Late information for Scrutiny Board (Adult Social Services, Public Health, NHS) on 18 May 2016

Pages 1-22: Agenda item 9 – Scrutiny Inquiry into Bereavement

Pages 23-34: Agenda item 10 – Scrutiny Inquiry into Cancer Wait Times in Leeds

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SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

BEREAVEMENT: POLICIES AND PRACTICE AT LEEDS TEACHING HOSPITALS NHS TRUST

DRAFT SCRUTINY INTERIM REPORT

Introduction

1. Following representation from a number of local councillors, in December 2015 during a meeting with the Chief Executive of Leeds Teaching Hospitals NHS Trust (LTHT), the Chair of the Scrutiny Board raised concerns regarding LTHT's processes for the timely release of deceased relatives for the purpose of burial. This was a particular issue for members of the Muslim community, who had previously raised concerns.

2. Further communication with the Patient Experience team at LTHT confirmed the process for releasing bodies would be described in a Trust policy that was being drafted and was expected to be finalised in the early 2016.

3. The Chair of the Scrutiny Board was subsequently advised that LTHT's Care After Death and Bereavement Policy was approved at the Executive Director's meeting on 11 January 2016. The Trust provided a copy of the policy, which included the procedure and flow chart to guide staff on the timely release of bodies for the families of deceased people with a Muslim or Jewish faith. The policy also included key contact details.

4. The Chair of the Scrutiny Board was also advised that LTHT's Patient Experience team had been engaging regularly with the Muslim community in Leeds and there has not been any recent material concerns raised regarding the process.

5. In order to discuss the new policy with members of the Muslim community, local councillors, Leeds City Council registrar's office and LTHT, working group meetings took place in February 2016 and April 2016. The Chair also held discussions with members of the Jewish community.

6. We do not intend to repeat all the evidence and input we have considered as part of this inquiry – but details of the working group notes and the information submitted are summarised in the appendices.

7. As ever, we are grateful to all those who have commented and contributed to our discussions: These have helped form our views and influenced this report and its recommendations, which we hope will raise awareness of the issues and further enhance the relationships across different communities of Leeds.

Background

8. Over a period of time, concerns had been raised by members of Leeds' Muslim communities regarding the timely release of deceased relatives from Leeds Teaching Hospitals NHS Trust (LTHT) for the purpose of burial. Some detailed discussions were held with LTHT during the previous municipal year (2014/15).

9. One of the main outcomes from those discussions was a request for LTHT to produce a quick step-by-step guide/ flow chart of the process for the timely release of deceased relatives, to share with councillors and leaders across the community.

10. In December 2014, LTHT provided the following response and information regarding the process:

    a) The process for facilitating timely release of deceased Muslim patients has been in place for a number of years, however there have been changes to the process in that time - the most recent being the authorisation by the Registrar's Office for additional Muslim faith leaders to issue green cards, which are required to release a body out of normal working hours. There are now four faith leaders who provide this service.

    b) There is information on the Trust Bereavement intranet website describing our processes for out -of-hours release of Muslim patients that is available for all staff to access. Clinical Site Managers (CSM's) support the Organisation out-of-hours to deliver this function. The last awareness raising exercise in the Organisation in relation to procedures to be followed took place in June 2014 and included CSM's and nursing staff. The next is planned to coincide with the launch of the Trust bereavement policy.

    c) The CSM role performs the duty of being the on-site manager for the hospital and operates 24/7. The role of supporting out of hours release of the deceased is one of a number of responsibilities that this role carries. CSMs are not however required to facilitate release within normal working hours, as the bereavement office and related services are able to perform this role during these times.

    d) Release of all bodies out of hours are recorded by Mortuary. CSM's involved in out -of hours release have a responsibility to raise areas of concern with their team leader. The team leader reports directly to the Nurse Director of Operations, who has a responsibility to ensure these processes are fit for purpose. The Nurse Director of Operations also attends the Trust End of Life Care Group, which monitors implementation of the bereavement policy and reports identified risks to the Trust Clinical Effectiveness and Outcomes Sub-Committee.

    e) The Trust has a Standard Operating Procedure (SOP) and will produce an easy-to-read flow chart from this that sets out the key steps to take.

11. As detailed above, following further representation from a number of local councillors, in December 2015 during a meeting with the Chief Executive of Leeds Teaching Hospitals NHS Trust (LTHT), the Chair of the Scrutiny Board raised concerns regarding LTHT's processes for the timely release of deceased relatives for the purpose of burial.

12. Working group meetings took place in February 2016 and April 2016. Details of attendance, information submitted and notes from the working group meetings are presented in the appendices as follows:

- Appendix 1 – working group meeting, 1 February 2016
- Appendix 2 – working group meeting, 21 April 2016

13. The Chair's discussions with members of the Jewish community are also reflected in this report.

Main issues and comments from the Scrutiny Board

14. We are pleased to report the production and agreement Leeds Teaching Hospitals NHS Trust's (LTHT's) Care After Death and Bereavement Policy, which was approved at the Executive Director's meeting on 11 January 2016: This includes the Trust's procedure and flow chart to guide staff on the timely release of bodies for the families of deceased people with a Muslim or Jewish faith.

15. Given this is the first formally adopted LTHT policy that includes a specific procedure on the timely release of bodies for the families of deceased people with a Muslim or Jewish faith, we recognise and acknowledge this as a significant milestone for both LTHT and the communities of Leeds. However, given we first started specific discussions with LTHT over 18 months ago (i.e. during the 2014/15 municipal year), we are concerned at the length of time taken to reach this stage. These comments are not intended to devalue or under-estimate the effort of the LTHT's Patient Experience team, but we feel it is important for LTHT to respond more quickly to matters where a specific community concern has been identified.

16. In addition, we believe it is in part a result of the time taken by LTHT to finalise and agree its policy that has led to further concerns being raised this year, albeit that most concerns tended to be of an historical nature.

Recommendation 1

(a) That, when undertaking future policy reviews, Leeds Teaching Hospitals NHS Trust clearly sets out a proposed forward plan, with key milestones and timescales.

(b) That, when establishing the forward plan (referred to in (a) above), that Leeds Teaching Hospitals NHS Trust keeps progress under review and reports any anticipated and/or unexpected delays.

17. Given the timing of LTHT formally agreeing and adopting its policy and procedure, it I clear that the Trust is in the early stages of implementing its new policy across the organisation; therefore it is difficult to fully assess the impact and associated level of progress.

18. However, from the discussions at the working group meeting in April 2016, we acknowledge that progress has been made and welcome the Trust's recognition that further work is still required, particularly in terms of data collection and analysis and the Trust's collaborative approach with the wider community.

19. As part of this further and additional work, the working group received some information on the processes and practices from the Heart of England NHS Foundation Trust. The process as described is set out in Appendix 2 and we

believe this is worthy of further consideration by the Trust to establish any potential improvements to its current process and procedures.

Recommendation 2

(a) That, by September 2016, Leeds Teaching Hospitals NHS Trust reviews and compares its current process and procedures for the timely release of the deceased, with those adopted and implemented by the Heart of England NHS Foundation Trust.

(b) That, Leeds Teaching Hospitals NHS Trust reports the outcome of its review to the Scrutiny Board by November 2016.

20. In its progress update in April 2016, Leeds Teaching Hospitals NHS Trust recognises the importance of changing organisational culture and behaviour through staff briefings and development session. We see this as an important element of the Trust's implementation plan, but would ask the Trust to consider extending invitations to such briefing sessions to key members of the wider community and outside the organisation, in order to help embed a shared understanding of the issues and processes associated with the timely release of deceased relatives.

Recommendation 3

That, Leeds Teaching Hospitals NHS Trust considers extending invitations to its briefing sessions to key members of the wider community and outside the organisation, in order to help embed a shared understanding of the issues and processes associated with the timely release of deceased relatives.

Access to pathology services

21. A significant issue raised by members of the community was in relation to access to pathology services, including out of hours arrangements and the opportunity of routine access to non-invasive post mortems as the first option.

22. The initial response from the Trust suggests that further resources would be required for an out of hours pathology service and that permission from the coroner would also be required to operate such a service.

23. While we have not explored the costs of the current service, nor the costs of providing an out of hours service, we feel that further work in this area could be warranted, including options for providing an out of hours service in partnership with neighbouring acute hospital trusts.

24. We understand the cost of non-invasive post mortems to be in the region of £550. We also understand that where such a process is inconclusive, then the charge is not payable. As such, we see limited risk in offering routine access to non-invasive post mortems to all families, where appropriate, with such costs potentially off-set by savings within the pathology service. We would urge the Trust to explore these potential options and undertake an appropriate cost benefit analysis.

Recommendation 4

(a) That, by December 2016, Leeds Teaching Hospitals NHS Trust reviews its arrangements for providing out of hours pathology services and considers the potential for providing such services in partnership with neighbouring acute hospital trusts.

(b) That, by December 2016, Leeds Teaching Hospitals NHS Trust explore the potential options for offering routine access to non-invasive post mortems to all families (where appropriate), and undertake an appropriate cost benefit analysis of such options.

Discussions with representatives from the Jewish community

25. As outlined in Appendix 2, the Chair of the Scrutiny Board shared the notes of the February 2016 working group widely and met with representatives from Leeds' (orthodox) Jewish community.

26. While some minor issues were highlighted in terms of 'out of hours' processes, there were no significant issues highlighted by the Jewish community.

27. We note that for religious reasons, any preparation for burial and/or the burial itself does not take place on the Sabbath (i.e. from the Friday evening until Sunday morning). We also note that repatriation does not appear to be a significant issue for the Jewish community, with around 2/3 repatriations per annum.

28. We recognise that while there may be similar needs within both the Jewish and Muslim communities for the timely release of the deceased for burial, there are also significant difference – which may be specifically related to out of hours arrangements on a weekend.

29. Nonetheless, we welcome the recognition that there is an opportunity for the Jewish and Muslim communities to work together and to share any learning and experience on this specific matter between the communities. We therefore support the suggestion of further discussions through Leeds' Faiths Forum.

Recommendation 5

That by September 2016, the issues and matters highlighted in this report are brought to the attention and discussed through Leeds' Faiths Forum to share any learning and experiences in respect of the timely release of the deceased, for the purpose of burial.

Independent Medical Examiners

30. The matter and potential impact of 'Independent Medical Examiners' was brought to our attention relatively late in the current municipal year. This was largely as a result of the consultation not commencing until 10 March 2016.

31. We recognise the background to the introduction of Independent Medical Examiners comes from the Harold Shipman Inquiry, which led to proposed reforms of the death certification process and a new system of scrutiny by Independent Medical Examiners. Clearly, measures are needed to safeguard the whole community from similar events highlighted by the Shipman Inquiry. However, there will need to be careful consideration around how such safeguards are implemented without causing further, undue delays to the timely release of the deceased for burial.

32. We have specifically shared details of the consultation with those that have contributed to the working group discussions and hope some will make a formal response. As responsibility for Independent Medical Examiners is likely to rest with local authorities, we hope that the responsible Director will also respond on behalf of Leeds City Council; and in doing so reflects some of the issues highlighted in this report.

Recommendation 6

That by 10 June 2016, the responsible Director from Leeds City Council formally responds to the Department of Health consultation on the implementation of Independent Medical Examiners; and in doing so reflects some of the issues highlighted in this report.

Out of Hours services in Primary Care

33. A further significant issue that was raised but not discussed in detail was in relation to appropriate GP access for the purpose of death certification.

34. We recognise this is not a matter for Leeds Teaching Hospitals NHS Trust, but more likely an issue to consider with those responsible for commissioning Primary Care services across the City.

35. Through our work in other areas, we are aware that local Clinical Commissioning Groups (CCGs) have recently taken on responsibility for the commissioning of local primary care services, therefore it would seem reasonable to suggest that further discussions should take place with Leeds CCGs.

Recommendation 7

That during the course of the 2016/17 municipal year, the Scrutiny Board (Adult Social Services, Public Health, NHS) discuss current and future arrangements for the provision of Out of Hours primary care services, specifically as they relate to death certification.

36. It is hoped these comments and recommendations further enhance the working practices and approach around the timely release of deceased relatives for the purpose of burial, further raising awareness of the issues and enhancing relationships with and across different communities of Leeds.

37. We look forward to a formal response to our comments and recommendations by July 2016.

Cllr Peter Gruen, Chair
On behalf of the Scrutiny Board (Adult Social Services, Public Health, NHS)

May 2016

APPENDIX 1

Bereavement – Policies and Practice Working Group Meeting

Committee Room 6/7, Leeds Civic Hall

1 February 2016, 5:00pm – 7:00pm

ATTENDANCE

Scrutiny Board Members

- Councillor Peter Gruen – Chair
- Councillor Arif Hussain
- Councillor Ghulam Hussain

Local Councillors

- Councillor Javaid Akhtar
- Councillor Mohammed Iqbal
- Councillor Asghar Khan

Apologies were received from Councillor Kamila Maqsood and Councillor Mohammed Rafique

Local Funeral Directors / Other attendees

- Mr Mir
- Mr Hussain
- Mr Younsis
- Dr Khan
- Salma Arif (guest of Councillor Arif Hussain)

Leeds Teaching Hospitals NHS Trust

- Krystina Kozlowska (Head of Patient Experience)
- Shaun Preece (Lead Nurse Patient Experience & Involvement)
- Alun Pymer Deputy Patient, Carer and Public Involvement Manager

Leeds City Council Officers

- Penny Whitehead, Registration Services Manager
- Steven Courtney, Principal Scrutiny Adviser

Background documents provided in advance of the meeting

Leeds Teaching Hospitals NHS Trust, Care After Death and Bereavement Policy (Adults): Specific reference Appendix K, pages 57-61) – approved January 2016

Notes of the meeting

The Chair opened the meeting and thanked everyone for attending. Introductions were given and apologies were noted.

The Chair outlined the purpose of the meeting was to:

- Discuss any community concerns regarding the release of deceased relatives from Leeds Teaching Hospitals NHS Trust;
- Ensure there was a better understanding and knowledge of the Trust's policy and procedures;
- Ensure that all partners and stakeholders were working together with shared aims and understanding; and,
- Identify any further improvements.

Leeds Teaching Hospitals NHS Trust

Representatives from Leeds Teaching Hospitals NHS Trust in attendance were invited to address the meeting. The main issues highlighted included:

- The Trust recognised that the importance of the issues associated with the timely release of bodies for the purpose of burial had not always been recognised across the Trust.
- As a result, the Trust also recognised there were improvements to be made in terms of consistently following an agreed process and procedure.
- The recently agreed *Care After Death and Bereavement Policy* provided a good foundation on which to make progress.
- The production of the policy document represented a significant milestone, as this was a new policy documents and had not previously been formulated.
- The new policy aimed to make the process:
    - More accessible for all stakeholders
    - Speedier and more streamlined
    - More consistently applied
- Staff communication would be a key aspect of the launch of the new policy, and a series of staff seminars and awareness raising was planned.
- There are specific legal requirements associated with issuing 'cause of death' certificates that must be complied with.

Local councillors and other stakeholders

The Chair invited local councillors and other stakeholders present to comment and outline any issues and/or matters of community concern. The main matters highlighted included:

- The timely release of deceased relatives should be considered to be a reasonable request.
- Difficulties were most evident when deaths occurred 'out of hours' and at weekends.
- There had been evidence and experience of inconstant practice within the Trust.
- The need for a completed 'cause of death' certificate to be provided and soon as possible following confirmation of the death.
- Difficulties associated with 'out of England' burials and repatriation issues: The involvement and cooperation of the coroner was essential.
- The opening hours of the bereavement office: The move from 10:00am to 8:30am opening was welcomed and seen as a positive improvement.

- Issues associated with the availability of 'out of hours' pathology and the costs of non-invasive post mortems – where post mortems were required.

Registrar's Office

The Chair invited specific discussion and comments in relation to the role of the Council's Registrar's Office. The main issues discussed included:

- The appointment of 3 community volunteers to assist with 'out of hours' working.
- Revised office opening hours and flexibility of appointments.
- The availability of further extended hours and details of the community volunteers.

All the issues highlighted were discussed in detail among the working group.

Conclusion

In summing-up the discussion, the Chair recognised and highlighted the following points:

- Some of the issues raised related to the Trust's historic practices and therefore the development of the Trust's formal policy was welcomed.
- It was clear that the Trust was in the early stages of implementing the new policy across the organisation; therefore it was currently difficulty to fully assess the impact and associated level of progress.
- The incidence and scale of the matters considered were not clear: It would be useful to have some indication of the monthly/ annual number of instances where the policy/ procedure were required.
- It was clear the Trust recognised the importance of training and culture-change needed to implement its new policy. However, it was not clear how the Trust could influence matters being incorporated into the general training of doctors; it was also unclear how the Trust would ensure the policy would be incorporated into the Trust's inductions for medics, as part of the general turnover during medical training and placements.
- It may be helpful for the Trust to develop some form of 'service standards' to help inform families of the level of service they can expect from the Trust.
- It was unclear if/ how processes for adults and children might differ, and why this might be case.
- The Trust should identify the average of cost of post mortems and consider off-setting this against the cost of non-invasive post mortems for all families who would prefer this as an option.
- The Trust, alongside the Council's Registrar's Office should consider jointly producing, and keeping under review, a family information leaflet to explain the process and provide key contact information.

While a follow-up meeting to review progress with the Trust would be beneficial, it was recognised that issues associated with the provision of death certificates 'out of hours' in the community was a matter for further discussion with local Clinical Commissioning Groups.

The Chair thanks all those in attendance for their contributions to the discussion and closed the meeting.

APPENDIX 2

Bereavement – Policies and Practice Working Group Meeting

21 April 2016

NOTES OF THE MEETING

The Chair opened the meeting and thanked everyone for attending. Introductions were given and apologies noted (details of attendance are presented at Annex A).

The Chair outlined the purpose of the meeting was to:

- Provide some feedback following discussions with representatives from the Jewish community;
- Discuss the previous notes and identified action points;
- Consider any additional matters and/or action points; and,
- Agree any next steps.

Discussions with representatives from the Jewish community

The Chair outlined he had shared the notes of the previous working group meeting with representatives from Leeds' Jewish community and he had met with representatives from Leeds' (orthodox) Jewish community.

The Chair reported that while some minor issues were highlighted in terms of 'out of hours' processes, 'no significant issues' had been highlighted. It had been noted that for religious reasons, any preparation for burial and/or the burial itself did not take place on the Sabbath (i.e. from the Friday evening).

It had also been reported that repatriation was not a significant issue for the Jewish community, with around 2/3 repatriations per annum.

Progress on previously identified actions

It was reiterated that representatives from Leeds Teaching Hospitals NHS Trust could not be in attendance due to other commitments and the relatively short timescales in making the meeting arrangements. Nonetheless, the Trust had provided a written response that was circulated to all those present.

This aim of the Trust's response was to address, where possible, the previously outlined actions, identify progress and a plan for moving forward.

The Trust's response was outlined at the meeting and is attached at Annex B.

Independent Medical Examiners

It was outlined in information from Leeds Teaching Hospitals NHS Trust that the Department of Health was currently conducting some consultation around the government's plans to introduce Independent Medical Examiners in 2018[1]. Further investigation had revealed the consultation process would run until June 2016.

[1] Details of the Department of Health's consultation can be accessed here.

As outlined in Annex 2, Leeds Teaching Hospitals NHS Trust confirmed that early analysis indicated that the requirement to have confirmation of the cause of death by an Independent Medical Examiner may introduce further delays into the current process, and may negatively influence the objectives of the working group, that is to have a more timely release of the deceased.

There was concern about the potential negative impact on the timely release of the deceased: Further information about the consultation and how to contribute was requested. The additional details provided are presented at Annex C.

Practice at the Heart of England NHS Foundation Trust

Cllr Iqbal submitted an outline of the process for releasing the deceased in operation at the Heart of England NHS Foundation Trust – which included Heartlands Hospital, Solihull Hospital and Good Hope Hospital. The process was summarised as follows:

- When an expected natural death happens, the doctors issue a medical note straight away and the bereavement office gets the family to sign a "quick release form".
- Once that form is signed then the body is released to the funeral director before registering the death and obtaining an out of England certificate.
- This practice enables the family to do the religious service and customs in advance while the necessary paperwork is done.
- This practice makes it certainly possible for burial or repatriation on the same day.

It was agreed to share the details with Leeds Teaching Hospitals NHS Trust as an example of good practice and what may be achievable within Leeds. However, it was recognised that that the proposed introduction of Independent Medical Examiners may have an impact on the process.

Discussion

The working group discussed all the information available at the meeting and the main issues highlighted were:

- The progress made by Leeds Teaching Hospitals Trust (LTHT) was seen as a step in the right direction; however it was felt there had been slow progress in relation to Out of Hours Pathology Services.
- It was important for LTHT to continue to ensure its workforce was briefed and understood the issues and the current / future processes for the release of deceased bodies: The speed of the process should not be dependent on individual staff members at LTHT.
- Further consideration and discussions about the availability and payment of non-invasive post mortems was needed.
- It was important for all parties (i.e. LTHT, local councillors, funeral directors and community leaders) to have a common understanding of the issues and the agreed processes. Therefore, joint briefings and communications may prove beneficial.
- There appeared to be potential for some significant learning from the example of working practice at the Heart of England NHS Foundation Trust.
- There also appeared to be the potential for shared learning between the Jewish and Muslim communities, which could be achieved through discussions through Leeds' Faith Forum.

- Despite some of the good progress achieved at LTHT, there remained an issue of providing the necessary documentation when the terminally ill passed away in the community 'out of hours'. It was highlighted that a number of different GP surgeries provided assistance 'Out of Hours', however these tended to be informal / good-will arrangements.
- It was highlighted that this was an issue for primary care and warranted further discussions with the local Clinical Commissioning Groups that had recently assumed responsibility for commissioning primary care services in Leeds.

Conclusion

In summing-up the discussion, the Chair highlighted the following points:

- As reflected by the views of those at the meeting, it should be recognised that progress had been made – however, further work was still required.
- There appeared to be potential for some significant learning from the example of working practice at the Heart of England NHS Foundation Trust.
- The matter and potential impact of 'Independent Medical Examiners' was a significant unknown, that was likely to impact on future processes and working practice.
- There appeared to be some merit in establishing some joint briefing sessions for all interested parties, in order to further improve relationships and embed common understanding around process.
- Matters around 'Out of Hours' pathology and the availability of different pathology services warranted further discussions.
- Issues associated with 'Out of Hours' arrangements in the community / primary care setting were worthy of further discussions.

While it was recognised that further work would be required, it was felt that an interim report would be helpful in both highlighting the progress made to date, while maintaining a focus on the areas where further work may be required.

The Chair thanks all those in attendance for their contributions to the discussion and closed the meeting.

Annex A

DETAILS OF ATTENDANCE

Scrutiny Board Members

- Councillor Peter Gruen – Chair
- Councillor Arif Hussain
- Councillor Ghulam Hussain

Local Councillors

- Councillor Javaid Akhtar
- Councillor Mohammed Iqbal
- Councillor Asghar Khan
- Councillor Kamila Maqsood
- Councillor Mohammed Rafique

Local Funeral Directors / Other attendees

- Mr Younsis
- Dr Khan

Leeds City Council Officers

- Steven Courtney, Principal Scrutiny Adviser

Apologies were received from:

- Mr Hussain (Funeral Director)
- Krystina Kozlowska (Head of Patient Experience) – Leeds Teaching Hospitals NHS Trust
- Shaun Preece (Lead Nurse Patient Experience & Involvement) – Leeds Teaching Hospitals NHS Trust
- Alun Pymer (Deputy Patient, Carer and Public Involvement Manager) – Leeds Teaching Hospitals NHS Trust

Background documents

Draft notes / action points from the previous meeting – 1 February 2016
Position statement from Leeds Teaching Hospitals NHS Trust
Submission from Cllr Iqbal

The Leeds Teaching Hospitals NHS
NHS Trust

THE LEEDS TEACHING HOSPITALS NHS TRUST

POSITION STATEMENT ON BEREAVEMENT POLICIES AND PRACTICE FOR WORKING GROUP FOLLOW UP MEETING ON 21/04/16

20th April 2016

LTHT are extremely keen to provide assurance that issues identified by the Working Group are being given priority and that implementation of the Trust Care after Death and Bereavement Policy, introduced in January 2016, will address many of these issues.

The notes of the meeting chaired by Councillor Peter Gruen on 1st February 2016 identify several key points. This paper aims to address these where possible and identify progress and a plan for moving forward.

1. **Training of medical staff, implementation of the new policy and on-going plans to embed culture change.**

   The key points of the new Trust Care after Death and Bereavement policy for medical staff will now form a mandatory component of induction for Trust medical staff, at both senior and trainee level. Induction comprises of Trust and local components. In Trust areas where care after death is a more significant feature these key points will be emphasised at local induction. Additionally, the Bereavement service provides a vital source of advice and training for junior medical staff and recent extension of hours and improved availability will enable the service to guide trainee medical staff in a more proactive way in the future. We are hopeful these measures will raise awareness of the importance of these issues within the frontline medical staff workforce.

2. **Provision of a Medical Certificate of Cause of Death (MCCD) in a timely way to enable prompt release of the body for families. Providing improved information to local communities on what provision they can expect from the Trust to support early release.**

   Healthwatch Leeds have identified End of Life Care as an area of focus for them in 2016/17. They held a workshop on the 22nd February 2016 to support the identification of workstreams which resulted in recommendations for service providers. One of the recommendations from this was for LTHT to work on delivering a MCCD within 24 hours of death, progressing to 12 hours once this has been achieved.

   The Trust Care after Death and Bereavement policy identifies the need to recognise family cultural requirements and to support early release of the deceased. Processes have been agreed with the Registrar and are outlined in the policy, specifically to support families from a Muslim and Jewish faith background. The processes described have been developed following previous feedback from these faith communities, demonstrating that the Trust has sought to improve reported unsatisfactory experiences. The pathways and processes to support early release have been

operational for some time and are overseen on a day to day basis by Clinical Site Managers within the Trust.

Since the working group meeting on 1st February 2016, a review of available data has been undertaken and has demonstrated that in the last 12 months, LTHT mortuary services have recorded 12 out of hour body releases, 8 of which related to a Muslim death. We do not have access to information however on the number of deaths that occurred out of hours and were not dealt with until the next working day or later. As a result, it has been identified that an improved method of data capture is required to audit time of death, to time MCCD is completed, to time body is released. This will enable the Trust to better challenge practice and seek to make improvements, where appropriate, once this data is understood and is a workstream that is currently being taken forward by the Bereavement team.

The policy also identifies the need for teams to recognise an imminent expected death and to take necessary steps to ensure that should a MCCD be required quickly, appropriate medical staff are available and on site to be able to provide this (a doctor who has seen the patient within the 14 days prior to death). The structured handover that occurs at every change of medical staff shift (usually twice in a 24 hour period) includes a review of deaths that have occurred during the preceding shift. The handover should include discussion about the need for referral to the Coroner, and about the correct cause of death for entry on the MCCD. National guidance on improvement of the accuracy and usefulness of this information now requires discussion with a Consultant. The handover process is designed to ensure these steps are taken and identifies where there may be difficulties locating a doctor who has seen the patient in the 14 days prior to death at the time the cause is agreed for certification. Again, data is important here to establish the extent to which access to appropriate medical staff is a significant problem and the Bereavement team will lead a workstream to better capture this information and advise future direction.

A point of clarity was raised at the last meeting in February 2016, where it was reported Adult and Childrens' services at the Trust operate different practices in relation to release of the deceased and the requirements for documentation. Specifically it was suggested that children have been released from the hospital without the need for the same documentation asked for in adult services. This has since been investigated and the Trust are happy to clarify that document requirements are the same for both adults and children. The Trust would be pleased to be given details of any specific incidents where alternative practices are known to have been followed, as these would be out with Trust procedures.

Representatives from the Trust Bereavement service have made contact with representative members from mosques over the past year in an effort to address community concerns about the service that is offered and to provide assurance that the Trust takes all such concerns seriously. It has been identified however that more work is needed to ensure that this collaborative approach has a wider community reach and the Trust have therefore pledged to make a renewed effort to identify one or two key individuals to work with, who collectively link to all sections of the Muslim faith community. As such, the Trust would be appreciative of any support Councillors could offer to advise who these key contacts would be.

3. Agreeing and delivering service standards to support early release.

As outlined above, Healthwatch have challenged the Trust to ensure delivery of MCCDs within 24 hours on all occasions and the Trust will be working towards this. Additional standards will be informed by the gathering of improved data, also outlined above, which will identify where there is further room for improvement.

In addition, the Patient Experience Team have agreed to work on developing an information resource in collaboration with the Registrar's office, which outlines what families can expect from the Trust to support early release of the deceased. This resource is seen as a key opportunity to support understanding of the processes involved and share information more widely.

4. Providing timely access to Pathologists where post mortem is required and considering the cultural needs of communities where decisions are made about prioritising cases.

Post mortems required by the Coroner are not controlled by the Trust. In undertaking these post mortems, the Trust is acting on behalf of the Coroner and has no authority to act without Coronial agreement. It is generally these post mortems that cause delays and they may not take place until the Trust has received authorisation from the Coroner to proceed. It is not unusual for delays in undertaking a post mortem to be a result of the Trust not having received Coronial authority to proceed.

On other occasions, access to a Pathologist may cause a delay. An example of this would be where post mortem lists are already agreed and underway prior to the Trust receiving Coronial authority to proceed with a post mortem. In these cases, it is not possible to change the list at short notice as significant preparation is required before a post mortem takes place. In such circumstances, post mortems will wait until the following day. Pathologists are a limited resource and have other commitments and therefore the number of post mortems and lists available per week are finite. The Trust does not deliver an out of hours Pathology (post mortem) service. To do so would require the Trust to have significant additional resource, which is not available and agreement from the Coroner to carry out post mortems out of hours. There are no plans in place to deliver this. The Trust would however like to provide assurance that Pathology services, including all Pathologists, are aware of and sensitive to the needs of faith communities when planning post mortem lists and this is taken into consideration alongside Coronial requirements, when lists are agreed.

5. Offering the option of non-invasive post mortem without cost to families.

Non-invasive post mortems are not standard hospital practice, are not as sensitive as a standard post mortem and can only be undertaken with Coronial agreement. It is not unusual for non-invasive post mortems to be inconclusive. When this occurs, a standard post mortem is required to identify cause of death, which lengthens the process for body release. The Trust provides a Pathology service for the delivery of standard post mortems at Coronial request. The Pathologists are funded by the Trust. The use of non-invasive post mortem techniques does not offset the need for the Trust to fund Pathologists. The Trust will not be exploring a position where it considers meeting the costs of non-invasive post mortems.

6. Establish a process for regularly meeting and identifying deaths where families expectations are not met and for making improvements.

As outlined earlier, the Trust would be keen to establish the key relationships it should foster to ensure concerns are managed quickly and lessons are learnt where necessary. This would work most effectively where one or two spokespeople are identified to represent a faith community as a whole. The Trust would welcome this approach and are happy to be advised on who the best contacts would be.

7. Response to recent DH consultation document on the Introduction of Medical Examiners.

This consultation document sets out the proposed procedures to be undertaken when the government introduces Medical Examiners in 2018. The Trust will respond to this consultation, which close in June 2016. Early analysis indicates that the requirement to have confirmation of the cause of death by the Medical Examiner may introduce further delays in the process. We will need to consider these changes as they become clearer, however early indications would suggest these new requirements will negatively influence the objectives of the working group to arrive at a quicker process for release of the deceased.

We hope this provides a clear summary of the main issues identified in the previous meeting and the steps the Trust are taking to address key points. We would be very happy to receive feedback and to further discuss areas that require additional support and clarity.

Ian Wilson
Associate Medical Director

Krystina Kozlowska
Head of Patient Experience

Annex C

Independent Medical Examiners – additional information

Details around the Department of Health's consultation on the introduction of Medical Examiners can be accessed here.

The background to the introduction of Medical Examiners comes from the Harold Shipman Inquiry, which led to proposed reforms of the death certification process and a new system of scrutiny by independent Medical Examiners. Proposals were put forward a couple of years ago following some work in a number of pilot areas, including Sheffield.

The Department of Health commenced its consultation on 10 March 2016, which now runs until 15 June 2016. The consultation focuses on the process for introducing independent medical examiners and the purpose of the consultation is described as:

> ***This consultation seeks views on proposed changes to the death certification process and accompanying draft regulations. These changes include the introduction of independent medical examiners who will confirm cause of all deaths that do not need to be investigated by a coroner.***
>
> ***The consultation also seeks views about making changes to cremation regulations – the current role of the medical referee, who authorises cremations at a crematorium, will be abolished when medical examiners are introduced.***
>
> ***In this consultation the Ministry of Justice seeks views on introducing a statutory duty on registered medical practitioners to report deaths in prescribed circumstances to the coroner for investigation.***

The target audience for the consultation is also set out in the consultation document and is summarised as follows:

- NHS and Social Care Organisations
- Local Government
- Central Government
- General public
- Bereavement Services
- Funeral Industry
- Professional and Regulatory Bodies
- Religious or Faith Groups
- Coroner Services
- Healthcare Professionals
- Registration Services

Steven Courtney
Principal Scrutiny Adviser

27 April 2016

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SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

BEREAVEMENT: POLICIES AND PRACTICE
AT LEEDS TEACHING HOSPITALS NHS TRUST

ADVICE FROM THE DIRECTOR OF PUBLIC HEALTH ON THE DRAFT RECEOMMENDATIONS

Thank you for your request for advice on the recommendations and I offer the following:

Recommendations 1, 2, 3, 4 and 5:

No specific advice or comments.

Recommendation 6:

> **Recommendation 6**
>
> That by 10 June 2016, the responsible Director from Leeds City Council formally responds to the Department of Health consultation on the implementation of Independent Medical Examiners; and in doing so reflects some of the issues highlighted in this report.

The response is likely to be a West Yorkshire response or possibly a Leeds/Bradford response. The consultation has very specific questions and the Scrutiny Board may wish to expand the recommendation to go beyond the consultation and request that the issues raised by Scrutiny are included as part of the future implementation of the Medical Examiners service regardless of the geographic footprint

Recommendation 7:

No specific advice or comments.

I hope these comments are helpful.

Dr Ian Cameron
Director of Public Health

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SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

CANCER WAITING TIMES IN LEEDS

DRAFT SCRUTINY INQUIRY REPORT

Introduction

1. In June 2015, we[1] identified Cancer Waiting Times as a specific area for inquiry during 2015/16. Part of the basis for this decision was based on advice from the Chief Executive of Leeds Teaching Hospitals NHS Trust (LTHT) that some of the national 'referral to treatment' time targets for suspected cancer were being adversely affected by delays within the patient pathway, particularly in relation to referrals to LTHT[2] from outside the Leeds boundary.

2. However, this report is not solely focused on 'waiting times', as aspects of our work have taken us beyond our original scope and considering wider issues around 'outcomes'.

3. We considered and discussed the matters set out in this report at our Board meetings; while some members also had discussions at the West Yorkshire Joint Health Overview and Scrutiny; and some also attended an 'Improving Cancer Outcomes' workshop (arranged and delivered through LTHT and the University of Leeds). This report seeks to cover the breadth of those discussions and details of the meetings are set out in the appendices.

4. We do not intend to repeat all the evidence and input we have considered as part of this inquiry – but again, those details are summarised in the appendices.

5. As ever, we are grateful to all those who have commented and contributed to our discussions: These have helped form our views and influenced this report and its recommendations, which we hope will help shape the future approach to spotting cancer sooner which will help lead to improved outcomes.

Background

6. The NHS Five Year Forward View[3] refers to a continued focus on improving care, treatment and support for everyone diagnosed with cancer. It sets an ambition to improve outcomes across the whole pathway, including:
    - Better prevention;
    - Swifter diagnosis; and
    - Better treatment, care and aftercare.

7. Following the publication of the Five Year Forward View, NHS England established the Independent Cancer Taskforce, which engaged with a range of stakeholders over a six month period, including:
    - Clinicians

[1] Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS)
[2] Leeds Teaching Hospitals NHS Trust (LTHT) is a regional specialist centre for cancer diagnosis and treatment.
[3] Published in October 2014, the intention of the NHS Five Year Forward View is to set out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens in order to promote wellbeing and prevent ill-health.

- Patients
- Charity representatives
- Policy-makers

8. In July 2015, the Cancer Taskforce published its report*, Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020*. The report included over 90 recommendations aimed at organisations across the healthcare system in order to achieve a step change in cancer care across the country.

9. The Cancer Taskforce report aims to guide work on cancer over the coming years and focuses on six key priority areas:

    - Prevention and public health;
    - Early diagnosis;
    - Patient experience;
    - Living with and beyond cancer;
    - Investment in a high-quality, modern service; and
    - Commissioning, accountability and provision.

10. In the summer of 2015, the Office of the Director of Public Health undertook a review of cancer outcomes in Leeds, with a focus on the three Clinical Commissioning Groups (CCGs) in Leeds – namely Leeds North CCG, Leeds West CCG and Leeds South and East CCG. Where possible, the review also sought to compare outcomes across Leeds and against the England average.

Main issues and comments from the Scrutiny Board

11. It is widely recognised that cancer can be a significant cause of anxiety for the public. However, it might be less well known that cancer remains the single greatest cause of death in our population, as well as being both a cause and consequence of health inequalities.

12. At the outset of our inquiry, we were specifically concerned with the waiting times from GP referral to treatment. As mentioned earlier, part of the basis for this decision was following advice from the Chief Executive of Leeds Teaching Hospitals NHS Trust (LTHT) that some of the national 'referral to treatment' time targets for suspected cancer were being adversely affected by delays in referrals to LTHT from outside the Leeds boundary.

13. Given the potential issues, we referred to the matter to the Joint Health Overview and Scrutiny Committee (West Yorkshire), for consideration and heard anecdotally that under performance could also be attributed to issues of capacity at LTHT. As such, it is difficult for us to assess with any certainty the true cause of delays in the referral pathway – although overall, we believe that delays are often likely to be multifaceted. However, given the understandable and significant cause of anxiety that cancer will often bring to members of the public, we believe it is incumbent on the different parts of the NHS and different NHS Trusts to work collaboratively for the benefit of patients and that organisational impacts must be secondary considerations.

14. However, we were heartened to hear during the course of our inquiry that performance against the national targets had improved and that there appeared

to be improved collaboration and communication between different parts of the NHS on a sub-regional (i.e. West Yorkshire) basis.

Recommendation 1

That all local NHS organisations involved in the commissioning and delivery of services for the diagnosis and treatment of cancer continue to work collaboratively for the benefit of patients and that organisational impacts are secondary considerations.

15. We also understand there are arrangements in place to routinely consider performance through a range of different bodies, including the LTHT Cancer Board and the LTHT Contract Management Board (for issues relating to activity, finance or performance). Nonetheless, we are mindful of the significance and importance to the public that the early diagnosis and treatment of cancer have. Therefore, we believe it is important to ensure recent improvements are both embedded and sustainable in the longer-term and that any successor Scrutiny Board should seek to assure itself that performance levels continue to be maintained and improved.

Recommendation 2

That commencing in the new municipal year (2016/17), the Scrutiny Board (Adult Social Services, Public Health, NHS) routinely and regularly considers the key performance indicators associated with the early diagnosis and treatment of cancer.

16. We understand that some of the improvements may be a result of the formal establishment of the West Yorkshire Association of Acute Trusts (WYAAT) – with a key focus of its work being to drive forward a 'model clinical network' that will deliver improved and consistent outcomes for patients by using the latest technology[4]. We see the establishment of the WYAAT as an important and helpful development that is likely to have implications beyond matters associated with the early diagnosis and treatment of cancer. As such, along with the Joint Health Overview and Scrutiny Committee (West Yorkshire), we look forward to receiving further reports on the plans and achievements of the WYAAT.

Recommendation 3

That by December 2016, the Chair of the West Yorkshire Association of Acute Trusts, provides a further report on the achievements to date and future plans of the association.

Prevention, early diagnosis and treatment

17. In order to inform a strategic approach to cancer prevention, early diagnosis and treatment in Leeds, the report from the Director of Public Health that we considered in February 2016, set out the review of cancer intelligence available

[4] As reported to the Joint Health Overview and Scrutiny Committee (West Yorkshire) in December 2015.

to the public health team. The report considered the available evidence under the following areas:

- Risk factors
- Incidence
- Early diagnosis outcomes
- Screening uptake
- Routes to diagnosis
- Stage at diagnosis
- Mortality
- Mortality in all ages
- Mortality in under 75s
- Avoidable Potential Years of Life Lost from Cancer (age under 75)
- Survival

18. The report highlighted the challenges facing Leeds in its approach to the prevention, early diagnosis and treatment of cancer. Issues around the performance of LTHT against the national performance targets for referrals to treatment formed only a part of the matters outlined to us, with some significant matters around health inequality issues across different parts of the City highlighted. Some of the other key issues we feel that have been identified, include:

    - Cancer incidence is generally rising, with a UK incidence modelling study projecting cancers in men and women to increase by 55% and 35%, respectively, between 2007 and 2030.
    - Cancer mortality rates for the under 75s in Leeds are higher than the Yorkshire and Humber and England averages: This being due to higher rates in Leeds South and East CCG and Leeds West CCG.
    - Cancer mortality rates in Leeds are significantly worse than the Yorkshire and Humber and England averages.
    - The higher incidence of prostate cancer in Black men (accounting for over 40% of Black Men's cancer).
    - Cancer screening uptake being lower in more deprived communities, which can worsen health inequalities – highlighted by the differential screening levels for bowel cancer across different CCG areas.
    - Screening uptake for both breast cancer and cervical cancer are currently below the 80% target and falling.
    - Insufficient quality data to present the routes patients use for cancer diagnosis and the stage[5] at which cancers are diagnosed.
    - A mixed picture when considering survival rates across Leeds and comparing these regionally and nationally.

19. The Director of Public Health's report also highlighted a new outcome measure – that of Avoidable Potential Years of Life Lost from Cancer (age under 75). This measure takes account of the age and cause of death. While some of the data used would be suggestive that treatment outcomes in the under 75s are improving, this also highlighted the stark inequalities across areas of the City, particularly in the area of Leeds South and East CCG.

[5] Earlier diagnosis and better planned treatment generally lead to better longer-term outcomes

20. Using the available intelligence to develop the Leeds Cancer Strategy and Improvement Plan is the logical next step. In doing this, we believe one of the challenges will be balancing the need to provide a 'core' or 'standard' offer for all patients from across the City, while recognising and addressing the identified and known aspects of health inequalities across different parts of the Leeds and its communities.

Recommendation 4

That in developing the Leeds Cancer Group due consideration is given to ensuring there is a balance between providing a 'core offer' for all patients from across the City, while recognising and addressing the identified and known aspects of health inequalities across different parts of the Leeds and its communities.

21. Within the report from the Director of Public Health and the available intelligence, it states that this does not cover patient reported outcome measures, measures on the process of care or patient experience of care.

22. As referenced elsewhere in this report, NHS commissioners and providers have a duty to involve the public and patients in developing services. As such, we believe patient experience and any associated data will provide a rich source of intelligence in the development of Leeds Cancer Strategy and improvement plan. As the patient champion and an organisation that aims to present the patient voice, we believe that HealthWatch Leeds could play an important role in helping to capture and report patient experience data and believe further discussions and investigations may be warranted.

Recommendation 5

That by September 2016, the Director of Public Health engages with HealthWatch Leeds to assess the current availability of patient experience data (as it relates to the prevention, early diagnosis and treatment of cancer) and/or the potential future role of HealthWatch Leeds in collating such data.

Leeds Cancer Strategy Group

23. In order to improve cancer outcomes in Leeds, the Director of Public Health's report also made reference to a new Leeds Cancer Strategy Group – setting out the group's Terms of Reference. The Terms of Reference were presented as draft and dated November 2015. The establishment of the Leeds Cancer Strategy Group was also referenced in the report we considered at our November 2015 Scrutiny Board meeting.

24. The Terms of Reference for the Leeds Cancer Strategy Group (LCSG) sets out the group is 'primarily a co-ordinating group', with its outputs feeding into a number of other settings. The LCSG is essentially a partnership group that draws its membership from a range of health and social care partners from across the City, and beyond. These include:

    - The University of Leeds

- Leeds Teaching Hospitals NHS Trust
- Leeds Clinical Commissioning Groups (CCGs)
- Leeds City Council – represented by Public Health and Adult Social Services
- NHS England (Specialist Commissioning)
- West Yorkshire commissioning group (10CC)
- Macmillan

25. However, in the spirit of improving overall involvement and engagement, we question whether or not the public voice is represented through the proposed membership. In addition, given some of the very specific health inequality issues identified with the Director of Public Health's review report, we would also question whether the diverse communities within Leeds are sufficiently represented by the current, proposed membership.

Recommendation 6

That by December 2016, the Chair of the Leeds Cancer Strategy Group reviews its currently proposed membership to ensure this includes:

(a) Appropriate patient and public representation; and,

(b) Appropriate representation to reflect the diverse communities within Leeds, particularly in those areas where specific health inequalities are known to exist.

26. The Terms of Reference for the LCSG also sets out a range of responsibilities for the group, including:

- Ensuring a coordinated plan to deliver the National Cancer Strategy for the population of Leeds and within the LTHT Cancer Centre;
- Defining Leeds' contribution towards National cancer policies through the development of the Leeds Cancer Strategy and plan;
- Ensuring a coordinated response and clarity about responsibilities for delivery of actions agreed by the LCSG;
- Ensuring a focus on cancer inequality reduction and improved outcomes.

27. We welcome the establishment of the LCSG and believe that through partnership working there are opportunities to improve the approach and outcomes for cancer prevention, early diagnosis and treatment in Leeds. We also recognise that through the LTHT Cancer Centre, Leeds also provides services to sub-regional and regional populations: As such, improvements are also likely to impact on a wider Yorkshire and Humber basis. However, what we believe to be less clear are the timescales associated with developing and agreeing an overall Leeds Cancer Strategy and improvement plan; and where these will be presented and agreed.

Recommendation 7

That by July 2016, the Chair of the Leeds Cancer Strategy Group reports back to the Scrutiny Board regarding the timescales associated with developing and agreeing an overall Leeds Cancer Strategy and improvement plan, including details of where these will be presented and agreed.

28. In developing an overall Leeds Cancer Strategy and improvement plan, we would again remind NHS commissioners and other stakeholders of the duty to involve patients and the public, alongside the separate duty and requirement to engage with the Scrutiny Board when considering any proposals to develop and/or changes services in the future. We would also highlight that where any changes are likely to impact on a wider population – such as West Yorkshire – it may also be necessary to engage with the recently established Joint Health Overview and Scrutiny Committee (West Yorkshire), in an appropriate and timely manner.

Recommendation 8

That by July 2016, and as part of the process for developing and agreeing an overall Leeds Cancer Strategy and improvement plan, the Chair of the Leeds Cancer Strategy Group:

(a) Recognises the duty on NHS commissioners and providers to effectively involve and engage patients and the public, setting out plans for public and patient engagement and involvement.

(b) Sets out proposals and timescales for engaging with the appropriate Overview and Scrutiny bodies.

Reaching New Heights: Improving Cancer Outcomes – Spotting Cancer Sooner.

29. As mentioned in our introduction, we are also pleased to report that some members of the Scrutiny Board had the opportunity to be attend and be involved in some of the work being taken forward by the LCSG, through the workshop *Reaching New Heights: Improving Cancer Outcomes – Spotting Cancer Sooner.* The workshop drew together a range of professionals, commissioners, clinicians and patient representatives – both from Leeds and beyond and considered:

- The national context and the national cancer strategy.
- Specifics for Leeds and how these compared nationally.
- An example from Denmark, where changes in the approach and the development of a diagnostics centre had significantly reduced the time taken to provide a definitive diagnosis.

30. Delegates were then engaged in discussions around the challenges and defining 'what good looks like'. We understand the outputs from the session are now being used to inform the strategy for Leeds aimed at improving outcomes for cancer patients. As part of our on-going involvement, we look forward to seeing how this work is used to inform the development of the Leeds Cancer Strategy and improvement plan.

Public Health Grant

31. Our consideration of cancer wait times has included some specific reference to the work around prevention – largely a function of Public Health services. However, through other aspects of our work during the course of the year, we have also considered the general role and pressures on the work of the Council's Public Health teams.

32. Despite a range of national statements of intent about the healthcare system focusing on prevention, over the course of the 2015/16 we have seen central government action to:
    (a) Implement a one-off in-year cut to the local authority public health grants, which had a local impact of around £3M; and,
    (b) Confirm the one-off cut as a longer-term cut to the public health grant.

33. It should also be recognised that cuts to the local public health grant was in addition to the Leeds public health grant being below the target level of funding: With the target level of public health grant being based on the needs assessment used by central government. In our view, the cuts to the local authority public health grant across England have therefore been disproportionate to those local authority arears where that grant is already known to be 'below target' and not sufficient to meet local needs.

34. By the nature of the services provided, public health services focus strongly on prevention of ill-health and health protection. Therefore, it is difficult to understand how any reduction to the public health grant can do anything other than undermine one of the cornerstones of the NHS Five Year Forward View – that of 'Better Prevention'.

35. Concern that a reduction in public health grant might impact negatively and disproportionately on prevention, cancer awareness and early diagnosis work was highlighted in the January 2016 report to the Health and Wellbeing Board – which we also considered in February 2016. We share the concerns about the reduction to the Council's public health grant and expressed our concerns as part of the Department of Health consultation on the in-year cuts earlier in the year.

36. It seems to us that if the need to focus on better prevention is being undermined by reductions to local authority public health grants, the only alternative source of funding is directly through local Clinical Commissioning Groups (CCGs). However, there are already pressures on commissioning budgets and it's likely that the local CCGs will need to make some decisions around the services they will continue to commission and those areas where services might change and/or be decommissioned. We believe the pressure on the preventative work undertaken through public health might, at least in the shorter-term, create further budget pressures elsewhere in the local health and social care economy.

Recommendation 9

That by September 2016, Leeds Clinical Commissioning Groups provide a joint report on the commissioning priorities and intentions for 2016/17, specifically identifying any preventative services and the associated budget allocations, identified within the overall priorities.

37. It is hoped these comments and recommendations further enhance the current focus on the prevention, early diagnosis and treatment of cancer in Leeds and we look forward to a formal response to our comments and recommendations by July 2016.

Cllr Peter Gruen, Chair
On behalf of the Scrutiny Board (Adult Social Services, Public Health, NHS)

May 2016

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SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

CANCER WAITING TIMES IN LEEDS

ADVICE FROM THE DIRECTOR OF PUBLIC HEALTH ON THE DRAFT RECEOMMENDATIONS

Thank you for your request for advice on the recommendations and I offer the following:

Recommendation 1:

Recommendation 1

That all local NHS organisations involved in the commissioning and delivery of services for the diagnosis and treatment of cancer continue to work collaboratively for the benefit of patients and that organisational impacts are secondary considerations.

The Scrutiny Board may wish to consider whether to broaden this recommendation beyond local NHS organisations as there is a West Yorkshire dimension plus the Council's own public health department contribution.

Recommendation 2:

Recommendation 2

That commencing in the new municipal year (2016/17), the Scrutiny Board (Adult Social Services, Public Health, NHS) routinely and regularly considers the key performance indicators associated with the early diagnosis and treatment of cancer.

Recommendation 7

That by July 2016, the Chair of the Leeds Cancer Strategy Group reports back to the Scrutiny Board regarding the timescales associated with developing and agreeing an overall Leeds Cancer Strategy and improvement plan, including details of where these will be presented and agreed.

This reads as though the Scrutiny Board is taking on routine performance monitoring function for a few indicators on one single subject. Would the Board prefer to have assurance on progress as part of Recommendation 7?

Recommendation 3 and 4:

No specific advice or comments.

Recommendation 5:

Recommendation 5

That by September 2016, the Director of Public Health engages with HealthWatch Leeds to assess the current availability of patient experience data (as it relates to the prevention, early diagnosis and treatment of cancer) and/or the potential future role of HealthWatch Leeds in collating such data.

The Scrutiny Board could ask Healthwatch directly rather than via the Director of Public Health.

Recommendation 6, 7, and 8:

No specific advice or comments.

Recommendation 9:

Recommendation 9

That by September 2016, Leeds Clinical Commissioning Groups provide a joint report on the commissioning priorities and intentions for 2016/17, specifically identifying any preventative services and the associated budget allocations, identified within the overall priorities.

I understand the wider concerns expressed about the Public Health grant reduction in para 31 onwards. The recommendation as written reflects those wider concerns about future prevention activity per se. If though this recommendation is to be set in the context of cancer being the subject of the Inquiry report, I would suggest replacing “preventative services” with “cancer prevention and early intervention initiatives” which both gives a greater focus and a stronger alignment with the work of the Leeds Strategy Group. I would suggest that this would be more helpful for the Scrutiny Board in September 2016.

I hope these comments are helpful.

Dr Ian Cameron
Director of Public Health