HEALTH OVERVIEW AND SCRUTINY COMMITTEE – WEDNESDAY 17 JANUARY 2024

QUESTIONS SUBMITTED UNDER STANDING ORDER 7(3) and (5)

The following questions are to be put to the Chairman of the Health Overview and Scrutiny Committee.

Questions by Mrs. Amanda Hack CC:

I understand that the winter is the busiest time across the Hospitals, but I have been hearing more and more on the doorsteps, through friends and colleagues about the way within which older people are managed throughout Leicestershire Hospital Trust.

Leicestershire has 8 Community Hospital facilities, to look after people once they no longer need treatment at the main hospitals. I am hearing that many patients are being moved from a city centre location that they feel they can access to community hospitals that they do not.

1. **Does the transition into the community hospital location include considerations about the patients home location and the ability to assist the transition back to home?**

2. **What proportion of patients are moved into community hospitals that are actually further away from their home and support network than the 3 main hospitals.**

3. **How are families, that are important for the recovery and care of the patient post discharge kept informed of decisions and considered as part of the decision making process?** I heard just last week of a patient that was supposed to be transferred to Hinckley (a location that was fairly easy for the family to access) to Market Harborough and the family was only informed when the carer called to check the ward they had been moved to that the patient was not where they expected. Why would this happen? And why was the family not informed in advance?

Within the acute hospitals, it has been raised with me that a family agreed on a care path for their family member. Only for that care path to change, but

also that their family member was being moved from one acute hospital to another.

4. How are families communicated with and what is the expected level of communication when alternative care decision have been made but also when a patient has been moved?

5. What is the standard of care provided on keeping the patient mobile whilst in hospital?

Reply by the Chairman:

I have received the following response from the NHS:

“Leicestershire has eight Community Hospital facilities, to look after people once they no longer need treatment at the main hospitals. I am hearing that many patients are being moved from a city centre location that they feel they can access to community hospitals that they do not.

1. Does the transition into the community hospital location include considerations about the patients home location and the ability to assist the transition back to home?

Due to the demands on the LLR system, including both UHL acute settings and EMAS provision for patients requiring assistance in the community - it is vital for LPT community beds to be fully utilised at the earliest opportunity for patient recovery and rehabilitation.

Therefore, for patients transferring from UHL to LPT wards, consideration is given by UHL to the patient’s home location, but the final decision is often dependent on where capacity is available.

We appreciate that for some families, the location of community hospitals is more difficult than for others. If a family/patient is experiencing difficulties we do our best to assist them by – where possible - moving the patient to a more convenient location. The decision is often based on the individual needs of each patient, and moving them is not always possible for every patient.

2. What proportion of patients are moved into community hospitals that are actually further away from their home and support network than the three main hospitals?

We are unable to provide figures on the proportion of patients who are moved to a community hospital that is further away from their home than one of the acute hospital locations.

3. How are families, that are important for the recovery and care of the patient post discharge kept informed of decisions and considered as

part of the decision making process? I heard just last week of a patient that was supposed to be transferred to Hinckley (a location that was fairly easy for the family to access) to Market Harborough and the family was only informed when the carer called to check the ward they had been moved to that the patient was not where they expected. Why would this happen? And why was the family not informed in advance?

It is good practice to ensure that both patients and families are aware of discharge plans. As the referring hospital, UHL promotes early discharge conversations with patients and families from when they are admitted to hospital. There is a “supporting your discharge” booklet which explains the process – which is currently under review due to the changes where the beds are provided.

Families may not be informed in advance if the patient has 'capacity' and is able to inform their own relatives of plans, or if there are difficulties in getting through to the nominated support person.

There have been a few occasions where a bed has been allocated but the patient may not end up being discharged – this could be because they become medically unwell. This can lead to another available bed in another part of LLR being reallocated to that patient. Again, the referring hospital will be informed and be required to update/communicate with the patient/family.

4. Within the acute hospitals, it has been raised with me that a family agreed on a care path for their family member. Only for that care path to change, but also that their family member was being moved from one acute hospital to another. How are families communicated with and what is the expected level of communication when alternative care decision have been made but also when a patient has been moved?

Due to the current emergency pressures facing UHL, additional wards have been opened at the LGH site to provide care to patients whilst they await their discharge destination. These areas provide care that reflects their changing and improving needs and allows the LRI site to care for patients arriving through the Emergency department who are in the acute phase of their admission.

The nurse or a member of the multi-disciplinary team caring for the patient will involve the patient and update them in decisions about their care. If the patient is unable to advise their relatives, then the most appropriate member of the team would. This may not occur overnight - it is dependant on the change to the care pathway so communication would be at the soonest appropriate time.

5. What is the standard of care provided on keeping the patient mobile whilst in hospital?

Some patients will experience a loss in their physical condition whilst in hospital. We are currently promoting early movement with patients across our wards in recognition of this, and to help prepare them to get home earlier. We are at looking at how we communicate this out to our patient and families and are promoting DrEaMing (drinking, eating and mobilising) after surgery. We have recently employed a number of ward-based therapists and meaningful activity coordinators who are working with patients earlier in their journey to promote early ambulation."