

## **INCOMING CHAIR'S STATEMENT**

The Board welcomed Matt Walsh, Calderdale, Kirklees & Wakefield District Cluster Executive Medical Director as the new Chair of the Board.

Matt Walsh opened the meeting with a statement on the continued importance of the Network's role in shaping and developing cancer services and highlighted the need for flexibility to work in the transforming NHS. The Board was congratulated on its achievements demonstrated within the quarterly Performance Report and outlined the challenges and focus for the Board during the oncoming months around early diagnosis; optimising uptake of screening; achieving 62-day pathways and securing relationships with primary care.

## **SMDT PATHOLOGY REVIEW**

Commissioners reported that there are no specific contracting arrangements for non activity related pathology reviews carried out in LTHT. Although there was recognition that the current network approach to pathology was robust, there was acknowledgement that the number of central reviews could be reduced through further education of unit pathologists.

It was agreed that a proposal be developed, led by NHS Leeds with contracting, commissioning and provider input, to be brought back to the March Board.

## **POLICY FOR THE MANAGEMENT OF URGENT SUSPECTED CANCER PATIENTS**

The agreed Network policy for the management of urgent suspected cancer patients (2ww) was presented to the Board for its bi-annual review. The policy was agreed subject to further amendments around Providers having a proactive approach to patients who DNA; and emphasising the importance of the conversations between GP and patient prior to referral.

Provider organisations were asked to confirm the policy formed part of their Access Policy. The policy would also be disseminated into primary care through GP NAEDI Cancer Leads and PCT Cluster leadership arrangements.

## **PERFORMANCE MANAGEMENT OF 62-DAY WAITING TIMES STANDARD**

The Board was updated on the progress of the performance management process for 62-day cancer waiting times. Urgent discussions are on-going regarding the development of a fair and transparent financial leverage to supplement existing performance improvement mechanisms. This is expected to be completed to feed in to the current round of contracting negotiations

## **PEER REVIEW UPDATE AND AGREEMENT OF EVIDENCE**

The Board received the latest update on Peer Review. The internal validation (IV) report from Acute Oncology, Brain and CNS, Chemotherapy, Teenage and Young Adult and Sarcoma services was noted and members were asked to ensure that action plans to address any serious concerns identified are produced by the 29<sup>th</sup> February 2012. Trust and Network action plans produced in response to the immediate risks and serious concerns identified in the internal validation of NSSGs and MDTs in September 2011 were presented. Localities were asked to ensure implementation is monitored via local appropriate governance mechanisms. Plans from Airedale and Leeds were awaited.

Following a review of the NCPD programme, the Board were asked to note the changes to the organisational structure with effect from 1<sup>st</sup> April 2012. An immediate change introduced for the 2012/13 cycle aims to reduce the workload on the service by reducing the IV to a 3 year cycle rather than every other year. In addition, there will be no local data collection required for Clinical Lines of Enquiry for the 12/13 cycle.

The Board supported Matt Walsh to take Chair's privilege to agree the evidence referred to in the paper (CYP, Head & Neck and Thyroid) is compliant with the peer review requirements.

## **END OF LIFE CARE (EoLC)**

June Toovey, YCN Nurse Director and Penny Kirk, EoLC Programme Manager gave an update on the End of Life Care workstream, highlighting progress to date nationally and regionally (<http://www.endoflifecareforadults.nhs.uk/>). The challenges for EoLC in cancer were highlighted as follows:

- At least 75% of cancer deaths are expected and can therefore be planned for
- Identifying patients at EoL and starting conversations early needs to be an important aspect of cancer services
- Integrated working with primary and social care to enable more patients to die at home
- Do we know what % of cancer patients who have been identified as palliative, have had EoL conversations & recorded their preferences for care?
- Do we have agreement for each cancer site when & what the triggers for starting EoLC conversations should be?

Planned work to overcome the challenges will include:

- pilot use of the AMBER tool within acute oncology to flag patients at risk of dying in the next 1-2 months (<http://www.guysandstthomas.nhs.uk/services/ambercare/amber-care-bundle.aspx>)
- work with NSSG/s to identify when within clinical pathways to start EoL conversations and triggers to start the EoLC pathway
- identifying education needs e.g. improving confidence of clinicians to start conversations

The Board were also informed that the SPC measures are currently out for consultation with impact wider than acute Trust SPC MDTs, including implications for hospices and a requirement for a 7-day face to face SPC assessment service.

The potential of EoLC to fit in with the reduction in unplanned admissions and reduced bed days was recognised within the QIPP agenda.