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Leeds CITY COUNCIL

WEST YORKSHIRE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Meeting to be held in Council Chamber, County Hall, Bond Street, Wakefield, WF1 2QW on Monday, 8th April, 2019 at 10.00 am

(Pre-meeting for all Committee Members at 9:45 am)

MEMBERSHIP

Councillors

Councillor N Riaz	-	Bradford Council
Councillor V Greenwood	-	Bradford Council
Councillor C Hutchinson	-	Calderdale Council
Councillor S Baines	-	Calderdale Council
Councillor J Hughes	-	Kirklees Council
Councillor E Smaje	-	Kirklees Council
Councillor B Flynn	-	Leeds Council
Councillor H Hayden (Chair)	-	Leeds Council
Councillor Y Crewe	-	Wakefield Council
Councillor B Rhodes	-	Wakefield Council

Co-opted Members

Councillor J Clark – North Yorkshire County Council
Councillor A Solloway – North Yorkshire County Council

Please note: Certain or all items on this agenda may be recorded

Principal Scrutiny Adviser:
Steven Courtney
Tel: (0113) 37 88666

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (*In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting.)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified on this agenda.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**PUBLIC STATEMENTS** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations on matters within the terms of reference of the Joint Committee. No member of the public shall speak for more than **three minutes**, except by permission of the Chair. Due to the number and/or nature of comments it may not be possible to provide responses immediately at the meeting. If this is the case, the Joint Committee will indicate how the issue(s) raised will be progressed. If the Joint Committee runs out of time, comments may be submitted in writing at the meeting or by email (contact details on agenda front sheet).	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
7			**MINUTES - 11 FEBRUARY 2019** To confirm as a correct record, the minutes of the meeting held on 11 February 2019	1 - 8
8			**ACCESS TO DENTISTRY** To consider a report from Leeds City Council's Head of Governance and Scrutiny Support providing background information and introducing an update from NHS England regarding access to dentistry across West Yorkshire.	9 - 38
9			**WEST YORKSHIRE AND HARROGATE CANCER ALLIANCE** To consider a report from Leeds City Council's Head of Governance and Scrutiny Support that introduces a report from the West Yorkshire and Harrogate Cancer Alliance providing an outline of the activity relating to the identified cancer priority / programme, as part of the overall West Yorkshire and Harrogate Health and Care Partnership.	39 - 62
10			**WORK PROGRAMME** To consider a report from Leeds City Council's Head of Governance and Scrutiny Support that provides an opportunity for members of the Joint Committee to consider and agree the priorities for developing its future work programme.	63 - 72

Item No	Ward/Equal Opportunities	Item Not Open		Page No
11			**DATE AND TIME OF NEXT MEETING** There are no further meetings of the Joint Committee planned for the current municipal year (2018/19). Future meetings of the Joint Committee in the forthcoming municipal year (2019/20) will be confirmed as soon as possible. **THIRD PARTY RECORDING** Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

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WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MONDAY, 11TH FEBRUARY, 2019

PRESENT: Councillor H Hayden in the Chair

Councillors S Baines, Y Crewe,
V Greenwood, C Hutchinson, B Rhodes,
N Riaz and L Smaje

38 Welcome and Introductions

The Chair welcomed all present to the meeting and brief introductions were made. The Chair also thanked representatives of Calderdale Council for hosting the meeting in Halifax Town Hall.

39 Appeals Against Refusal of Inspection of Documents

There were no appeals against the refusal of inspection of documents.

40 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information.

41 Late Items

There were no formal late items of business, however the Committee was in receipt of a supplementary pack in respect of agenda item 9 “West Yorkshire and Harrogate Health and Care Partnership – Mental Health Programme. (Minute 47 refers).

42 Declaration of Disclosable Pecuniary Interests

No declarations of disclosable pecuniary interests were made, however Councillor Baines MBE wished it to be recorded that he had a non-pecuniary interest in Agenda Item 10 “Proposed changes to specialist vascular services for adults in West Yorkshire” as a member of the Council of Governors at Calderdale and Huddersfield NHS Foundation Trust. (Minute 48 refers).

43 Apologies for Absence and Notification of Substitutes

Apologies for absence were received from Councillor J Hughes. Apologies submitted by Councillors B Flynn and J Clark were picked up after the meeting.

44 Public Statements

The Joint Committee had received notice of intention to speak from Jenny Shepherd, Calderdale & Kirklees 999 Call or the NHS, however she was unable to attend. In her absence, the Joint Committee received the following statements:

Dr John Puntis, Leeds Keep Our NHS Public – made a representation regarding proposed changes to specialist vascular services for adults, particularly the proposal to reduce the number of arterial centres in the perceived face of rising demand for that service and the impact this may have

on patient access to the centres. He additionally commented on urgent and emergency care for paediatric cases in the Bradford area and the ability of a hospital based responsible consultant to evaluate patients at home and the risks/pressures which could be associated with that model of care.

Gilda Peterson made a representation regarding the award of the 111 NHS helpline contract to Yorkshire Ambulance Service; recognising this would be a key gateway to accessing care and emphasising the need to guarantee a quality service.

Following the statements, the Chair thanked those making representations and the Joint Committee

RESOLVED –

a) To thank the members of the public for their attendance and representations made to the Joint Committee.
b) To note the contents of the representations and to have regard to them during consideration of the matters included within the formal agenda.

45 Minutes - 5 December 2018

RESOLVED – That the minutes of the previous meeting held 5th December 2018 be agreed.

46 West Yorkshire and Harrogate Health and Care Partnership: Urgent and Emergency Care Programme

The Joint Committee received a report from West Yorkshire and Harrogate Health and Care Partnership presenting an outline of the activity taking place across the Partnership relating to the urgent and emergency care programme.

The following were in attendance and contributed to the discussions:

- Keith Wilson – Programme Director (Urgent and Emergency Care), West Yorkshire and Harrogate Health and Care Partnership
- Rod Barnes – Chief Executive, Yorkshire Ambulance Service NHS Trust
- Karen Coleman – Communication and Engagement Lead, West Yorkshire and Harrogate Health and Care Partnership
- Ian Holmes – Director, West Yorkshire and Harrogate Health and Care Partnership

The Programme Director (Urgent and Emergency Care), West Yorkshire and Harrogate Health and Care Partnership and the Chief Executive, Yorkshire Ambulance Service NHS Trust, introduced the report, which included information on the role of the Urgent & Emergency Care Programme Board and the five Accident & Emergency (A&E) Delivery Boards. The report outlined the following key areas of work within the urgent and emergency work programme:

- 100% of the population to have access to an integrated urgent care Clinical Assessment Service by March 2019

- Working with CCGs, the GP Out of Hours Service and NHS 111 to increase the number of patients receiving clinical advice.
- Bookable face to face appointments in Primary Care services through NHS 111 where needed
- A WY&H campaign – 'looking out for your neighbours'
- Identifying and sharing good practice across A&E delivery boards

The Joint Committee was advised of Yorkshire Ambulance Service NHS Trust's recent award of the NHS 111 contract and, through the combined work with the 999 Service, this would help provide access to integrated urgent care clinical assessment service by March 2019.
Current challenges / risks identified included:

- Achieving the national target of over 50% of patients receiving clinical advice (where this would be beneficial). By the end of March 2019, estimated performance would be 47%.
- National IT issues affecting the successful rollout of direct booking (of primary care appointments) through NHS 111 (where needed).

The Communication and Engagement Lead also provided the Joint Committee with an overview of the "Looking out for our Neighbours" West Yorkshire and Harrogate campaign, due to be launched on 15th March 2019.

The Joint Committee discussed a number of key issues, including:

- Overall plans to improve the NHS 111 service and service user's experience of the service.
- General workforce and workforce retention issues that may impact on the objectives and desired outcomes of the programme; and the alignment with the overall NHS workforce strategy.
- The level of support from GPs in order to provide a direct booking facility to primary care from NHS 111 (where needed).
- Implications of a direct booking facility for branch surgeries.
- General capacity issues within Yorkshire Ambulance Service NHS Trust.
- Potential safeguarding issues and considerations associated with the 'Looking out for our neighbours' campaign.
- The level of contingency associated with identifying additional service users (who may be currently 'unknown') through the 'Looking out for our neighbours' campaign.

Specific matters were identified for further consideration with reports back to the Joint Committee at a future meeting:

- A review of the outcomes following the roll-out of the expanded NHS 111/999 service, to include consultation with service users to ensure that the patient experience is reflected and reported.
- A review of the capacity of the expanded NHS 111/999 service, specifically to provide information on the capital and revenue investment to secure delivery of the contract.

Additionally a request to inform all local Councillors when the “Looking out for our neighbours” campaign was to be launched in their wards was noted, along with the offer to share further information with the Joint Committee.

RESOLVED

a) To note the contents of the report and the comments made during the discussions
b) To note the intention for the Joint Committee to receive further reports in due course on the following matters:
   i). A review of the outcomes following the roll-out of the expanded NHS 111/999 service, to include consultation with service users to ensure that the patient experience is reflected and reported.
   ii). A review of the capacity of the NHS 111/999 service, to include information on the capital and revenue investment.

47 West Yorkshire and Harrogate Health and Care Partnership: Mental Health Programme

The Joint Committee received a report from West Yorkshire and Harrogate Health and Care Partnership presenting an outline of the activity taking place across the Partnership relating to the mental health programme and in particular the Learning Disability and Autism Programme.

The following were in attendance and contributed to the discussions:

- Sara Munro, Mental Health Programme Board Chair, West Yorkshire and Harrogate (WYH) Health and Care Partnership
- Ian Holmes, Director, West Yorkshire and Harrogate Health and Care Partnership

The Mental Health Programme Board Chair introduced the report, which identified the following objectives:

- Development of standard operating models for acute and specialist services; with care delivered in the least restrictive environment possible and more care in the community.
- Improved patient experience and access to services for the people of WY&H
- Reduction in A & E attendances (40% reduction in unnecessary A&E attendance)
- 50% reduction in number of section 136/ Places of Safety
- A zero suicide approach to prevention (10% overall reduction in the population and 75% reduction in targeted service areas and suicide hotspots by 2020-21)
- Elimination of adult out of area placements for non-specialist acute care
- Development of new care models for CAMHs T4, Adult Eating Disorders and Forensic services
- Reduction in waiting times for autism assessments and development of future commissioning framework for ASD/ADHD.

It was noted that these objectives were framed within the overarching principles of reducing local variation in the quality of services across the partnership and providing more consistent pathways for service users.

The following specific work streams were detailed in the report and also highlighted at the meeting:

- Suicide prevention.
- New care models for children and adolescent mental health services and adult eating disorders.
- Autism and Attention Deficit Hyperactivity Disorder (ADHD)
- Assessment and treatment services for people with learning disabilities.
- West Yorkshire Transforming Care Partnership and Programme.

The Joint Committee considered the information provided and discussed a number of issues, including:

- Concerns regarding the significant variance in waiting times across the partnership for the assessment of autism and ADHD.
- Concern regarding the potential re-referral issues and alignment of autism and ADHD assessment pathways across the partnership.
- Clarification sought around 'tackling the waiting list as one' and outsourcing of autism and ADHD activity to independent providers.
- Recognising the new model of tertiary Child and Adolescent Mental Health Services (CAMHS), the JHOSC questioned the nature of the current referral system and the role of schools, academies and other places of learning.
- Consideration of whether there was a need for a more joined-up and consistent multi-agency approach regarding children and young people's mental health services – preceding secondary and tertiary care.
- How the West Yorkshire Mental Health Collaborative could work differently to address the general lower life expectancies of people with long-term mental health problems and learning disabilities
- Ensuring any reduction in the bed-base for mental health patients was accompanied with sufficient, effective and accessible community support in local areas.
- Assurance sought that real-time information sharing was available in relation to the suicide prevention work, and whether it was audited and resourced.
- Confirmation on no planned changes to the number of Assessment and Treatment Units (ATUs) – currently three – for people with learning disabilities requiring specialist inpatient support.

In conclusion the Joint Committee welcomed the recognition given to autism and ADHD and requested a further report to a future meeting in order to provide the Joint Committee with an update on the progress of the Programme and the specific matters identified during the discussion.
RESOLVED

a) To note the contents of the report, the supplementary information and the discussions held at the meeting.
b) To note the requests for the Joint Committee to receive further information on the matters identified during discussions in due course
c) To receive a report to a future meeting of the Joint Committee, providing an update on the overall progress of the Mental Health Programme and the specific matters identified at the meeting.

(Councillor Riaz withdrew from the meeting for a short while at this point)

48 Proposed changes to specialist vascular services for adults in West Yorkshire

The Joint Committee considered a report from the NHS England Specialised Services Commissioners relating to the proposed reconfiguration of specialist vascular services for adults in West Yorkshire; namely the number of arterial centres required to provide complex vascular care across West Yorkshire. The report also set out the proposed approach to future public consultation and engagement on the proposals for consideration by the Joint Committee.

The following key points were highlighted in the report:

- The current service provision across West Yorkshire, including three arterial centres (Bradford Royal Infirmary, Leeds General Infirmary and Huddersfield Royal Infirmary) and two non-arterial centres (Pinderfields and Airedale General Hospitals).
- The National Service Specification Requirements to ensure resilience and maintain the skills and competence of the team.
- The options appraisal for the future of the service and the impact of the preferred option.
- Proposals for the approach to public engagement and consultation.

The following were in attendance and contributed to the discussions:

- Matthew Groom – Assistant Director of Specialised Commissioning (Yorkshire and Humber), NHS England
- Sarah Halstead – Senior Service Specialist for Specialised Commissioning (Yorkshire and Humber), NHS England
- Mr Neeraj Bhasin – West Yorkshire Vascular Service Clinical Director
- Matt Graham – Programme Director, West Yorkshire Association of Acute Trusts

In introducing the report and associated proposals, the Assistant Director of Specialised Commissioning stated that NHS England Specialised Services Commissioners did not envisage significant growth in patient numbers / demand for the specialism to warrant retaining a third arterial centre to provide complex vascular care across West Yorkshire.

The following key points were highlighted by the Joint Committee during its discussions:

- Acknowledgement that the proposals:

    - Aimed to provide a regional solution for the provision of urgent and non-urgent vascular care services, through a network of hospital centres offering a range of services.
    - Envisaged clinicians working across different hospital centres within the network, rather than a single centre.
- Concern over the potential impact on other services provided by Calderdale and Huddersfield NHS Foundation Trust (CHFT), should the hospital no longer function as an arterial centre (as proposed).
- Concern over potential, and as yet undetermined, future consequences of centralisation of the service.
- Assurance sought over long-term service provision and that workforce matters were not the principle driver for the proposed reconfiguration of services.
- Assurance sought that there were sufficiently robust plans in place to train and retain and relevant clinicians required to deliver the proposed services.

The Joint Committee heard that recruitment and retention of staff was at the heart of the proposals – a single service for WYH would provide an attractive opportunity for consultants to undertake intensive work and gain extensive skills and experience, on rotation with less intensive work; and ensure the WYH service remained sustainable.

- A request for more detailed information regarding journey times, and the associated assumptions, for patients and their families in the areas most affected by the proposals.
- Concern that public consultation would be limited to 'a single option' and that details of the other (discounted) options should be presented to the public as part of the consultation phase.
- A request for more detailed information on the plans for consultation, alongside the public consultation materials.
- Confirmation around the potential impact of in/out of area patient flows and any capacity implications for the ambulance service (Yorkshire Ambulance Service NHS Trust).

The Joint Committee considered the nature of consultation already undertaken and expressed its disappointment that, although there had been some engagement with Trusts, clinicians and patients in early 2017, the issue had only very recently been brought to the Joint Committee's attention and only now being presented in the public domain, as a point when formal public consultation was due to commence. .

RESOLVED -

a) To note the contents of the report and the proposals put forward. .
b) That the further information and/or assurance sought at the meeting be provided to all members of the Joint Committee.
c) That further consideration of the proposals be considered at a future meeting of the JHOSC, including any emerging themes from the public consultation.

49 Work Programme

The Joint Committee received a report from Leeds City Council's Head of Governance and Scrutiny Support on the continuing development of the Joint Committee's future work programme.

The Joint Committee considered the proposed future work programme and also discussed the following matters:

- The letter received from the Chief Executive Officer, West Yorkshire and Harrogate Health and Care Partnership setting out the implications of the NHS Long Term Plan, as published on 7 January 2019 (attached at Appendix 2 of the report).
- Other matters discussed earlier in the meeting that should be reflected in the Joint Committee's future work programme.
- The proposed review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy – A Healthy Place to Live, a Great Place to Work, including:
    - The proposed Terms of Reference (attached at Appendix 3 of the report).
    - Arrangements to establish a sub-committee to undertake the review; and to receive its evidence in public.
    - Any substitute arrangements should be limited to the membership of the Joint Committee.
    - The indicative timescales set out in the proposed Terms of Reference

RESOLVED –

a) To agree the proposed future work programme (attached as Appendix 1 to the report), subject to the inclusion of other matters highlighted at the meeting.
b) To agree the Terms of Reference for the review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy (attached as Appendix 3 to the report).
c) To appoint a sub-committee to undertake the review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy, as set out in the agreed Terms of Reference and discussed during the meeting, as part of the outlined general arrangements.
d) That officers continue to develop the Joint Committee's work programme, based on comments made at the meeting and a revised version be presented for consideration at a future meeting of the Joint Committee.

50 Date and Time of Next Meeting

RESOLVED - To note the date and time of the next meeting as Monday 8th April 2019 at 10.30 am (with a pre-meeting for Committee Members at 10.00 am). This meeting will be held in County Hall, Wakefield.

Report author: Steven Courtney
Tel: (0113) 378 8666

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 8 April 2019

Subject: Access to Dentistry

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Purpose

1. The purpose of this report is to introduce an update from NHS England regarding access to dentistry across West Yorkshire.

Background

2. In March 2017, the Joint Committee considered a range of information and contributions in relation to access to NHS dental services across West Yorkshire – as requested by scrutiny members from Bradford and Kirklees.

3. At that time, it was reported that accessing routine NHS dental services was difficult for some people in West Yorkshire, particularly in Bradford and north Kirklees. NHS England also reported that demand for unscheduled dental care (UDC) in West Yorkshire had been rising year on year, an indication that an increasing number of people having to access emergency dental services because they could not register with an NHS dentist. This had resulted in an over-spend for UDC of £1.5m across West Yorkshire in 2014/15. It was reported that UDC services were due to be re-contracted in 2017 [1].

4. At its meeting in July 2018, the Joint Committee considered a further update from NHS England regarding NHS dental services. This focused on primary care dental services and unscheduled dental care (UDC) and reported the following:

[1] Report of NHS England – North (Yorkshire and Humber) to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 06 October 2016: Dental Commissioning Update https://bradford.moderngov.co.uk/documents/s11[illegible]tOctDocM.pdf

Access

5. NHS England (Yorkshire & the Humber) had completed a review of the availability of access to dental services and developed a strategy to improve this across the region.

6. Additional funding had been identified to support the commissioning of an increase in primary care capacity in 20 constituencies – 7 in West Yorkshire. Dental practices in these areas had agreed to offer additional appointments to new patients commencing in July 2018. This approach would be reviewed in early 2019.

Urgent Care

7. NHS England was leading a procurement to secure services for call handling and urgent treatment provision to be in place from 1 April 2019. The main aims of the procurement process being to ensure providers could deliver a model to meet the demands for urgent dental care treatment across the locality and to ensure:

    - Opening hours that fit with demand.
    - A number of clinics across Yorkshire and the Humber to ensure equity of access.
    - The provision of timed appointment.
    - Call handling arrangements clinically assess 75% of calls.
    - Partnership working with other providers across the urgent care system.
    - A minimum dataset, as agreed by the overarching urgent care system management boards.
    - All patients are encouraged to source a regular dentist.

8. Following that meeting, the Chair of the Joint Committee raised a series of supplementary questions with NHS England. These are summarised at Appendix 1, along with the associated response.

Summary of main issues

9. Representatives from NHS England have been invited to provide the Joint Committee with a further update on improving access to dental services across the West Yorkshire and Harrogate Health and Care Partnership area.

10. Earlier in March 2019, the Chair of the Joint Committee also wrote to NHS England following concerns raised about changes to the provision and location of Urgent Dental Care services in some areas across West Yorkshire. A copy of the letter is attached at Appendix 2.

11. NHS England has also been invited to provide an overall written response in advance of the meeting to provide an overall update on improving access to dental services and the specific issues regarding urgent dental care services.

12. Appropriate NHS representatives have also been invited to attend the meeting to discuss the details presented and address questions from members of the Joint Committee.

Recommendations

13. That the West Yorkshire Joint Health Overview and Scrutiny Committee considers the details presented in this report and associated appendices, and agrees any specific scrutiny actions and/or future activity.

Background documents[2]

14. None.

[2] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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APPENDIX 1

Commissioning of Dental Services across West Yorkshire

At its meeting in July 2018, the West Yorkshire Joint Health Overview and Scrutiny Committee considered an update from NHS England regarding access to dentistry across West Yorkshire.

Following the meeting, a series of supplementary questions that warranted further discussion and consideration were raised with NHS England regarding the commissioning and provision of non-specialist dentistry. The additional questions related to services provided on a West Yorkshire and Harrogate basis, but also the placed based developments specific to Leeds.

The additional questions are detailed below, along with NHS England's initial response (provided in September 2018), which will be considered by the JHOSC at its meeting in April 2019, alongside any further details provided by NHS England. Any matters specifically relating to individual local authority areas will be brought to the attention of the relevant local health overview and scrutiny committee.

	Question	Initial Response (September 2018)
1	The report refers to a review of the availability of access to dental services and development of a strategy to improve dental access across Yorkshire and the Humber. Please provide the following: (a) A copy of the review report, the associated strategy and implementation plan. (b) Details of any financial/budgetary implications and how any additional spending will be financed. (c) Details of any public/stakeholder engagement undertake as part of the review and development of the strategy.	Please see Annex 1.

APPENDIX 1

Commissioning of Dental Services across West Yorkshire

	Question	Initial Response (September 2018)
2	Please also confirm where (and when) the review and strategy were reported and agreed.	The discussion regarding the dental strategy was held at the Direct Commissioning Management Team on 14 August 2017 and 11 September 2017 when the following was agreed: • The criteria for selection with include the Y&tH commissioned UDA average will be combined with their deprivation scores to prioritise areas for investment. • Assuming they have delivered their core contract, primary care providers in the identified constituencies will be offered a 3 year contract variation. • The average UDA value of £28.30 was agreed as a unit of value – set as at 14/08/17 • The ambition is to bring all commissioning areas up to the Y&tH average 1.72. The value of 1.72 will be set for future investment decisions as the ambition for Y&tH. On the basis of these principles, it was agreed to undertake some modelling to support the utilisation of available recurrent funding.
3	As a profession body, dentists are largely behind a more responsive approach to practice. The NHS Dental contract has been in reform for some considerable time and the current dental contract is seen (by many) as unhelpful and a barrier to a responsive approach. Some dentists in Leeds have expressed a great deal of enthusiasm for reform but felt 'the brakes are still on'. Are there any plans to progress this area? If so, what are they? If not, why not?	NHS England's national dental team is leading on a programme of work looking at reforming the current contract used for primary care dental provision. As the local direct commissioning office, NHS England – North (Yorkshire and the Humber) is also keen to see these reforms - and the proposed revised contract - but there are no defined timescales identified by the national team.

APPENDIX 1

Commissioning of Dental Services across West Yorkshire

	Question	Initial Response (September 2018)
4	NHS dental contract reform work includes the piloting of different arrangements, such as the Dental Prototype Agreement Scheme. There appears to be no mention of this scheme with the report for JHOSC – including the overall aims and objectives of the scheme; levels of take-up within WY&H; how long the scheme has and will continue to run; how the scheme is being evaluated; how successful (or otherwise) the scheme has been in achieving its original objectives. Please provide some specific details.	The prototype programme is run by the Department of Health in conjunction with the NHS England central dental commissioning team. There are currently two practices in West Yorkshire taking part in the programme and these will be joined by a further three during this financial year. The length of the prototype work, monitoring and measurement of the outcomes is being managed centrally.
5	Previously, the JHOSC has been advised that the three tests to consider whether or not issues should be considered on a WY&H basis are: • Scale • Good practice to share • Issues cannot be resolved individually/locally. As such, given the issues patients face regarding access to dental services, why is access to dental services not a specific aspect of work within the WY&H&CP. What freedoms might be available to help better support and drive this area of work forward?	This refers to national policy so not something we are able to comment on locally. If this is not the case then, we would be happy to review if a further explanation could be given.

Commissioning of Dental Services across West Yorkshire

<table>
<tr><th></th><th>Question</th><th>Initial Response (September 2018)</th></tr>
<tr><td>6</td><td>During the discussion at the JHOSC meeting, the annual ‘underspend’ or ‘clawback’ was referenced (i.e. money clawed back from dentist because they do not deliver the amount of dental care for which they were originally commissioned). However, no specific details were provided or presented in the report. Whilst it may be difficult to predict likely levels on underspending in the current year, please provide details on the level of underspending/ clawback across Yorkshire and the Humber (and specifically WY&H) in each of the last three full financial years. Please also detail levels of any variation against the financial trajectory in the current financial year.</td><td>Dental practices are paid an annual contract value that is spread equally across 12 months – within this, the practice has the ability to flex their activity between months so it is not a straight line projection of activity for us to detail any variances within this financial year.

The table below details the clawback for the last 3 financial years for Yorkshire and the Humber, and then specifically for West Yorkshire. Please note the following:
2017/18 reconciliation has not been completed.
For the purposes of this exercise, West Yorkshire does not include Harrogate.

<table>
<tr><th>Year</th><th>Total clawback Y&H</th><th>West Yorkshire clawback</th></tr>
<tr><td>2015/16</td><td>£8,669,260</td><td>£1,917,132</td></tr>
<tr><td>2016/17</td><td>£13,336,042</td><td>£2,973,367</td></tr>
<tr><td>2017/18</td><td>£19,450,202</td><td>£5,724,024</td></tr>
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APPENDIX 1

Commissioning of Dental Services across West Yorkshire

	Question	Initial Response (September 2018)
7	Early dental disease is unevenly distributed across WY&H. Where are those areas and how is better access being targeted through regular access to a dentist?	Following investment in the identified areas to improve access to a dentist from 1 July 2018, work will now focus on how the access can deliver better outcomes in oral health. The Dental Clinical Commissioning Executive is currently working with Public Health England to develop appropriate initiatives, using the learning from other projects such as Starting Well (currently implemented in Wakefield) which focuses on dental service for young children. The first data is due in October 2018.
8	The Leeds DPH report indicates significant preventable disease on average but hides very high rates in poorer areas of the city. Therefore, in terms of dental care, how do we identify, target and improve the health of the poorest fastest?	Please see the answer to point 7. There are also arrangements in place to link in with Leeds Plan
9	How and where will the 'Starting Well' scheme be rolled out, monitored and reported across the WY&H footprint?	The Starting Well programme has been developed nationally by the NHS England and Public Health England central teams. There are 13 areas that have been identified to take part in this programme. As stated above, this will be considered in terms of the future access work.

Commissioning of Dental Services across West Yorkshire

	Question	Initial Response (September 2018)
10	What other schemes of prevention or better early intervention are being deployed across WY&H? In which areas? How have these been decided? How are such schemes funded, and is the funding recurrent? How do any such schemes connect to the wider prevention approach that is fundamental to the WY&H HCP?	The Office of the Chief Dental Officer has proposed a number of initiatives, within a 'SMILE4LIFE' programme. The programme is intended to increase access for children to dental services particularly supporting preventative interventions. 'Starting Well Core' is one of these initiatives and NHS England North - Yorkshire and the Humber's dental commissioning team is working with Public Health England and local dental clinicians to identify areas of the highest deprivation and where access to dental services for children under 4 years of age is particularly low. The purpose of this scheme is to encourage practices to accept more children in to their service and to spend more time with them encouraging tooth brushing, improving diets and reducing sugar intake. This work has just started and implementation of the scheme will be put in place once areas have been identified.
11	If through local care partnerships, one of the overall aims is to make community services more joined up through primary care networks across WY&H how are we enabling dentistry to join up better with other parts of primary care in local areas – such as GPs?	Links are being made with the networks through the STP/ICS function. This is in early stages but there is a commitment to explore how these services can be more effectively aligned.

Commissioning of Dental Services across West Yorkshire

	Question	Initial Response (September 2018)
12	How are new roles and culture for dental health professionals and sufficiency of supply being explored? In Leeds, we are working on different roles for the rest of primary care and we are developing a Health and Care Academy to support this – how can this local approach with NHSE role as commission of dental services?	NHS England – Yorkshire and the Humber has strong links with Health Education England (HEE). They have a seat on the local Dental Clinical Commissioning Executive and play a key role in developing a workforce to support the services we commission.

Access to General Dental Services – Yorkshire and Humber

Introduction

This paper should be seen in the context of the wider dental commissioning plan which considers the approach to 111 signposting, urgent dental services and primary care access to dentistry.

In order to prepare for this, it will be beneficial to understand the specific issues affecting dental access across the geography so options can be discussed, and the preferred recommendation developed, ahead of consideration of the wider plan.

Background

Yorkshire and Humber commissions 9.5 million UDAs across 651 General Dental Services contracts - this excludes specialist contracts like Orthodontics and Urgent Care. These contracts were agreed prior to the inception of NHS England in 2013 and have resulted in inherited legacy arrangements which, in the main, cannot be changed.

UDA values vary from around £19 to over £40, with an average of £28.30. This figure has been reconciled for the year 17/18. A precedent for using the average price per UDA has already been set within two recent procurements, Great Horton in West Yorkshire and Scunthorpe in North Yorkshire and Humber where £27.12 was the value used. This has changed due to the DDRB uplift and renegotiations of contracts since that time.

The rate of 'UDAs Commissioned per Capita' is 1.72, compared to 1.62 across England. Across each parliamentary constituency, these rates vary from 0.8 in Scunthorpe to 3.5 in Hull West and Hessle.

The lack of routine dental care impacts on the demand and availability of urgent care. GP Patient Survey results for January to March 2017 show that 63% of patients in West Yorkshire were successful in getting an appointment when new to a practice, 66% in North Yorkshire and 80.4% in South Yorkshire, compared with 74% across England. The use of 111 and dental urgent care services has increased which also highlights that patients are unable to gain access to regular dental care. The providers of this care have reported that the weekend slots are being filled during the week as patients are unable to gain care during weekdays.

In financial year 15/16 a significant amount of clawback from contracts was identified due to underperformance. This occurred for a variety of reasons and has affected the ability for patients to gain access to dental services. This funding is contractually allocated, so opportunities to release funds need to be explored, and priorities set on how that funding will be re-commissioned. It is noted that there is still a significant number of areas that have a high level of underperformance. This is due to a number of factors but the main one is the difficulty in recruitment of dentists to practices on the East Coast. The explanation of this from practices is the areas are remote from main travel systems and dentists do not want to move to an area that is difficult to travel to and is away from families, friends and peer groups made during training.

Another contributing factor is that some practices have a very low UDA rate this prevents the practice from offering a premium to attract dentists and still maintain a viable practice.

Oral health Health Needs:

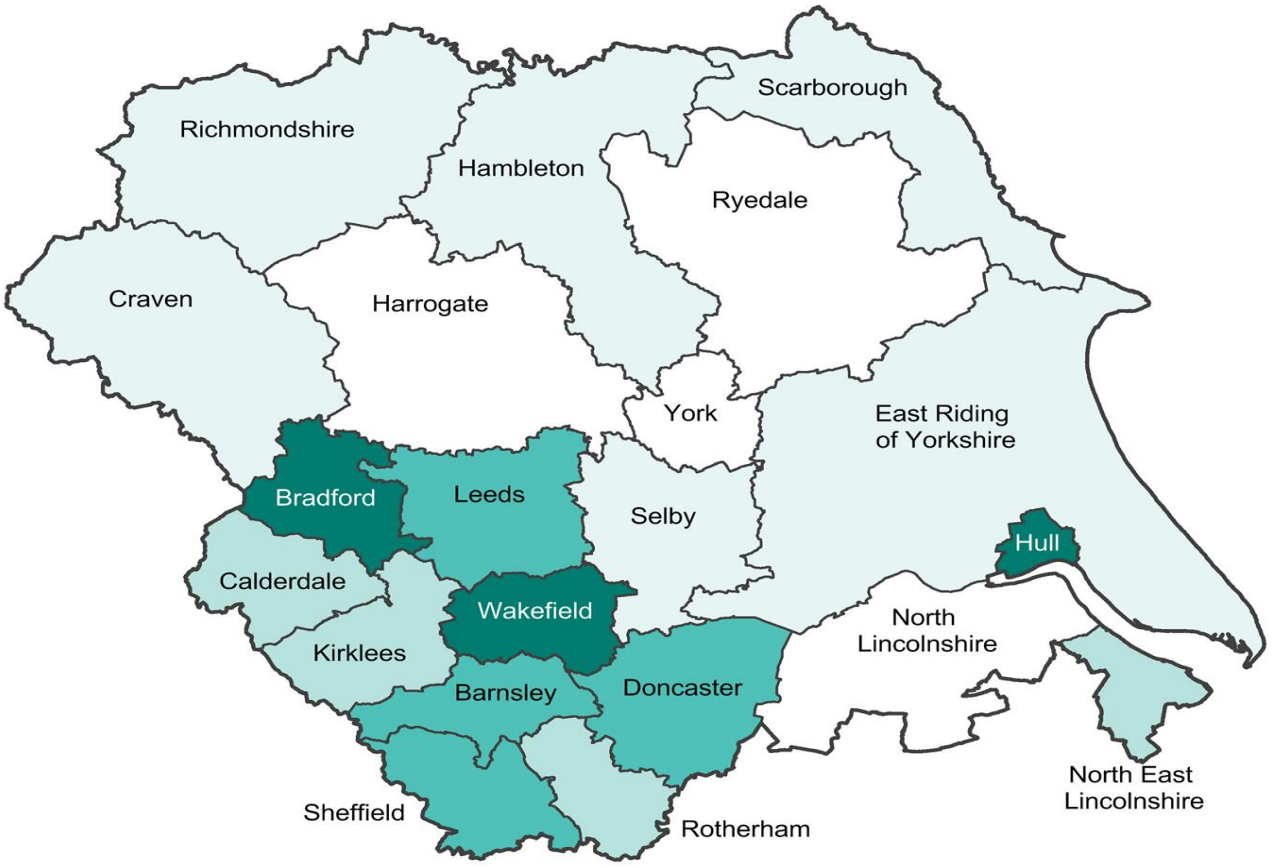
Despite improvements in oral health over the last forty years, many people continue to suffer the pain and discomfort associated with oral diseases, which are largely preventable. The distribution and severity of oral diseases varies between and within areas with the more disadvantaged and socially excluded groups experiencing higher levels of disease.

Deprivation in Yorkshire and the Humber is higher than the England average with 47.4 % of the population of Y&H in the lower two national quintiles of deprivation.

Oral health of children in Yorkshire and the Humber 2015

Findings from the most recent survey of five-year-old-children indicate that Yorkshire and the Humber remains the second worst region in England with 28.5% of children experiencing tooth decay compared with 24.7% nationally. Within Y&H the proportion of children with dental disease varied from 16.5% in York to 37.8% in Hull (Figure1).

Figure 1. Map of percentage of five-year-old children with tooth decay experience in Y&tH by local authority, 2015

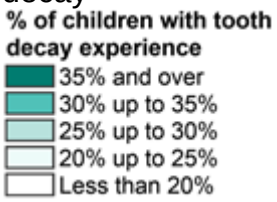


Published data shows that 220 children aged 0 -19 years had extraction of one or more teeth under general anaesthesia in 2012/13. However, it is likely that this figure underestimates the true figure due to inconsistencies in hospital coding and may not include all activity carried out by a primary dental care provider at Hull Royal Infirmary. Dental treatment under general anaesthesia is expensive for the NHS, disruptive for families and presents a small but real risk of life threatening complications for children.

Adults

Across the UK the oral health of adults has improved significantly over the last 40 years. More people are retaining more of their natural teeth into older age. Trends from national and local surveys show that edentulousness (having lost all teeth) is now uncommon amongst people over the age of 65 years of age. Even the very old (85 years plus) have in many cases retained some natural teeth. This has important implications for the future in terms of good oral function but carries service, including oral health improvement programme, implications related to the continued maintenance and advanced restorative and preventative care of older adults who are likely to be increasingly frail with complex medical histories and difficulties accessing dental services.

Between 1998 and 2009 the prevalence of active tooth decay in England fell from 46% to
30%. There were reductions across all age groups but the largest reduction was in those aged 25 -34 years. As adults age the accumulated effects of gum disease may cause exposure of root surfaces, therefore with age the prevalence of decay on the root surface is likely to increase. Seven per cent of adults in England had active decay



Further analysis of the data shows that those children living in the most deprived quintiles experience significantly higher levels of dental disease.

Oral health of adults

A self -reported adult postal survey was carried out across Y&H in 2008, the key findings were:

- Adults living in the most deprived areas reported poorer oral health and more difficulties accessing dental services.
- Almost a third of respondents reported that that they had a painful ache in their mouth, occasionally or more often, this varied from 23% in East Riding to 35% in Bradford and Airedale.
- A quarter of adults rated their oral health as fair, poor or very poor
- A quarter of respondents felt that they required treatment
- 23% reported that they had difficulties gaining access to routine dental care and 18% to urgent dental care. Difficulties varied across Y&H and by deprivation quintile.

- Respondents living in North and North East Lincolnshire experienced difficulties due to the lack of dentists taking on patients.

In conclusion the report highlighted variations in reported oral health status, experience of using dental services and demand for dental care by former PCT area.

The 2009 Adult Dental Health Survey reported that the average number of decayed teeth was higher in Yorkshire and the Humber than the England average. Mouth cancers account for 1-2% of all new cancers in the UK. The risk of developing mouth cancer is greater in people living in areas of deprivation.

Dental Services

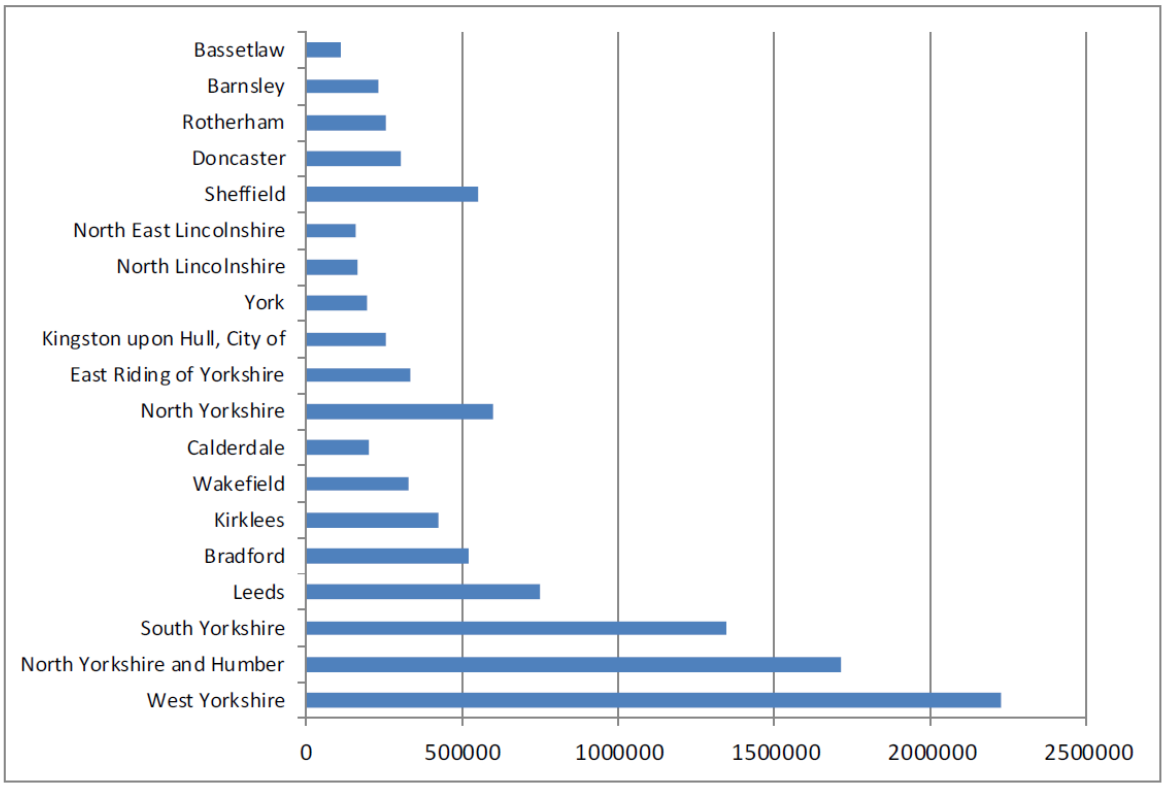
The access rate, which is number of patients seen as a proportion of the resident population is a measure of the effectiveness of dental commissioning. Access rates can be influenced by a number of factors such as the number of dentists in an area, the oral health needs of the population, levels of deprivation and patient choice.

Although dental services are demand led, they should be targeted to those population groups and areas where oral health is poor.

Population estimates

80% of the Y&tH population live in urban areas with WY being the most densely populated (42.1%).

Population of Yorkshire and the Humber (year/ reference)



Source: Office for National Statistics, Census Sex, 2011 (QS104EW) 2011

Population projections suggest a 4.6% increase in population across Y&H in all areas with the exception of Richmondshire. (ONS ref)

Findings

From the information provided it is difficult to identify one particular measure to prioritise areas for investment eg Scunthorpe constituency UDAs per head is 0.8 but the deprivation ranking is 162 (the range is between 11 and 530) and the average percentage of patients seen in the previous 24 months is 34%.

What do we know from patients/MPs/public

The West Yorkshire MPs for Dewsbury, Bradford and the North Yorkshire MP for Ryedale are raising concerns about access to dental services regularly with NHS England both locally and centrally also via Parliamentary questions.

Complaints – the Dental team has received 23 complaints around access to dental services since the start of June 2018.

Healthwatch – are receiving complaints from patients about the lack of access to regular dental services and undertake regular surveys. Feedback from these surveys is shared with NHS England.

What have we done so far?

The Oral Health Needs Assessments completed in each of the localities, and published in September 2015, highlighted areas where additional services are required, but do not allow for comparison of these areas to assist in prioritisation for commissioning. To this end, a new database of commissioning and access information has been developed to enable us to drill down to Council Ward and Constituency level. This data is being triangulated with deprivation and health needs data to support prioritisation areas for commissioning.

Access Pilot Schemes

North Lincolnshire

The North Yorkshire LDN developed a scheme whereby 8 practices in North Lincolnshire were commissioned to deliver an access/unscheduled care service, signposted through the existing urgent care provider and 111, on the following principles:

- The ran over January to March 2017
- Practices were to provide dental care for new patients only
- The activity target for each practice was 333 UDAs
- The activity will be mainly for urgent, band 1 and band 2 courses of treatment
- Practices submitted a simple audit, the verified results of which are below:

Provider	Patients Treated	General Child No of Pts	Band 1 Treatments	Band 2 Treatments	Band 3 Treatments	Urgent Treatments
Barton Dental Care Limited	119	20	51	51	10	7
OASIS DENTAL CARE LTD	209	22	155	39	3	10
MR AN GATECLIFF	117	23	55	48	6	8
MR A BAGGA	128	24	73	43	11	2
Winterton Dental Practice	85	27	50	22	2	20
The Dental Design Studio	119	63	79	26	1	14
The Dental Design Studio	70	15	25	14	2	28
K L DOBBS	136	26	33	45	9	49

Bradford and North Kirklees

Practices participating in this scheme were required to keep free an agreed number of one-hour slots in which to see four new patients. They agreed to provide full courses of treatment, offering further appointments where appropriate. Patients were initially all booked in to these slots directly by Local Care Direct (LCD), via 111. £100 per slot was paid to practices to keep the surgery time free, and 12.8 UDAs per slot (or 3.2 UDAs per patient) are also awarded. Participating practices are required to deliver the additional UDAs awarded as part of this scheme, in addition to their contracted UDAs, in the 2016-17 financial year.

Jan–Mar 2017

Over the period of 9 January to 31 March 2017, 25 practices participated in total (9 in Bradford City, 8 in Bradford District and 8 in North Kirklees). 4,260 appointments were made available for new patients (1,764 in Bradford City, 1,292 in Bradford District and 1,204 in North Kirklees). 13,582 additional, non-recurrent UDAs were commissioned in these areas (5,644 in Bradford City, 4,135 in Bradford District and 3,803 in North Kirklees.

Challenges:

- The activity at LCD was lower than expected throughout January to March, resulting in some unfilled appointments. We are still working through the data, and the activity picked up through February and March, but we know that in January 92.5% of Access Scheme appointments were filled in Bradford, and 66.95% in North Kirklees (84.29% in total).
- Because of the lower than expected overall activity at LCD, activity at the Bradford urgent care service at BRI was at times been significantly affected by the diversion of patients into regular practice appointments.
- There has also been a relatively high rate of patients failing to attend appointments: 18% in January (the LCD UDC rate is usually around 10%).
- None of the practices in Dewsbury expressed interest initially. After conversations with these practices, however, one practice joined the scheme to deliver 40 access slots in March 2017.

The challenges of low activity at LCD, and patients failing to attend, were somewhat mitigated, as the additional UDAs awarded under the scheme still being delivered. Unfilled appointments are, however, very frustrating for all involved.

Revision

From April 2017, participating practices filled two appointments per slot themselves with new patients, and have two patients booked in directly by LCD. LCD were then able to fill the slots easily, with most appointments being booked days in advance, including the urgent care service at BRI. This change also addressed the disparity between patients who may have been on a waiting list for some time, and patients who are contacting 111 to find a dental appointment, being able to access the appointments available as part of the scheme.

April – June 2017:

In March, practices already participating in the scheme were asked if they would be willing to continue in the scheme over April - June. One Dewsbury practice participated. Over the period of April -June 2017, 20 practices participated in total (9 in Bradford City, 6 in Bradford District and 5 in North Kirklees). A maximum of 3,508 appointments have been made available for new patients (1,840 in Bradford City, 1,112 in Bradford District and 556 in North Kirklees). 11,225 additional, non-recurrent UDAs have been commissioned in these areas (5,889 in Bradford City, 3,557 in Bradford District and 1,779 in North Kirklees.

Appointments made available under the scheme:

Area	Appts available - Jan to March	Appts available - April to May
Bradford City	1,764	1,840
Bradford District	1,292	1,112
North Kirklees	1,204	556

We know that patients failing to attend for appointments will mean that the actual numbers of patients seen are less than the numbers of appointments available. Work continues to reconcile the data from LCD and logs of patients seen from the participating practices.

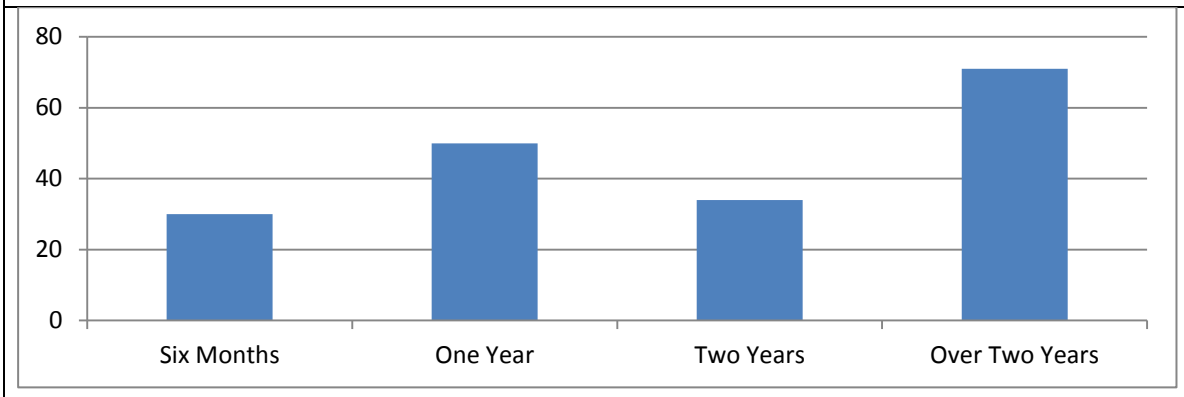
Impact of the scheme on the Urgent Care service in Bradford

LCD have advised they are seeing increasing levels of activity and that, since the scheme stopped, patients are having to wait around 5 days for an urgent care appointment in Bradford. Evidence of this from LCD is not yet available but will be for September.

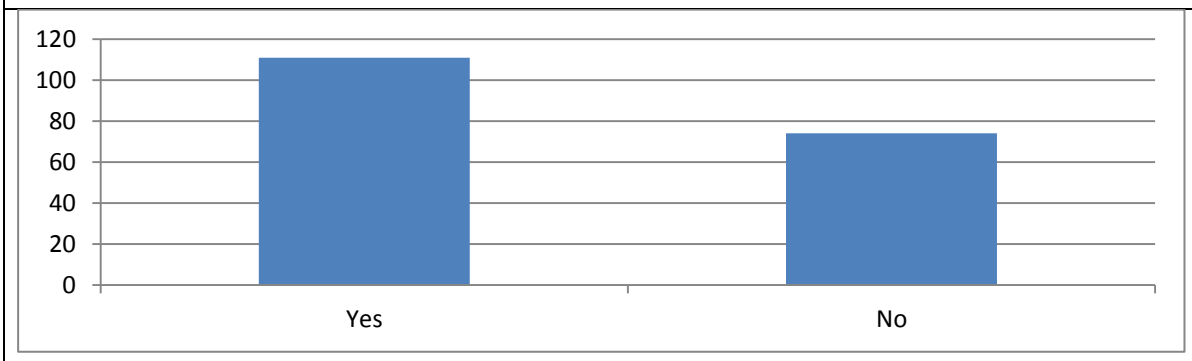
Patient Questionnaire:

Over the final 6 weeks of the pilot scheme, participating practices were asked to request that patients seen under the scheme complete questionnaires. 185 completed questionnaires were received, the results of which are illustrated below:

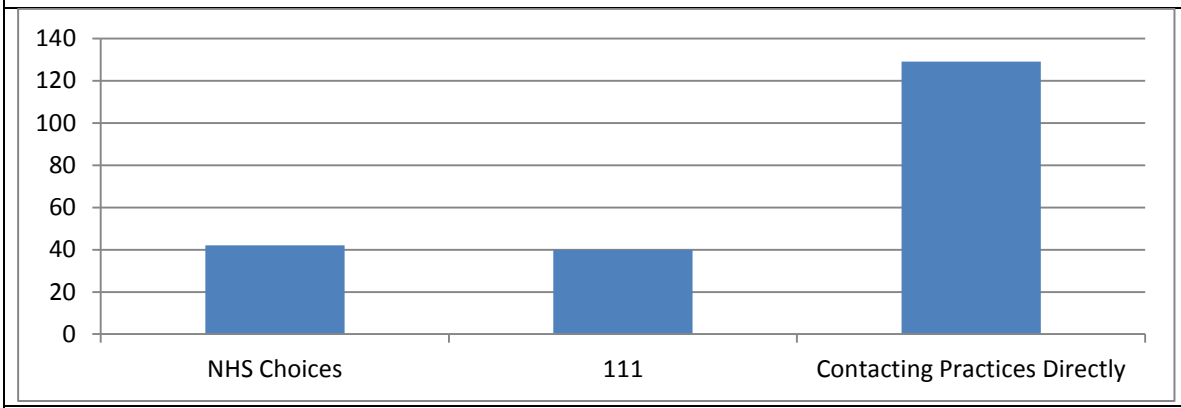
Q1. Roughly how long has it been since your last dental appointment?



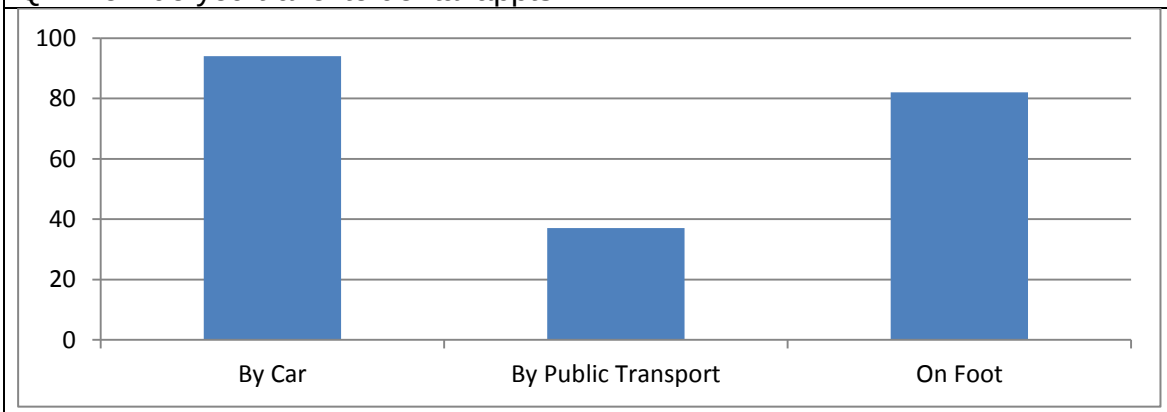
Q2. Have you been trying to register with a dentist in this time?



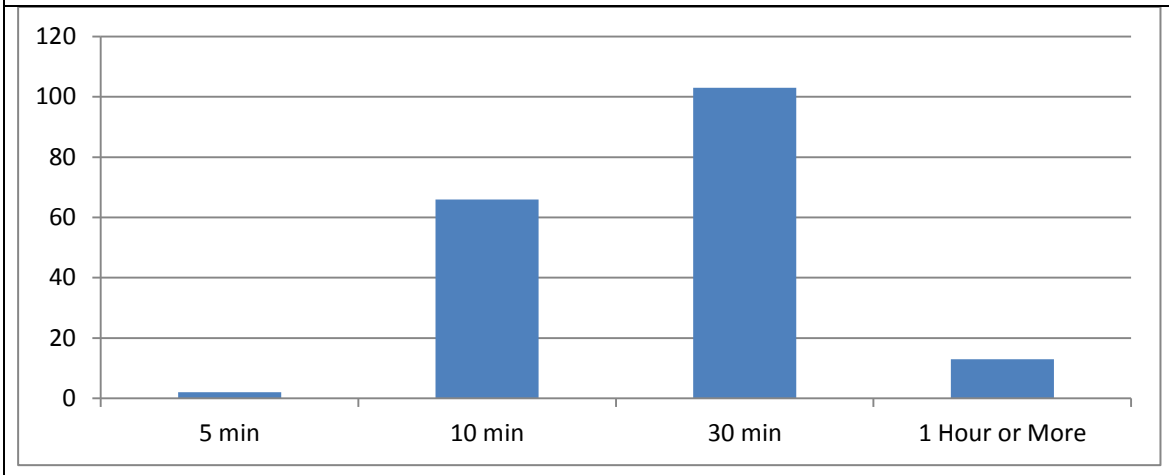
Q3. If yes, how have you been trying to register?



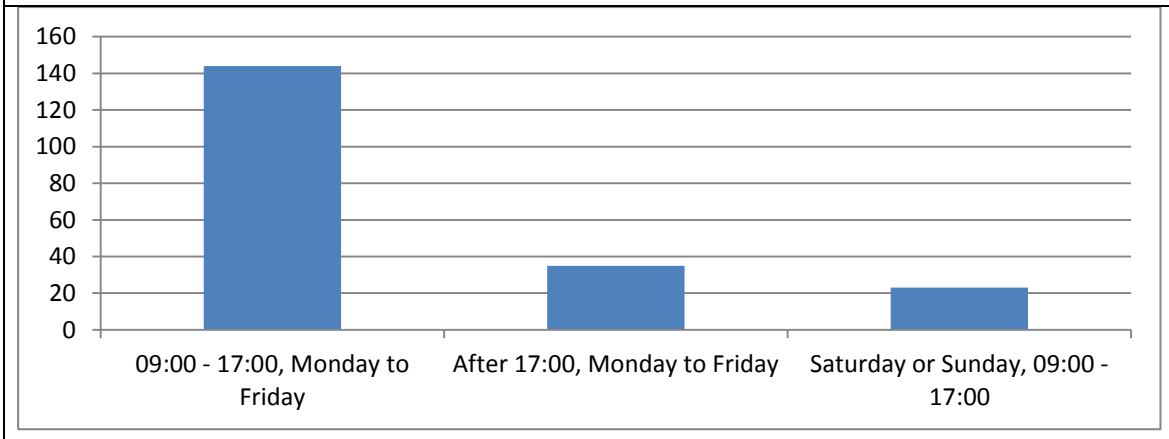
Q4. How do you travel to dental appts?



Q5. Roughly how much time would you be willing to spend travelling to a dental apt?



Q6. When would be most convenient to you attend a dental appointment?



What does good look like and what service do we wish to commission for the patients of Y&H

The ideal situation is that all practices are equal in the access they are offering and they are able to meet clinical need rather than patient demand. A measure to use to achieve this is UDAs per head of population.

Challenges:
Once prioritisation of areas for additional investment has been identified the challenge is how do we address the shortfall?

Recommendation 1: That the main level for the data available to be considered should be subdivided by constituency.

This will gives enough sensitivity in the data to identify local issues without being too small to have any meaning. Local Authority level is too big and lacks that sensitivity as some areas where the access is good masks the areas where access is poor – ie

Kirklees and Dewsbury Ward level is too small as there are many wards that do not have a dental practice within them. However, the agreed list by constituency can be broken down further by Ward so the resources can be directed to the correct areas.

Within these areas the criteria for prioritisation was agreed as:

Primary criteria:	The number of UDAs commissioned
Secondary criteria:	the number of patients seen (this will be the number of patients from within the constituency seeing a dentist anywhere)
Tertiary criteria:	Deprivation by constituency appendix 3

Recommendation 2: Price per UDA £28.30 which is the Yorkshire and Humber average

UDA's commissioned to increase activity – 3 per additional patient. The following figures are based on the 10 constituencies with the lowest UDA per head followed by the lowest percentage of patients seen and finally by the deprivation ranking for the constituency.

UDAs per head of population

This indicator is based on the UDAs commissioned shown against the total population within the area being reviewed. This relates to an amount being commissioned and not to the need of the patients within the area.
Based on UDAs per head of population

- National average 1.65 UDA per head
- Yorkshire and Humber average 1.72 per head
- The 10 areas of lowest commissioning range from 0.8 to 1.17 per head
- Should the aim be to build this figure to the national average of 1.63 at a total cost of £12.4 million

The number of patients seen in the last 24 months

This indicator is based on the number of patients seen in a practice within the area being reviewed – this is regardless of where the patient lives – so they could live in the area in which the practice is based or be travelling in to that area. Based on % of patients seen in the last 24 months

- National average of 55.4%
- Yorkshire and Humber average 57.4%
- To build this to the National average % and using 3 UDAs per head of population the cost will be £11.8m
- Yorkshire and Humber average the cost will be £15.5m

The funding for the increased commissioning will need to come from within the existing dental budget. This funding is tied up in contracts so cannot be easily moved to support this initiative. Underperforming contracts can be renegotiated but this does need to be with the agreement of the provider. If there has been underperformance for 2 years or more gives greater leverage for re-negotiation.

Patient engagement

The patients who will be accessing this service are those who are currently without a dentist so are hard to reach to obtain their views on the service they require. Dental practices will be contacted to get an understanding of the numbers of patients that they have waiting to get access to their services.
Learning from the pilots that were undertaken in both West Yorkshire and North Lincolnshire will also be fed in to the model to assist in developing the service that patients are seeking.

Commissioning Model

The above figures are made on assumptions that will bring services up to either the national or Yorkshire and Humber averages. This may not be appropriate so need to be tested around the number of UDAs required and the percentage of the population that wishes to see a dentist on a regular basis. The amount on investment in an area will determine if another practice should be commissioned or if the additional activity is offered to current providers. This can bring additional challenges.

The contract should be for 3 years to allow time for patients to have the treatment required to ensure they are dentally fit and to give the commissioners the flexibility to change the model if required at a later date.

The majority of dental practices are on GDS contracts – this does not allow the flexibility to time limit the contract (other than where NHSE has terminated the contract) so a contract variation for a GDS contract to be time limited needs to be explored or could an additional PDS agreement be used.

The current average is £28.30 so there are practices with an average both above and below this. As the additional activity is time limited this should be kept separate and offered at the average regardless of the current rate within a practice.
Staging of the contract should be considered where there are high areas of need as the initial treatment needs may be higher than in other areas. This will be limited by the amount of finance that is released either through the renegotiation of contracts after the year end or from contracts that the provider has given notice on

Finance

There have been contracts in previous years that have been renegotiated and two contracts that the provider has recently terminated that has given some finance to start this additional access work.

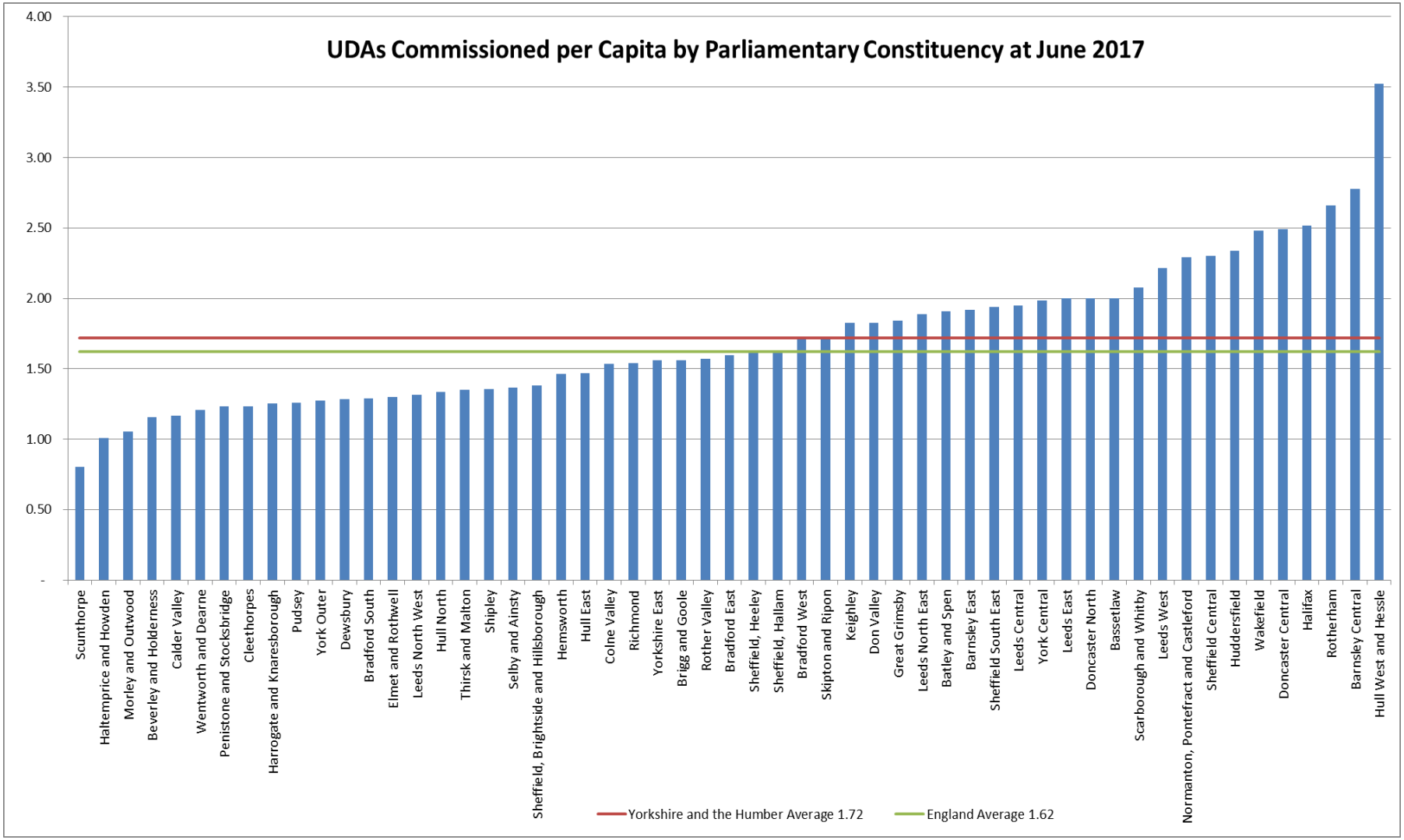
Work is ongoing to review the Urgent Care services and as there are many patients currently accessing out of hours services that should be seen in the General Dental Services any saving released will be available to invest in the General Dental services in the future.

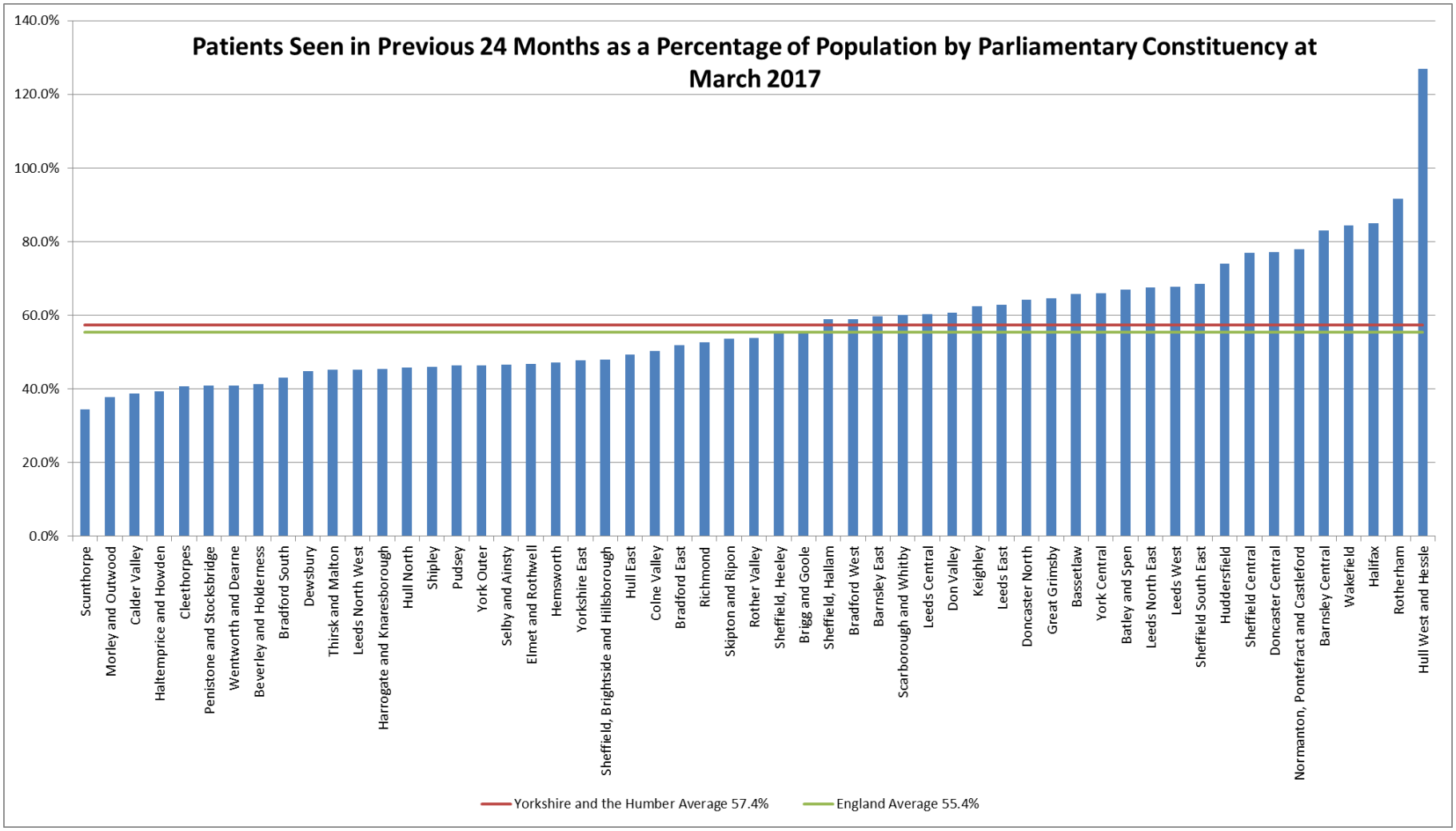
1 The data is prioritised using Constituency as the primary level then subdivided using UDAs per head, number of patients seen in the last 24 months and then deprivation.

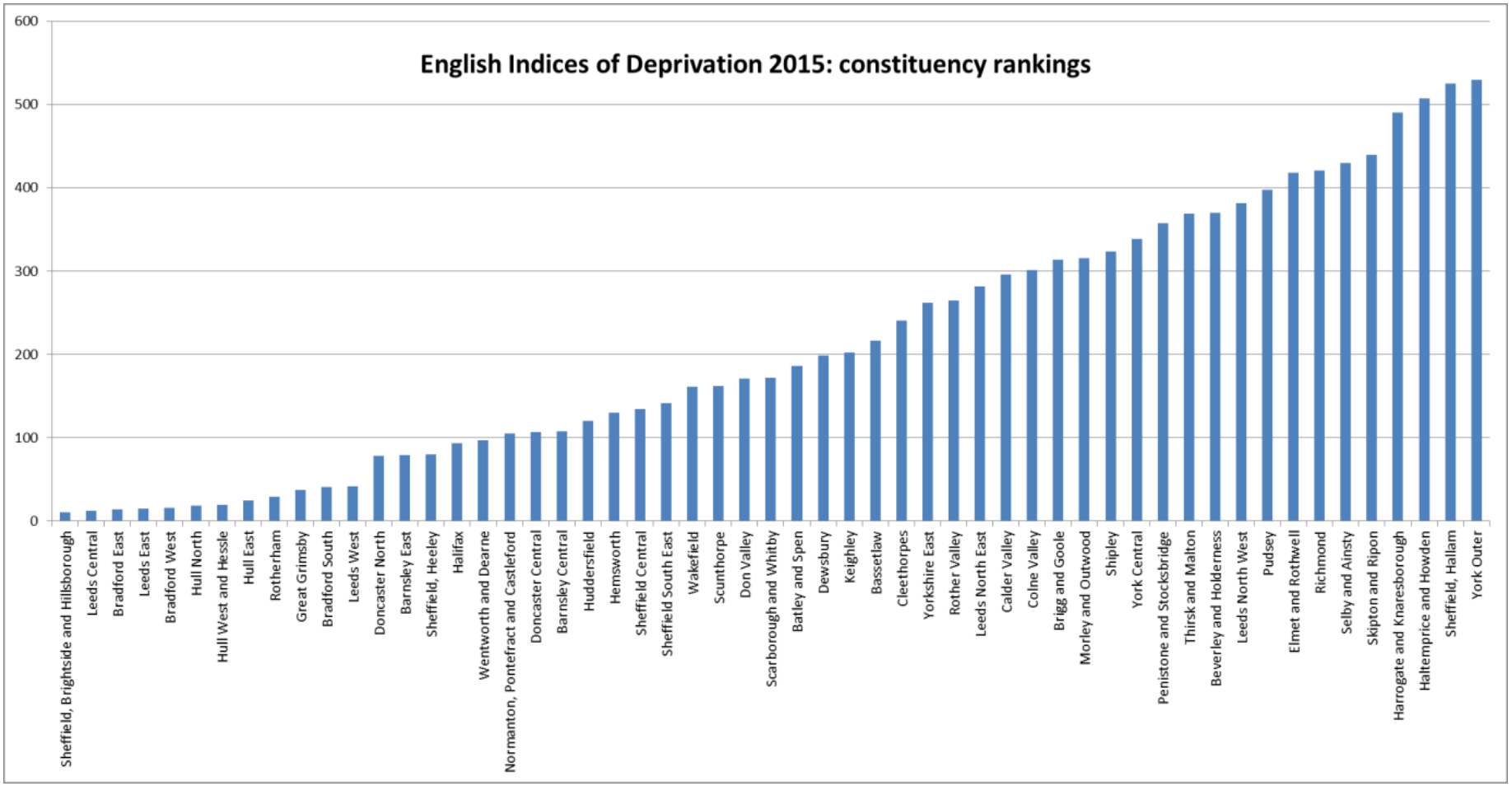
2 The average £ per UDA is used for pricing the service and a staged approach using UDAs per head of population as the measure is used to inform commissioning decisions
3 The commissioning model is to contract on a time limited basis to ensure that the amount of activity commissioned is effective and allow the flexibility to include additional services in future.

Dental Commissioning Team
Summer 2017

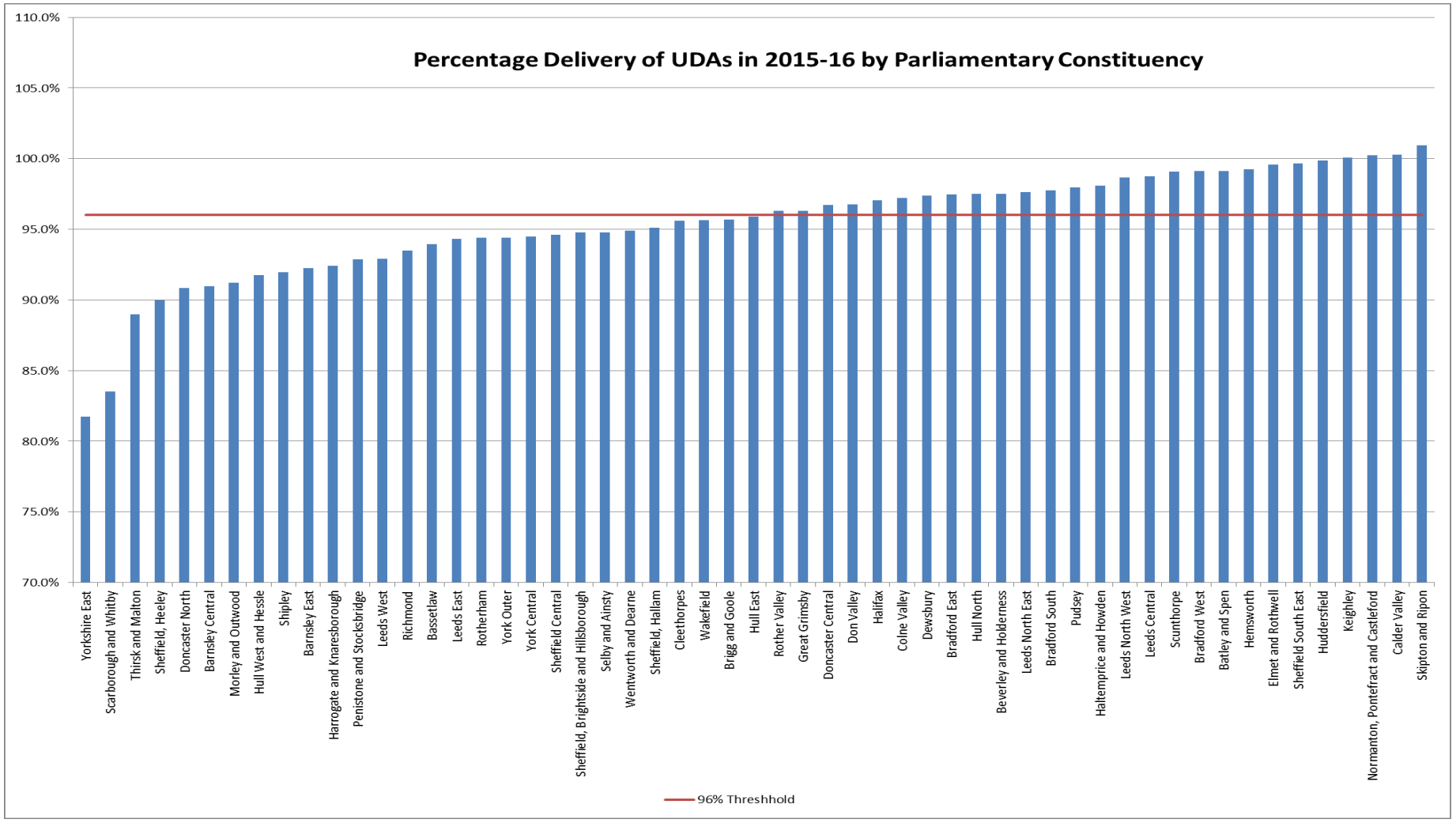
Appendix 1


UDAs Commissioned per Capita by Parliamentary Constituency at June 2017
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
-
Scunthorpe
Haltemprice and Howden
Morley and Outwood
Beverley and Holderness
Calder Valley
Wentworth and Dearne
Penistone and Stocksbridge
Cleethorpes
Harrogate and Knaresborough
Pudsey
York Outer
Dewsbury
Bradford South
Elmet and Rothwell
Leeds North West
Hull North
Thirsk and Malton
Shipley
Selby and Ainsty
Sheffield, Brightside and Hillsborough
Hemsworth
Hull East
Colne Valley
Richmond
Yorkshire East
Brigg and Goole
Rother Valley
Bradford East
Sheffield, Heeley
Sheffield, Hallam
Bradford West
Skipton and Ripon
Keighley
Don Valley
Great Grimsby
Leeds North East
Batley and Spen
Barnsley East
Sheffield South East
Leeds Central
York Central
Leeds East
Doncaster North
Bassetlaw
Scarborough and Whitby
Leeds West
Normanton, Pontefract and Castleford
Sheffield Central
Huddersfield
Wakefield
Doncaster Central
Halifax
Rotherham
Barnsley Central
Hull West and Hessle
Yorkshire and the Humber Average 1.72
England Average 1.62


Patients Seen in Previous 24 Months as a Percentage of Population by Parliamentary Constituency at March 2017
140.0%
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Scunthorpe
Morley and Outwood
Calder Valley
Haltemprice and Howden
Cleethorpes
Penistone and Stocksbridge
Wentworth and Dearne
Beverley and Holderness
Bradford South
Dewsbury
Thirsk and Malton
Leeds North West
Harrogate and Knaresborough
Hull North
Shipley
Pudsey
York Outer
Selby and Ainsty
Elmet and Rothwell
Hemsworth
Yorkshire East
Sheffield, Brightside and Hillsborough
Hull East
Colne Valley
Bradford East
Richmond
Skipton and Ripon
Rother Valley
Sheffield, Heeley
Brigg and Goole
Sheffield, Hallam
Bradford West
Barnsley East
Scarborough and Whitby
Leeds Central
Don Valley
Keighley
Leeds East
Doncaster North
Great Grimsby
Bassetlaw
York Central
Batley and Spen
Leeds North East
Leeds West
Sheffield South East
Huddersfield
Sheffield Central
Doncaster Central
Normanton, Pontefract and Castleford
Barnsley Central
Wakefield
Halifax
Rotherham
Hull West and Hessle
Yorkshire and the Humber Average 57.4%
England Average 55.4%


English Indices of Deprivation 2015: constituency rankings
600
500
400
300
200
100
0
Sheffield, Brightside and Hillsborough
Leeds Central
Bradford East
Leeds East
Bradford West
Hull North
Hull West and Hessle
Hull East
Rotherham
Great Grimsby
Bradford South
Leeds West
Doncaster North
Barnsley East
Sheffield, Heeley
Halifax
Wentworth and Dearne
Normanton, Pontefract and Castleford
Doncaster Central
Barnsley Central
Huddersfield
Hemsworth
Sheffield Central
Sheffield South East
Wakefield
Scunthorpe
Don Valley
Scarborough and Whitby
Batley and Spen
Dewsbury
Keighley
Bassetlaw
Cleethorpes
Yorkshire East
Rother Valley
Leeds North East
Calder Valley
Colne Valley
Brigg and Goole
Morley and Outwood
Shipley
York Central
Penistone and Stocksbridge
Thirsk and Malton
Beverley and Holderness
Leeds North West
Pudsey
Elmet and Rothwell
Richmond
Selby and Ainsty
Skipton and Ripon
Harrogate and Knaresborough
Haltemprice and Howden
Sheffield, Hallam
York Outer

Appendix 4


Percentage Delivery of UDAs in 2015-16 by Parliamentary Constituency
110.0%
105.0%
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
Yorkshire East
Scarborough and Whitby
Thirsk and Malton
Sheffield, Heeley
Doncaster North
Barnsley Central
Morley and Outwood
Hull West and Hessle
Shipley
Barnsley East
Harrogate and Knaresborough
Penistone and Stocksbridge
Leeds West
Richmond
Bassetlaw
Leeds East
Rotherham
York Outer
York Central
Sheffield Central
Sheffield, Brightside and Hillsborough
Selby and Ainsty
Wentworth and Dearne
Sheffield, Hallam
Cleethorpes
Wakefield
Brigg and Goole
Hull East
Rother Valley
Great Grimsby
Doncaster Central
Don Valley
Halifax
Colne Valley
Dewsbury
Bradford East
Hull North
Beverley and Holderness
Leeds North East
Bradford South
Pudsey
Haltemprice and Howden
Leeds North West
Leeds Central
Scunthorpe
Bradford West
Batley and Spen
Hemsworth
Elmet and Rothwell
Sheffield South East
Huddersfield
Keighley
Normanton, Pontefract and Castleford
Calder Valley
Skipton and Ripon
96% Threshhold

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Councillor Helen Hayden
Chair, Scrutiny Board
(Adults, Health and Active Lifestyles)
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LEEDS
LS1 1UR

E-Mail address: Helen.hayden @leeds.gov.uk
Civic Hall tel: 0113 3950456
Our ref: HH/SMC

Emma Wilson
Head of Co-commissioning
NHS England

Sent via e-mail only

15 March 2019

Dear Emma,

RE: Urgent Dental Services in Leeds and across West Yorkshire

You will no doubt recall attending the West Yorkshire Joint Health Overview and Scrutiny Committee (the JHOSC) to discuss Access to Dental Services on 30 July 2018.

The minutes from the JHOSC meeting specifically highlight that, '…*the Joint Committee was assured that the refocus of access to dentistry was not "a service reconfiguration" and that NHS England would not miss the opportunity to engage with scrutiny on such matters."*

You will also recall my subsequent letter, dated 14 August 2018, where I highlighted I had become aware of '…*a communications and engagement plan produced by NHS England regarding what was described as 'Urgent and unplanned dental care reconfiguration in Yorkshire and the Humber'*.

In that letter I asked that you clarify the following points:

- The exact nature of any 'reconfiguration' of urgent and unplanned dental care services in Yorkshire and the Humber – but specifically across West Yorkshire and Harrogate.
- What level of public and stakeholder engagement has or is planned to take place in relation to the 'reconfiguration of services'?
- Local Authorities (and specifically Health Overview and Scrutiny Committees) not being identified on NHS England's list of stakeholders. What assurances can you provide that NHS England recognises its responsibilities and duties to engage with relevant local authorities and Health Overview and Scrutiny Committees? Please provide details of NHS England's plans in this regard relating to urgent and unplanned dental care services.

Your response, received in early October 2018, was shared with all members of the JHOSC; however it does not address any of these specific queries / matters.

Cont./

It is therefore very regrettable that I have become aware of planned changes to the urgent dental services in Leeds and across West Yorkshire. Please see the Yorkshire Evening Post article, '*Will it be harder to see an emergency out-of-hours NHS dentist in Leeds and Wakefield?',* published on 13 March 2019 (accessible through the following link: https://www.yorkshireeveningpost.co.uk/news/will-it-be-harder-to-see-an-emergency-out-of-hours-nhs-dentist-in-leeds-and-wakefield-1-9648634)

The article not only sets out a change in service provider, but also a reduction / change to the location of services in Leeds and elsewhere in West Yorkshire, which are due to come into effect from 1 April 2019.

As such, please provide the following details as a matter of urgency:

- Details of all the changes to urgent dental care services in Leeds, due to come into effect from 1 April 2019.
- Details of all the changes to urgent dental care services across the West Yorkshire and Harrogate Health and Care Partnership, due to come into effect from 1 April 2019.
- A copy of the 'Urgent and unplanned dental care reconfiguration in Yorkshire and the Humber' communications and engagement plan, produced by NHS England; and confirmation of the status of this document.
- Details of any stakeholder engagement or consultation undertaken by NHS England regarding proposed changes to urgent dental care services in Leeds and across the West Yorkshire and Harrogate Health and Care Partnership.

It is my intention to include this matter on the agenda for consideration by the JHOSC at its next meeting and require your attendance. The meeting is scheduled to take place at County Hall, Wakefield on 8 April 2019, commencing at 10:30am. Please confirm your attendance.

Please be aware that I intend to draw this matter to the attention of all Health Scrutiny Chairs across Yorkshire and Humber; should there be any specific implications for other local areas they may wish to consider. As such, please also be aware that consideration of this matter at the above JHOSC meeting is not intended to preclude any local discussions at any of the constituent local authorities represented on the JHOSC; nor any other relevant local health overview and scrutiny committee across Yorkshire and the Humber.

As a matter of urgency, I look forward to receiving the information requested, along with confirmation of your attendance at the above meeting.

Yours sincerely

H Hayden

Councillor Helen Hayden
Chair, Scrutiny Board (Adults, Health and Active Lifestyles), Leeds City Council and Chair, West Yorkshire Joint Health Overview and Scrutiny Committee

cc All members of the Scrutiny Board (Adults, Health and Active Lifestyles), Leeds City Council
All members of the West Yorkshire Joint Health Overview and Scrutiny Committee

Report author: Steven Courtney
Tel: (0113) 378 8666

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 8 April 2019

Subject: West Yorkshire and Harrogate Cancer Alliance

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Purpose

1. The purpose of this report is to introduce a report from the West Yorkshire and Harrogate Cancer Alliance that provides an outline of the activity relating to the identified cancer priority / programme, as part of the overall West Yorkshire and Harrogate Health and Care Partnership.

Summary of main issues

2. A report from the Cancer Alliance is attached at Annex 1. In broad terms covers the following areas:

   - Context and ambitions of the programme;
   - Governance arrangements
   - System-wide transformation activity
   - Transformation programme highlights
   - Future and long-term plans

3. The following details are also attached for information / consideration of the JHOSC:

   - Minutes of the West Yorkshire and Harrogate Cancer Alliance Board meeting held on 23 January 2019 (Annex 2)
   - Agenda of the West Yorkshire and Harrogate Cancer Alliance Board meeting held on 20 March 2019.(Annex 3)

<u>Approach of the Joint Committee</u>

4. In considering the details provided in relation to any of the West Yorkshire and Harrogate Health and Care Partnership priority programmes, the JHOSC previously

agreed it would seek to consider the details provided in the context of the high level aims of the programme, alongside the criteria for working jointly across the Partnership area, namely to:

- Achieve a critical mass beyond local population level to achieve the best outcomes;
- Share best practice and reduce variation; and
- Achieve better outcomes for people overall by tackling 'wicked issues' (i.e., complex, intractable problems).

5. Appropriate NHS representatives have been invited to the meeting to discuss the details provided and address questions from Members of the JHOSC.

Recommendations

6. That the West Yorkshire Joint Health Overview and Scrutiny Committee considers the details provided in this report and the associated appendices and agrees any specific scrutiny actions and/or future activity.

Background documents[1]

7. None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

West Yorkshire and Harrogate Cancer Alliance

Overview, Progress Update and Next Steps – March 2019

1. Context

1.1 The West Yorkshire and Harrogate (WY&H) Cancer Alliance is one of nineteen nationally designated structures established by NHS England to drive delivery of the national cancer strategy. There is a long history of working at scale across multiple statutory organisations in cancer driven primarily by the complexity of cancer pathways. It is the exception rather than rule for someone diagnosed with cancer to receive all their care from a single NHS provider organisation, thus it is crucial for all those involved in diagnosis and care to work together to ensure people receive the best outcomes and experience. Moreover as survival rates improve the care of people living with and beyond their treatment requires a more personalised approach to health and wellbeing support in place in collaboration with specialised health care providers.

1.2 In WY&H we are relatively unusual in having a single coterminous Alliance and Integrated Care System (ICS) footprint which means the WY&H Health and Care Partnership has adopted the Alliance for delivery of its priority programme for cancer. The Partnership benefits from having a cancer delivery programme supported by external programme resource (NHS England and third sector) and the Alliance benefits through integrated working with other priority and enabling programmes, for example the Primary and Community Services work, and direct access to collective decision-making capability and system leadership.

1.3 As an Alliance, we have a direct line of accountability to the National Cancer Transformation Board via NHS England (North) which sets our scope and influences our ways of working in a more direct way that some of our other ICS programmes. This includes access to earmarked Cancer Transformation Funding which is routed through Alliances and for which they are accountable. This can be simultaneously challenging and also an opportunity for the Alliance to test new ways of working as a system within the context of our health and care partnership.

2. Programme Ambitions

2.1 Programme ambitions are informed by national strategy, developed by the Cancer Alliance Board and agreed locally through WYAAT Programme Executive and the WY&H Joint Committee of CCGs. The 2020 programme ambitions are summarised as follows:

- Reducing adult smokers from 20% to 13% (125,000 fewer).
- Increase 1 year survival from 69.7% to 75% could save 700 lives per annum.
- Stage shift from 40% to 62% stage 1&2 – potentially 3,000 curative/survival improving treatments.
- Increased % patients formally invited to feedback or involved in service improvement
- Build on efforts for sustainable delivery of existing Cancer Waiting Times standards to develop pathways to meet the new 28 day to diagnosis standard to be introduced from 2020– reducing the c. 5000 diagnoses currently made through routine Referral To Treatment pathways.
- Deliver on the Five Year Forward View mandate to make the Cancer Recovery Package interventions available to all cancer patients and spread use of stratified follow up care including supported self-care.

- Lower treatment costs as result of our stage shift ambition could deliver efficiency savings of up to £12m**.**

2.2 Through the above system leadership groups the following strategic delivery proposal was also agreed:

- Develop a single cancer plan for West Yorkshire and Harrogate
- Create an Alliance - with senior clinical and managerial leadership and engagement – which behaves as a system (virtual team, common metrics with transparency and local delivery, system performance assessment).
- Empower the Alliance to lead the local system and develop new ways of working including exploring more strategic approaches to commissioning and delivery to the benefit of people affected by cancer.
- Align with other ICS and WYAAT developments.

3. Alliance Governance

3.1 Although the WY&H Cancer Alliance is first and foremost the cancer programme of the WY&H Health and Care Partnership, its governance and accountability arrangements are more complex than some other programmes. The Alliance has a line of accountability to NHS England and is required to produce an NHS England agreed delivery plan, backed up by a quarterly assurance process in order to receive the cancer transformation funding which supports local improvement work.

3.2 Locally, the Alliance aims to function as closely as possible to any other priority programme. A programme infrastructure is established and mobilised with a stakeholder Alliance Board which has met regularly since November 2016. Following discussion and agreement with the Joint Committee of CCGs and WYAAT Programme Executive in May 2018, the Alliance restructured its Board to reflect its developing role as system leader for cancer on behalf of the Partnership. This has involved strengthening the place based representation alongside sector representation and a stronger lay representation.

3.3 The Alliance is actively pursuing the offer from the WY&H Organisational Development network to support the system leadership role at Board level, place-based cancer team level and Alliance Core Support Team level.

3.4 In October 2018 the Alliance hosted a visit from Cally Palmer, National Cancer Director and David Fitzgerald, National Cancer Transformation Programme Director which included a showcase of the work to the Alliance and also a ‘round table’ session with Health and Care Partnership and Alliance leadership. The Alliance was commended for the strength of its system connections and governance embedded in the Health and Care Partnership. Alliance leadership have since been invited to provide case studies and present at a cancer alliance leadership and other national events as an exemplar for Alliance integration in local systems.

3.5 The Alliance Programme Director reports to the Programme Director for the Health and Care Partnership and meets regularly with other programme leads to maximise the opportunities for sharing and learning. The Alliance has a particularly close working relationship with WYAAT leadership and relevant programmes.

3.6 The Alliance Board has been supported to date by five priority work programmes (tobacco control, early diagnosis, high quality services, patient experience and living with and beyond cancer). Through this infrastructure the Alliance has the active engagement of over 60 front line staff, patients and lay members, third sector partners and managers from both health and local government. Organograms showing the

Alliance programme structure and connection to the Health and Care Partnership are included at Appendix 2.

3.7 At its meeting in November 2017, Alliance Board approved its Communications and Engagement Strategy which will support the strengthening and broadening of our communication and engagement work with our stakeholders. Our dedicated website went live in January 2018, which describes our work and where minutes of Alliance Board meetings are made public, and is available using the following link: https://canceralliance.wyhpartnership.co.uk/ .

4. System-wide Transformation Activity

4.1 Conceptually, Cancer Alliances are an alliance of all stakeholders involved in the improvement of cancer outcomes and experience so the issue of WY&H level activity vs place is quite blurred. The vast majority of cancer transformation activity happens in place. The role of the dedicated Alliance core team is to support the Alliance Board develop its system leadership role and lead, coordinate and facilitate stakeholders to come together across West Yorkshire and Harrogate to identify scope for improvement or unnecessary variation, agree remedial action planning and then hold each other to account for delivery.

4.2 The Cancer Alliance Transformation Programme has been structured around the strategic priorities identified in the report of the National Cancer Taskforce 'Achieving World Class Outcomes – a Strategy for Cancer 2015-2020'. The Alliance was able to bid for specific Cancer Transformation Funding in 2016/17 for initiatives focussed on improving early diagnosis of cancer and improving our offer to people living with and beyond cancer. In early 2017/18 NHS England approved proposals from West Yorkshire and Harrogate totalling around £13 million over two years.

4.3 In early 2018/19 NHS England introduced a hard conditionality linking ongoing receipt of these transformation funds to system-wide performance against the 62 day standard from urgent GP referral to first treatment standard. As a result of this, a 25% financial penalty was applied to the anticipated funds received in West Yorkshire and Harrogate during 2018/19. System performance in quarters 3 and 4 would actually have resulted in a 50% penalty, but this was adjusted upwards for a small number of Alliances including West Yorkshire and Harrogate based on an unprecedented surge in referrals and diagnoses of prostate cancers.

4.4 An unfortunate consequence of the national policy to connect receipt of transformation funds to a single cancer waiting times standard has was to introduce a considerable degree of risk and uncertainty into our transformation plans, with a number of elements of the original proposal being delayed, slowed down or abandoned in order to mitigate the financial risk to the system where activity was already underway.

4.5 Despite this disturbance to our transformation ambitions we are pleased to outline a number of programme highlights below which will either directly or indirectly result in improvements in the care and support we offer to people affected by cancer in West Yorkshire and Harrogate. Headlines are in the following sections; further detail is in the appendix.

5. Transformation Programme Highlights

5.1 Tobacco control and smoking cessation

- Our ambition is to reduce adult smokers from 20% to 13% by 2020 meaning 125,000 fewer smokers.
- Latest smoking prevalence figures have declined in-line with predicted forecast to 17.3%. This equates to a reduction of 22,067 smokers. The estimated cost saving directly attributed to healthcare after 5 years is £16.2m. *(Based on Commissioning for Prevention: North Central London SPG (100 people quitting smoking - total direct healthcare cost saving after 5 years = £73,400))*
- There is also an ambition to reduce smoking inequalities for routine and manual workers (R&M) and this has fallen from 29.8% to 29%. (5724 people)

5.2 Earlier Diagnosis

- Our ambition is to increase patient diagnoses at a stage where they are more likely to be offered curative or 'survival improving' treatments from 40% to 62% by 2020 affecting around 3,000 people - this is currently 53%
- We also aim to increase survival at one year from 69.7% to 75% by 2020 equating to 700 lives per year – this is currently 71%.
- We have a particular focus on lung cancer which is our biggest killer – with a multi-pronged approach based on tobacco control, awareness raising of symptoms, targeted lung health checks and optimising treatment pathways.
- This is a large and complex programme of work covering optimising screening uptake, redesign of diagnostic pathways (including for vague but concerning symptoms), introducing new diagnostic approaches (both techniques and workforce models) and support for major transformation change programmes such as the Yorkshire Imaging Collaborative and Digital Pathology initiatives led through the West Yorkshire Association of Acute Trusts which will help maximise the effectiveness of our diagnostic resources in West Yorkshire and Harrogate.

5.3 Whole pathway redesign and improvement including delivery of High Quality Modern Services

- This programme covers the treatment phase of cancer care and involves bringing together patients, primary care and hospital teams to review our care services improve our offer to patients and address any unwarranted variation in outcome of experience.
- As a system we are required to implement national optimal pathways. Based on our cancer waiting times performance the local priorities have been Cancer Pathway Groups for bowel cancer, lung cancer, prostate cancer and upper gastrointestinal cancer. Although the national focus is on recovery of cancer waiting times standards and preparation for the introduction of the new 28 day referral to diagnosis standard by 2020, our Alliance groups have a whole pathway remit to ensure people are referred quickly for investigation, get the right test first time and if a cancer is diagnosed, they receive rapid treatment and appropriate personalised follow up care.
- Working together our acute providers have assessed against national optimal pathways and identified where we needed to improve access to some diagnostic testing. Cancer transformation funds have enabled us to invest in specialist diagnostic ultrasound equipment in two hospitals to speed up the pathway for people with lung cancer. Expected outcomes of this investment include a doubling of capacity for endobronchial ultrasound (EBUS) diagnostics and reduced waiting time for investigations from 15-20 days to 7-14 days.

5.4 Improving our offer to people living with and beyond cancer

- Almost 90,000 people are currently living in WY&H beyond a cancer diagnosis. Our ambition is to deliver on the Five Year Forward View mandate to make the interventions known as the 'Recovery Package' available to all cancer patients and spread the availability of personalised follow up care including supported self-care where appropriate.

Since coming into post in March 2018, the Living with & beyond Cancer (LWBC) team has:

- Audited current coverage of the Recovery Package and agreed the priorities for improvement focussing on holistic needs assessment at end of treatment, care planning and treatment summaries.
- Engaged extensively with front line staff to standardise our offer across WY&H and support implementation.
- Developed an integrated pilot scheme for improving personalised community based health and wellbeing support.
- Engaged extensively to develop standard principles for personalised follow up care tailored to individual risks and needs, extending the offer of supported self-management where appropriate. This includes addressing the needs of people living with a palliative diagnosis.

5.5 Listening to Patients and the Public

As an Alliance we are committed to openness and transparency, and to listening to patients and the public to inform and influence our work. Alliance Board approved a comprehensive Communications and Engagement Strategy in November 2017.

- As part of the restructure of the Alliance Board earlier this year we held an open recruitment for two new lay members (one of whom has been a patient and one a carer)
- We have successfully tendered for and commissioned a Community/Patient Panel through Healthwatch Wakefield and the Yorkshire Cancer Community, with a part time coordinator and membership to reflect geography, tumour site, and as far as possible a range of protected characteristics. We currently have around 40 active members and continue to develop and improve the approach and this model has attracted national interest.
- Our Alliance Patient Experience Group is championing an approach to 'People Powered Service Improvement' which builds on West Yorkshire and Harrogate becoming the only Alliance to implement the Breast Cancer Now Service Pledge methodology based on developing national and local patient champions to work alongside health care professionals to identify and implement service improvements. We are currently planning to test a similar approach with other tumour patients and teams, starting with prostate cancer.

5.6 Cancer Waiting Times Recovery

As an Alliance we are committed to delivering timely care to people affected by cancer, and to this end recovery of the NHS Constitutional standard for all cancer waiting times standards, but in particular the urgent GP referral to treatment (62 day) standard is a priority both for individual stakeholder organisations and West Yorkshire and Harrogate at system level. An additional consideration at system level is that our collective performance is likely to have continued impact on the amount of national transformation funding we can attract to further our ambitions to improve outcomes and experience for our citizens during 2019/20.

Comprehensive plans are in place in individual acute provider organisations to address local issues affecting performance. In addition the Alliance has facilitated joint work and investment opportunities during 2018/19 with considerable engagement and support from WYAAT Strategy and Operations Group and the acute provider Lead Managers. Highlights of this joint work are:

- All acute Trusts in the Alliance have agreed to prioritise bowel cancer, lung cancer and prostate cancer pathways as these are the cancer pathways having most impact on cancer standards performance.
- All the acute Trusts agreed to work with the NHS Intensive Support Team, who are part of NHS Improvement, and through detailed analysis, identify where services and processes could be improved that can help speed up the pathway for patients. For example, better co-ordination of multiple hospitals appointments and improving administration and communication processes.
- The Alliance received additional non recurrent funding from NHS England to unblock these local issues affecting performance, particularly in the prostate cancer pathway, due to a significant rise in referrals (also seen nationally). Through the WYAAT Strategy and Operations Group acute providers collectively agreed to direct this funding to the parts of WY&H where patients were experiencing the greatest delays in getting access to diagnostic tests or treatments.
- Providers are also working together to explore how they could offer patients access to diagnostic services across WY&H and share services when one hospital or service may be experiencing particular pressures or demands.

6. Forward look to 2019/20 and Long Term Plan

The priorities and agenda for the Cancer Alliance are determined by the 2019/20 Operational Planning Guidance and the Long Term Plan for the NHS. All Alliances have recently submitted draft Delivery Plans for 2019/20 for approval by NHS England in April. This is required to release Cancer Transformation Funding. Priorities will be:

- Supporting and informing place based operational planning for 2019/20.
- Continuing efforts to improve and sustain our operational performance standards as ambition in its own right and as an enabler to maximise our transformation potential through receipt of Cancer Transformation Funds.
- Continued efforts to influence stage shift and improve survival through:
  - Development of rapid diagnostics pathways/centres
  - Development of pathways to deliver new 28 day standard
  - Development of case finding approaches such as Lung Health Checks building on work already planned for Wakefield and Bradford, and the recent announcement of North Kirklees CCG as a national pilot site.
- Through the Living with and Beyond Cancer (LWBC) programme, there will be a continued focus on quality of life and personalised care, combining the outputs from the focus groups and engagement events held with patients and staff with existing community services in each place to ensure quality of life is as important as survival.
- We are developing a composite patient experience metric using data from the national Cancer Patient Experience Survey which will be built into our Cancer Outcomes and Assessment Framework and used to support and encourage work to improve experience alongside harder clinical outcomes.
- Building our future workforce – Workforce development will be undertaken to introduce advanced nurse consultants and consultant radiographers for non-surgical oncology roles to ensure a more sustainable workforce model supporting

patients during treatment. In addition, the potential to develop our current endoscopy teams from single skills (e.g. flexible sigmoidoscopy) to multi-modal capabilities (full range of endoscopy procedures) will be scoped out (including a regional training programme), in collaboration with Health Education England.

- Linked to this, as we see increasing numbers of positive diagnoses in some tumours, e.g. prostate cancer, and as we actively change the profile of presentation for others, e.g. lung cancer, we will need to work with colleagues in NHS England Specialised Commissioning team to ensure treatment capacity is developed to match the profile of patient needs.
- To support the above activity we will be reshaping our programme infrastructure to make best use of interdependencies with other programmes and Partnership infrastructure more generally – and also effective use of the time of people in the system we need to involve in this work.

7. Discussion and recommendations –

Members of the West Yorkshire Joint Health Overview and Scrutiny Committee are asked to:

- Note progress made by the Alliance since inception in 2016.
- Note and support the ongoing priority to recover performance against cancer waiting times standards.
- Note and support the priorities for the Alliance as determined by national policy, specifically the ongoing focus on finding more cancers at a stage when they are potentially curable and developing more personalised, integrated health and wellbeing support to people living beyond their diagnosis in their own communities.
-

Professor Sean Duffy - WY&H Cancer Alliance Lead and Clinical Director

Carol Ferguson – WY&H Cancer Alliance Programme Director

Appendix 1

Examples of Alliance Activity and Impact

Tobacco Control

- The WY&H Tobacco Advisory Board has been established and is working towards the agreed trajectories.
- The programme has successfully attracted funding from West Yorkshire and Harrogate Health and Care Partnership for a TV mass media quit campaign and a practical guide to supporting hospital trusts implement smoking cessation interventions – based on NICE PH48/Ottawa Model.
- Figures from local authority commissioned 'specialised stop smoking services' are down 12% on quit rates and 16% on quitters last year, however, this masks underlying issues e.g. good success rates, targeted services but low footfall to services.
- The programme is also supporting the implementation of the Prevention of Risky Behaviours Tobacco/alcohol Commissioning for Quality and Innovation (CQUIN) incentive.
- Elsewhere in the Alliance Mid Yorkshire Acute Trust has an ambition to be a smoke free organisation. It has made e learning for 'Very Brief Advice' part of the mandatory staff training, invited smoking cessation services to operate within its hospitals and has installed a speaker system to deter smoking on Trust premises
- The Alliance Tackling Lung Cancer Programme is funding carbon dioxide monitors to be used in hospital outpatient departments within the Mid Yorkshire Acute Trust
- Funding is also being provided for an on-site smoking cessation service within Dewsbury Hospital
- Bradford Acute Trust has set a date for the removal of smoking shelters in hospital grounds for the end of December 2018
- Bradford Acute Trust will launch an e-learning programme to all staff for 'Very Brief Advice' in January 2019
- A proposal is being developed to increase the smoking cessation service within the Bradford Hospital sites.

Earlier Diagnosis

- GPs and hospitals are working together to improve investigation and management of people who have vague but concerning symptoms, which may or may not be cancer. In each area, GPs are now able to refer people for rapid and co-ordinated investigations for review by an expert team of diagnostic professionals, who then determine the best treatment pathway. Over 1,300 patients have been referred on this pathway of which 10% were found to have cancer. This vague symptoms service works alongside the urgent suspected cancer referrals pathway where people who visit their GPs with more obvious symptoms of cancer, are referred for an appointment with a cancer specialist or test within 2 weeks. By offering this range of pathways this will help ensure that people are supported through a managed and co-ordinated programme of investigation towards diagnosis.
- The introduction of a test, given out by GPs, which detects if a person with 'low risk' bowel symptoms requires further investigation – called the 'Faecal Immunochemical Test' or FIT, is being rolled out in practices in the Alliance. An Alliance steering group is working in partnership with GPs and hospital teams to provide the test to people who visit GPs with symptoms and to monitor how this test can help avoid the need for

more invasive diagnostic tests and free up resources for urgent symptomatic patients and screening services.

- Using technology and cameras to speed up the referral of suspected skin cancers and avoid hospital out patient's visits, is now in place in Leeds. This service, which involves GPs taking images of skin lesions, which are then transferred electronically to clinical experts for review within 48 hours, has been operating since June 2018. This quick access has enabled GPs to provide reassurance to patients that their lesion is not cancer and avoid a hospital attendance. If a cancer is diagnosed, then the patient can be referred rapidly for treatment. The Alliance is working with partners to roll this out across remaining 230 GP practices during Spring 2019.
- The Alliance has also invested in technology and training to support digital review and transfer of pathology slides and imaging scans across hospitals in WY&H. As part of a bigger programme of investment, the Alliance transformation funding resource has secured an additional 5 pathology scanners and equipment, so each hospital is able to benefit from this technological advancement.
- The Alliance is working with the Yorkshire Imaging Collaborative by providing funding for clinical and management input to implement a technological and transformational programme that will allow hospitals in WY&H to transfer images and scans electronically and enable quick access to specialist review. It will improve team working and reporting of images and also allow staff to work across hospital sites. The first digital stage of this programme is underway and hospital teams and services are now working to develop joint guidelines and test new systems.
- The Alliance has a specific programme focussed on improving lung cancer outcomes in collaboration with Yorkshire Cancer Research and the Roy Castle Lung Cancer Foundation:
    - Plans for a Wakefield Lung Health Check programme are well developed. The Lung Health Checks will be delivered using a primary care model delivered by the local GP Federation. The contract will be ready for signature in December. Mid Yorkshire Acute Trust has begun the work on procurement of the Low Dose computerised tomography (CT) service to support this.
    - Plans in Bradford are developing well. Target populations have been identified and Bradford Acute Trust is completing an internal review of their capacity. Early discussions on workforce options for the delivery of Lung Health Checks and Low Dose CT are in progress.
    - It is estimated that in 2019/20 a maximum of 5,000 Lung Health checks will be delivered to populations in the most deprived areas of Wakefield and Bradford. The outcome will be 123 lives saved through earlier diagnosis.
    - NHS North Kirklees has recently been invited to join a national cohort of pilot sites delivering Lung Health Checks with planning underway for commencement during 2019/20.

Whole Pathway Redesign and High Quality Treatment

- Patients and carers, who are part of our Cancer Patient Panel, are working with us to ensure that tailored information and support is provided at all points of need along the pathway.
- The Alliance has worked with hospital cancer multi-disciplinary teams to review how teams work together to make the best use of time and skills of hospital staff in the face of increasing caseload whilst ensuring patients are offered the most appropriate care. By streamlining the way teams operate across West Yorkshire and Harrogate the aim is to generate more time for expert and specialist review of more complex cases.
- Work is underway to ensure that Children and Teenage Cancer services develop a high-quality service specification. In addition, the national charity, Teenage Cancer

Trust, is working with the Alliance to embed educational programmes on cancer in our schools.

Living with and Beyond Cancer

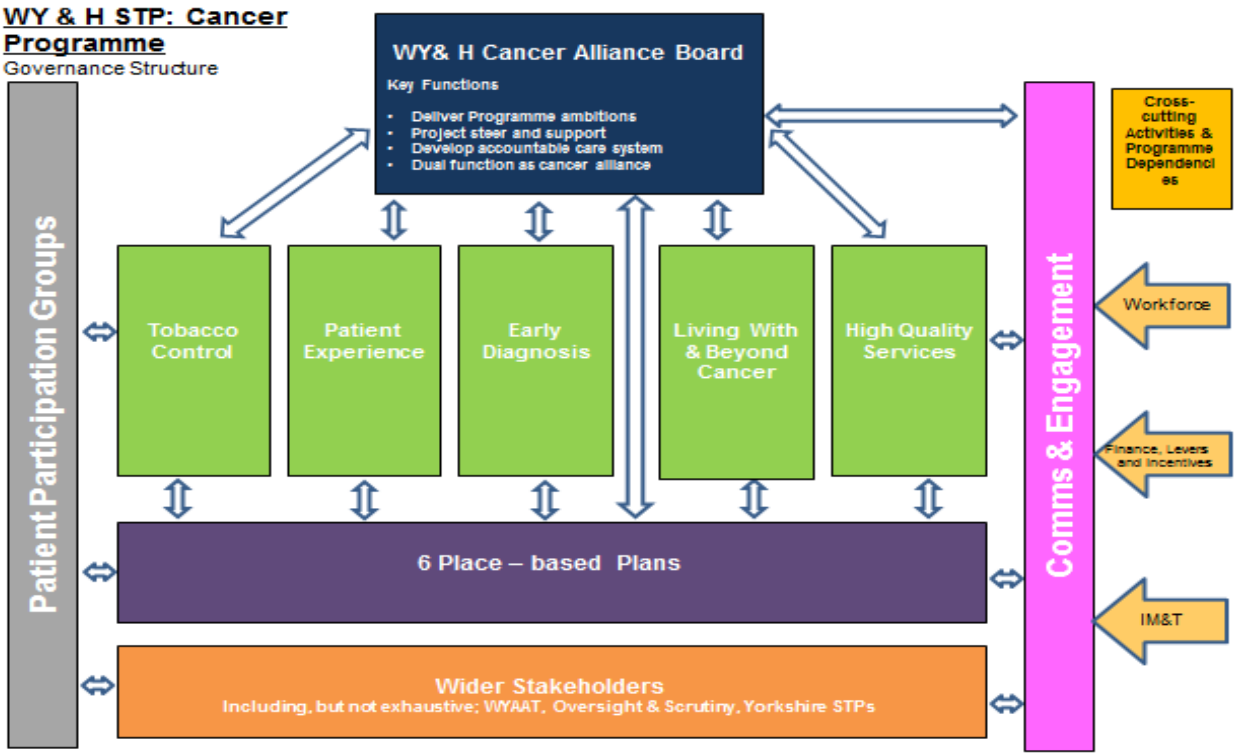
- Worked with over 160 of front line staff and patients across all 6 places to agree a 'gold standard' for implementing holistic needs assessments and care plans as part of the Recovery Package, including common definitions and standard templates and are now working towards the standardisation of treatment summary content. This has resulted in the development of a training package offer to 280 front line staff in both acute and community settings to identify solutions to barriers to implementation and share best practice across the patch.
- The team has worked in partnership with Cancer Support Yorkshire, Bradford Royal Infirmary and Macmillan to develop a pilot project to improve access and test out a new model of more personalised health and wellbeing support for people affected by cancer in Bradford. This will also be a pilot site for the roll-out of new tools which support staff and patients work together to assess holistic needs and devise support arrangements that are most likely to be appropriate and effective for the individual. Funding from Macmillan has resulted in successful recruitment to a part-time administrative post and 2 Support Coordinator posts which will begin in January.
- The offer of risk stratified post treatment management (including supported self-care where appropriate) is a national priority aimed at simultaneously improving patient experience and freeing up resources to meet increasing demand, for example use of CT in follow management of colorectal cancers. In West Yorkshire and Harrogate a range of models and service options exists for some tumour sites. The Alliance team has been working to address unwarranted variation, engaging with national charities, patients, commissioners, GPs and stakeholders from all 6 trusts, including Lead Cancer Nurses, Cancer Nurse Specialists, Consultants, Cancer Care Coordinators and General Managers. As a result we are developing key principles which will promote best practice and make the most of resources we have locally and supporting in the implementation of these key principles.
- Our 'learn and design event for prostate cancer follow up care, run in collaboration with Prostate Cancer UK generated commitment from Harrogate and District Foundation NHS Trust and Calderdale and Huddersfield Foundation NHS Trust to implement stratified follow up care.
- Co-production events in each place have been held to find out from patients and carers what support is required following cancer treatment and how this support may be accessed and provided within existing community services. This is being used to inform the development of potential commissioning models for the future.
- We have engaged with over 170 patients and professionals across WY&H on what support patients living with a palliative cancer diagnosis require and how these needs can best be met. This will result in a report of recommendations to be progressed over the next year.

Listening to Patients and the Public

- Our partnership with Breast Cancer Now to implement their Service Pledge methodology (which involves service users and staff working together on improvement plans) across the Alliance has resulted in practical improvements in service delivery relating to privacy, dignity, communications and morale. Such as:
  - the development of a business case for a clinical support worker to answer and triage phone calls to the Breast Care Nurses (MYHT & LTHT)
  - The review of clinic templates to give patients more time at diagnosis appointments (Airedale)

- Updating of information packs and tailoring information to patient needs. (LTHT & Airedale)
- Auditing the value of using mobile chemotherapy units in terms of staffing & freeing up space on the units (Airedale & MYHT).
- Implementing a ‘Think Drink’ campaign to raise awareness amongst staff of when patients can drink prior to surgery. (LTHT)
- Developing on-line videos to show patients what to expect when they come in for treatment (C&H)
- Requesting patients to come into hospital based on what time their breast cancer surgery is scheduled, so that afternoon patients do not have to arrive first thing in the morning (MYHT)

Appendix 2



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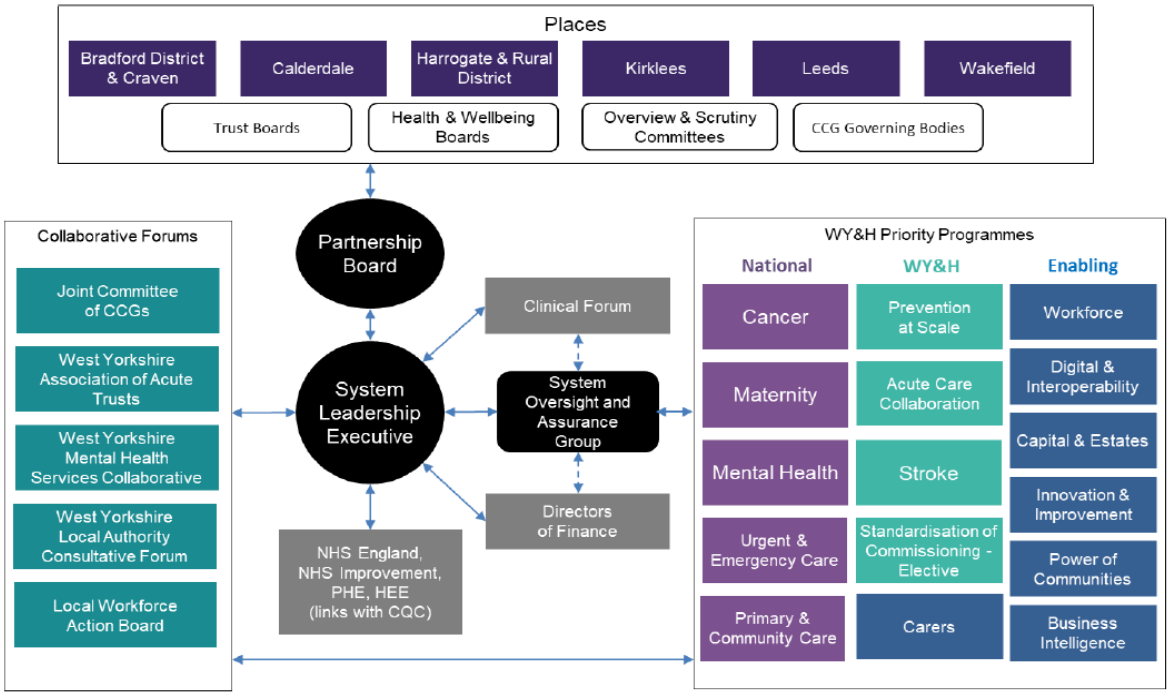
Annex 2 – Schematic of Governance and Accountability Arrangements



West Yorkshire & Harrogate Cancer Alliance

Board Meeting

Wednesday 23rd January 2019, 14:00 – 16:30hrs

Sandal Rugby Club, Standbridge Lane, Milnthorpe Green, Wakefield, WF2 7DY

Attended:	Sean Duffy, Cancer Programme Clinical Director, WY&H Cancer Alliance	SD
	Michele Ezro, Ass Dir Acute Comm Wakefield CCG	ME
	Carol Ferguson,Cancer Programme Director, WY&H Cancer Alliance	CF
	Mike Frazer, Board Layperson, Patient Representative	MF
	Jo Halliwell, Director of Operations, Surgery MYHT	JHa
	Robert Harrison, Chief Operating Officer, Harrogate & DFT	RH
	Mike Harvey, on behalf of David Berridge	MH
	Jane Hazelgrave, Director of Finance, MYFHT	JHz
	Fiona Hibbits, Senior Delivery Improvement Lead, NHSI	FH
	Jules Hoole, Strategic Partnership Manager (Yorkshire), Macmillan	JHo
	Stacey Hunter, Chief Operating Officer, Airedale HT	SH
	Clive Kay **(Chair)**, Chief Executive Officer, Bradford THT	CK
	Matt Kaye, GH CCG GP Cancer Lead and WY&H CRUK GP Lead	MK
	Akram Khan, Clinical Chair, Bradford City CCG	AK
	Kath Nuttall, Regional Manager, CRUK	KN
	Maureen Overton on behalf of Ashwin Verma	MO
	Visseh Pejhan-Sykes, Chief Finance Officer, Leeds CCG	VPS
	Kevin Peters, Specialised Commissioning Cancer, NHSE	KP
	Amanda Procter, Lead Cancer Nurse, Bradford THT	AP
	Sandra Shannon, Chief Operating Officer, Bradford THT	SS
	Nigel Taylor, GP Member of Governing Body, Calderdale CCG	NT
	Ashwin Verma, Consultant Gastroenterology, Calderdale & Huddersfield Trust	AV
	Paul Vose, Board Layperson, Patient Representative	PV
In Attendance:	Tracy Holmes, Comms & Engagement Lead, WY&H Cancer Alliance	TH
	Fiona Stephenson, Head of Quality & Optimal Pathways, WY&H Cancer Alliance	FS
	Lindsay Springall, Senior Commissioning Manager, NHS Leeds CCG	LS
	Catherine Weir, Senior Lecturer, Birmingham University	CW
	Sue Ellis, OD Consultant, WY&H OD Network	SE
	Keith Derbyshire, Consultant, Health Informatics	KD
	Craig Shenton, Consultant, Health Informatics	CS
Apologies:	Amanda Bloor**,** CCG Chief Officer, HaRD CCG	AB
	David Berridge, Deputy Chief Medical Officer, Leeds THT	DB
	Anna Hartley, Deputy Director of Public Health, Wakefield Council	AH
	Helen Lewis, Head of Planned Care & LTC Commissioning, Leeds CCG	HL
	Lyn Sowray, Assistant Director Social Care, Bradford Council	LS
Secretariat:	Tracy Short (Minutes)	TS

1.0 Welcome, Introductions & Apologies

1.1 CK welcomed the attendees and round the table introductions were made. CK advised members that he has accepted the position of Chief Executive of Kings College, London however his start date is yet unknown. He advised that discussions for a replacement Chair has already commenced.

	Actions
2.0 Declarations of Interest: 2.1 There were no declarations of interest made.	
3.0 Minutes of meeting held on 30th October 2018: 3.1 The minutes of the meeting were checked for accuracy and were agreed to be a true record.	
4.0 Actions/Matters Arising: 4.1 There were a number of outstanding actions or matters arising that were not covered on the agenda and CF provided an update to the members.	
4.2 **Highlight Report & Risk Register:** 4.2.1 It had been agreed at the last meeting that these documents would be issued with meeting papers and questions and comments sought in advance of the meeting. MF has raised a number of issues that had been picked up by FS.	
4.3 **Data Sharing Agreement:** 4.3.1 CF advised that the Health and Care Partnership (HCP) Programme Management Office is still waiting for colleagues in Information Governance to provide the appropriate advice regarding wording. CF agreed to follow this up.	**CF to follow up with HC Partnership PMO colleagues. CK & AB to request early resolution via SOAG**
4.4 **Smoke free Statement:** 4.4.1 CF advised that Scott Crosby (Tobacco Control Lead) would be attending the next Board meeting to provide an update.	
4.5 **Clinical Engagement:** 4.5.1 As there a number of outstanding issues regarding clinical engagement it was suggested by CF to add Delivery of Optimal Pathways which delivers both performance and outcomes, to the next meeting agenda.	**TS to include delivery of optimal pathways discussion to March agenda.**
4.6 **System Oversight and Assurance Group (SOAG):** 4.6.1 CF advised that this would be discussed at agenda item 10.	
4.7 **Organisational Development (OD) Support:** 4.7.1 CF introduced Sue Ellis who was in attendance to observe the meeting. Sue is part of the WYH OD network offering OD support in helping the Board develop as a mutually supportive system leadership for cancer. SE advised that the joined up approach by the network should alleviate duplication across the programmes.	
4.8 **NHS England Self-Assessment:** 4.8.1 CF advised that formal feedback from the national team is still	

awaited, although informal feedback would suggest that it will take the form of guidance regarding structures for the Alliance and interdependencies with HCPs.

5.0 Cancer Waiting Times:

5.1 FS introduced this paper which has been provided to highlight some of the challenges faced and to ask the Board for guidance on some of these issues.

5.2 FS advised that although there has been some slight improvement in performance the Trusts are still some way from achieving the target.

5.3 She informed the group that West Yorkshire Association of Acute Trusts (WYAAT) Strategy and Operations Group is working with the Alliance, NHS England and NHS Improvement and operating as an effective vehicle to enable coordination and deployment of resources and effort and providing strategic forward planning for cancer within wider system pressures.

5.4 FS drew attention to the three main points discussed in section 4 of the paper:

5.4.1 **Prostate & Lung Pathway**: all organisations have action plans in respect of the prostate pathway and are working collaboratively. The diagnostic part of the lung pathways are being overseen by pathway improvement groups, however guidance from the Board was being sought as it was acknowledged that not all issues can be addressed by those groups alone.

5.4.2 **Demand & Capacity Diagnostics**: FS advised that work is underway to commission a piece of work which will provide a significant standardised approach to assessing capacity and demand across the whole system. The establishment of a cancer hub to provide dedicated resource to interprovider working will be explored and should provide a shared resource and learning from the outputs of the modelling exercise.

5.4.3 **CWT Analysis:** this will provide the opportunity to undertake deep dives into the performance of individual Trusts and collectively as a system and look for improvements.

5.5 Discussion followed regarding specifics particularly around the prostate figures and the diagnostic end of the pathways.

5.6 JHz commented about the danger of assessing performance without understanding volume and demand.

5.7 MF made reference to 4.1 of the paper which referred to the national problem of the availability of the PET CT Scans and asked if anything could be done.

5.8 SD advised that NHS England Specialised Commissioning team are responsible for the contract and KP is working closely with NHSE north of England to resolve these issues. He advised that though there isn't much we can do as an Alliance Board, we could ensure that communication is maintained and mitigation is in place.

5.9 MF also questioned whether the Board can do anything to speed up the development of the Cancer Hub and CF advised that the CT Fund supports this, that design work is underway. FS stated that the three asks of the Board were to steer the improvement work with focus and to prioritise the prostate pathway. Endorse the demand and capacity analysis across diagnostics for all disease areas to establish which is cancer specific and support the development of the cancer hub.

5.10 FS agreed to bring this item back to the Board in 6 months with data showing demonstrable improvement. **Schedule update paper for July's Board agenda**

5.11 Discussion followed regarding the evident signs of maturity of system leadership and the success of collaboration which FHi stated was the driving force.

5.12 CK questioned how much further the Board was prepared to hold one another to account across the system regarding delivery and whether members were comfortable so far with the approach.

5.13 MHa commented that the approach is not just entering into discussions but is actually assisting in the streamlining of pathways.

6.0 Lynch Syndrome Testing:

6.1 LS attended the meeting to present the paper which recommends a consistent approach to Lynch Syndrome Testing across the Alliance. For the past three years, activity has been funded by Yorkshire Cancer Research and to ensure that this becomes business as usual, LS has worked extensively with stakeholders and other Alliances.

6.2 The paper sets out the delivery costs if the tests are undertaken at LTHT (which has capacity to undertake BRAF & MLH1 tests from April), explains the tests required and outlines the costs pressures for each CCG.

6.3 SD advised members that the recommendations are in line with the ambitions of the Alliance e.g. stage shift, it also delivers consistency of approach, alleviating some forms of chemotherapy that adds no benefit to patients.

6.4 CK asked if the savings to the system have been modelled but was advised that the outcomes are the biggest benefit.

6.5 The paper sought three recommendations from the Board:

- To support the consistent policy

- Providers to confirm whether they will undertake their own IHC or MSI testing (LTHT is able to undertake BRAF and MLH1 tests for all if required)…….
- Agree the strategy for risk sharing e.g. pursue through Joint Committee of CCGs.

6.6 SH advised that these issues of where the tests should be undertaken should be considered by the WYAAT Pathology group.

6.7 SS added that workforce issues should be considered as a result of more test and more diagnoses.

CF to approach AB re commissioning arrangements

6.8 Following further discussion it was agreed that the decision regarding the commissioning approach would need further consideration and CK suggested that PMO colleagues approach AB to progress this.

6.9 CK concluded that the approach was endorsed in principle subject to agreement re commissioning and laboratory provision.

7.0 Macmillan Evaluation of Alliance/Leeds Integrated Cancer System (LICS) Update:

7.1 CW attended the Board to provide an update to colleagues on the evaluation of the Alliance which is being undertaken by Birmingham University. A short presentation was sent out with the papers.

7.2 CW advised that the joint working, collaboration and mutual accountability have been stretched and developed over the period that the evaluation has been taking place.

7.3 She also advised that what has emerged from the evaluation so far is that local relationships and the local story is key.

7.4 MF raised the issue that in the NHS Plan it stated that they would provide extra capacity for engagement with the public and in particular seldom heard groups. MF questioned how the Board communicates with the patients and public and if there is anything that we can improve on.

Comms & engagement to be added to March agenda

7.5 CF suggested that an update on Patient and Public Engagement is provided at the next meeting and that perhaps MF could assist what further action may be required.

8.0 Macmillan Strategy:

8.1 JHo talked through the presentation, which outlined Macmillan's national strategy with particular emphasis on the 6 priorities, and how these align with the Cancer Alliance.

8.2 Main focus includes:

- Personalised care & improved patient experience
- Cancer workforce investment
- Integrated pathway – diagnosis to EoLC

- Times of need

8.3 She advised that the Cancer Workforce investment would be heavily focused on the acute and secondary care sector in 2019 and primary and community care in 2019/20 and was pleased to announce that funding had been secured to fund 3 Band 7 posts.

8.4 These posts will provide practical support for front-line staff across the system and will deliver interventions that are proven to improve personalised support for people beyond their cancer diagnosis.

8.5 CF raised the significant issue of Wakefield CCG hosting the posts and the mitigation of risk. She advised that it is sensible for the posts holders to be managed through the existing Alliance arrangements; however this adds to the burden of the CCG, though the CCG have agreed host them.

8.6 CF asked for agreement in principle to share the risk across the system, advising that the HCP is undertaking a bigger piece of work to identify a more sustainable solution and that this would supersede any agreement reached here.

8.7 SHu stated that there should be confidence to do this and was happy to sign Airedale up to this mutual accountability.

8.8 VPS questioned whether the system should underwrite the redundancy and suggested in reality we should guarantee the post holders employment in a redundancy situation.

9.0 Cancer Outcomes Assessment Framework:

9.1 KD and CS attended the meeting to provide an overview on the development of the Cancer Outcomes Assessment Framework (COAF). The framework supports the Alliance and the six places to focus on outcomes and track meaningful and realistic strategic plans.

9.2 KD described the functionality of the tool which is based on a series of links between several specific risk factors including socio-economic, demography, cancer prevalence, and selected cancer outcomes e.g. smoking prevalence, screening uptake CWT and patient experience etc., therefore making it an improvement on RightCare.

9.3 This allows for comparison and benchmarking against like for like organisations, rather than the England average and will enable realistic planned improvements in performance.

9.4 SD advised that all the data used is in the public domain but not in this format**.** Two main questions to the Board members were:

- Do the Board members wish to adopt the tool
- Should this tool drive the Board's improvement agenda in being a method of measuring one another.

9.5 A positive discussion followed amongst members.

9.6 KD directed the attendees to table 2 of the paper which identifies four possible uses for the tool. It was agreed that the following would be useful approaches:

1. **Oversight:** discuss and share at Board level where the current strengths, weaknesses and future opportunities and threats may lie for the Alliance.
4. **Support:** identify areas of weakness and opportunity where resources could be deployed to support improvements with generalizable lessons reported back.

9.7 The members were optimistic that the following approaches would follow once the clinicians become engaged:

2. **Assess:** reporting of risk adjusted outcomes that are significantly better or worse than statistical neighbours

3. **Monitor:** routinely consider in the same format the movement of risk adjusted outcomes over an agreed period.

10.0 Strategy Oversight and Assurance Group:

10.1 CK advised that this item had been covered throughout the meeting.

11 Any Other Business

11.1 **Alliance Plan**: CF advised that it was still not known what the Alliance budget would be for 19/20 but NHSE have advised that we may know by the end of January.

11.2 Indications are that the Alliance will be required to submit a plan by the end of February and as the next meeting of the Board isn't until March, CF asked for volunteers to shape this. SHu, RH & JH all volunteered to assist. CF also invited PV & MF to help.

11.3 Clive Kay: Shu thanked CK for his leadership and chairmanship to the Alliance Board, wishing him every success for the future and members also passed on their best wishes.

12 Date & Time of Next Meeting:
Wednesday 20th March 2019, 14:30 – 17:00.

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West Yorkshire and Harrogate Cancer Alliance

NHS

West Yorkshire & Harrogate Cancer Alliance

Board Meeting

Wednesday 20th March 2019, 14:30 – 17:00hrs

Sandal Rugby Club, Standbridge Lane, Milnthorpe Green, Wakefield, WF2 7DY

AGENDA

No	Item	Lead	Action Required	Time
1.	**Welcome, Introductions & Apologies**	Amanda Bloor	Information	14:30
2.	**Declarations of Interest**	Amanda Bloor	Update	
3.	**Minutes of Meeting held on 23rd January 2019** (Appendix 1)	Amanda Bloor	Information/ Review	14:35
4.	**Actions/Matters Arising** (Appendices 2 & 3) • Review of Highlight Reports & Risk Register	Amanda Bloor	Information/ Review	14:45
5.	**Cancer Waiting Times Update/Dashboard** (Appendix 4)	Carol Ferguson/ Fiona Stephenson	Information/ Discussion	15:00
6.	**Delivery Plan – 19/20 Priorities** (Final version to follow)	Carol Ferguson	Information/ Discussion	15:20
7.	**Northern Cancer Alliances Collaboration to Deliver the Long Term Plan**	Carol Ferguson	Information/ Discussion	15:40
8.	**Clinical Networking to Drive Improvements in Cancer Outcomes** (Appendix 5)	Fiona Stephenson	Information/ Decision	15:50
9.	**Radiotherapy Operational Delivery Network Development** (Appendix 6)	Carol Ferguson	Information/ Decision	16:15
10.	**Tacking Lung Cancer** (Appendix 7)	Sean Duffy	Information/ Decision	16:30
11.	**SOAG Reporting** (14.02.19)	Amanda Bloor	Information/ Discussion	16:45
12.	**Any Other Business**	Amanda Bloor	Information/ Update	16:50
13.	**Date & Time of Next Meeting:** Wednesday 8th May 2019, 14:00 – 16:30	Amanda Bloor	Information	17:00

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 0113 37 88666

Report of Head of Governance and Scrutiny Support

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 8 April 2019

Subject: Work Programme

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report provides an opportunity for members of the West Yorkshire Joint Health Overview and Scrutiny Committee to consider and agree the priorities for developing its future work programme.

Recommendation

2. The West Yorkshire Joint Health Overview and Scrutiny Committee is asked to note the overall matters set out in this report and associated appendices and agree (or amend):

   a) The JHOSC's proposed future work programme, presented at Appendix 1.
   b) Any next steps associated with the review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy.

1.0 Purpose

1.1 This report provides an opportunity for members of the West Yorkshire Joint Health Overview and Scrutiny Committee to consider and agree its priorities and future work programme.

2.0 Background information

The West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC)

2.1 The JHOSC was originally established in December 2015; drawing its membership from the five constituent West Yorkshire local authorities.

2.2 At its meeting in July 2018, the JHOSC requested that officers proceed to review the current arrangements and develop proposals for the future operation of the JHOSC. Appropriate officers from each of the six local authorities1 within the West Yorkshire and Harrogate Health and Care Partnership footprint continue to contribute to the development of future arrangements.

2.3 Until such time that any future arrangements are in place, work continues to support the current joint scrutiny arrangements and to develop the future work programme for the JHOSC.

Summary of previous work programme discussions

2.4 Since the formal establishment of the JHOSC, a number of issues / work streams have been considered by the Joint Committee, including:

- The Urgent and Emergency Care Vanguard
- Work of the West Yorkshire Association of Acute Trusts
- Cancer waiting times
- Autism assessments
- Stroke Services
- Access to dental service
- Specialised services

2.5 In noting that some of the above areas form part of the agreed priority areas and programmes of the West Yorkshire and Harrogate Health and Care Partnership (the Partnership); the JHOSC previously concluded its future work programme should be developed to reflect the nine clinically based programme / priority areas of the Partnership.

2.6 The JHOSC also agreed that in considering the Partnership's nine clinically based programme / priority areas, the JHOSC would seek to consider how the work meets and/or supports the following agreed aims and criteria for working jointly across the Partnership:

- To achieve a critical mass beyond local population level to achieve the best outcomes;
- To share best practice and reduce variation; and

[1] This refers to the six top-tier authorities across West Yorkshire and Harrogate with specific Health scrutiny functions/ powers.

- To achieve better outcomes for people overall by tackling 'wicked issues' (i.e., complex, intractable problems).

2.7 The Partnership priority areas and programmes also includes a number of areas described as 'enablers', alongside a number of collaborative forums. At its meeting in December 2018, the JHOSC agreed that future reports on the Partnership's nine clinically based programme / priority areas, should specifically seek to convey:

- How relevant 'enablers' are contributing / supporting the specific clinically based programme/ priority under consideration; and,
- The role, arrangements and contribution of any relevant collaborative forum.

2.8 At its meeting in December 2018, the JHOSC also agreed the following guiding principles for the ongoing development of its work programme.

Good Practice

- Avoid duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue.
- Ensure any Scrutiny activity has clarity and focus of purpose; adding value within an agreed time frame.
- Avoid pure "information items" except where that information is being received as part of an identified policy/scrutiny review.
- Seek advice about available resources and relevant timings, taking into consideration the overall workload of the JHOSC and the Health Overview and Scrutiny Committees across the constituent authorities.
- Build in sufficient flexibility to enable the consideration of urgent matters that may arise during the year.
- Have due regard for the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, which provides for local NHS bodies to consult with the appropriate health scrutiny committee where they have under consideration any proposed substantial developments or variations in the provisions of the health service in the area(s) of a local authority; alongside the associated good practice regarding the early engagement of appropriate health scrutiny committees.

3.0 Main Issues

Developing the work programme

3.1 In considering additional items/ areas for inclusion on the work programme, the JHOSC previously agreed it would consider how such matters meet and/or support the agreed aims and criteria for working jointly across the Partnership, namely:

- To achieve a critical mass beyond local population level to achieve the best outcomes;
- To share best practice and reduce variation; and
- To achieve better outcomes for people overall by tackling 'wicked issues' (i.e., complex, intractable problems).

3.2 The JHOSC has previously recognised that in developing its work programme, it would remain necessary for the JHOSC to consider the scope of the agreed areas / topics it wishes to consider, alongside the overall level of resource available to support its work.

3.3 The proposed work programme for JHOSC is attached at Appendix 1 for consideration and agreement.

Review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy

3.4 At its meeting in February 2019 the JHOSC agreed terms of reference for the review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy.

3.5 A further planning meeting for members of the JHOSC is scheduled for 3 April 2019 and the outcome / suggested plans arising from that meeting will be reported to the JHOSC.

3.6 The JHOSC will be asked to consider any update provided at the meeting and agree any next steps.

4.0 Recommendations

4.1 The West Yorkshire Joint Health Overview and Scrutiny Committee is asked to note the overall matters set out in this report and associated appendices and agree (or amend):

c) The JHOSC's proposed future work programme, presented at Appendix 1.
d) Any next steps associated with the review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy.

5.0 Background documents[2]

5.1 None

[2] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

APPENDIX 1

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2018/19 Municipal Year (Draft)

July 2018	August 2018	October 2018	November 2018
Meeting Agenda for 30/07/18 at 1.30 pm.	**No meeting**	**Meeting Agenda for 8/10/18 at 1.30 pm.**	**No meeting**
<u>Governance Matters</u> • JHOSC Governance arrangements • Integrated Care System (ICS) Update • West Yorkshire and Harrogate Health and Care Partnership – Next Steps <u>Programme Matters (WY&H)</u> • Specialised Stroke Care Programme <u>Other Matters</u> • Access to Dentistry		<u>Governance Matters</u> • Draft Partnership Memorandum of Understanding <u>Programme Matters (WY&H)</u> • Specialised Stroke Care Programme <u>Other Matters</u> • Financial Challenges	
Working Group / Development Session			

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2018/19 Municipal Year (Draft)

December 2018	January 2019	February 2019	March 2019
Meeting Agenda for 5/12/18 at 10:30am	**No meeting**	**Meeting Agenda for 11/02/19 at 10:30am**	**No meeting**
<u>Programme Matters (WY&H)</u> • Acute Care Collaboration <u>Programme Matters (Enabling)</u> • Workforce challenges		<u>Programme Matters (National)</u> • Urgent and Emergency Care • Mental Health <u>Programme Matters (WY&H)</u> • None <u>Other Matters</u> • Specialised Services – Vascular Services Proposals	
Working Group / Development Session			
	• 21 January 2019 – Informal briefing regarding Vascular Services proposals. • 23 January 2019 – Initial discussion regarding the proposed scrutiny review of WY&H Workforce Matters (Meeting 1)		

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2018/19 Municipal Year (Draft)

April 2019	May 2019	Unscheduled
Meeting Agenda for 8/4/2019 at 10:30am	**No meeting scheduled**	
<u>Programme Matters (National)</u> • Cancer <u>Programme Matters (WY&H)</u> • None <u>Other Matters</u> • Access to Dentistry – update		<u>Programme Matters (National)</u> • None <u>Programme Matters (WY&H)</u> • Prevention at Scale – timing to be confirmed. • Acute Care Collaboration – timing and focus of update to be confirmed. <u>Other Matters</u> • Partnership Risks – reporting principal and timings to be confirmed • Scrutiny review of WY&H Workforce Matters (Working Group report) – date TBC
Working Group / Development Session		
• Scrutiny review of WY&H Workforce Matters (Meeting 2; planning) – 2 April 2019		• NHS Long Term Plan – date TBC. • Scrutiny review of WY&H Workforce Matters (Meeting 3; evidence gathering) – date TBC • Scrutiny review of WY&H Workforce Matters (Meeting 4; draft report) – date TBC

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2019/20 Municipal Year (Draft)

June 2019	July 2019	August 2019	September 2019
Meeting date TBC	**Meeting date TBC**	**No meeting scheduled**	**Meeting date TBC**
<u>Governance Matters</u> • New Municipal Year arrangements <u>Programme Matters (National)</u> • Primary & Community Care <u>Programme Matters (WY&H)</u> • Standardisation of Commissioning <u>Other Matters</u> • TBC	<u>Programme Matters (National)</u> • Maternity <u>Programme Matters (WY&H)</u> • Specialised Stroke Care Programme – update <u>Other Matters</u> • Specialised Services Update		<u>Programme Matters (National)</u> • TBC <u>Programme Matters (WY&H)</u> • TBC <u>Other Matters</u> • TBC
Working Group / Development Session			

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2019/20 Municipal Year (Draft)

October 2019	November 2019	December 2019	January 2020
No meeting scheduled	**Meeting date TBC**	**No meeting scheduled**	**Meeting date TBC**
	Programme Matters (National) • TBC Programme Matters (WY&H) • TBC Other Matters • TBC	•	Programme Matters (National) • TBC Programme Matters (WY&H) • TBC Other Matters • TBC
Working Group / Development Session			

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
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WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2019/20 Municipal Year (Draft)

February 2020	March 2020	April 2020	Unscheduled
No meeting scheduled	**Meeting date TBC**	**No meeting scheduled**	
	Programme Matters (National) • TBC Programme Matters (WY&H) • TBC Other Matters • TBC		
Working Group / Development Session	**Working Group / Development Session**	**Working Group / Development Session**	**Working Group / Development Session**

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response