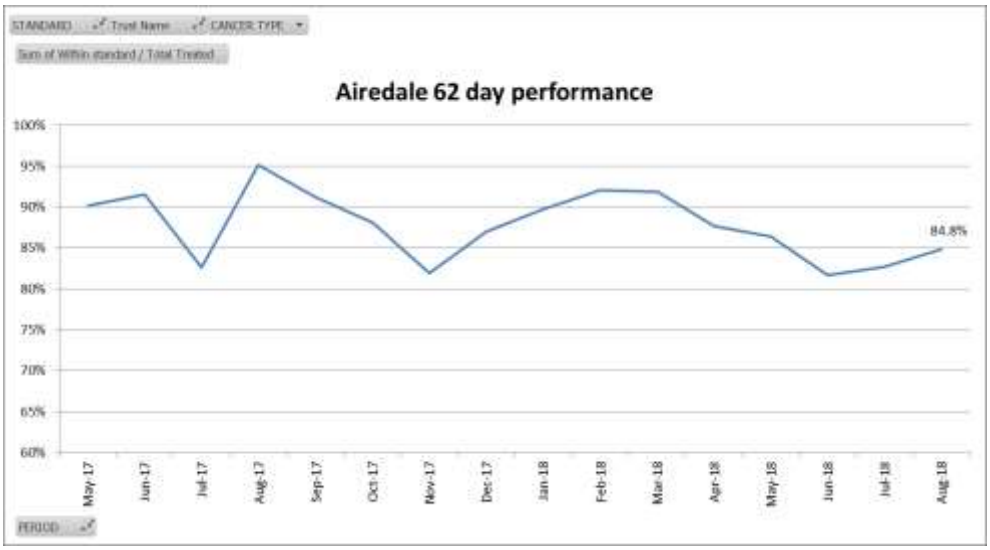
Trusts are meeting all the High Impact Actions with the exception of root cause analysis of near misses. A specific challenge common across providers is root causes analysis of near misses (Trusts do RCA each pathway not meeting the current standards and review the last ten patient's breaches) but Bradford, Calderdale and Huddersfield, Leeds and Mid Yorkshire do not analyse near misses, due to the volume of referrals and the lack of administrative staff capacity to do this. The RCA was also thought to be poor time spent because it was after the event and revealed little pattern overall when RCA on near misses had been undertaken in the past. As a more effective approach, all Trusts are investing in more sophisticated and proactive real time pathway management, using the local electronic Patient Pathway Manager IT system and adopting the 'Red to Green' pathway management tool which Trusts feel is a more effective way of engaging clinicians and the wider team.

3.8 Recommendations

1. Note the progress updates contained in the following paper and acknowledge the significant efforts of Trust managers, teams and clinical staff for their ongoing work on this topic
2. Note the current Cancer Waiting Times position, recent trends and current challenges
3. Note the Alliance response to recent national support for focussed additional non recurrent resource to deliver improvements in the urology pathway, specifically the prostate cancer pathway
4. Note the progress made on the WY&H wide, the WYAAT Strategy and Operations Group endorsed programme of activity to recover the 62 day standard through a focussed system-wide effort to undertake cancer pathway diagnostic deep dive analysis, to continue to achieve inter-provider transfer (IPT) referral by day 38 and deliver optimal pathways of care and experience for patients
5. Advise on what additional further action could be taken to assist with the recovery of the 62 day standard for patients in WY&H.
6. Consider how our Alliance should continue to provide system-wide assurance and effectively hold each other to account for the delivery of optimal pathways and in particular the recovery of Cancer Waiting Times Standards

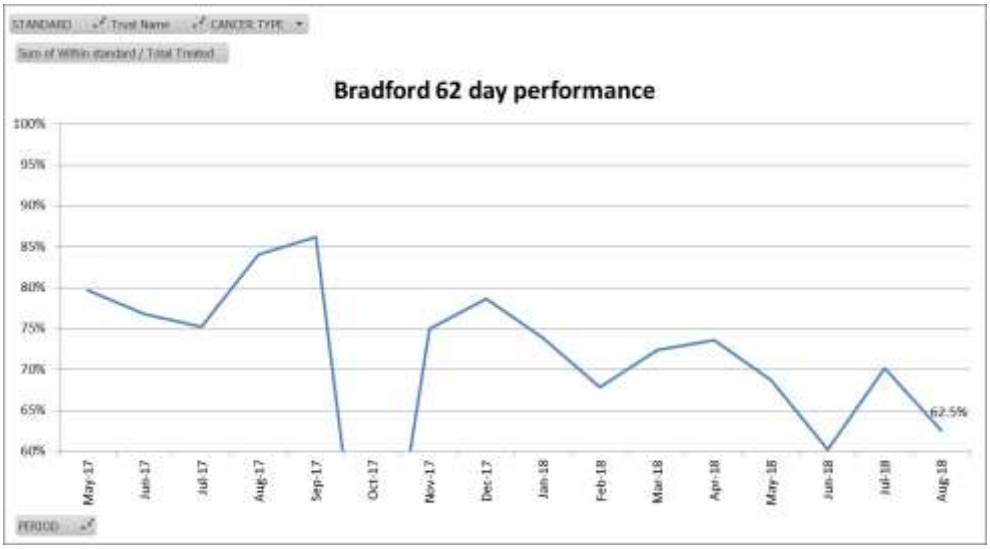
Appendix 1

Airedale Hospitals NHS Foundation Trust



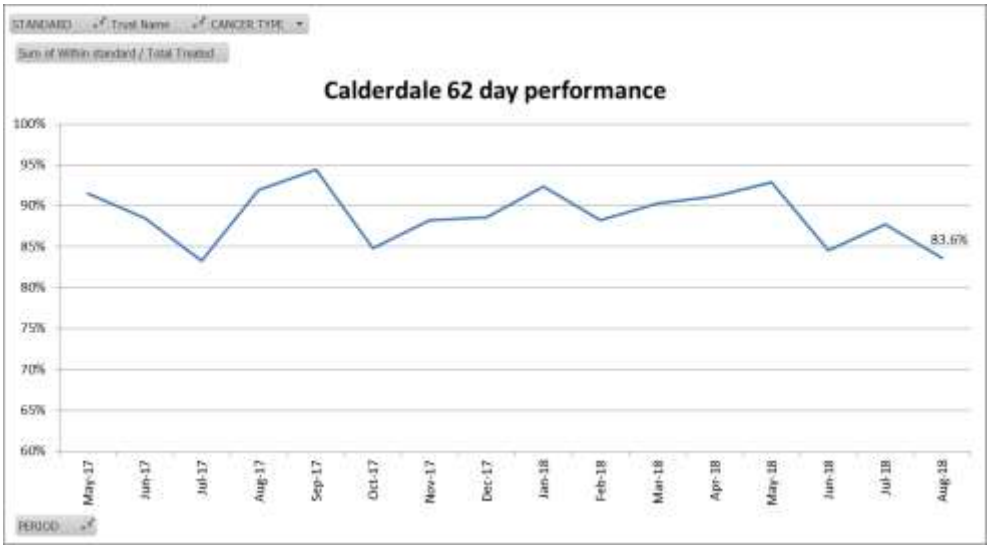
Whilst current in month performance stands slightly below target at 84.8%, Airedale has performed above the 85% target for 11 of the last 16 months, and is currently the second highest performing Trust in the Alliance. Performance is improving, following a steady deterioration from February to June this year.

Bradford Teaching Hospitals NHS Foundation Trust



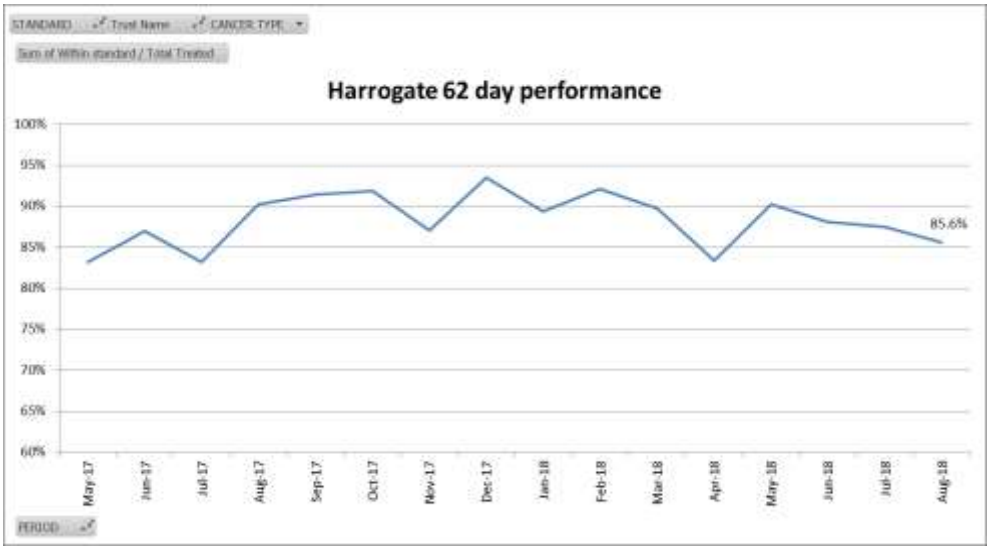
Bradford's 62 day performance currently stands at 62.5%, and the Trust has only exceeded the 85% target once in the last 16 months. Performance shows a markedly declining trend, and the Trust currently has the lowest performance in the Alliance. October 2017 is a data artefact and should be ignored.

Calderdale and Huddersfield NHS Foundation Trust



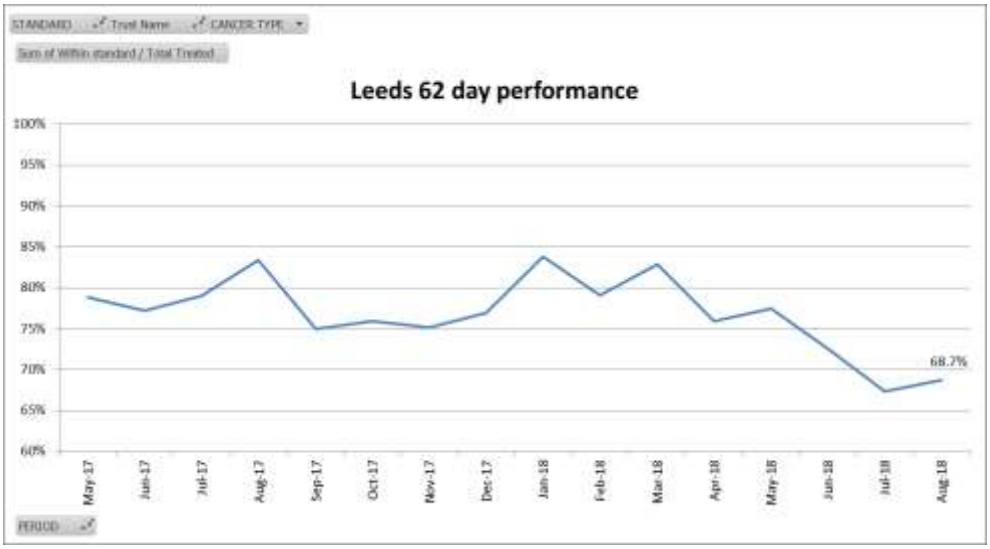
With a current in month rate of 83.6%, Calderdale has the third highest 62 day performance across the Alliance. Whilst performance has been broadly flat, the last quarter shows a deteriorating position compared with previous months.

Harrogate District Hospitals NHS Foundation Trust



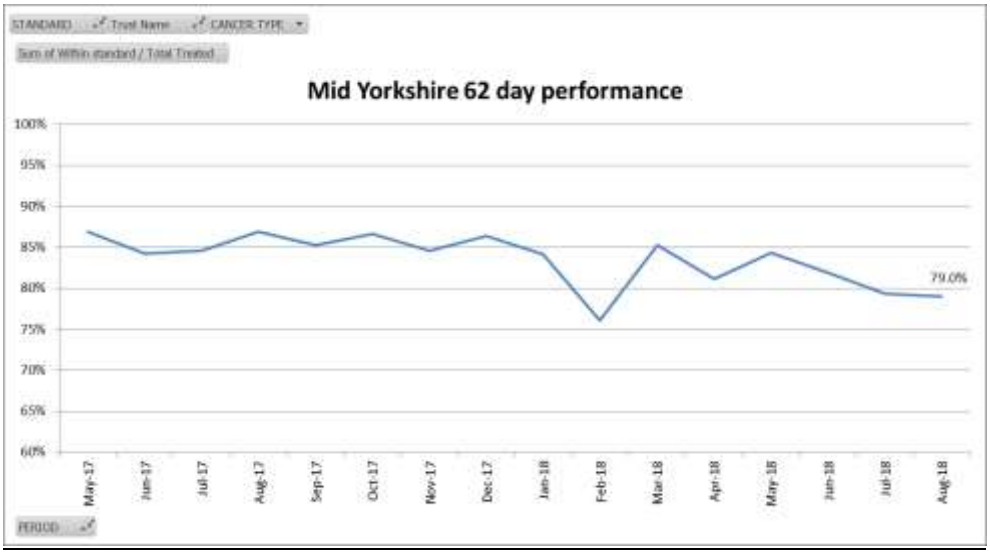
Although performance has declined slightly over the last three months the current month achievement of 85.6% means Harrogate remains the highest performing Trust within the Alliance. The Trust met the 85% target 13 out of the last 16 months.

Leeds Teaching Hospitals Trust



Leeds has shown a substantial decrease in performance since the start of this financial year, and the current performance of 68.7% is 5th out the 6 Trusts in the Alliance. The Trust has not met the 85% target at any point over the last 16 months.

Mid Yorkshire Hospitals Trust



Whilst the trend in performance of Mid Yorkshire Trust is fairly flat, performance has been below target for the last 5 months.

Title of meeting:	**West Yorkshire and Harrogate Cancer Alliance Board**	**Agenda Item:**	**5**
Date of Meeting:	**23.01.19**	**Public/Private Section:**	
Paper Title:	**Cancer Waiting Time update**	Public	
		Private	
		N/A	✓

Purpose (this paper is for):							
Decision	✓	Discussion	✓	Assurance		Information	

Report Author and Job Title:	**Fiona Stephenson, Head of Quality and Optimal Pathways, WY&H Cancer Alliance**

Recommendation (s):

It is recommended that the West Yorkshire and Harrogate Alliance Board:

Note the current Cancer Waiting Times (CWT) position and update on actions to recover the standards as part of the West Yorkshire Association of Acute Trusts (WYAAT) Strategy and Operations Group endorsed programme of activity through focussed system wide efforts.

Endorse and advise on the specific issues and actions described in section four:

- Cancer pathways for prostate and lung cancer
- A proposal to invest in activities to enable WY&H to operate more effectively as a system including demand and capacity modelling of diagnostic services and the development of a WY&H 'Cancer Hub'
- Support further detailed analysis of CWT performance data by pathway, Trust and WY&H level to support system achievement to identify where specific pathway, organisation and Alliance wide improvements are required; at what scale and what support will be required to achieve these

Consider how the Alliance should continue to provide system-wide assurance and effectively hold each other to account for the delivery of optimal pathways for patients and in particular the recovery of Cancer Waiting Times Standards.

Executive Summary:

West Yorkshire and Harrogate continue to invest significant system wide activity and shared commitment to deliver optimal care and experience for patients, which includes the recovery of the 62 day Cancer Waiting Times (CWT) standard. The Board received a detailed update at the October 2018 meeting which described our approach and activity, which includes targeting resource and action at the most challenged pathways and Trusts; with all Trusts working together to deliver system wide improvements. This paper provides a summary overview of our system and Trust 62 day performance and provides an update on specific issues which require a system wide response and/or decision which are described in section four.

The 62 day performance for the Cancer Alliance has shown a slight improvement from 74.9% in August 2018 to 76.6% in November 2018. Trusts continue to implement detailed individual performance recovery plans which have executive level support. They are also prioritising joint work to improve inter provider transfer (IPT) referral by day 38 to deliver optimal pathways for patients and in readiness for the implementation of the new CWT Guidance and logic from 1 April 2019.

The Trust performance recovery and improvement plans are supported by the West Yorkshire Association of Acute Trusts (WYAAT) and the Joint Committee of CCGs which provides system wide focus and leadership to ensure we work to recover the 62 day standard and are doing all we can, individually and collectively.

WYAAT Strategy and Operations Group, working with the Alliance, NHS England and NHS Improvement are also

operating as an effective vehicle to enable co-ordination and deployment of resources and effort; and providing strategic forward planning for cancer within wider system pressures.	
Outline of engagement activity – public/patient, clinical, stakeholder	Patient panel engagement in the development of optimal cancer pathways, and new diagnostic models
Risk Assessment:	Risk in terms of progress against planned action is low. However, risk against cancer standard recovery as per the national plan is high.
Finance/ resource implications:	WY&H have commenced agreed a plan for the use of WY&H redirected non recurrent CTF resource to support CWT recovery in 18/19 which was finalised at the end of December.

West Yorkshire and Harrogate Cancer Waiting Times update

1. Introduction

1.1 West Yorkshire and Harrogate continue to invest significant system wide activity and shared commitment to deliver optimal care and experience for patients, which includes the recovery of the 62 day Cancer Waiting Times (CWT) standard. The Board received a detailed update at the October 2018 meeting which described our approach and activity, which includes targeting resource and action at the most challenged pathways and Trusts, with all Trusts working together to improve and deliver system wide improvements. This paper provides a summary overview of our system and Trust / place 62 day cancer waiting times performance and highlights specific issues in section four, which require Board support.

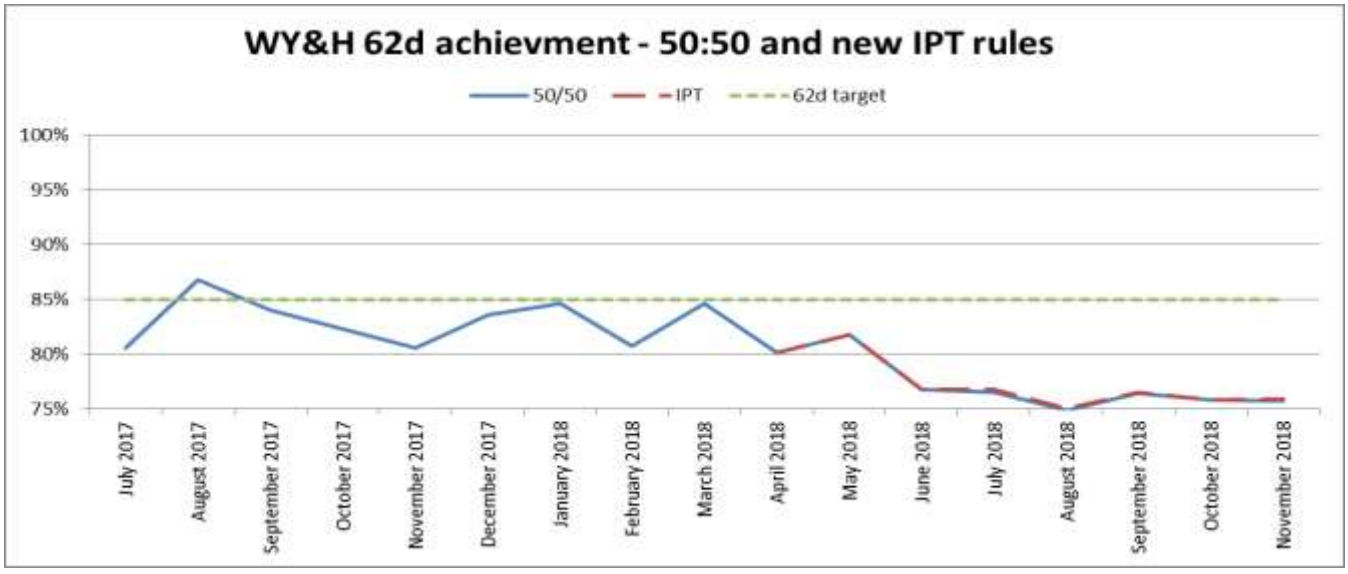
2. CWT performance position update

2.1 The West Yorkshire and Harrogate Cancer Alliance is currently performing at 76.6% against the 62 day CWT target of 85% which has shown a slight improvement since August 2018. Providers are continuing to collaborate and deliver improvements in the diagnostic pathways and increase inter provider transfer (IPT) referral by day 38 and deliver optimal pathways for patients in readiness for the implementation of the new CWT Guidance and logic from 1 April 2019.

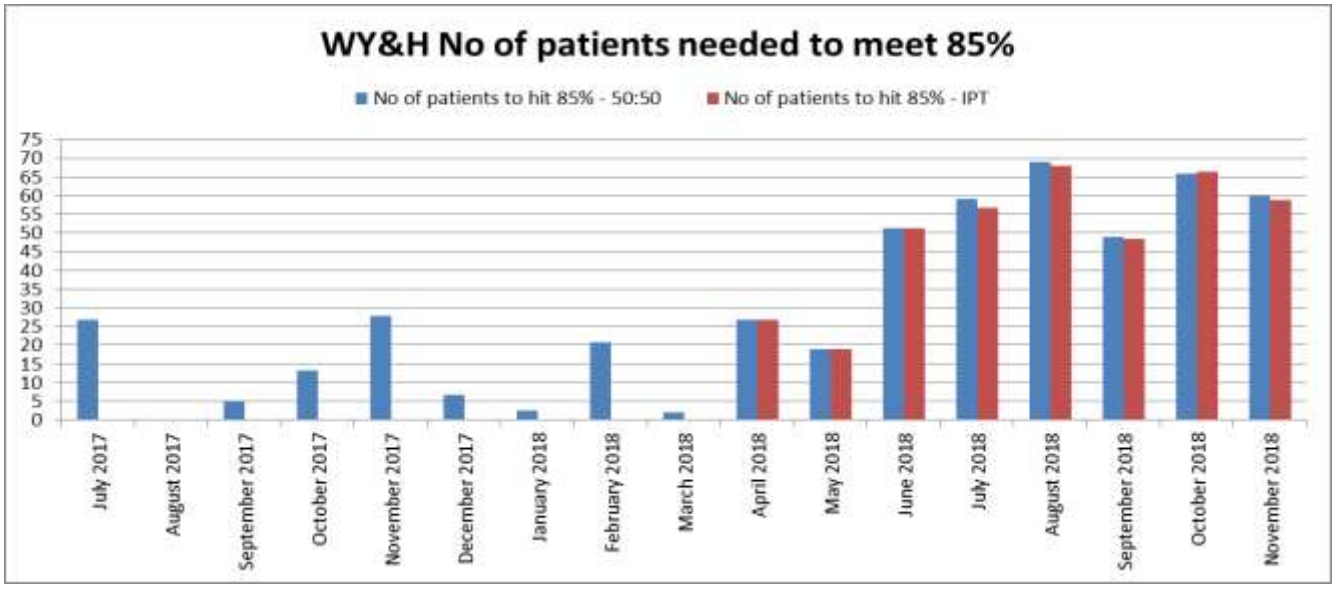
First tranche analysis of CWT performance using the new CWT logic has been released and the tables below describe the impact of this new logic at Trust and Alliance level. Allocation of a breach in a cancer waiting times standard is currently allocated on a 50:50 split between referring and treating providers. The new logic will mean breach is allocated between referring and treating provider, based on referral from the investigating hospital by day 38 and then treatment within 24 days by the treating provider. A number of detailed scenarios and application of rules are described in the revised Cancer Waiting Times guidance. The new approach will provide a more transparent view of where the delays in pathways are being experienced so providers can work together to improve the issues.

2.2 All the data is taken from the CADEAS 'Shadow report: 62 day wait from GP referral', updated 11 Jan 2019 to include revisions to April to September 2018 data. Data extracted from the '62 Day Provider Time series' worksheet, for all 6 WY&H providers. The WY&H position is an aggregate of those 6 providers.

2.3 Where a Trust is below the 85% target, the additional number of patients that would require treatment in order to achieve 85% has been calculated. Where a Trust is above the 85% target, the additional numbers of patients treated has not been reduced. When calculating the overall WY&H position, this treats the system as a single volume of activity and therefore the additional number of patients required is different to the aggregate of the Trusts within the area. Further analysis by Trust is described in **Appendix 1** which demonstrates the application of the new logic on individual provider Trusts.



2.4 The above graph shows that at the WY&H level only a slight difference in overall 62d performance (<0.3%) occurs when the new IPT logic is applied, compared to the 50:50 rule.



2.5 Based on the above and in readiness for the application of the new logic in April 2019, the Alliance and partners will undertake further analysis of day 38 data including a detailed review of cancer site pathway performance by Trust and WYH, to identify where pathway, Trust and WY&H improvements are required to help achieve system delivery.

3. Update on progress since October 2018

3.1 Improving the prostate cancer pathway

3.1.1 As part of our local strategy and approach in WY&H to deploy resource to best effect; WYAAT Strategy and Operations Group have now agreed a plan for use of £400,000 of non-recurrent WY&H CA resources. Improvements will focus on the prostate cancer pathway, including investing in new Advanced Clinical Practitioners roles in non-surgical oncology to support patients with treatment decisions and shorten their pathway and the provision of additional surgical capacity in specialist urology team.

3.1.2 Alongside Trust's on-going operational efforts, Alliance and providers have responded rapidly and at very short notice to the release of NHS England non-recurrent funds to submit proposals to recover performance. This national resource (10m nationally) was previously withheld from Alliances for non-delivery of the 62 day standard. In late October 2018, WY&H secured £415,000 to fund additional

capacity to recover the prostate cancer pathway – and Bradford, Leeds and Mid Yorkshire specialist urology teams are now delivering additional outpatient appointments, some MRI and reporting capacity, additional capacity to delivery biopsy and some additional consultant surgical time to fully utilise theatre capacity, which will benefit all patients across WY&H.

3.2 Collaboration across West Yorkshire and Harrogate

3.2.1 A further opportunity is currently being scoped to progress a system wide capacity and demand modelling of diagnostic services with Yorkshire Imaging Collaborative (YIC) pathology and endoscopy services to inform future planning, identify pressures and risks and enable WY&H to work more effectively as a system. The programme will consider focussing on one modality; imaging, in the first instance as this is a common theme affecting all cancer pathways. It is anticipated that the programme would be implemented over the next 12 months, commencing in Feb/March 2019.

3.2.2 Alliance stakeholders are also exploring how to collectively manage CWT and patient pathways more efficiently and share capacity and demand across WY&H; including in the first instance, the establishment of a WY&H 'cancer hub' to co-ordinate Inter Provider Transfer (IPT) agreed pathways and application of our agreed framework.

4. Issues and actions

4.1 Cancer Pathways:

4.1.1 Pressures on cancer pathways continue and specifically for some, such as the ongoing and sustained rise in referrals (and diagnosis and treatment) for prostate cancer; will require forward planning to identify and meet service capacity requirements. The lung cancer pathway also remains challenged overall; however the provision of two additional endobronchial ultrasound (EBUS) facilities will provide additional capacity to improve the diagnosis of lung cancer. Also, the availability of PET CT, which is a nationally commissioned service is currently experiencing concerning delays in access to PET CT scans and reporting, due to disruptions in radioactive tracer supplies to PET CT sites that are part of the national contract with Alliance Medical.

4.1.2 Action: The Alliance Optimal Pathway Improvement Groups, with engagement from stakeholders across WY&H, will continue to identify and address these pathway challenges working together to plan and deliver changes, to drive improvements in outcomes for patients. The Alliance on behalf of Trusts is also liaising directly with NHS England (Yorkshire and Humber) Specialised Commissioning colleagues on both pathway issues to address and mitigate immediate impact on patients where possible.

4.2 Collaboration across West Yorkshire and Harrogate:

4.2.1 The proposal to model diagnostic capacity and demand as a system, which will give us a consistent and standardised baseline position across all provider Trusts, provides an opportunity to understand in depth and detail our gaps and where we could collaborate more effectively to share capacity. The analysis will also model future demand including demographic change and implementation of new guidance, policy and technologies. Exploring the establishment of a WY&H 'cancer hub' initially to co-ordinate Inter Provider Transfer (IPT) agreed pathways and application of our agreed framework will also provide a starting point to explore wider collaborative work and system working.

4.2.2 Action: Continue system wide collaboration to test ways of operationalising shared improvements and solutions.

4.3 CWT analysis to support system achievement:

4.3.1 The ongoing investment and commitment to achieve the 62 day CWT standard and the successful implementation of an agreed WY&H Inter Provider Transfer (IPT) policy in readiness for the application of the new logic which commences in April 19 will be a priority. The lead Chief Operating Officer and the WYAAT Strategy and Operations Group have endorsed the WY&H Inter Provider Transfer Framework, and as the new system and rules are implemented, the nominated Lead COO (Airedale FT) will oversee the adoption and implementation of the IPT and seek support of fellow COOs to ensure

individual Trusts CE level support is maintained and that any issues requiring a system wide response or mediation are taken forward. Further analysis referred to in 2.5 will identify where specific pathway, organisation and Alliance wide improvements are required; at what scale and what support is required to achieve this.

5. Recommendations

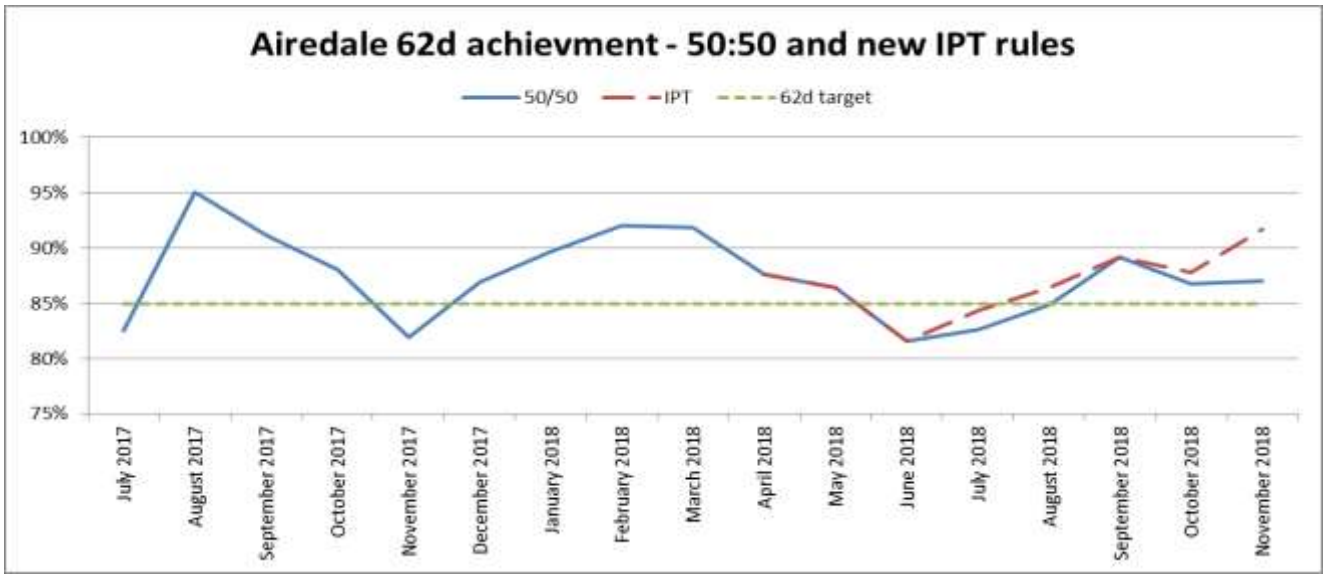
Note the current Cancer Waiting Times (CWT) position and update on actions to recover the standards as part of the West Yorkshire Association of Acute Trusts (WYAAT) Strategy and Operations Group endorsed programme of activity through focussed system wide efforts.

Endorse and advise on the specific issues and actions described in section four:

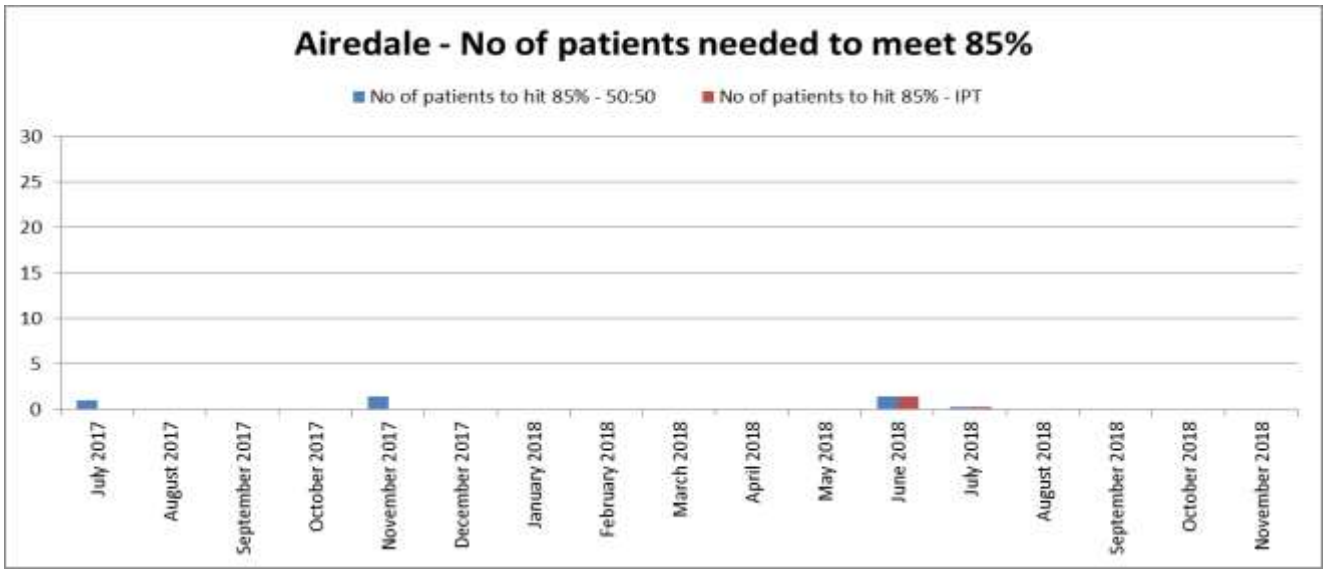
- Cancer pathways for prostate and lung cancer
- A proposal to invest in activities to enable WY&H to operate more effectively as a system including demand and capacity modelling of diagnostic services and the development of a WY&H 'Cancer Hub'
- Support further detailed analysis of CWT performance data by pathway, Trust and WY&H level to support system achievement

Consider how our Alliance should continue to provide system-wide assurance and effectively hold each other to account for the delivery of optimal pathways for patients and in particular the recovery of Cancer Waiting Times Standards.

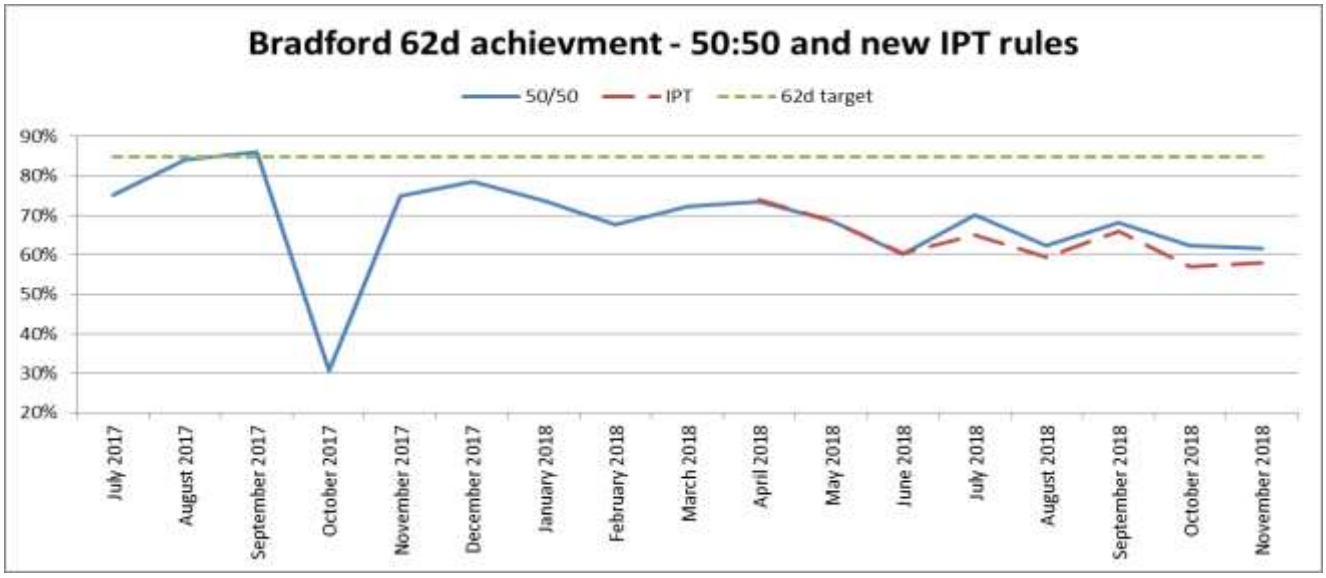
Appendix 1



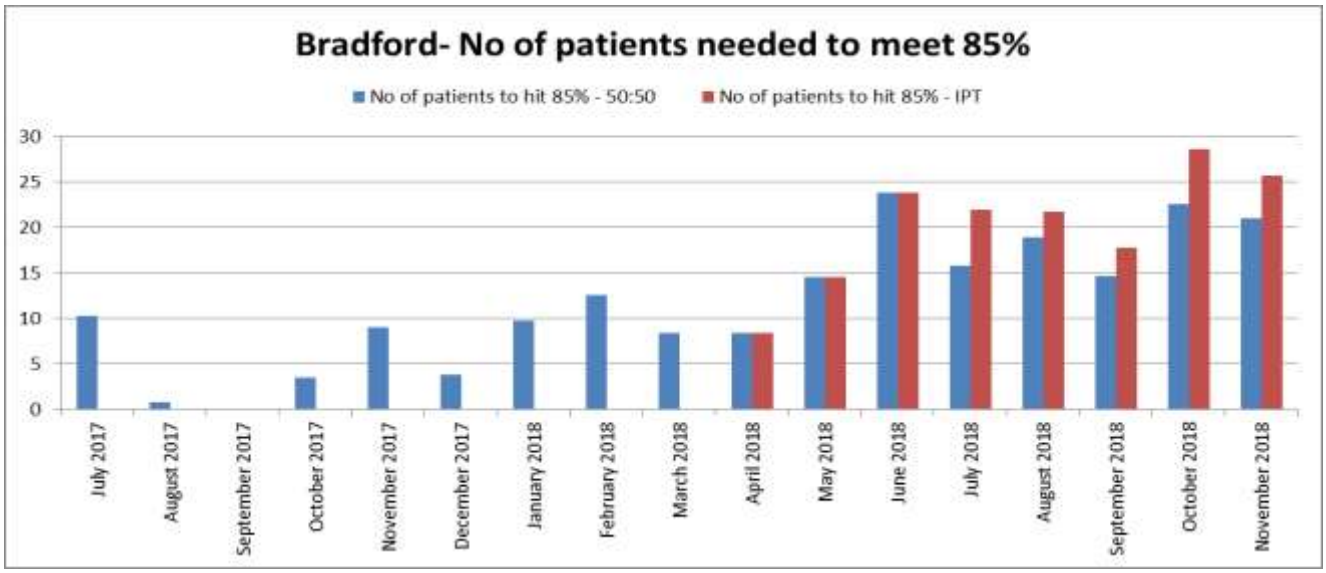
Applying the IPT rules lifts Airedale's performance, with the largest difference between the 50:50 and IPT being in November 2018, where the difference is 4.7% (91.7% IPT vs 87% 50:50).



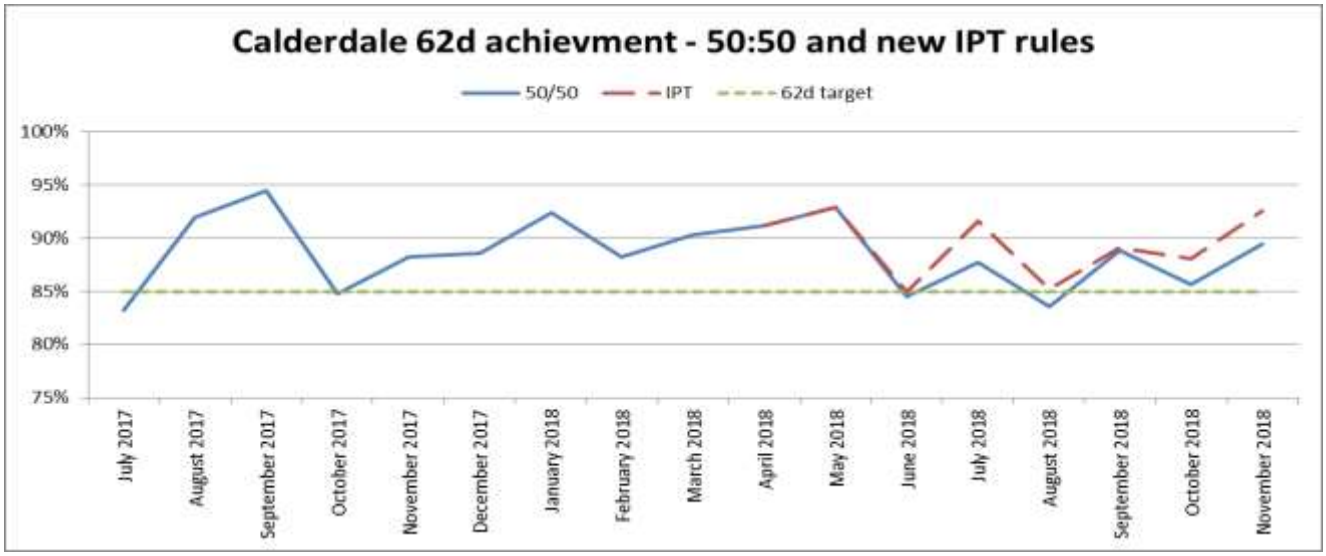
As Airedale's performance drops below the 85% level only rarely, and then only by a small amount, only very small numbers of patients would have required treatment in those months to once again meet the target.



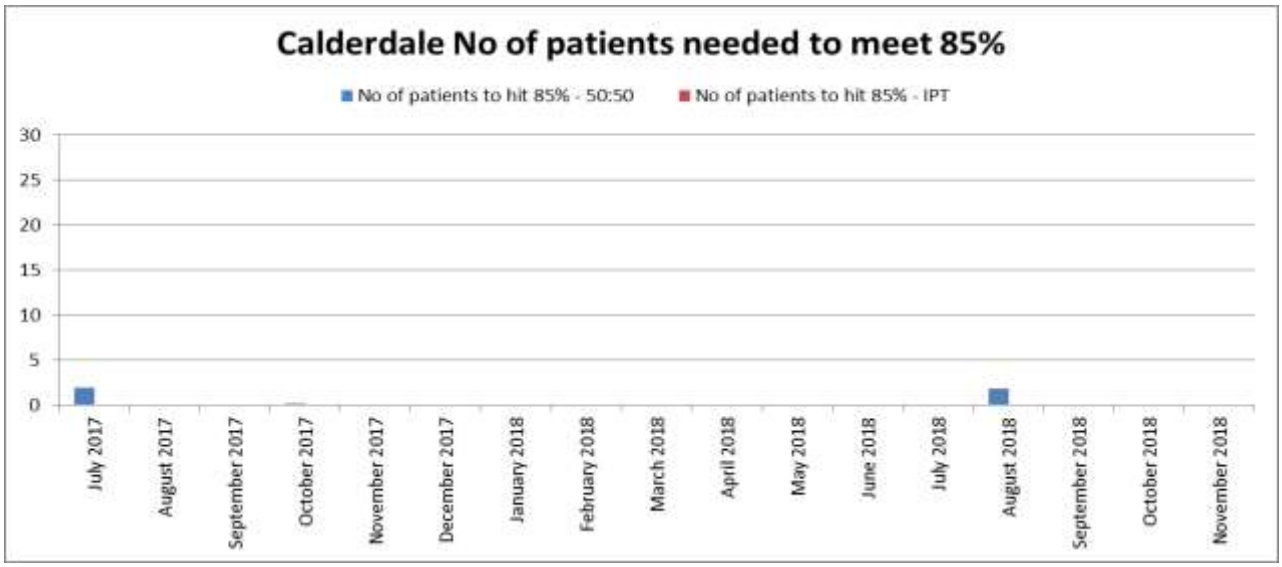
When IPT rules are applied, Bradford's performance decreases, the biggest impact is in October 2018 where performance using IPT is 5.2% lower than when using the 50:50 rule.



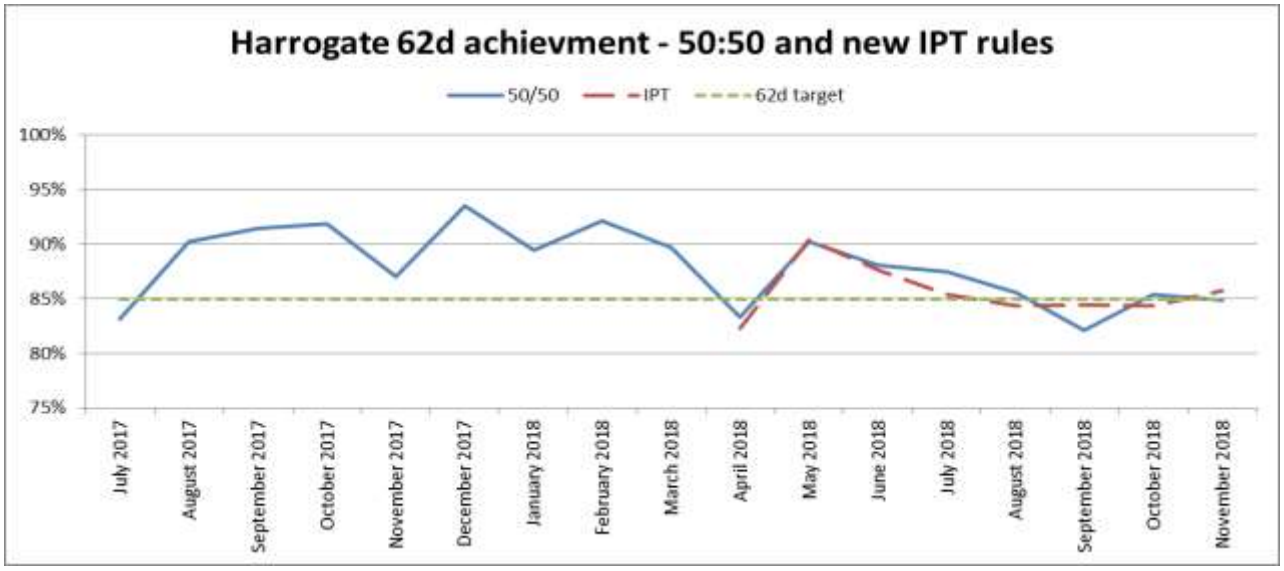
As Bradford's performance decreases when IPT rules are applied, the number of additional patients requiring treatment increases in those circumstances.



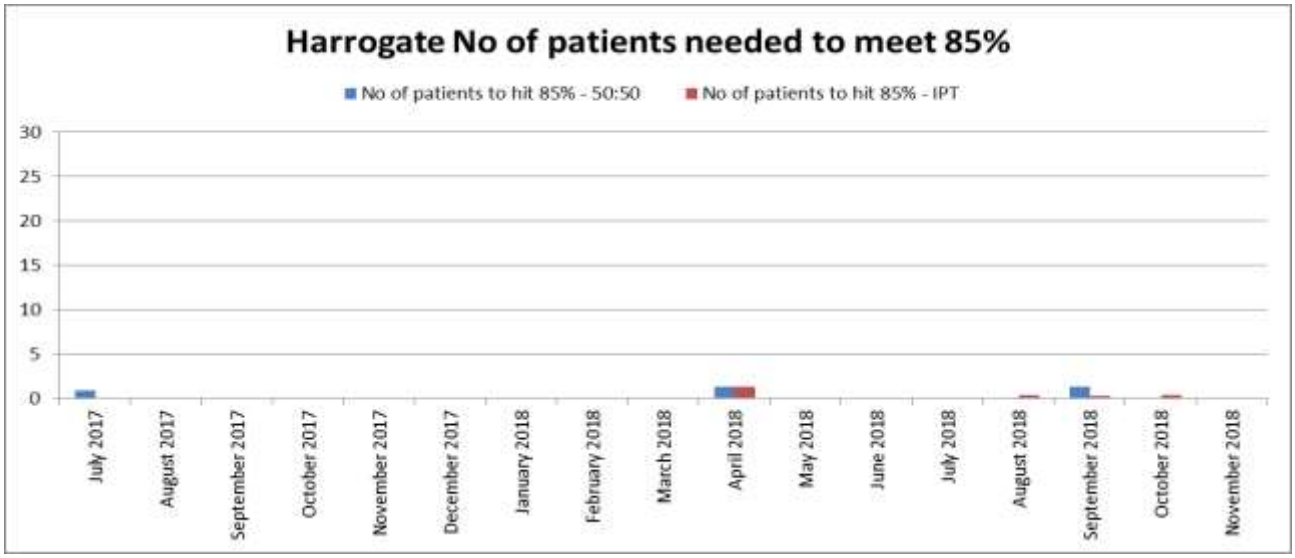
Calderdale's 62d performance improves when the IPT rules are applied, with the biggest increase of 3.9% in July 2018.



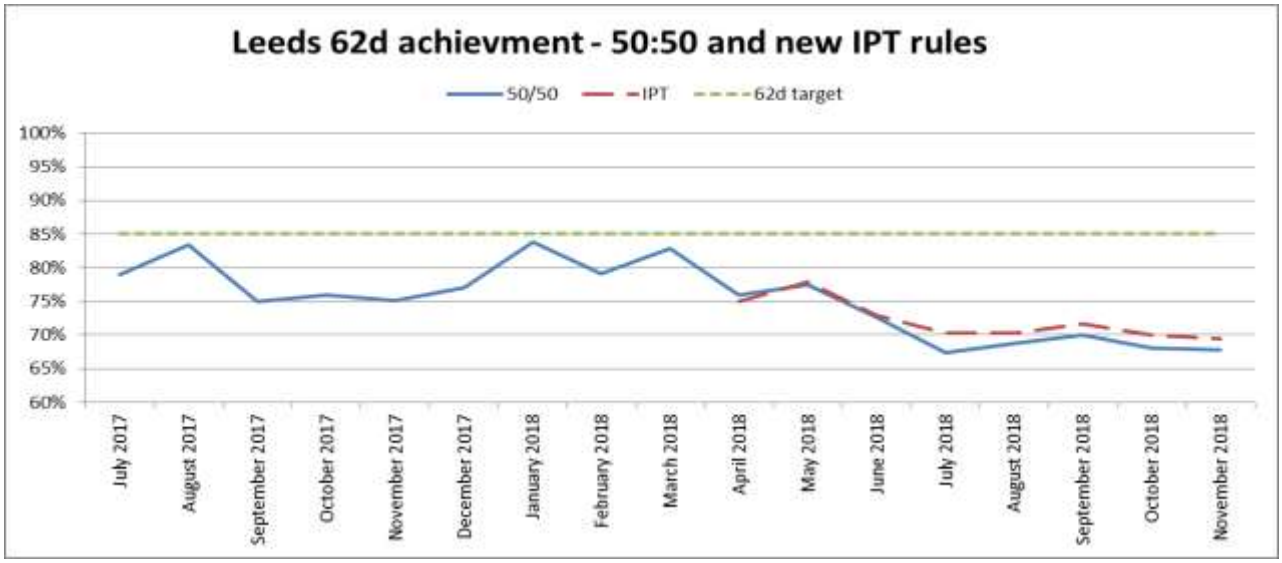
Again, as Calderdale only rarely fails to meet the 85% target, and only by a small margin, only very small patient numbers would be required to meet the target.



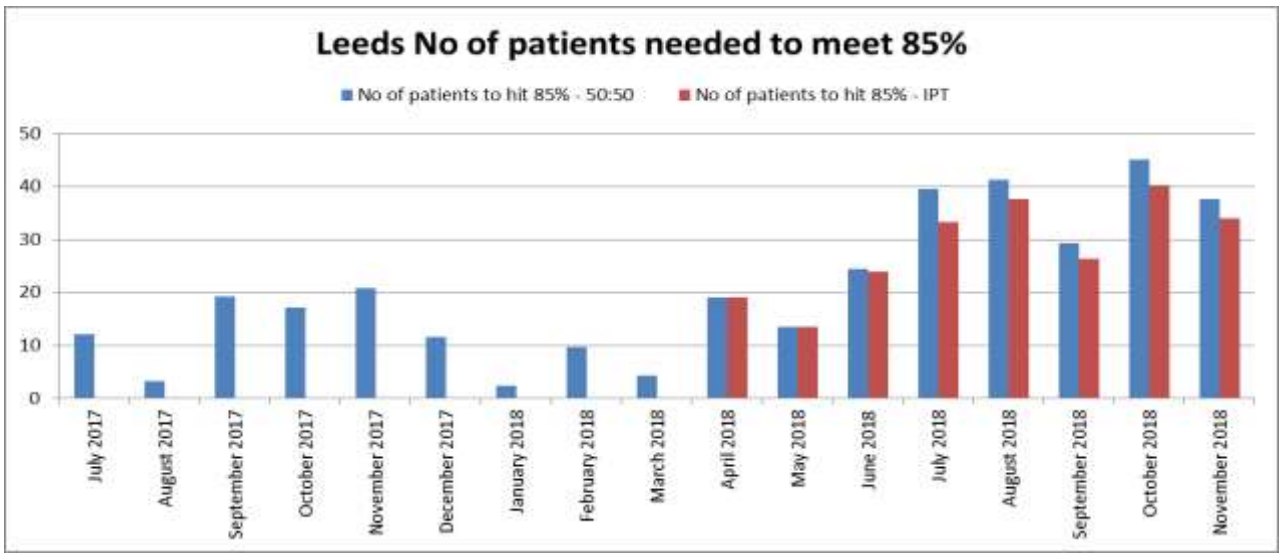
The impact on Harrogate's performance varies – mostly applying IPT rules decreases performance against the 62 day standard, although in September 2018 performance is increased by 2.3%.



As an organisation delivering the 85% target for the majority of the time, small numbers required.

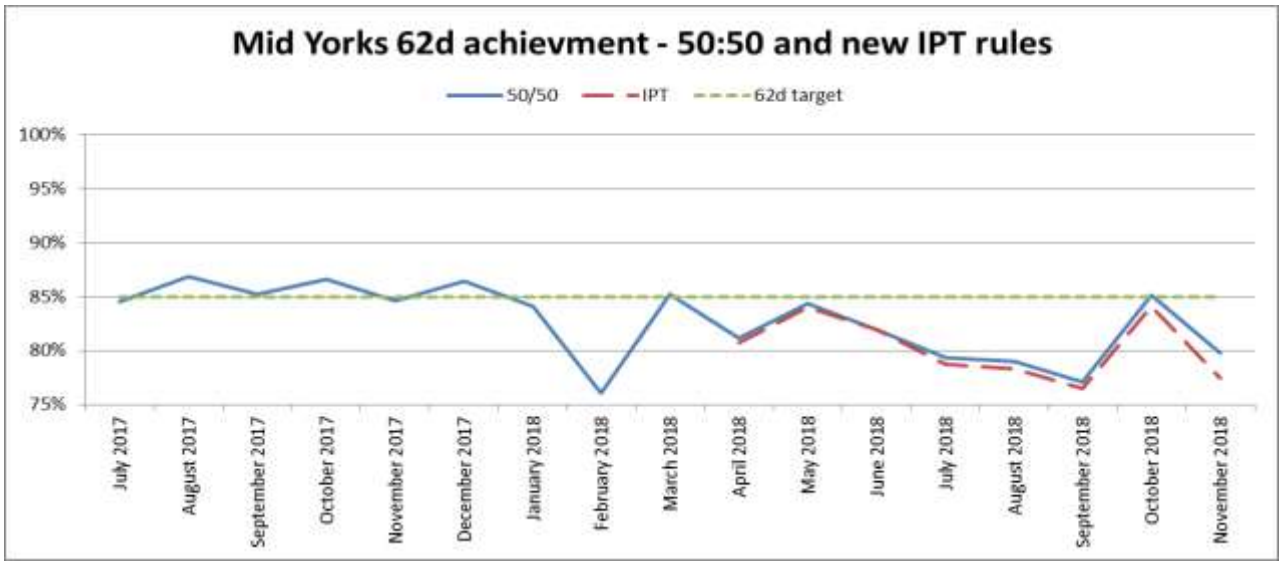


The performance of Leeds is consistently improved (by an average of 1.2%, max 2.9%) by the application of the IPT rules, although in April 2018 a decrease of 0.9% in performance is apparent.

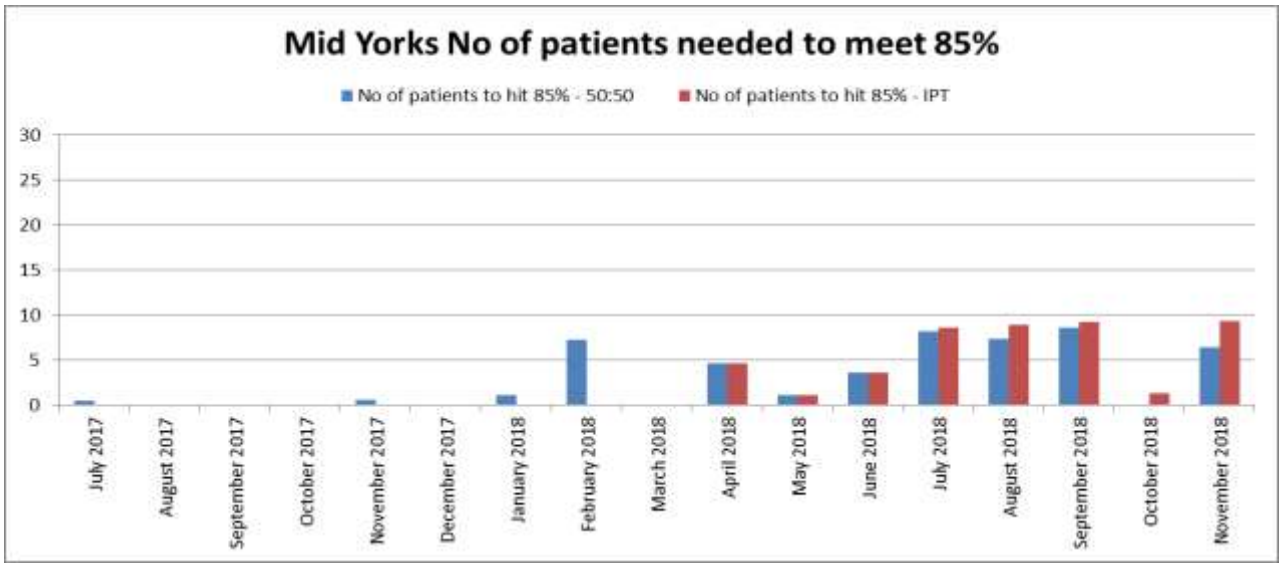


As the largest Trust in WY&H, large patient numbers would need to be delivered within the 62 day timeframe in order to meet the 85% target. As the IPT rules benefit Leeds (increasing its 62d performance), that obviously

leads to a smaller volume of patients requiring treating within the 62 day window in order to achieve the standard when those rules are applied.



Mid Yorkshire shows a decrease in performance when IPT rules are applied, by an average of -0.7%. The largest decrease is apparent in November 2018, when performance is decreased by -2.3%, falling from 79.8% to 77.4%.



Relatively large additional numbers of patients would require treating, with that number growing larger when IPT rules are applied.

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