

Title of meeting:	West Yorkshire Association of Acute Trusts – Committee in Common (CiC) Meeting				Agenda Item:	
Date of Meeting:	January 2024				Section:	
					Public	
Paper Title:	Non-Surgical Oncology (NSO) – Programme Update				Private	x
					N/A	
Purpose (this paper is for):	Decision		Discussion		Assurance	x
					Information	x
Report Author and Job Title:	Angie Craig – Programme Director NSO - WY&H Cancer Alliance					
Recommendations:						
<p>It is recommended that the West Yorkshire Association of Acute Trusts notes:</p> <ul style="list-style-type: none"> • The progression of the implementation model for NSO, as previously shared and agreed with the CiC. • The scheduled update being provided to the West Yorkshire Joint Health and Overview Scrutiny Committee, via the Director of Strategy and Partnerships, Ian Holmes. This paper will be shared with that forum. • The proposal to continue implementation processes for the model in West Yorkshire alongside consideration of the tests for service reconfiguration; discussions with NHS England; and regional collaborative work operating across the North East and Yorkshire footprint. • That the Cancer Alliance proposes to continue implementation funding as part of its allocation of service development funding for 24/25, subject to the formal agreement of the WY&H Cancer Alliance Board, ICB, and NHSE. 						
Executive Summary:						
<p>The paper describes the development and design process for non-surgical oncology in the form to be presented as the update paper to the JHOSC.</p> <p><u>This covers:</u></p> <ol style="list-style-type: none"> 1 The governance, decision-making, and scope arrangements for the programme. 2 The context and approach for a review of these services in West Yorkshire including the impact on the population affected; and arrangements for maintaining service sustainability during the review itself. 3 The case for change, co-designed with patient input. 4 Creating a clinical vision. 5 Creating a model of care. 6 Developing the options for change and a preferred new model. 						

- 7 Summary of the use of clinical, patient, and public engagement processes to establish **resonance and sentiment** to the proposals for improvement of the service, based on the new model.
- 8 The improvement and refinement of the **new model** based on engagement outcomes.
- 9 Our assessment if the engagement outcomes cause the new model to need to be **substantively reconsidered** or refined through co-designed implementation processes.

The paper indicates support for proceeding with the current preferred option, as agreed by the Committee in Common. The paper indicates that, subject to engagement outcomes from phase 2, it is likely that these arrangements will be satisfactory to demonstrate patient and public co-design and improvement of the proposals set out. This builds on the excellent staff and clinical work which has already occurred, and continues, through the Targeted Operating Model workstreams.

Outline of engagement activity – public/patient, clinical, stakeholder	Details are contained in the substantive paper and in the supporting appendices.
Risk Assessment:	The headline risks for service sustainability, quality, and delivery of effective change are reported through to the ICB Board via the board assurance framework. Implementation of the model acts as a mitigation to these risks.
Finance/ resource implications:	Funding will be required to continue implementation of the programme in 24/25. Implementation funding is proposed to be continued via service development funding provided to the WY&H Cancer Alliance.

Introduction

The West Yorkshire non-surgical oncology (NSO) model relates to the six trusts in the West Yorkshire Association of Acute Trusts and their respective catchment populations. These areas include Airedale, Calderdale, Leeds, Kirklees, Bradford District and Craven, and Harrogate and District. The relevant catchment populations are approximately 2.5 million people¹. This is the population to be considered in scope.

Five of these six trusts are co-terminus with the boundaries of the NHS West Yorkshire Integrated Care Board whilst the sixth, Harrogate and District NHS Foundation Trust has a population which is managed by the NHS Humber and North Yorkshire Integrated Care Board.

This paper describes:

- 10 The **governance, decision-making, and scope** arrangements for the programme.
- 11 The **context** and approach for a review of these services in West Yorkshire including the impact on the population affected; and arrangements for maintaining service sustainability during the review itself.
- 12 The **case for change**, co-designed with patient input.
- 13 Creating a **clinical vision**.
- 14 Creating a **model of care**.
- 15 Developing the options for change and a **preferred new model**.
- 16 Summary of the use of clinical, patient, and public engagement processes to establish **resonance and sentiment** to the proposals for improvement of the service, based on the new model.
- 17 The improvement and refinement of the **new model** based on engagement outcomes.
- 18 Our assessment if the engagement outcomes cause the new model to need to be **substantively reconsidered** or refined through co-designed implementation processes.

¹ Office for National Statistics, UK Census data

1 Governance, Decision-Making, and Scope:

Governance:

The NHS West Yorkshire and NHS Humber and North Yorkshire Integrated Care Systems determine the arrangements for these services.

It has been agreed that the NHS West Yorkshire Integrated Care System lead on the process and outcomes notified to the NHS Humber and North Yorkshire Integrated Care System, through the full engagement and inclusion of stakeholders from Harrogate and District throughout.

The NHS West Yorkshire Integrated Care System discharges its decision-making functions through a Transformation Committee, which acts as a sub-group of the full Board. The Transformation Committee has been formally established by the Board and is chaired by a Non-Executive Director. The Transformation Committee comprises representation from each constituent Place in West Yorkshire and other relevant representatives of the West Yorkshire Health and Care Partnership, using an agreed decision-making model.

The Transformation Committee discharges its functions based on the recommendations agreed by the Committee in Common of the West Yorkshire Association of Acute Trusts (WYAAT); its operative sub-groups; and the opinions of the West Yorkshire and Harrogate Cancer Alliance Board. All these forums are in support of the direction of travel indicated in the NSO review, as outlined in this paper.

The Transformation Committee has been appraised of progress with the review and has supported the direction of travel indicated. It has also guided the service review to presentation at the Quality Committee and ICB Clinical and Professional Forum, which has again been supportive.

The West Yorkshire ICS Transformation Committee shall be responsible for taking a decision on the service review relating to section 14z2 of the Health and Social Care Act 2022 (as amended) from previous legislation.

The NSO service review requirement was notified to the Joint Health and Overview Scrutiny Committee in 2021, who will act in that function relating to this review. The notification was initially made by Mid Yorkshire Teaching Hospitals NHS Trust, until the review arrangements were adopted as indicated in the paper.

The provisions of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations) 2013 apply to the service review. The provisions of the Health and Social Care Act 2022 relating to the role of the Secretary of State for Health and Social Care have not been advised to the responsible commissioning authority as applying to this service review. The ICS will be notified of any further necessary arrangements for conducting the regulation functions.

Programme development:

The programme was commissioned by the West Yorkshire Association of Acute Trusts (WYAAT), with the agreement of the commissioning authority. WYAAT requested for the West Yorkshire and Harrogate Cancer Alliance to be the delivery agent for the review.

The Cancer Alliance is a non-statutory NHS body led by two Senior Responsible Owners (SROs), a Managing Director and a Clinical Director. The Cancer Alliance employed a Programme Director, Angie Craig, to develop the review following initial work from a project manager, external consultant, and the Managing Director. Angie Craig has developed a clinical and project support team and the costs of the review have been met by the Cancer Alliance. They have led decisions as to scope in reference to the decision-making infrastructure.

The Cancer Alliance is governed by a Board, chaired by the SROs. The Board has lay representation at the heart of its decision-making. The Cancer Alliance has more than twenty sub-clinical forums to ensure that its work, priority setting, and decision-making is clinically led. The Cancer Alliance has also assured full internal and external clinical leadership of the programme; arrangements for co-production and design of the proposals from formative stage; and relevant engagement processes with NHS England.

Linked to the proposals, a quality impact assessment has been developed; an equalities analysis is being refreshed linked to phase 2 engagement outcomes; financial modelling and impact activities are ongoing; travel and access modelling has taken place, demonstrating a positive impact on sustainability. The proposals are also consistent with established mechanisms for data sharing agreements.

In Scope

- The NSO model generally refers to the management of patients receiving systemic anti-cancer treatment (SACT) and most commonly chemotherapy, again most delivered either intravenously (through a vein), or orally.
- The model refers to both adult and paediatric patients, however, only the service for adult patients has been under review. Adult patients are defined as those aged 25 or over, or, alternatively, those aged between 16 and 25 who choose to have their care delivered in an adult setting. Most users of the service are aged 50 and above, reflecting the age-distribution curve for cancer service.
- 70% of these patients have been diagnosed with a cancer of common incidence. Cancers of common incidence are breast, bowel, lung, and prostate cancer. Breast cancer is the most common cancer affecting female patients; prostate cancer is the most common cancer affecting male patients. Activity data shows that 20,000 treatments are provided to patients in West Yorkshire each year.
- The model also refers to the management of patients who use acute oncology services. Acute oncology services were established as part of the NHS Improving Outcomes Guidance (IOG) and are concerned with ensuring the safe and effective management of patients who experience toxicities associated with cancer treatment or are managing complications associated with the progression of the underlying disease.
- Acute oncology is also concerned with the management of patients who present with suspected, or confirmed, cancer symptoms through emergency care. All hospitals with an accident and emergency department in West Yorkshire have a safe and compliant service to manage acute oncology and this will continue with the NSO model.

- SACT and acute oncology are in-scope of the review within these terms.

Out of scope

- The Leeds Cancer Centre provides some specialist services to patients outside of the West Yorkshire and Harrogate boundary areas however, these arrangements are not affected by the changes agreed to the NSO model. Some of these services are provided on a national basis. Surgical oncology is also out of scope, directly.
- Radiotherapy services, as commissioned by NHS England, are also not directly affected by the changes agreed to the NSO model. Improvements to the access and infrastructure of radiotherapy services locally are being developed by Leeds Cancer Centre, working in conjunction with the Yorkshire and Humber Operational Delivery Network (ODN) and Yorkshire and Humber Strategic Collaborative Commissioning Committee.
- A regional group, operating at NHS North-East and Yorkshire level, meets to consider improvements to NSO services which have joint applicability to each of the four constituent systems within its boundaries. None of these proposed improvements have implications for where and how services are provided. Instead, they comprise of functions where there is a shared focus in collaboration, such as encouraging workforce innovation and international recruitment; developing shared protocols; and engaging in capacity and demand modelling.
- The NSO model principally refers to patients with solid tumour cancers, meaning that haemato-oncology services are also considered to be formally out of scope and not directly affected by the model. Haemato-oncology will be considered in conjunction with a fragile service review of haematology services, and it is recognised that the arrangements for these services will continue to need to take account of provisions made in NSO.
- Provisions for supportive and palliative care are not affected by the proposals. It remains recognised that access to timely, comprehensive, supportive, and palliative care provision is vital. The ICB has supported national consultation work to increase funding for palliative care, whilst the Cancer Alliance has supported work focussing on service improvement, including referral pathways and common standards of care frameworks for patients needing support.

Demographic of the population in scope

- All users of the service are considered to meet the legal definition of having a disability, as cancer is a long-term illness or condition expected to last for twelve months or more. With respect to the application of other protected characteristics under the Equality Act, a person could have a cancer diagnosis and have one or more other protected characteristics. There is no evidence that most people with protected characteristics other than age and disability are more likely to experience a cancer diagnosis than the underlying population.

- Therefore, cancer prevalence is not usually considered to be more commonly associated with incidence of protected characteristics, other than advanced age and the direct implication of disability status arising from the condition itself.
- However, outcomes from cancer continue to be poorer in lower socio-economic groups. This includes the disproportionately high number of persons from a minority ethnic background who are from a low (Index of Multiple Deprivation 1-4) socio-economic group within the catchment population. This is partly because of awareness of cancer signs and symptoms – impacting on early presentation rates; participation in cancer screening programmes; and poverty associated factors, such as not being able, aware, or supported to, eat healthily.
- The proposals are positive, overall, for the protected characteristics of age, and disability and for persons who are affected by lower socio-economic status and their associated characteristics. The impacts are otherwise neutral. The positive effects are because, overall, the NSO model delivers more care closer to home and has features which intend to reduce prevailing health inequalities, such as creating more equitable access to clinical trials; more locally defined treatment options (such as mobile units for chemotherapy treatment); and improved resilience for acute oncology services which are more likely to be used by patients who present as an emergency.
- Other provisions being developed by the Cancer Alliance have reciprocal benefit for these communities including targeted screening awareness campaigns and access programmes for minority groups, such as targeted lung health checks; challenging misconceptions and stigma associated with cancer screening – for example amongst the transgender community. They have benefits for the users of NSO services.
- Where, by exception, there is a change of service location which is further away, for example very complex medical oncology inpatient care which needs to be directly overseen by a consultant-level oncologist, the impact of this has been mitigated by making provisions for supported transfers between institutions (typically via ambulance for patient safety) and by exploring dispensatory travel cost schemes, either via the West Yorkshire Combined Authority; a charitable grant system through Macmillan Cancer Support; or by existing schemes to remunerate travel costs for patients and their families – i.e., car parking provisions. Travel and cost analysis has taken place.
- More details about the demographics affected by the NSO model can be found in the NHS West Yorkshire Equality, Diversity, and Inclusion Report² which has been used as part of the analysis of equalities factors.
- The model makes a positive contribution to sustainability by reducing unnecessary travel journeys for patients, carers, and others using NSO services. This includes ensuring that most of the acute oncology care continues to remain provided in the local hospital of the patient concerned.

2 Context

Incidence of cancer

Cancer is a major population health challenge in West Yorkshire, with an estimated one in two people expected to develop the condition at some stage of their lifetimes.

The incidence of cancer is expected to rise associated with increases in life expectancy and as a residual feature of premature mortality events. The impact of cancer in West Yorkshire is strongly associated with a national picture and indeed the burden of cancer is considered a worldwide health challenge, particularly in middle to high income countries.

Cancer referrals

In the last ten years, the number of patients referred by the GP for an urgent suspected cancer referral has more than doubled, a rate of growth exceeding the underlying rate of increased headline demand by some margin. Every week, 250 people in West Yorkshire and Harrogate are diagnosed with cancer.

Of these cases, around four out of every ten could be avoided by changes to lifestyle including stopping smoking; maintaining a healthy weight and physical exercise; adopting safe approaches to sun-care; avoiding substance misuse; and taking action to improve air quality.³ 115 people die each week because of the condition in West Yorkshire. Cancer causes one in four of all deaths and is expected to cause death in more than 200,000 cases per annum by 2038-40, compared to 167,000 cases now.

Early diagnosis rates

Rates of early diagnosis have improved in West Yorkshire to approximately 56%⁴ and some improvement programmes, like targeted lung health checks, have disproportionately benefitted populations experiencing health inequalities⁵. However, there is much more work to be done to meet the ambition set out in the NHS Long-Term Plan, which is that three out of every four cases of cancer diagnosed will be at stages one and two by 2028.

The ICB Joint Forward Plan has identified an initial goal of 62% as a stepping-stone to this level of achievement and the Cancer Alliance coordinates with all partners on developing an Early Diagnosis plan, operative across the system. Cancers detected at stages one and two are associated with a higher probability of receiving active treatment intervention, with favourable impacts for the prognosis and outcomes of the person concerned.

Improving early diagnosis

³ Cancer Research UK

⁴ Rapid Registration Dataset, published by NHS England.

⁵ NHS England National Cancer Programme

To achieve this goal, all partners are involved in delivering a range of interventions seeking to promote healthier lifestyle choices and improved population health awareness and early presentation; encourage adoption and uptake of the national cancer screening programmes (bowel, breast, and cervical); deliver population-wide rollout of targeted screening approaches for lung cancer; trial targeted screening opportunities for cancer including of the kidney, prostate, and multi-cancer early detection tests (MCED) such as the NHS Galleri (GRAIL) trial. These initiatives are being matched with investments in the diagnostic infrastructure, such as the role of community diagnostic centres (CDCs) and a range of plans to promote the necessary investment in workforce, as described in the NHS Workforce Plan⁶

Cancer survival

Cancer survival in the UK has also improved and has doubled over the last 50 years, associated with the development of new treatments and technologies. Half (50%) of people diagnosed with cancer in England and Wales survive their disease for ten years or more (2010-11). However, cancer survival is higher in women than men and the five-year relative survival for cancer for both men and women remain below the European average in England, Wales, and Scotland⁷.

Modalities of cancer treatment

UK Government data⁸ shows that for cancers diagnosed between 2013 and 2016 in England, of those receiving at least one of the main treatment types (surgery, chemotherapy, or radiotherapy), 28% were treated with chemotherapy, 27% with radiotherapy and 45% with surgery, with some cancers receiving a combination. A third of diagnoses had no record of receiving any of these most common treatment types.

For cancers diagnosed between 2013 and 2016 in England, 39% were treated with one of chemotherapy, radiotherapy, or surgery, 22% were treated with two of these, and 7% with a combination of all three. For cancers diagnosed at a later stage, chemotherapy was used more commonly than for early-stage diagnoses; less surgery was used for later-stage diagnoses. Cancers diagnosed in younger patients are more likely to be treated than those diagnosed in older patients. For example, 76% of cancers in patients aged under 50 are treated with surgery, compared to 23% of cancers in patients aged 80 or over.

Growing use of NSO (and SACT)

Associated with the above, the use of SACT treatments can occur in multiple lines, or episodes, or treatment, associated with the care of the same patient. Sometimes these occur successively, or over the course of several years. This means that as the incidence, impact, and prognostic indicators of cancer change favourably, including the extension of early diagnosis to more patients with survivability benefit, the expected demand curve for NSO is similarly projected to increase significantly over the next 20 to 30 years.

How patients access NSO services

⁶ <https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/>

⁷ Cancer Research UK

⁸ <https://www.gov.uk/government/statistics/chemotherapy-radiotherapy-and-surgical-tumour-resections-in-england/chemotherapy-radiotherapy-and-surgical-tumour-resections-in-england>

Patients can enter cancer services via several different routes, and this impacts on how they initially interact with NSO services, following diagnosis and agreement of the respective treatment option/s. This is managed via a multi-disciplinary team (MDT) comprising of a range of specialists involved in cancer care diagnosis, assessment, management, and treatment. Most patients enter a cancer diagnostic pathway through a referral made by a GP under what is the faster diagnosis standard (FDS).

FDS means that at least three quarters of patients should either be confirmed with cancer, or be excluded from the cancer pathway, within 28 days of the date of referral. This standard is usually met within West Yorkshire. This accounts for 40% of referrals⁹. GP referrals for other reasons, where a cancer is detected incidentally, account for 21% of referrals. 18% of cancers are detected via emergency presentation; whilst the residual is split between screening, inpatient elective, and other outpatient referral streams.

Referrals from screening are highest in those specialties with a national screening programme, with emergency presentation rates highest in typically more aggressive cancers, such as malignancies of the brain and central nervous system; and where survival prospects are typically lower – for example liver and pancreatic malignancies.

Overall, for patients diagnosed with cancer, irrespective of the means of presentation, the first definitive treatment should commence within 62 days (two months). This period allows for tests, investigations, personalised care planning and patient choice. The NHS Constitution standard is set at 85%, which is not being met across the United Kingdom at present. Treatment should also be commenced within 31 days of the date of decision to treat, and this standard is usually met, particularly in the case of treatments classified in scope of the review.

Cancer patient support

For patients diagnosed with cancer, they have access to a key worker to support and coordinate the care they need. This is supported by a holistic needs assessment (HNA). Patients also receive tailored support and advice around how to manage chemotherapy, including advice and a single support hot-line number if they are feeling unwell, or need support.

This hotline is available 24/7/365 and is equitably provided by the constituent hospital services across West Yorkshire. Patients should also receive a personalised care support plan and cancer care reviews, supported by their GPs. They also require timely and comprehensive access to palliative and supportive care, where needed.

NSO service set-up

In the context of rising demand and complexity of care associated with NSO, West Yorkshire remains unusual nationally in the way that its medical oncology non-surgical oncology (NSO) services are delivered. The most recent significant change to NSO services in West Yorkshire occurred more than twenty years ago.

Across West Yorkshire, NSO is provided through local Cancer Units (5), each with its own resident medical oncologists, alongside a specialist Cancer Centre (1), delivering care for rarer cancers and specialist treatments such as radiotherapy.

⁹ Routes to Diagnosis, 2018, National Cancer Registration Dataset.

Elsewhere in the country, a “hub and spoke” model is more usual, where medical oncology is provided as a visiting service from the Cancer Centre. All hospitals with an accident and emergency department have an acute oncology service.

Challenges in delivering NSO – Prevalence

Over time, since the introduction of the West Yorkshire model, the delivery of NSO services has become significantly more challenging. As has been stated, the growth in the prevalence of cancer, increases in early diagnosis and more options for the type and amount of treatment now available has significantly raised the demand for NSO services and outstripped the growth in the medical oncology workforce, regularly creating capacity and resilience risks within the system.

Challenges in NSO service delivery – new treatments

This growth has also included new indications for treatment from NICE appraisals and the wider / more routine use of immunotherapies. The positive impacts of new, combination and extended treatments, whilst hugely positive for patients, have an associated impact on the workforce required to diagnose, prescribe, and manage the care of the greater number of people undergoing care for their cancer.

Challenges in NSO service delivery – national workforce deficits

Medical and clinical oncology is recognised as a significant workforce deficit area,¹⁰ particularly at qualified consultant oncologist level. The workforce demographic is also ageing and disproportionately featured of clinicians who are within ten years of their scheduled age of retirement. This means that, nationally, the number of consultant oncologist vacancies is expected to near treble by the end of the decade.

The distribution of the deficit is inequitably spread across most of the regions of England except for London, due to the higher concentration of Cancer Centres in the capital and the resulting higher ratio of consultant oncologists to head of population and cancer incidence rates as a result. Specifically, workforce census data shows that workforce challenges are sharpest across most of the North of England, the Midlands Region and the South-West of England.

Challenges in NSO service delivery - mitigations

The different model of care for services in West Yorkshire may have made the system more vulnerable to these supply and workforce sustainability issues, however, the strong culture of mutual aid, provider collaboration has been hugely beneficial in working to address and mitigate current issues.

The frequency of on-call working in smaller services has created a further recruitment disadvantage, given that comparative structures in neighbouring geographies see centralised recruitment to cancer centres, giving more attractive working conditions for some oncologists.

As mitigations, systems, including this one, have been developing non-medical consultant roles, such as consultant nursing and pharmacist opportunities, and seeking to increase supply by considering international routes; reviewing retention packages; reviewing the opportunities to provide more favourable and equitable on-call arrangements; improving job plans; and by

¹⁰ Royal College of Radiologists

encouraging a growth in the number of training places for medical oncology commissioned via the training deaneries.

3 Summary of the Case for Change

The issues in West Yorkshire were brought into sharp focus with the immediate, and now ongoing challenges, faced in recruiting substantive, local, medical oncologists to provide NSO services in Mid Yorkshire Teaching Hospitals NHS Trust. These were first brought into acute focus in 2021. Principally, the case for change in NSO is that the unavoidable growth in demand from demographic factors, matched with sustained workforce deficits at consultant level means that the model in place before 2021 is not clinically viable to proceed with. This caused the need to review the service.

Since the onset of the service review in that year, and following notification of the challenges to the commissioners, acute provider collaborative and the overview and scrutiny committee, these challenges have persisted. A complex, open-minded, and broad-based programme of service review and improvement has occurred, whilst the immediate sustainability concerns were addressed at the same time. In essence, the continued workforce supply deficit, contextualised in the exponentially growing demand requirement, has created the case for change for NSO, and the context of the service review.

Maintaining sustainability

During the review, and ongoing, providing sustainability at Mid Yorkshire and other trusts across the system has required significant support with locum staff; new ways of working; and mutual aid from Leeds Teaching Hospitals NHS Trust (LTHT), Calderdale and Huddersfield NHS Foundation Trust (CHFT), and wider, to address the shortfall of seven oncologists.

Some of this support has now been in place for a significant number of years, as part of an interim solution agreed at the start of the NSO review process (2021). The context of the requirement for mutual support was presented to WYAAT, the West Yorkshire Health and Care Partnership Executive Leadership team, and the Joint Health Overview and Scrutiny Committee (JHOSC) at the time, with an updated position since.

Case for Change - why no change was not an option at the time and remains the case now?

There is wide acknowledgement from senior clinicians, patient representatives, and corporate leaders that without service transformation, present risks for patients in the delivery of their face-to-face care locally would continue and the Mid Yorkshire Teaching NHS Trust (MYTT) staff would struggle to deal with multiple ways of working alongside the uncertainties created by high levels of locum staff.

From the point in time when the service review was initially commissioned, in 2021, these factors have persisted and no significant, sustainable improvement in workforce supply has

materialised to enable the *status quo ante* provision to be restored, in its exact form. Some of the challenges are referenced below:

- Medical Oncologist recruitment across the six West Yorkshire Association of Acute Trusts (WYAAT) has not improved since the review and supply of clinical oncologists is also challenged. The national job market remains very constrained with an ongoing significant deficit predicted by the Royal College of Radiologists.
- Advertised roles to date – including for locum positions - in both Cancer Units and the Cancer Centre have not attracted suitable candidates, resulting in continued pressures across all services. All partners continue to work hard to retain trainees as they emerge from training and have had some success via our international recruitment efforts, although not at consultant level.
- With regards to the other roles involved in NSO care, there are still insufficient suitably qualified staff to meet current needs across the region, even before future requirements are considered. Currently, existing Advanced Nurse Practitioner (ACP) and Advanced / Consultant Pharmacy colleagues are moving for opportunities across the sector, but there is not yet any increase in the overall numbers of these vital groups of staff.
- Additionally, there are significant gaps and use of agency staff within the chemotherapy delivery workforce, including cost premia. We are working to develop potential solutions, increase training and the use of common frameworks via an NSO workforce group. This is linking with WYAAT wide HR and Nursing Directors work programmes and is utilising the ACCEND programme where appropriate.

In practical terms, without considering changes to the delivery model, the following adverse outcomes would be likely:

- **Inequitable waiting times** for patients requiring NSO services.
- **Shortfalls in the quality and efficacy of** specialist inpatient care delivered to patients experiencing either complications of SACT or their underlying disease.
- **Risk of service failure**, as has been seen in neighbouring systems - where no specialist medical provision remains to attend to patient needs.
- **Significantly diminished patient experience.**
- **Worsened health inequalities** and inequitable access based on geographical factors in West Yorkshire.

As evidence of the above, in some instances, mutual aid has also been required outside of the geographical boundaries of West Yorkshire – for example services in Hull, York and paediatric clinical oncology in Sheffield, whilst the review has been ongoing.

When these gaps in services have occurred, the system response has been to work together across West Yorkshire to agree the provision of temporary support arrangements. However, this reactive approach, and the fragility and often short-term nature of this support, has

required regular and significant senior operational input to ensure day to day risks for patients and staff are managed. The impact on current staff working additional sessions without a long-term plan also have a significant effect. It follows that a more sustainable model of care is necessary.

4 Creating a clinical vision

The Cancer Alliance deployed an adapted improvement methodology including a broad-based clinical and operational engagement approach across all six WYAAT Trusts with lay input from the outset, dedicated programme management and tight operational oversight. The Cancer Alliance has shared this improvement methodology with WYAAT to inform best practice in reviewing other fragile services.

The principles of appreciative inquiry were used to:

- Form a realistic appraisal of the problem-faced, based on a core clinical vision.
- Develop set of design principles, against which any redesign option would be assessed.
- Draw together local and external expert opinions.
- Design a suggested model of care.
- Ensure that engagement outcomes and key considerations from a patient perspective informed the review arrangements at this stage.

This approach was fostered by creating a Steering Group, which was formed of clinicians from across all six provider trusts and each constituent discipline involved in delivering NSO care. Patient representatives also formed part of the review and the development of the work proceeded on a consensus-based model.

This work of the Steering Group was supplemented by an external review, carried out by Professor Sir Mike Richards, former National Cancer Director. Due to the specialist nature of the service line, the Cancer Alliance agreed with WYAAT that this route for external review was advantageous and would permit the effective external scrutiny of services which can sometimes be provided alternatively by clinical senates. The external clinical review would also make recommendations against which the new model could be evaluated for completeness and benefits realised, once complete.

The Cancer Alliance also arranged for informal peer discussions about its proposals and emerging thinking with neighbouring Cancer Alliances in the North-East and Yorkshire Region.

5 Developing a model of care

The model of care identified from the external review suggested that:

- The problem statement, as developed by the programme, was broadly correct.
- A focus on delivering effective support arrangements for patients receiving NSO services was necessary, including wider considerations than consultant oncologist provision.
- Referral volumes to responsible medical oncologist consultants were inequitable, and there was a risk of further service failure. Workforce innovation was needed.
- Common systems were needed to manage care protocols and tasks such as electronic prescribing to support the safety and sustainability of revised arrangements.
- Arrangements should be considered around centralised employment provisions for consultant oncologists.
- A revised service model would need to allow supported access for patients into clinical trials.
- To deliver a more sustainable NSO model, arrangements for the provisions of complex acute oncology care, provided in an inpatient setting, would need to be reviewed and consolidated. This could allow for the development of care on a networked basis (in sector/s), and/or with the application of Tiers.

Specifically on this final point, the external review of services suggested that the system would need to see the retention and expansion of sustainable acute oncology services across the Cancer Alliance, but with medical oncologist led assessment in an inpatient environment concentrated in two provider trusts. This would be a reduction from the current four provider trusts where this care was provided in the *status quo*, and fewer than the model of five provider trusts in the *status quo ante* model.

As part of his review, Professor Richards incorporated into his terms of reference a discussion with each of the constituent provider trusts around which arrangements they considered might operate most effectively if this recommendation was proceeded with. This also created, in effect, a long list of options. However, all permutations of options which either reverted to the prevailing *status quo*, the *status quo ante* position, or any option which involved care being co-

located in three or more providers was discounted. The other options which were implicitly discounted were any variable including service reconfiguration of the Leeds Cancer Centre site and its provision, plus the creation of a new inpatient infrastructure for acute oncology on the sixth site (Harrogate).

In doing so, the review acknowledged that a fuller impact assessment would be needed for headline viability of each approach, and that amalgamation of these discussions with local clinical and other stakeholder opinions would be necessary in considering an agreed way forward.

Professor Richards also worked with patient representatives from the Steering Group to confirm that the priority, from a lay perspective, was to expand access to chemotherapy services locally, if necessary, in precedence to the role of acute oncology.

This was a key change in the design of the programme, which had previously focussed on the importance of the infrastructure for acute oncology. The recommendations from the review also identified several other key considerations for patients including travel and access; information signposting, access, and support; providing for the wider needs of patients beyond medical review; and ongoing engagement. The review of Professor Richards will be published alongside other programme engagement materials and outputs.

6 Developing and assessing the options for change

The Steering Group reviewed Professor Richards report to consider if, in principle, they agreed with how the available long-list of options had been developed. The Steering Group involved patient representation.

In summary, the Steering Group agreed that:

- Any option would need to be **consistent with the design principles**, to be viable.
- The Steering Group would **prefer to develop a preferred option** for change.
- The factors outlined in Professor Richards recommendations should be used to assess if an option could deliver the **wider service change** needed across NSO, including all identified components.
- Professor Richards indication of the views of provider trusts could be considered, but this was not directive, as it was **important to listen to the views of all stakeholders equally**.
- An option meeting each requirement in Professor Richards review would be considered viable and **more engagement around the design of any viable option/s would be needed**.
- The demarcation of options, specifically which trusts had an inpatient acute oncology service overseen directly by consultant oncologists was **the relevant differentiating factor**. Provision of local treatment for cancers of intermediate incidence was also a factor.
- The patient consideration of the **accessibility of chemotherapy and supportive services** should guide the development of any preferred option. Specifically, it was important that the preferred option **improved access to care overall; delivered more care closer to home; improved wrap-around support access for patients**; and considered strongly factors such as **travel, logistics, and patient choice** wherever possible.
- The NHS England service reconfiguration tests would also need to be applied to the scheme¹¹. Specifically, these tests are i) strong public and patient engagement; ii) consistency with current and prospective need for patient choice; iii) a clear clinical evidence base; and iv) support for proposals from clinical commissioners. The fifth test relating to reductions in inpatient bed base numbers would not apply to any option,

¹¹ [Effective service change toolkit FINAL.pdf \(eoesenate.nhs.uk\)](https://www.eoesenate.nhs.uk/effective-service-change-toolkit-final.pdf)

because the consideration was the staffing provision for an inpatient capacity unit, as opposed to the provision of a unit of inpatient capacity itself.

Long-list of options

Based on the above, the Steering Group concurred that:

- Professor Richards had developed a long list of options.
- Professor Richards' rationale for excluding any option as clinically viable which featured either three or more providers with care delivered by consultant medical oncologists in an inpatient setting was realistic and reasonable.
- This meant that the *status quo* option and *status quo ante* provision, from the long list were both not clinically viable. This meant that they could not be presented to stakeholders as representing a viable choice, however this decision-making would remain under review were the workforce availability and other considerations rendering them not to be viable to change during option development, engagement, and subsequent implementation.

Short-list of options:

Stage 1:

To develop a short-list of options, the NHS England service reconfiguration tests were applied and a series of additional assessments undertaken.

These assessments considered equally the potential site option for the second inpatient facility against the following:

- 1 **Infrastructure and affordability:** The established estate infrastructure to host the inpatient facility at that site, without incurring capital expenditure, which was not accessible to the programme as a revenue-only scheme, and therefore would directly fail the iv) support from clinical commissioners' test.
- 2 **Travel, logistics, and health inequalities:** The impact of changing existing flows to each provider, from the perspectives of patient travel; addressing health inequalities. Any option which created a net increase in patient travel time, overall, balancing acute oncology and chemotherapy (and outpatient) attendances would directly fail the ii) consistency with patient choice test
- 3 **Clinical support:** Maintaining access to the residual consultant workforce and willingness to support the change as a factor under iii) a clear clinical evidence base.
- 4 **Views from patients:** Patient engagement returns so far (reference the work so far on test i).

These assessments concluded that the only viable second inpatient base would be based at Calderdale and Huddersfield NHS Foundation Trust, with an option to deliver this capacity at either Huddersfield, or Halifax, depending on the outcome of wider reconfigurations at the site. Other options were discounted based on considerations of established estate infrastructure and maintaining access to the residual consultant workforce.

Stage 2

With the preferred site identified, and being limited to a single option, the second phase of short-listing considered how would the networked care model be established. This approach recognised that the “boundary lines” for where patients would be referred to Leeds or Calderdale in the eventuality of them requiring specialist inpatient acute oncology infrastructure could be developed in more than one way. This also included splitting the Trust catchment populations, which were excluded for patient safety reasons. The question here was to establish if more than one sub-variant was viable and if so, which sub-variant was preferable. The identification of sub-variants included development of networked care sector population sizes and prevailing levels of consultant level support for each tumour group.

The questions asked at this stage of assessment were as follows:

- **Clinical support:** Which option/s would be likely to have the most significant clinical support overall, recognising that any further reductions or fragilities established in the consultant oncologist provision would undermine the model as a whole?
- **Travel and Health Inequalities:** Which option/s would mitigate the risk of extended travel to the demographic group in West Yorkshire experiencing the most significant health inequalities, overall?
- **Adjacencies:** Which option/s would be consistent with the provision of infrastructure such as multi-disciplinary team structures; surgical oncology; and haemato-oncology, as essential adjacencies?

The programme team assessed that:

- An option which featured an organisational pairing between the clinical teams of Bradford and Calderdale was unlikely to be attractive, based on the stated expectations of each, and considerations around job plans, travel, and retention.
- An option involving a pairing between Bradford and Calderdale was also likely to lead to incidental changes to MDT arrangements and surgical oncology provision which were both out of scope, and further unlikely to attract stakeholder support, including from patients.
- An option which would involve extended travel for the population of the City of Bradford would unlikely be acceptable on the grounds of test iv) given that health outcomes for that population are worst and rates of emergency presentation are significant. Travel times and access routes appeared to be prohibitive, particularly in relative terms.

The programme team advanced this assessment to the Steering Group. The Steering Group concluded that the programme team assessment of the sub-variants was reasonable. Therefore, the short-list was reduced to one option. The shortlisted option was checked against the initial criteria/objectives set by Professor Richards and proceeded to be the preferred option on this basis.

The summary report profiling the development of this preferred option was submitted at the end of the year 2021/2022 and agreed by WYAAT leaders in April 2022. This process determined:

- That the inferences and assimilations drawn from Professor Richards' report were reasonable.
- That a series of options had been properly considered.
- That a preferred option should be developed for implementation purposes, subject to the need to ensure full consistency with engagement outcomes.

Specifically, the report was considered by the sub-committees of the WYAAT Committee in Common; the NSO Steering Group (now Delivery Group); the Cancer Alliance Programme Board; and the ICB Transformation Committee as the formal decision-making authority. For confirmation, the summary report aligned with the view of internal stakeholders that delivering no change was not viable as an option and therefore could not be presented for comparative purposes.

The Option Developed

The proposed West Yorkshire model is still unique nationally, however nuances the strong commitment to locally organised care delivery with the realities of needing to create sustainable workforce and care delivery models. The model operates on a two-sector networked care basis, with a division of the population between the North and the South of West Yorkshire.

Specifically, and permitting for patient choice, the provisions are that the typical catchment population of the City of Leeds, Airedale, Bradford District and Craven, and Harrogate, would be managed via the inpatient facility in Leeds where the care requirement is highly complex and requires the direct oversight of consultant oncologists. Relating to the established service at Bradford Teaching Hospitals NHS Foundation Trust, this model would be developed on a phased basis, permitting the necessary development of resources to manage this structure in acute medicine and also considering the physical capacity needed in the North sector.

The residents of North and South Kirklees, Wakefield and District, who typically attend a site at Mid Yorkshire Teaching Hospitals NHS Foundation Trust or Calderdale and Huddersfield NHS Foundation Trust would use the latter provision in similar circumstances.

The main aims of the model are to:

- Join up services between hospitals across West Yorkshire and Harrogate to deliver services which are resilient, using a sector-based networked care model.
- Organise care which is accessible and of the highest quality at all locations.
- Make the best use of available resources.
- Prioritise those aspects of the NSO services for local delivery which have been identified, by patients, as being the most important to them.
- Create the conditions for workforce development, innovation, and sustainability, but also the environment which will be attractive to new entrants in a competitive job market space.

In practice, what this would mean for patients is:

When they are **acutely unwell**:

- All patients to have access to a properly staffed 24-hour acute hotline.
- Patients to be maintained at home with follow-up where possible, with an outpatient appointment or assessment by an acute oncology team if required.
- For those who are very unwell, patients would be admitted, with the significant majority of those remaining at their local hospital, under the care of specialist disease/ area specific teams (colorectal, respiratory, urology, etc.) or acute medicine.
- For those patients needing oncology input, they would be transferred to oncology inpatient beds, currently in Calderdale in the south sector and Leeds in the North. Assessing the exact impact of this change is challenging, although the numbers are agreed to be small and projected to reflect less than 10% of the treatment activity. The number of spells in such cases will be significantly smaller than repatriated chemotherapy delivery. There is expansion of the Calderdale beds, due to be completed in early 2024, to accommodate the Mid Yorkshire patients currently being admitted to Leeds. We are currently discussing how this could be consolidated in the North, using a phased implementation approach.
- Patients with rarer cancers or needing specialist input would continue to be admitted to Leeds Cancer Centre, reflecting the essentials of clinical safety and the aspect of the model endorsed both by the Richards report and the Steering Group.

When they are having **cancer drug treatment**

- All patients will be able to access routine cancer drug treatment for the four most common cancers (Breast, Colorectal, Lung and Prostate) at their local hospital, or via mobile facilities where available. We will maximise the use of oral chemotherapy where clinically appropriate. Across West Yorkshire we deliver approximately 20,000 cancer drug treatments of which 70% are for the four common cancers.
- We will work to enhance the access to clinical trials closer to home, in conjunction with our current research centres in Leeds and Calderdale. We hope that this would begin to improve the opportunity for patients, particularly in Mid Yorkshire and Bradford, to access research treatments locally. In 2022/23 there were 7,953 patients participating in research via Leeds, with only 44 research patients at Bradford and 18 in Mid Yorkshire. There is an opportunity to extend this significantly.
- We will explore the options for most suitable patients with intermediate and rarer cancers to have their treatment locally, where the anti-cancer drug treatment is not complex, and it is clinically appropriate. This could mean six to twelve less visits to Leeds for each patient we can achieve that for. 30% of patients have a cancer which is of intermediate to rare incidence, so the reduced number of extended travel visits may be possible to reduce by several thousand a year.

- Considerable work has taken place to develop the operating model so that it provides improved access for patients, continues to ensure safe care, and ensure that quality/performance standards can be met.
- There is a focus on safety and sustainability, building on existing work and service, and ensuring that staff health and wellbeing is protected.

To support the model, we have formed a **North** and **South** Sector delivery and oversight infrastructure for the NSO programme:

North Sector

This is a proposed collaboration between LTHT, Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), Airedale NHS Foundation Trust (ANHSFT) and Harrogate and District NHS Foundation Trust (HDFT). Under the proposed model, LTHT will remain as the designated Cancer Centre, delivering an acute oncology service and dedicated oncology inpatient beds, outpatients' and day case chemotherapy. It will also continue to deliver radiotherapy and patient management for the rarest cancers for patients across West Yorkshire and Harrogate.

BTHFT, ANHSFT, and HDFT will continue to provide an acute oncology service and outpatient and day case chemotherapy for, as a minimum, the four most common cancers (breast, colorectal, lung and prostate). The arrangements for the North Sector have been developed in collaborative and externally facilitated Targeted Operating Model sessions, using a three-step approach.

These sessions have drawn together large teams of staff from each organisation and across each discipline, ensuring that the mechanics of the model have listened to staff feedback and perspective. The sessions have been highly successful and well received. The sessions have led to improvements in the management of the model including:

South Sector

The South Sector delivery of the model is proposed as a partnership between CHFT and The Mid Yorkshire Teaching NHS Trust (MYTT).

Under the proposed model, CHFT will be the lead provider, delivering an acute oncology service and dedicated oncology inpatient beds, outpatients, and day case chemotherapy. MYTT will continue to provide an acute oncology service and outpatient and day case chemotherapy for, as a minimum, the four most common cancers. Both Trusts will remain in partnership with the Leeds Cancer Centre, where all radiotherapy will continue to be delivered, alongside patient management for the rarest cancers.

The arrangements for the South Sector have been developed in collaborative and externally facilitated Targeted Operating Model sessions, using a three-step approach.

These sessions have drawn together large teams of staff from each organisation and across each discipline, ensuring that the mechanics of the model have listened to staff feedback and perspective. The sessions have been highly successful and well received.

7 The use of clinical, patient, and public engagement processes to establish resonance and sentiment to the proposals for improvement of the service, based on the new model.

With the preferred model developed, the programme has developed a significant process of staff, patient, and other stakeholder engagement activities. The programme has a defined communications and engagement delivery group and an external communications strategy group, the Patient Experience Strategy and Improvement Group (PESIG), which has approved and held the engagement approach to account.

Public Engagement

The public engagement approach has focussed on a two-pronged strategy. The **first prong** of the strategy has been to **compare public resonance and sentiment** towards the proposals with the views of cancer patients who have informed and co-produced the option, via the Steering Group, Cancer Alliance Board, Patient Experience Strategy and Improvement Group, Patient Panel, and through other means.

This approach has recognised that to be representative of public feedback, it is important that the programme engages with both current and prospective users of non-surgical oncology services.

The second prong to the strategy has been to **secure representative engagement**, meaning that we can identify sentiment and resonance towards the proposals from geographical communities affected, alongside the protected characteristic groups set out in the Equality Act.

A full communications and engagement strategy describes the approach taken, including the use of in-person and online focus groups; market research; and digital engagement. Focus groups have been promoted via partners such as Healthwatch and have used hard copy collateral to support delivery.

To be effective, we have sought to ensure that:

- A comprehensive approach is taken.
- That the approach is geographically representative.
- That the approach is representative of seldom heard communities.
- The results of the engagement impact on the design and further development of the option.

Alongside the above, we continue to work with our patient groups as well as attending place based and ICB meetings. We have received positive support for the way we have approached this work to date from the West Yorkshire ICB Transformation committee. We are due to report to the West Yorkshire Joint Health Oversight and Scrutiny Committee (JOSC) in January 2024. Further communication and involvement work will be undertaken as plans develop and will be regularly updated. More detail of our engagement work to date is available in Appendix 1.

1st phase of public engagement:

Within this two-pronged strategy, we have undertaken two phases of engagement. The **first** phase of engagement, focussing on an approach of inclusive listening, has considered the following:

- Has the preferred model taken account of what matters most to people?
- What haven't we thought of?
- How can we improve our ideas?

A series of nine community based public engagement events across West Yorkshire and Harrogate was completed across summer 2023. The inclusive listening phase of engagement consisted of face-to-face events at the following community locations between July and September 2023

- Wakefield - St Swithuns Centre, Eastmoor
- Bradford - The Thornbury Centre
- Kirklees – Birstall Community Centre
- Harrogate – Oatlands Community Centre
- Calderdale - Brighouse Library
- Leeds - Hamara Centre, Beeston
- Skipton Town Hall

Two online sessions, via Zoom, were also held in August 2023 to provide access to those unable to attend the face-to-face events.

2nd phase of public engagement:

The **second phase** (in Winter 2023/24) is linked to the theme of addressing gaps and **reporting back** and will undertake additional sessions / market research to address those groups and geographical areas not yet represented. Information on underrepresented groups and planned activities to address gaps is provided at Appendix 1.

This phase of engagement focusses on:

- Checking that what we have heard feels representative of the communities affected by the proposals and their diverse views and perspectives.
- Explaining what improvements, we have made to the proposals arising from the feedback received.
- Finding out what matters most as we progress.
- Considering and responding to the views of formal decision-makers.

The final outputs of the engagement processes are being prepared. The outcomes of the phases will be shared with the programme governance infrastructure, the JHOSC and the ICB Transformation Committee to make a formal decision about how to proceed.

Additionally, the **second** phase of the engagement has presented back to representative groups what we have heard from the initial phase and the changes made to arrangements as a result. The intention behind the engagement has been to address:

- Whether or not strong public and patient support for the proposals can be evidenced.
- If significant option review or formal consultative process (on a statutory basis) may be required to ensure that the commissioning authority undertakes conscientious consideration of its involvement duties.

Specifically, this will also include an assessment of the five tests for service reconfiguration, equivalent to stage 1 of the NHS England process and engagement with that body. This will determine if full adoption of stage 2 of the process is likely to be considered necessary in the circumstances of the changes proposed.

Clinical Staff Engagement

Clinical staff engagement has occurred via a wide variety of means including newsletters; briefing visits and meetings at local trusts; engagement with primary care clinicians via locality groups and other means; and the creation of seminar activities through the Targeted Operating Model groups for the North and South Sector. These sessions have taken a fixed approach encouraging the development of a shared vision for the sector; the development of a gap analysis; and the creation of shared action plans to resolve the gaps. The sessions have been attended by more than sixty colleagues involved in care delivery.

They have resulted in improvements as follows:

- Bridging and building relationships between clinical teams.
- Developing opportunities for workforce innovation and sharing of clinical protocols and best practice.
- Agreeing a common system for electronic prescribing.
- Developing protocols for the management of outpatient activity and patient information.
- Ensuring provision of improved supportive care and holistic needs arrangements.
- What are the infrastructure, staffing, and other gaps needing to be fulfilled to create service sustainability?
- Determining how will the acute oncology service hotline work best?

Other staff engagement:

Staff and members of the Cancer Alliance have been engaged in the project from the outset and were a key part of the external expert review. They continue to receive updates and opportunities to influence and become involved as the model is developed and refined.

The NSO System Delivery Group is constituted by senior members of each Trust, a patient

advocate, who was also a member of the Cancer Alliance panel and is chaired by the CEO of MYTT. Staff in all cancer units and the Cancer Centre have been involved in the development of the future operating models through a series of clinical workshops in each sector. This has also included briefing and co-working with staff-side groups.

The Cancer Alliance has provided funding to support system engagement and solution design to both sectors, including dedicated clinical and corporate leadership capacity.

8 The improvement and refinement of the new model based on engagement outcomes.

The engagement outcomes with the different stakeholder groups have identified several improvements which could be made to the model, within the established parameters. Some of these features are listed below.

International recruitment

Our engagement processes with clinical staff have identified that increasing and diversifying workforce supply remains crucial to enabling any option to work. For this reason, we have focussed on supporting international recruitment efforts, with a view to maintaining and enhancing service sustainability across both sectors.

In this vein, we continue to work with NHS England Workforce, Training & Education (formerly Health Education England) and our local leaders to try and progress our international recruitment efforts. The sponsorship route to GMC registration for potential candidates at consultant level is proving to be more complicated than anticipated, so we are looking at a range of levels of engagement and international supply, including trainee level. We are also continuing to collaborate with our colleagues in NHS North-East and Yorkshire region.

Systemic Anti-cancer prescribing system

Our engagement processes with clinical staff identified that the lack of a shared interface for SACT prescribing would make the implementation of any networked care model, on a sector basis, more challenging. For this reason, the programme has prioritised the assessment/procurement process is continuing across all six Trusts, with the aim to have all Trusts on the same version of the same system being used in the same way. This model will better support ease of transfer of patients, efficient pharmacy working and closer collaboration in service delivery between hospitals. Systems assessment is now planned for April 2024.

Finance, Contracting and Commissioning

Our engagement processes with corporate teams have established that to establish the networked care model effectively, it is necessary to understand the hosting of current costs in more detail and how implementation costings may be delivered. For this reason, two working groups have been established to support the NSO programme:

- A finance, contracting and commissioning group that will lead on engaging with partner organisations to firstly agree and secondly approve the business case.

- A finance technical group that will be responsible for developing the financial model to ensure that the proposed operating models are financially sustainable.

We are also developing the timeline and information required for the supporting NSO financial business case, alongside proposed implementation phasing.

Electronic Patient Reported Outcomes (EPROMS)

Our engagement processes with clinical staff and referring back to the report of Professor Richards indicated that investment in EPROMS would be helpful. The sector teams therefore developed a successful bid for Innovation monies to support the further development of EPROMS remote monitoring systems across both sectors. This will enable us to continue our focus on supporting patients through their chemotherapy journey. Pilots of this work continue in Mid Yorkshire with the North Sector pilot beginning work at this stage.

Pathway work

Our engagement work with clinical staff identified the need to work more closely on mapping pathways, at an operational level, to ensure that unwarranted clinical variation was managed within pathway settings. For this reason, the existing pathways for Breast and Acute Oncology have been mapped in both sectors.

We have identified variations, workforce innovation and opportunities to further develop these pathways to maximise available workforce. The next stage is to refine the future model with identified competency requirements for each stage, aligned to the Aspirant Cancer Career and Education Development (ACCEND) and relevant pathway and professional specific frameworks, such as the UK Oncology Nursing Society (UKONS).

We will then continue to scope training and education provision to support those requirements and address any gaps. Our aim will be to support patients getting the right care by the right people at the right time.

Capacity and Demand

Our engagement work with clinical teams identified the need to address further the capacity requirements for the delivery of SACT in day unit settings. This specifically reviews the physical and staffing and infrastructure requirements for the delivery of chemotherapy, in ways which maximise patient choice; ensure the delivery of chemotherapy in accordance with cancer waiting times; optimise patient experience; and enable the system to supply access to newly emergent therapies from NICE, for system-wide patient benefit.

Linked to the above, we have launched a system wide capacity and demand piece of work involving all of our West Yorkshire chemotherapy services who have agreed to use the same tool, to allow a comparable baseline of capacity to be established. This tool has been used by the Wessex Cancer Alliance and we will be learning from them in order to help us model future demand and support the development and costing of our future services and workforce.

Sector-Based Improvements from engagement

South:

Our engagement processes with clinical staff and the completion of the Targeted Operating Model sessions have enabled us to invest in a full programme delivery team. The programme delivery team is focussing on:

- Having a single dedicated Acute oncology phone line across the sector.
- Increasing the capacity within the Calderdale and Huddersfield NHS Foundation Trust Oncology inpatient bed base.
- Developing governance arrangements across the joint service.
- Further developing their non-medical workforce including aligning policies and protocols for the delivery of chemotherapy.

North

Our engagement processes with clinical staff and the completion of the Targeted Operating Model sessions have enabled us to invest in a full programme delivery team. The programme delivery team is focussing on:

- Developing governance arrangements across the Trusts who are part of the service.
- Developing improvement group arrangements for SACT.
- Developing improvement group arrangements for the delivery of outpatient care.
- Developing a shared approach to the implementation of a shared acute oncology helpline and the assessment service.

Engagement Outcomes – Patient and Public

As a summary, we have learnt from patient and public engagement that what matters the most is as follows:

To have **information about the proposed improvements to care**. For this reason, we have publicised details of the improvements on the Cancer Alliance website and have also made information about the improvements available via each Trust.

We have also heard that **access to, and support from, primary care** is a key consideration for patients. For these reasons, we have continued to expedite work looking at the development of cancer care reviews by GPs; have piloted access to self-referral routes; have established a GP forum, led by the Cancer Alliance, to enable greater prominence about the proposed improvements and engagement opportunities with primary care clinicians. We have also supported work being developed across the wider ICB, reviewing functions such as improved telephony access for making appointments. We have also worked with our partners to promote the available streams of access and support for patients via a range of Macmillan Information and Support centres; dedicated helplines for advice and support; and have also used the National Cancer Patient Experience Survey (NCPES) to review areas for improvement from each Trust's returns, based on the work of the PESIG.

We have also heard that **transport, travel, and access**, is a key issue. We have heard that most people expect to receive their diagnostic and treatment care in their local hospital wherever safe and practical. This has remained central to the development of the preferred option.

We have also heard that most people accept that Cancer Centres will deliver the **most complex treatment** and support for patients and that travel to a Cancer Centre is necessary for this purpose. Most people also understand that if a patient is very seriously unwell, they may need to be offered specialist care in such a unit. The impact of this has been mitigated by making the initial access point for support being the patient's local hospital in almost all cases; by creating managed transfers to specialist units where required (often by ambulance); and by examining methods of creating supported travel choices where needed. This has involved reviewing dispensatory travel passes; making accessible information about travel grants and financial support; and working with Trusts to ensure that secondary costs are properly managed, such as car parking. We have heard that making these improvements will make a positive difference to reducing health inequalities as patients will benefit more universally from support for care delivered as part of research and clinical trials; and complex inpatient care will be of the same high standard, where needed, irrespective of the access point in West Yorkshire.

We have also heard that **choice** is a key consideration and sometimes patients will elect to choose a hospital at the start of their pathway and may indicate a preference around where their treatment and support will take place. These features have remained central to the preparation of the option and we have reviewed how the infrastructure processes can support this, for example common electronic prescribing systems, EPROMS, information sharing protocols, and protocols for the management of outpatient care. This has also promoted continuity of care, which we heard was also important to patients.

We have heard that having access to **outpatient and chemotherapy care locally matters** and that the barriers experienced by people in relation to transport can be significant, particularly those from low-income backgrounds or without access to private car transport within the household unit. In this respect, public resonance to the proposals has broadly reflected that of existing cancer patients. Therefore, the capacity and demand profiling will protect access to chemotherapy delivery departments and locally, services work with patients to provide choice around appointment times wherever possible. Patients have access to pre-treatment consultations; allocated specialist nurses/key workers; and specific, tailored information about their chemotherapy treatment, side effects, and what to do in case of an emergency.

Services have also reviewed the set-up of chemotherapy delivery from the perspective of patient experience considerations which matter to people, such as allowing patients to be accompanied to their appointments; providing access to comfortable seating; providing food and drink; and supporting patients to access amenities during long appointments. Many of these considerations arise from the NCPES.

9 Engagement outcomes – new model

Overall, our engagement outcomes to date, recognising that the full report and completion of process is necessary, indicate a strong level of public, patient, and other partner support for the proposals.

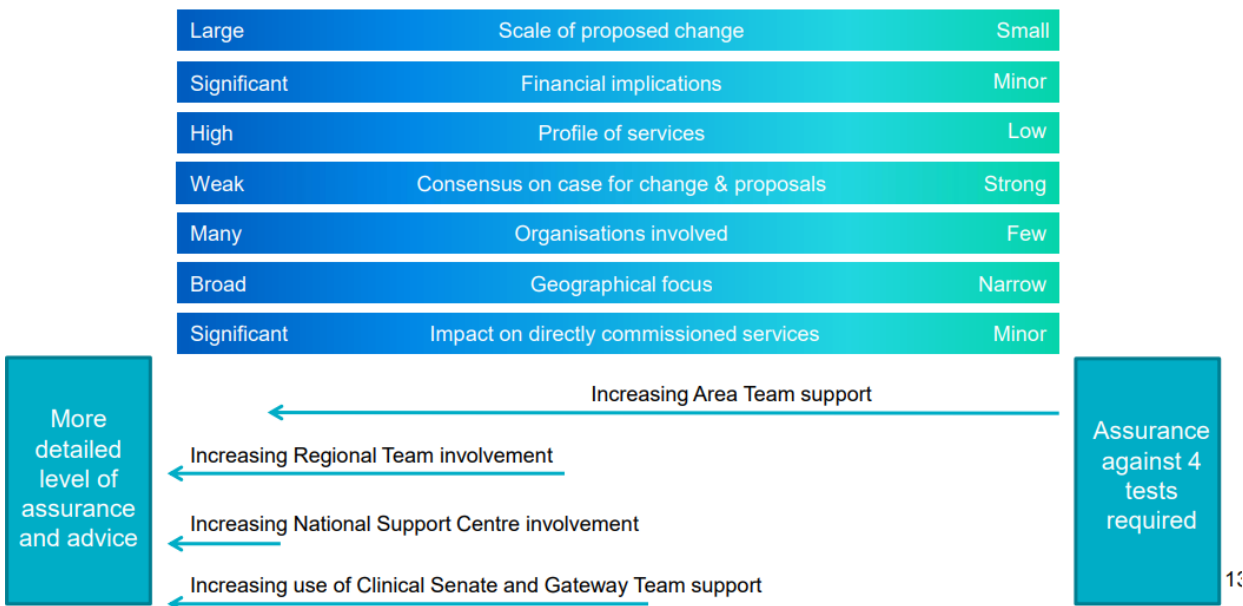
The proposals have been strengthened by co-design features from the outset, including the identification of the problem statement and case for change; the development of a clinical vision and new model of care; consideration of the available options for change; and detailed consideration and improvement within the implementation phase.

The proposals appear to be well supported both on a geographical basis, and on the basis of representative groups. It appears to be well accepted that the option developed will result in improved access, experience, and quality of care delivered to patients.

To support application of the NHS England service reconfiguration tests, NHS England has also published a framework to support their level of involvement and oversight with schemes of this nature. A copy of the framework is shown below.

Decision making tool – level of assurance

This model may assist decisions about the level of assurance required by NHS England for particular service change proposals.



In this case, the scale of the proposed change and geographical are **larger** because it effects the entirety of the West Yorkshire and Harrogate delivery system.

The financial implications of the scheme are **more minor** because the options rely on existing revenue and capital funding. Where revenue funds have been identified or will be further identified as part of the finance and contracting sub-group, these have been offset by making financial improvements – for example encouraging workforce innovation and improvements to vacancies will reduce agency pay rates. Implementation costs have been separately financed and so are less relevant to solution design.

The profile of these service lines is **higher**, although feedback from patients and public suggest that their key consideration is the delivery of chemotherapy and outpatient care for cancer, as opposed to unusual scenarios where complex acute oncology care is needed.

The consensus on the case for change is **stronger**. There appears to be unanimity of opinion that no change or reverting to the *status quo ante* position is viable. There is also a strong consensus between the clinical, external clinical review, and patient and public engagement outcomes, all of which are consistent with the preferred option identified, and the improvements made to that preferred option during the design and developmental phases of the work.

The range of organisations directly involved in the service is **relatively narrow** and established arrangements for collaboration already exist. The design of the proposals and governance arrangements have ensured that a consensus between the organisations has emerged and that the decision-making functions are effective.

The scoping arrangements for the proposals and their consistency with the application of the engagement outcomes and tests for reconfiguration mean that the impact on directly commissioned services by NHS England are **minor**.

The application of the model against the applicable service reconfiguration tests from NHS England suggest that:

- The model identified continues to have a clear, clinically led, evidence base.
- The model identified is consistent with current and prospective need for patient choice.
- The model identified is supported by clinical commissioners.
- The model identified has been supported through strong patient and public engagement, commensurate with the scope and profile of the proposals being undertaken.
- The inpatient bed test does not apply to this scheme.

Linked to the above, the NHS England service reconfiguration guidance about these proposals has been considered; regular updates have been provided to NHS England; and the approval from NHS England to proceed on these grounds will be sought.

It is also assessed that, in the context of the scheme, and subject to the ongoing outputs of engagement work; and the wider preparation and publication of modelling activities; that the ICB Transformation Committee are unlikely to assess that the costs and time-based impacts of

statutory public consultation processes for this scheme are warranted in the circumstances of non-surgical oncology. To be clear, this decision will be taken formally and separately, linked also to scrutiny processes, and this represents an indication of the possible direction of travel.

Appendix 1

Summary of current reach of inclusive listening phase of public engagement and planned activities in phase 2

The reach of phase 1 was measured by comparing the proportion of people with statutorily protected characteristics around sex, religious beliefs, carers, age, disability, sexuality, gender reassignment and pregnancy/breastfeeding engaged with as compared to the proportion in the general population, as per 2021 census data. The programme also monitored whether the inclusive listening phase had reached groups at risk of health inequalities and whether all geographies had been equitably represented.

As at end of 2023 the reach of the engagement programme, by protected characteristic was as shown below. Each was RAG rated to indicate level of assurance of reach.

1. Protected characteristic of **sex** - RAG **GREEN** Sufficiently representative of WY&H population

Attendees were asked to describe their gender.

Sex	Population WY&H	No of Engagement Attendees	% of Attendees
F	51.1%	45	58.4%
M	48.9%	31	40.3%
Other	Not an option in Census question	1	1.3%

2. Protected characteristic of **religious beliefs** - RAG **GREEN** – Sufficiently representative of WY&H population

Religious Belief	Pop WY&H	Engagement Attendees
No religion	36.7%	29.9%
Christian	46.3%	35.1%
Buddhist	0.5%	1.3%
Hindu	1.8%	6.5%
Jewish	0.5%	1.3%
Muslim	6.7%	22.1%
Sikh	0.9%	1.3%
Other religion	0.6%	0.0%
Not answered	6.0%	2.6%

3. Protected characteristic of **carer status** - RAG **GREEN** – Sufficiently representative of WY&H population

	Population WY&H	Engagement Attendees
Provider of care	8.7%	28.6%
Not a provider of care	91.3%	70.1%
Not Answered	-	1.3%

4. Protected characteristic of **age** - RAG **GREEN** – Sufficiently representative of WY&H population

Only the population aged 25+ was considered as teen and young adult cancers are outside the scope of the NSO programme

Age Group	Pop WY&H ¹²	Attendees	Adult incidence
25-49	47.3%	24.7%	9.3%
50-64	27.4%	26.0%	24.5%
65-79	18.6%	45.5%	43.9%
80+	6.7%	1.3%	22.2%
Did not answer	0.0%	1.3%	-

Although the 80+ group were under-represented in our sample that might be expected, given that age and/or infirmity might be a barrier to that age group choosing to participate in public engagement activity. There is additional planned activity which will target the older population living in assisted living schemes.

5. Protected characteristic of **disability** - RAG **GREEN** – Sufficiently representative of WY&H population

	Pop WY&H	Engagement Attendees
Self-certified as disabled	17.3%	37.7%
Did NOT self-certify as disabled	82.7%	59.7%
Did not answer		2.6%

6. Protected characteristic of **sexual orientation** - RAG **GREEN** – Sufficiently representative of WY&H population

	Pop England	Engagement Attendees
Heterosexual	89.4%	77.9%
Gay or Lesbian	1.5%	3.9%
Did not respond	7.5%	13.0%
Bisexual	1.3%	3.9%
Other	0.3%	1.3%

7. Protected characteristic of **gender reassignment** - RAG **GREEN** – Sufficiently representative of WY&H population

	Pop England ¹³	Engagement Attendees
Gender identity is same as assigned at birth	93.5%	97.4%
Gender identity is not the same as assigned at birth	0.5%	2.6%
Did not answer	6.0%	0.0%

¹² Proportional split of population aged 25+

¹³ Data source <https://commonslibrary.parliament.uk/2021-census-what-do-we-know-about-the-lgbt-population/>

8. Protected characteristic of **pregnancy/ breastfeeding** - RAG **RED** – Not representative of WY&H but plans in place to mitigate to a **GREEN** rating

	Pop WY&H ¹⁴	Engagement Attendees
Pregnant or breast feeding	1.1%	0.0%
Not pregnant or breast feeding	99.0%	98.7%
Did not answer	0.0%	1.3%

9. **Geographic coverage** - RAG **RED** – Not representative of WY&H but plans in place to mitigate to a **GREEN** rating

Table below evidences that the geographical spread of our attendees does not represent WY&H as a whole. The most significant underrepresentation was from the city of Bradford, with many attendees from BD postcodes being residents of towns around the city such as Bingley, Cleckheaton, Skipton and Birstall.

Postcode area	2011 ¹⁵ Population	% of WY&H population	% of attendees from postcode area ¹⁶
BD	578,336	23.8%	11.1%
HD	262,814	10.8%	8.3%
HG	138,343	5.7%	1.4%
HX	160,378	6.6%	1.4%
LS	774,180	31.9%	51.4%
WF	512,657	21.1%	26.4%
Grand Total	2,426,708	100.0%	100.0%

To address the current imbalance a market research company has been commissioned to undertake 500 further street surveys. The distribution of these will be proportionate to the population of each place

10. Groups at risk of **health inequalities** RAG **AMBER** – More work required in phase 2 to mitigate

RAG rating summary

Characteristic	RAG Rating
Place of Residence	
Pregnancy and breast feeding	
Groups a risk of health inequality	
Sex	
Religious Beliefs	
Carer Status	

¹⁴ There were 27218 births in WY&H in 2022. This is taken as a proxy for the total number of persons pregnant or breast feeding.

¹⁵ Office of National Statistics did not release a 'population by postcode' dataset from the 2021 census return

¹⁶ Excluded from the data set are two attendees, representing third sector organisations, who provided a postcode from outside of the WYAAT catchment

Age	
Gender Reassignment	
Sexuality	
Disability Status	

Phase 2 public engagement activities

The first step in phase 2 of engagement is to undertake additional activities to address those groups and geographical areas not yet represented. Activities planned or proposed in this step are described below.

Group / Characteristic	Activity planned	Status
Place of residence	500 field interviews undertaken across all place and trust boundaries	Work commissioned through private sector provider. To be completed Jan/Feb 2024
Pregnancy/ breast feeding	Digital version of market research survey to be forwarded to members of a local maternity group	Agreed with facilitator of maternity group
Risk of health inequalities – military veterans	Programme to address breakfast meeting of local veterans' group	Still at planning stage with group facilitator
Risk of health inequalities – residents of assisted living schemes	Event in communal lounge of a scheme in South Elmsall	Agreed with landlord and residents. To be delivered January 2024
Risk of health inequalities – Gypsy and traveller community	Engagement event at offices of LeedsGATE which will be marketed at traveller communities in Leeds and Bradford	Agreed with LeedsGATE charity. Event to be delivered January 2024
Risk of health inequalities – Homeless / risk of homelessness	Discussions with a charity which supports both these groups, advised that access to NSO services was not a high priority for these groups and an event would not attract much interest or attendance.	Abandoned Not a viable line of enquiry
Risk of health inequalities – Drug or alcohol dependency	Priority health issues for these groups were described as mental health services, drug/alcohol services, access to primary care and dentistry	
Risk of health inequalities – English not as a first language	Three engagement events held: <ul style="list-style-type: none"> • Karmand Centre - Elderly day care group for men of south Asian origin. • Great Horton Library – Eastern European women • Cancer support Yorkshire – Women's group, mostly of south Asian origin 	Delivered 3 events in November 2024

Risk of health inequalities – LGBT+ community	Engagement event held at MESMAC, a charity promoting LGBT issue	Delivered November 2023
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