# Minutes

of the Meeting of the

# Health Overview & Scrutiny Panel

# Thursday, 26th October 2017

held at the Town Hall, Weston-super-Mare, Somerset.

Meeting Commenced: 1.30 pm Meeting Concluded: 3:40 pm

**Councillors:**

P Roz Willis (Chairman)
P Ruth Jacobs (Vice-Chairman)

| | |
|---|---|
| A Michael Bell | Sarah Codling |
| P Andy Cole | P Bob Garner |
| P Ann Harley | P David Hitchins |
| P Reyna Knight | P Ian Parker |
| A Liz Wells | |

P: Present
A: Apologies for absence submitted

**Also in attendance:** Councillors Jill Iles, Dawn Payne, Tom Leimdorfer

**Health Colleagues:** Mary Backhouse (North Somerset CCG), Colin Bradbury (BNSSG CCG), Peter Collins (Weston Area Health Trust), Rosie Edgerley (Weston Area Health Trust), Rachel Goddard (Weston Area Health Trust), Phil Walmsley (Weston Area Health Trust)

**Officers in attendance:** Shelia Smith (Director, People and Communities), Leo Taylor (Corporate Services), Julia Parkes (Corporate Services)

**HEA 10 Declarations of Interest by Members**

None

**HEA 11 Public Discussion (Standing Order SSO 9)** (agenda item 2)

None

**HEA 12 Minutes of the Meeting held on 26 June 2017** (agenda item 4)

**Resolved:** that the minutes of the meeting be approved as a correct record.

**HEA 13** **Healthy Weston Programme update** (agenda item 5)

Colin Bradbury, BNSSB CCG Area Director (North Somerset) presented the report outlining the Healthy Weston Programme, a vision for delivering health and care services in Weston-super-Mare, Worle, Winscombe and the surrounding villages of the south rurals. The programme set out a proposed way forward for organising and delivering health and care services in a way that better met the needs of local people, and ensured services met national quality standards and were affordable.

Phil Walmsley Director of Operations (WAHT), Mary Backhouse, Clinical Chair (NSCCG) and Peter Collins, Medical Director, (WAHT) supported Colin Bradbury in responding to the following comments and queries from Members:-

*There was a public perception that the focus of this work was on the Weston-super-Mare area whilst the towns and villages north in the rest of North Somerset were being left out* – This process was to a large extent about addressing financial and service delivery challenges. The priority challenges in North Somerset were focussed in Weston-super-Mare and it made sense therefore to start out by developing a service model addressing identified need in the Weston area. This approach could then be rolled out throughout the rest of the Bristol, North Somerset and South Gloucestershire (BNSSG) footprint.

*Concern that acute services were being "downgraded"* – This was fundamentally not the case. Acute services would need to be retained in Weston since there was insufficient corresponding capacity elsewhere. There were, however, significant benefits from better matching resource and capacity with need throughout the BNSSG footprint and whilst some elements of Weston's health and care services might be provided elsewhere it was also likely that other elements currently provided in other locations would be brought into Weston.

*Concern about the future of the maternity unit at Weston General* - Significant numbers were not choosing to have their babies at the Weston midwife-led maternity unit, possibly due to a perception that the lack of obstetrics and neonatal services at the hospital impacted on safety. Whilst no decision had yet been reached about the future of the service, there were issues around its sustainability. Members noted, however, that a campaign was underway to encourage greater use of the unit by improving awareness of the service.

*Were there any problems arising from the collaborative arrangements with UBH? Could the collaboration develop further?* - both organisations were committed to the current partnership arrangements, meeting regularly and sharing some staff. Further options for partnership working were being considered but it was emphasised that both organisations remained separate corporate entities.

*If the Emergency Department reopens, would this result in the closure of other services and, if so, which ones?* - there was a need to think about this

the other way round, starting with what was needed rather than focussing on what had been in place. Due to resourcing issues, the Trust had had no choice about the temporary closure: the challenge now was to consider all options going forward, including potentially more sustainable and effective ways of providing emergency cover; and to have honest and potentially difficult conversations about these issues.

*What can Members do to support commissioners and providers to have greater clarity about how change will be delivered?* Members could best help by helping to focus the debate on the wider picture rather than on details: the Emergency Department, for instance, accounted for a small fraction of the whole system in activity terms.

*With the emphasis in the document on frail and older patients, should other patient categories feel left out?* – No one should feel left out, this process was about considering the matrix of health and care services holistically and focussing integrated delivery where/when it was most needed.

*The proposed more holistic and locality driven approach to delivering health and care services was generally understood and supported by Members but there was concern that this could be undermined by the current (payment by results) system leading to resources being centralised around hospitals rather than towards community based services and the prevention agenda. -* The critical issue was how get the best value from the available allocation. It was acknowledged that there were perverse incentives within the system that could prevent money from flowing to where it was needed eg following the patient and freeing up providers. New approaches to addressing these issues were being explored such as capitated funding models (eg as pioneered in Valencia, Spain).

*Would there be additional rehabilitation capacity in the new model?* – Rehabilitation at centres like Draycott was expensive and, in general, resources would be more effectively directed by providing these services at home and in the community.

*If the proposed Care Campus and Community Campus were to be delivered, what difference would people see when arriving at the site?* – In the short term, one of the main changes would be the “front door”, where there would be a bigger range of entrances (and places to go). In the longer term, the Trust was considering ambitious plans to develop available land on site whereby the fully functional hospital could be attached to a range of facilities including for instance supported living, rehabilitation, other community organisation facilities and student accommodation.

Members were introduced to two new appointments to the Trust, Chief Registrar and General Manger Surgical Directorate and heard about their roles and how they contributed to improving services at the hospital.

The Chairman, on behalf of Members, thanked the CCG and Trust for their interesting contributions and it was:-

**Concluded**:-

(1) that the report be received and that Members comments and queries be forwarded to the Trust and CCG in the form of the minutes; and

(2) that consideration be given to submitting a formal Panel response to the Health Weston commissioning context for North Somerset document and consultation.

**HEA 14** **The Panel's Work Plan** (agenda item 6)

Members considered the Work Plan which had been updated to reflect the outcome of discussions from the Previous Panel meeting and other Panel activity.

**Concluded:** that the Work Plan be updated, picking up actions and discussion outcomes from the present meeting.

_____

Chairman

_____