Agenda Item 1

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 17 January 2024.

PRESENT

Mr. J. Morgan CC (in the Chair)

Mr. N. D. Bannister CC	Mr. R. Hills CC
Mr. M. H. Charlesworth CC	Ms. Betty Newton CC
Mr. D. Harrison CC	Mrs B. Seaton CC

In attendance

Mrs. L. Richardson CC – Cabinet Lead Member for Health
David Williams, Group Director of Strategy & Partnerships, Leicestershire Partnership NHS Trust (agenda item 50 refers).

41. Minutes of the previous meeting.

The minutes of the meeting held on 1 November 2023 were taken as read, confirmed and signed.

42. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 34.

43. Questions asked by members.

The Chief Executive reported that the following questions had been received under Standing Order 7(3) and 7(5):

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.”

Supplementary question from Mrs Amanda Hack CC

Mrs Hack noted the important role the families of patients played to keep patients out of hospital and she asked how much communication the hospitals had with the families (particularly where the patient had dementia) and what was being done to prevent those cases where families were not informed of changes to the patient's care.

Reply by Chairman

The Chairman agreed that a further written answer would be provided to Mrs Hack after the meeting.

44. Urgent items.

There were no urgent items for consideration.

45. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Mrs. M. E. Newton CC and Mrs. B. Seaton CC both declared non-registerable interests in all agenda items as they had close relatives that worked for the NHS.

46. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

47. Presentation of Petitions.

The Chief Executive reported that no petitions had been received under Standing Order 35.

48. Public Health Medium Term Financial Strategy 2024/25 to 2027/28.

The Committee considered a joint report of the Director of Public Health and the Director of Corporate Resources which provided information on the proposed 2024/25 to 2027/28 Medium Term Financial Strategy (MTFS) as it related to Public Health. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Chairman welcomed Mrs. L. Richardson CC, Cabinet Lead Member for Health, to the meeting for this item.

Arising from discussions the following points were noted:

(i) The Public Health Department had 118 members of staff and this figure included the inhouse services that the department provided such as the Quit Ready scheme. Members commended the work that had been carried out by Public Health with that level of staffing.

(ii) Members welcomed the role the Public Health department played in adding value to the work of other County Council departments and the NHS. It was emphasised that more needed to be done to publicise this.

(iii) Members noted the large amount of savings that were projected for the MTFS period 2024/25 to 2027/28 and queried whether these numbers were achievable. In response it was explained that most of those savings had already been achieved for example with the difficult decisions that had been made around the homelessness support service, sport and physical activity programmes and school food.

(iv) A member queried whether Public Health was spending the correct proportion of its budget on tackling obesity. In response the Director of Public Health acknowledged that more needed to be done in this area particularly as the percentage of adults aged 16 and over in Leicestershire that were meeting the '5 a day' recommendations was not as good as hoped. However, there were budget constraints and core costs such as the health visiting service had to be met. The weight management service received more Public Health funding than general obesity campaigns. On the whole the Director of Public Health felt that the balance was the correct one under the circumstances.

(v) In 2023 a procurement process had taken place for the Integrated Sexual Health Service. Whilst there had been expressions of interest at the soft market testing stage, no providers had bid at the final stage. Therefore a decision had been made to extent the contract of the current provider for a further 12 months.

RESOLVED:

(a) That the report and information now provided be noted;

(b) That the comments now made be forwarded to the Scrutiny Commission for consideration at its meeting on 29 January 2024.

49. Vaping and Young People.

The Committee considered a report of the Director of Public Health regarding work that was being carried out relating to vaping and young people in Leicestershire. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

Arising from discussions the following points were noted:

(i) Vaping was originally intended to be a safer alternative to smoking and a way to stop people smoking. However, it had now become a problem in itself and had been linked to some lung complaints. The full extent of the impact of vaping on the body was not yet known. Vapes contained nicotine which was addictive. Members were of the view that all this information needed to be better communicated to the public, particularly to parents of children that were vaping.

(ii) In November 2022 a survey was conducted to gain feedback on the use and prevalence of E-cigarettes amongst young people in Leicestershire. There were 1100 respondents, and it was found that 25% of children used vapes. Some of the children vaping had previously smoked tobacco whereas others had started vaping without any previous smoking history. Members welcomed the numbers that responded to the survey but were extremely concerned about the findings.

(iii) Leicestershire Trading Standards reported receiving a total of 84 complaints regarding vapes, 63 relating to children under the age of 18 years old being sold

vapes. Members raised serious concerns that selling vapes to children was illegal but giving them out for free was not.

(iv) Vapes were attractive to young people because the packaging used bright colours and there were different flavours. Action needed to be taken to change the way vapes were being marketed.

(v) The Government was intending to create the first smokefree generation by passing legislation to prevent children turning 14 from ever being legally sold tobacco products. Members emphasised that these proposals also needed to cover vaping. There was no national direction on what support should be available to help young people stop vaping. Members felt that tackling the problem of vaping required a more strategic approach supported by legislation.

(vi) It was suggested that vaping could be made available by prescription only, which would ensure that only the appropriate people were able to vape.

(vii) Between October and December 2023 the Government had carried out a consultation regarding creating a smokefree generation and tackling youth vaping. The proposals to tackle the problem of vaping included restricting the number of different flavours, requiring vendors to have a licence, and imposing a duty on the sale of vapes. Both the Public Health and Trading Standards departments at Leicestershire County Council had responded to the consultation.

(viii) Funding had been allocated to Local Authority Stop Smoking services through the Smokefree Generation Programme, resulting in an additional estimated £716,000 being allocated to Leicestershire Public Health from 2024/25 to 2028/29 in line with the grant conditions. Leicestershire Trading Standards were also being allocated some of the Smokefree Generation Programme funds in order to tackle illicit products arriving in the county at East Midlands Airport.

(ix) Were schools and parents to have any information or concerns about the underage sales of vapes and tobacco they should make contact with Trading Standards by reporting via the anonymous helpline.

(x) In the past Leicestershire Trading Standards carried out test purchasing in stores using underage children to see if the shops would sell products that they should not to people of that age. However, Trading Standards no longer had the funding and resources to carry out test purchasing. Therefore, Trading Standards now had to take a more reactive approach and only visit premises where intelligence had been received that the shop was making illegal sales. In those cases, Trading Standards would give a warning to the establishment, and if there was sufficient evidence take enforcement action. Prosecutions were now being carried out much more quickly by way of a fixed penalty notice rather than requiring the person to attend court.

(xi) Adults were provided with vapes as part of the smoking cessation service but they were given the information to enable them to make an informed decision and required to provide identification. These people were then monitored.

RESOLVED:

(a) That the contents of the report be noted with concern;

(b) That the Chairman be authorised to write to all Leicestershire MPs on behalf of the Committee raising concerns about vaping and asking for help with regards enacting legislation to tackle the problem.

50. LLR LeDeR Annual Report 2022/23.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided a summary of the Leicester, Leicestershire and Rutland LeDeR Annual Report 2022/23 and key actions from learning for all partners. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed to the meeting for this item David Williams, Group Director of Strategy & Partnerships, LPT.

Arising from discussions the following points were noted:

(i) One of the key learning points that had arisen related to widespread misuse of the Mental Capacity Act where decisions were being made by care providers around medical interventions. On occasions it was being assumed that a patient did not have the capacity to consent when in fact they did or vice versa. This was a particular problem with regards decisions being made on whether to resuscitate a patient. All services and care providers needed to review their practices to ensure compliance with the legislation.

(ii) A total of 83 deaths were notified to the LeDeR Programme during 2022/23 of which 70% of the patients were male. The disparity towards males was likely because learning disabilities were more easily identifiable in males due to the way the disability manifested itself in males. There was likely to be more females with learning disabilities that were not diagnosed.

(iii) Whilst people with learning disabilities did not undergo a different type of medical screening to the rest of the population, they did have medical checks more frequently.

(iv) Work was taking place with GP Practices to better understand why patients with learning disabilities did not attend appointments.

RESOLVED:

(a) That the contents of the report be noted;

(b) That officers be requested to provide a further report to the Committee regarding the LeDeR Programme at a future date.

51. Noting the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee.

The Committee considered the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee, a copy of which marked 'Agenda Item 11', is filed with these minutes.

RESOLVED:

That the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee be noted.

52. Date of next meeting.

RESOLVED:

That the next meeting of the Committee be held on Wednesday 6 March 2023 at 2.00pm.

2.00 - 3.38 pm CHAIRMAN
17 January 2024